Title V Five Year Needs Assessment Training
Part 2: The Nuts and Bolts on Using Data

Thursday, May 1, 2014

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AMCHP
• All lines have been muted. To un-mute your line please dial*6

• Asking a Question
  – You can type your questions into the chat box (shown right)
  – Raise your hand. Using the icon at the top of your screen (example shown right)

• Lastly active participation will make sure today’s presentation a success!
Quick Overview
How to Use Web Technology

• Downloading Files

1. Name: Participant Homework.docx Size: 1019 KB
2. Upload File
3. Save to My Computer
4. Click to Download
Using Data in the Needs Assessment Process

AMCHP Webinar: May 1, 2014
Caroline Stampfel, MPH
Senior Epidemiologist, AMCHP
Learning Objectives

By the end of this webinar, participants will be able to:

• Give examples of effective uses of qualitative and quantitative data sources for the needs assessment
• Begin to identify possible frameworks to organize needs assessment data
• Develop next steps/strategies for using data in their own Title V five year needs assessment

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Some Big Ideas

Things to keep in mind as we share this information

• There is no single "right" way to do a needs assessment
• It is never too late (or too early) to use data
• Engage internal and external stakeholders early and often
• MCH 3.0 and needs assessment
NEEDS ASSESSMENT GOALS:

1. Set Priorities
2. Set Performance Measures
Needs Assessment Data

Quantitative Data: HOW MANY & WHO

• Prevalence of health conditions
• Disparities (race/ethnicity, education, eligibility levels, age)
• Trends

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Qualitative Data: WHY & WHAT TO DO

• Context for health of populations and capacity to meet needs
• Clues to why disparities exist (and maybe what to do about them)
• Events or environment that drive trends
Needs Assessment Data

Quantitative Data

Vital Records
Hospitalizations
State-level surveys
  - PRAMS, BRFSS, YRBS
Information collected by partner agencies
National data
  - NSCH, NS-CSHCN

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Qualitative Data

Open-ended survey responses
Health jurisdiction surveys
Focus groups
Key informant interviews
# Needs Assessment Data

<table>
<thead>
<tr>
<th><strong>Quantitative Data</strong></th>
<th><strong>Qualitative Data</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strengths:</strong></td>
<td><strong>Strengths:</strong></td>
</tr>
<tr>
<td>• Core public health data</td>
<td>• Primary data</td>
</tr>
<tr>
<td>• Readily explained and understood</td>
<td>• Fills in the blanks</td>
</tr>
<tr>
<td>• Availability, completeness, quality are known</td>
<td>• Audience relates to experiences and stories</td>
</tr>
<tr>
<td><strong>Limitations:</strong></td>
<td><strong>Limitations:</strong></td>
</tr>
<tr>
<td>• Collected for other purposes</td>
<td>• Labor intensive collection and analysis</td>
</tr>
<tr>
<td>• What are we missing?</td>
<td>• Additional costs</td>
</tr>
</tbody>
</table>

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Examining Selected Indicators of the Health of MCH Populations

• Preconception Health Indicators
   http://www.cste.org/?PreconIndicators

• Life Course Indicators
   www.amchp.org/lifecourseindicators

• Existing Title V Indicators / Measures
   https://mchdata.hrsa.gov/tvisreports/MeasurementData/MeasurementDataMenu.aspx

• Healthy People 2020 MCH Topics and Objectives

• Chronic Disease Indicators
   http://www.cdc.gov/nccdphp/cdi/overview.htm
Low on Data Capacity?

• AMCHP Data Resource Portal
  

• MCH Navigator
  
  http://www.mchnavigator.org/
Key Informants and Focus Groups

- What impacted the health of families and children over the last 5 years?
- Current most pressing MCH needs
- Populations or subpopulations in greatest need
- Opportunities for improvement of the MCH public health system
- Priorities for the Title V Agency
- Key emerging issues (next 3-5 years)
Putting it all together

• Create summaries
• Interpret the data
• Ask questions
  • What’s missing?
  • How does this compare to what you know from your perspective?
  • What surprised you?
  • Where does this take us?
State in Action: Alaska
Title V Needs Assessment
Alaska

AMCHP Webinar
May 1, 2014

by
Yvonne Goldsmith
Alaska Division of Public Health
Section of Women’s, Children’s & Family Health
MCH Epidemiology Unit
Overview of Alaska’s Needs Assessment Process

1. Organized internal leadership structure
2. Reviewed Department’s existing plans
3. Conducted outreach
4. Analyzed data
5. Produced written materials
6. Solicited input
7. Developed priorities
Reviewed Existing Plans

- **Alaska Division of Public Health Strategic Plan**
  - By 2015, 75% of 19 to 35 month olds will be fully immunized for the series 4:3:1:3:3:1:4 (goal target)

- **Department of Health 2014 Priorities**
  - Objective: Decrease substance abuse and dependency

- **Alaska Oral Health Plan 2012-2016**
  - Priority Recommendation: Preventing and/or decreasing the use of tobacco products

- **The Burden of Overweight & Obesity in Alaska – 2010**
  - Obesity and its contributors are linked to poor academic performance among Alaska high school youth.
Conducted Outreach

SWOT Analysis -
- Strengths - positive attributes that help the mission
- Weaknesses - negative attributes that hinder the mission
- Opportunities - external conditions favorable to the program's mission
- Threats - external conditions that are unfavorable to the mission
Produced Written Materials

Fact Sheets
http://dhss.alaska.gov/dph/wcfh/Pages/mchepi/mchfacts/na.aspx

Life Course Narratives

Data Books
http://dhss.alaska.gov/dph/wcfh/Pages/mchepi/mchdatabook/default.aspx
World Café Model

Think of the women, children and families we work with or advocate for. How might we improve their health over their entire lifespan?

Think of maternal and child health populations in Alaska that experience health inequities. What can we do so that this population would have an equal chance at attaining good health?

How might we work together to make the most of our resources, to promote a healthier maternal and child population?

Prioritization Method: voted on the themes with stickers
Developed Priorities

- Used qualitative analysis of stakeholder input to understand strengths, weaknesses, opportunities & strengths
- Used quantitative analysis to understand seriousness, urgency, disparities & capacity
- Used existing Title V and other state-wide priorities as the foundation
- Justified each change

Alaska Title V FY 2010 Needs Assessment
http://dhss.alaska.gov/dph/wcfh/Documents/titlev/assets/AK_TitleV_NA.pdf
State in Action: Virginia
Percentage of women having a live birth who had **no** health care coverage during the month prior to pregnancy

25% of women did not have health insurance before they got pregnant.
Percentage of women who currently smoke everyday or some days

<table>
<thead>
<tr>
<th>Year</th>
<th>Women, 18-44</th>
<th>Women, 45+</th>
</tr>
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<tbody>
<tr>
<td>2003</td>
<td>20</td>
<td>16</td>
</tr>
<tr>
<td>2004</td>
<td>24</td>
<td>15</td>
</tr>
<tr>
<td>2005</td>
<td>23</td>
<td>16</td>
</tr>
<tr>
<td>2006</td>
<td>24</td>
<td>14</td>
</tr>
<tr>
<td>2007</td>
<td>19</td>
<td>15</td>
</tr>
<tr>
<td>2008</td>
<td>19</td>
<td>13</td>
</tr>
</tbody>
</table>
Duration of breastfeeding (%) by any and exclusive breastfeeding

- Healthy People 2010 goal: 75%

- PRAMS
- VA PRAMS

<table>
<thead>
<tr>
<th>Time</th>
<th>Any breastfeeding</th>
<th>Exclusively breastfeeding</th>
<th>Healthy People 2010 goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth</td>
<td>80%</td>
<td>21%</td>
<td>75%</td>
</tr>
<tr>
<td>2 months</td>
<td>55%</td>
<td>16%</td>
<td>40%</td>
</tr>
<tr>
<td>3 months</td>
<td>53%</td>
<td>8%</td>
<td>50%</td>
</tr>
<tr>
<td>4 months</td>
<td>50%</td>
<td>3%</td>
<td>35%</td>
</tr>
<tr>
<td>5 months</td>
<td>35%</td>
<td>1%</td>
<td>20%</td>
</tr>
<tr>
<td>6 months</td>
<td>20%</td>
<td>0%</td>
<td>17%</td>
</tr>
</tbody>
</table>
Regional Prevalence of Cavities and Needed Care, 2009

- Eastern
  - % Untreated cavities: 14
  - % Need early or urgent care: 15
- Central
  - % Untreated cavities: 14
  - % Need early or urgent care: 11
- Southwest
  - % Untreated cavities: 25
  - % Need early or urgent care: 22
- Northern
  - % Untreated cavities: 12
  - % Need early or urgent care: 11
- Northwest
  - % Untreated cavities: 14
  - % Need early or urgent care: 11
Bullying

• In the 08-09 school year, there were 6,595 incidents of bullying reported to DOE
  – 2,422 in elementary schools
  – 3,799 in middle and high schools

• Of students who participated in the Virginia Youth Survey 2009:
  – 43.9% strongly agreed or agreed that harassment and bullying by other students is a problem at their school
  – 16.7% had ever been electronically bullied, such as through e-mail, chat rooms, instant messaging, Web sites, or text messaging, during the past 12 months
  – 22% had ever been bullied on school property during the past 12 months
MCHB Core Outcome #2
43.9% of children with special health care needs age 0 to 18 receive coordinated, ongoing, comprehensive care within a medical home.
TITLE V NEEDS ASSESSMENT PROFILE
CHILDREN (1 TO 18 YEARS)

Overview

Early Childhood (1-5 years)
- More parents identified child’s health as fair/poor
- Number of children with high blood lead levels dropping
- Fair/poor tooth conditions increased among minorities
- Virginia’s unmet needs compared to the Nation’s

Middle Childhood (6-11 years)
- Shift in insurance coverage from private insurance to public insurance
- More physical activity, less sedentary living
- Decrease in single mother households, yet one race/ethnicity comprises a large majority

Adolescence (12-18 years)
- Rising rates of teenage pregnancy among Hispanics
- Increased use of alcohol, tobacco, and other drugs with age
- State obesity rates higher than the National average

Three Leading Causes of Death in 2007

<table>
<thead>
<tr>
<th>Early Childhood</th>
<th>Middle Childhood</th>
<th>Adolescence</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Unintentional drowning and submersion</td>
<td>1. Motor vehicle crashes</td>
<td>1. Motor vehicle crashes</td>
</tr>
<tr>
<td>2. Congenital anomalies</td>
<td>2. Exposure to smoke, fire, and flames</td>
<td>2. Homicide by firearm</td>
</tr>
<tr>
<td>3. Motor vehicle crashes</td>
<td>3. Malignant neoplasms</td>
<td>3. Suicide by firearm or other means</td>
</tr>
</tbody>
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In 2006, Virginia was ranked among the top 10 states with the lowest child death rates (16 deaths per 100,000 children aged 1-14).

Three Leading Ambulatory Sensitive Hospitalizations in 2007

<table>
<thead>
<tr>
<th>Early Childhood</th>
<th>Middle Childhood</th>
<th>Adolescence</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Dehydration</td>
<td>1. Bacterial pneumonia</td>
<td>1. Dehydration</td>
</tr>
<tr>
<td>2. Bacterial pneumonia</td>
<td>2. Dehydration</td>
<td>2. Diabetes</td>
</tr>
</tbody>
</table>

Hospitalizations Covered Mostly by Public Insurance: In 2007, the leading payer for ambulatory sensitive hospitalizations for all age groups was government/public insurance, including Medicare and Medicaid. About one-third of the payers for each condition is private insurance.

Poverty: Between 2003 and 2007, the percentage of children under 18 years old at the 130% poverty level increased from 24.9% to 25.5% with the percentage of children under age 5 being consistently higher than the percentage of children aged 5-17.

Various Indicators on the Parent’s Perception of the Child’s Health Status:
From the 2007 National Survey of Children’s Health, 59.88% of adolescents aged 12-17 were regarded as having excellent health. But what about the other 40% with not-so-excellent health? In a logistic analysis, those indicators that are considered to be more at-risk were compared to reference groups. Having an unmet health need, race/ethnicity, and not being able to talk to the child well were found to be significant indicators. For race/ethnicity, those classified as “other” were 2 times more likely to not have excellent health than white, non-Hispanics. Parents who could not or talk about things that matter with their child very well were 4 times more likely to have children with less than excellent health than those who could. Other indicators examined were poverty level, mother’s highest education, family structure, and extras-curricular participation, which were all not significant.

All data reported is from the 2003 and 2007 National Survey of Children’s Health, unless otherwise denoted by the following symbols:
- Virginia Youth Tobacco Survey
- Virginia Community Youth Survey
- Virginia Youth Health and Behavioral Survey
- Virginia Department of Health
- Virginia Department of Human Services
- Virginia Department of Education
- U.S. Census 2000-2007
- *2006 Kids Count Data Book

Graphic: Percentage of Hospitalizations Covered by Public Insurance 2007

Legend:
- Early Childhood
- Middle Childhood
- Adolescence

(Percentage of hospitalizations covered by public insurance in 2007)
State in Action: Rhode Island
MCH Needs Assessment Process: Rhode Island

Samara Viner-Brown, MS
Rhode Island Department of Health
AMCHP Webinar
May 1, 2014
Key Components

- Surveillance
- Parent and Community Input
- Interagency Collaboration
Framework

- Access and Service Utilization
- Health Behaviors and Risks
- Well-Being and Health Status
- Life Course Perspective
  - Health Disparities
    - Racial and Ethnic
    - Geographic
  - Social and Environmental Determinants of Health
  - Health Equity
Document Structure

• Organized by MCH population group across the life course
  – Pregnant women and mothers
  – Infants
  – Children (early and middle childhood)
  – Adolescents
  – Children with special health care needs
  – Women across the life course

• Topics organized by priorities identified through Needs Assessment process
SURVEILLANCE
Surveillance Data

- Time Trends
- Prevalence and Incidence
- Outcomes
- Demographics
  - Age, race/ethnicity, city/town, insurance, marital status, income, etc.
- Risk factors and impact (e.g., tobacco use and birth outcomes)
Data Sources: Quantitative Examples

- Vital Records
- KIDSNET (Integrated Child Health Information System)
- Program Data
- Surveys
- Hospital Discharge and Emergency Visit Data
- Other Agencies (community, state, national)
Data Sources: Qualitative Examples

- Focus Groups
- Key Informant Interviews
- Forums/Community Meetings
- Other Agencies (community, state, national)
Data and Trends
(Over 60 topics/issues)

- **Preconception and Pregnancy**
  - Family Planning, fertility rates, prenatal care, tobacco use, c-section

- **Infants**
  - Infant mortality, low birth weight, preterm, multiple, breastfeeding, perinatal depression

- **Children (well-being and health status)**
  - Poverty, child care, medical home, immunizations, healthy housing, lead poisoning, hospitalizations, asthma, obesity, food insecurity, oral health, homelessness, domestic violence, abuse/neglect, mental/behavioral health, foster care, school based health, deaths

- **Adolescents**
  - Medical home, risk behaviors, violence, mental/behavioral health, obesity, STDs, contraception, pregnancy, out-of-home placement, homelessness, academic performance, school attendance, graduation, juvenile referrals to court, deaths

- **Children with Special Health Care Needs**
  - Medical home, family impact, birth defects, newborn developmental risk screening, early intervention, home visiting, special education, autism, TBI, transition

- **Women through the Life Course**
  - Cancer screening, health practices/behaviors, chronic diseases, STDs, mental health
EXAMPLES
Low Birth Weight by City/Town
Rhode Island, 2004-2008
Low Birth Weight*
Rhode Island, 1991-2012*

*Notes: Low Birth Weight = <2,500 grams; Very Low Birth Weight = <1,500 grams; 2011-2012 data are provisional
Source: Maternal and Child Health Database, Rhode Island Department of Health
Low Birth Weight by Race/Ethnicity
Rhode Island, 2008-2012

Source: Maternal and Child Health Database, Rhode Island Department of Health
Births to Mothers with Public Insurance as a Percentage of Total Births by Providence Neighborhoods
COMMUNITY INPUT
Engaging Stakeholders

• Community Input Meeting
  – Created population specific data briefs or epidemiologic profiles for each priority group
  – Sent to meeting participants in advance

• Community Forums
  – Multiple forums throughout the state
  – Range of settings
  – Attended council meetings, children’s advocacy organizations, state and local committees, etc.

• Public Hearing
INTERAGENCY COLLABORATION
Partnerships and Collaborations

- State agency partnerships
- Interagency agreements
- Legislative Initiatives
- Coordination with Other Health Department Programs
- Collaboration with Private, Community-Based Organizations and Associations
- Coordination with Other Federal Grant Programs
- Advisory Committees
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Thank You!

Questions or Comments?