

MCH/CSHCN Director Webcast

Meeting State MCH Needs:

A Discussion of Changing State Priorities

May 8, 2008

CHRIS DEGRAW: Good afternoon and welcome to the webcast coming to you from Rockville, Maryland. This is the latest in our series of monthly interactive internet webcasts. I'm Chris DeGraw from the division of research training and education. We have a very interesting program for you today but before I introduce Pam Eason who will be introducing today's speaker, I would like to review some technical information about the webcast.

Please note that in response to your suggestions, the speaker's power point presentation is now available on the MCH website so you can download the slides from the webcast. Slides will appear in the central window and should advance automatically. The slide changes are synchronized with the speaker's speech. You may need to adjust the timing to match the audio by using the slide delay control at the top of the messaging window.

We encourage you to ask the speaker questions at any time during the presentation. Simply type your question in the white message window on the right of the interface, click on question for speaker and hit send. Please include your name and organization so we know where you're participating from. The questions will be given to the speaker. If we don't have the opportunity to respond to all questions during the webcast, we will email you afterwards. Again, we encourage you to submit questions at any time during the webcast.

On the left of the interface is the video window. You can adjust the volume of the audio using the volume control slider which you can access by clicking on the loud speaker icon. Those of you who selected accessibility features when you registered will see text captioning under the video window.

At the end of the broadcast, the interface will close automatically and you'll have the opportunity to fill out an online evaluation. Please take a couple of minutes to do so. Your responses will help us plan future broadcasts in this series and improve our technical support. At this point I would like to turn things over to Pam from MCHB who will introduce our program and the speaker.

PAM EASON: Good afternoon. I'm Pam Eason and I work for the division of state and community health at the maternal and child health bureau. I am happy that you joined us today for our webcast. This webcast will provide highlights from the recent review of the 2005 state maternal and child health programs needs assessment. I'm also delighted to introduce our speaker for this presentation, Dr. Victoria Freeman. Dr. Freeman is a research fellow at the Sheps Center at the University of North Carolina at Chapel Hill. Dr. Freeman has worked with the federal maternal and child health bureau and studies the best practices for specific national conformance measures and the detailed evaluation of the performance measures with recommendation for change. She currently provides agency trends and priority needs and performance measures. Dr. Freeman previously worked as a nurse at the university of New Mexico hospital. She received her doctorate and public health in maternal and child health from the University of North Carolina. I present to you Dr. Victoria Freeman.

VICTORIA FREEMAN: Thank you, Pam. I appreciate it. I'm happy to be here today to talk about the work that we've been doing for MCHB over the past year or so. I need to say that the needs assessments that the block grantee do are very impressive and we want to learn as much as we can from them. That's what we've been doing. Our work has been focused on using the needs assessments to examine trends and priority needs for block grantees regarding the care for women, children and families. This is work that I've done with Priscilla who is a long time researcher that many of you may know and who incidentally has just retired. But her support has been invaluable as has been the feedback from our project officer Pam Eason as well as others, including Cory Palmer and Michelle and Cassie Lauver. I also want to mention that we have prepared a report on our work for MCHB and this will be mailed in the next few days to each state director and each children and social health care needs director. The report is also available on our website and available on the MCHB website and I'll give you the addresses at the end of the presentation.

Next slide, please. This was essentially a review in three parts. I'm going to give you a brief overview and not all of the boring details. This is what we did. We focused on the documents by the states and jurisdictions. For simplicity, when I talk about the states in this presentation, I mean the states and the jurisdiction. In part one, we looked at each state's priority needs statements to see how they've changed from 2000 needs assessment to the 2005 needs assessment. This was looking at your needs assessment statements only. Those that are listed on form 14. Number two, they need to list no more than 10 needs but realize that many other needs are identified. We want to review those other needs by state block grantees that maybe did not make their final 10. So -- and then finally, we -- so that might tell us a little bit what to expect in the future. Timely we looked at state performance measures and how they relate to priority needs. What general topics

and areas are covered and what data are used and I will briefly talk about this part of the study but spend more time talking about the first two parts, particularly the first one. Back to the first question, how about MCH priority changes need from 2000 to 2005? Brief review of the review process, this is what we did. We looked at the exact wording of state priority needs. We did not look at program detail background information, accomplishments to date, et cetera, how specifically or generally you worded your priority needs told us what those needs were. What needed addressed. That was one thing we characterized it on. For example, the need might be to review obesity and overweight or to improve access to health care. Who is the target population? Is it all MCH population? Mothers? Children? Some were simply stated, such as reducing intentional and unintentional injuries. Sometimes there was a subpopulation stated. For example, reducing obesity and overweight among school age children. So some needs were very broad, improved the health of MCH population, and that essentially can include just about any activity. Or they could be very specific, reduce motor vehicle crash mortality among 15 to 19-year-olds. What was important for this review and what we really focused on was being consistent. We used the same rules to look at 2000 and 2005. So hopefully they were consistent over time and that's what we were interested in was looking at the trends over time. Characterizing change. I'm going to focus on the change in issues and problems. If you look at the full report, in the appendix there's a summary of how needs have changed in addition, for specific M.C.H. Population. But we're just going to talk about how they changed in terms of issues and problems. Now, this looks pretty obvious. Some areas were a new focus for many states. Some areas have remained constant in the number of states that have this as a priority need and finally there are areas that fewer states listed. We might say that there were -- these were areas of decrease but that's not accurate. I doubt any states have any reduced need. They just replaced the needs with other needs. It's important to acknowledge there were many things at play, including to

name a few, the form 14 restriction, how one measures success, some states are likely to pay more attention to this and how they craft their needs statement says. State priorities, sometimes larger state health department priorities often guide the various fees and also the agency philosophy. Sometimes M.C.H. agencies deliberately write very broad statements that reflect their overall goals and philosophy.

Next slide. So let's jump into these needs. What were the areas of increase in focus? First of all, the first thing that stood out to us was that obesity and overweight is a priority need was a big increase, a big number of states increased their focus on this area. To be counted in this category, the need has to say something about reducing weight or obesity or promoting healthy weight. And so you can see, three times as many states in 2005 had the priority need to address obesity and overweight and that's more than half of all states. Closely related to this was the priority needs to excess our promote nutrition and physical exercise. Again, twice as many states indicated a priority need in this area. And then there were a few states that said they would reduce obesity and overweight by increasing nutrition and physical exercise so they got credit in both categories. I'll come back to this in a little bit and show you a map as well. Other new areas included mental health and mental health care. It was important because sometimes priority need was worded to improve mental health and sometimes it was worded to improve access to mental health care. We lumped those two together in this category. Again, twice as many states had this as a priority need in 2000 and added in 2005. It's another area that I'll come back to and show you a map of area. Fourth area was medical home and care coordination. Again, 11 more states in 2005 had this as a priority need than had it in 2000. This is a need that's often associated with children with social health care needs and indeed, many of these needs focused on that population but in 2000 there were a few more states that talked about medical home, care coordination for other population that are among the M.C.H.

target group. Some areas that were constant or had no change at all, there were four areas that stood out. It's important to note that these are important issues for many states, even though the number of states hasn't changed. Sometimes even more states identified the needs. Health improvement and access to care, 38 states in 2005. That's basically what M.C.H. is all about. It's not unusual. This is a very broad category that in this state where the wording could make a lot of difference. It could improve health or improve access to care. It was just as common to see goals stated either way. But in this category, we also saw a lot of mention of primary care or preventive health care. But not specific subcategories of care such as in the next group, oral health. Oral health and oral health care is another big area for M.C.H. agencies and priority needs. It's obviously important and has been for many states. When I was in school for my public health degree, we didn't talk much about oral health but that's changed and the state and federal M.C.H. recognized the importance of oral health.

Next slide. Two more areas that were mentioned by almost half of all states in terms of priority needs were pregnancy outcomes such as a long standing focus of MCH. and includes many aspects of healthy pregnancy, including reducing low birth weight and improving pregnancy spacing and also disparity reduction, another important area for many states and likely more states than are listed here and their efforts than are listed here. You had to talk about disparity reduction for us to count you in this group. This included disparities of all kinds, such as disparities in outcomes and for minority populations and disadvantaged population. Here is say slightly different twist on the change in focus. This is a new focus on an old issue. Prenatal care provides a nice example of how M.C.H. needs have evolved. A number of states with priority needs to improve access to prenatal care or received prenatal care has not essentially changed over the two years. But what has changed is the number of states with the priority need to

include preconceptional or interconceptional care. It's quadrupled since then and I'll come back to this topic a little later on. Then there were the categories of needs that were -- we are calling that were replaced. This is purely based on the number of states with these needs and the change from 2000 to 2005. But you can see there's still a big focus for many state M.C.H. agencies. I doubt any state has completely reduced all of their injury problems and no longer have a problem with substance abuse but what they have done is replaced their priority needs or they have incorporated it into another, more broadly stated but not specifically stated priority need. It could be that they were just dropped but I think that's unlikely. An example would be a focus on healthy lifestyle the second part of the study and what I've just talked about is part one and specifically in the second part, we, M.C.H., asked to look at what needs might have been just discussed by M.C.H. grantees in their needs assessment documents but they didn't put on their list. To see if this might help M.C.H.B. anticipate what's on the horizon, the emerging issues. We know that there are lots of other areas that might have been included there.

So the next slide, this is -- once again, we had to have a systematic way to look at documents and this involves a little more comprehensive review of documents. I'll tell you a little bit about what we did to do this. We didn't look at all states. So instead we took a semi random sample. We took two states from each region and added one more for balance. We wanted to make sure they had jurisdiction represented and make sure the various demographics were covered. We read the needs assessment documents to see how states spelled out the problems that were examined. For example, by state group or expert panel and whether their lists were created that were ranked or otherwise listed all of the problems that were identified and discussed by the state. About 2/3 of the states we looked at actually did have preliminary lists from which their final priority needs were

derived. If no lists were provided, we scanned the text for references to, for example, something that might say this need was discussed but not included for this reason.

You probably can't read this and that's OK but the point is, this is a list from California. I was able to extract from their needs document four different lists and their reference by the page. The first one is a list of problems as ranked by local jurisdictions. The second is a list of priorities ranked by state participants. The third list is a list of priorities ranked by children with special health care needs and then finally is the list of California's 10 priority needs. So we could look across all of these lists and see what ended up on the final list and what didn't. In addition to looking for clues about what needs were not included, we wanted to know why they were not. There was not a lot of information in the state priority and state needs assessment documents about why needs were not included. But there was some. This is, of course, partly a function of the guidance for the needs assessment and the sheer complexity and everything else included, it may have been the last thing the states were thinking about but the addition of this kind of reasoning does make a more comprehensive document and one that is easier for us, at least as researchers to follow exactly what's happening in the states. And more importantly, I think it would be helpful in terms of helping states document their process and MCHB help make state needs. For example, developing programs for technical assistance.

But anyway, there were three things that were mentioned as reasons for not including needs by state in their final priority needs. One was that the need was already a state performance measure or a national performance measure. The state may have identified the need for oral health care but felt it was covered so they didn't list it. A second reason was that states said that another organization has responsibility. For example, they may not have listed a priority addressing the need for -- to improve immunization rates because

there was an immunization division responsible for it. Similarly reduction of child mortality may be addressed by a review board so it was not included. And the final reason was that it was too broad and needed a statewide effort and we saw this in terms of asthma, also in terms of health ability of the whole state department, not just MCH so that was another reason the state did not put some needs on their needs assessment documents. Or on their list of priority needs. Excuse me. There were a few categories of unlisted needs that did stand out. Are these a sign of things to come? That's a good question. One was insurance, even though there is a national performance measure for insurance, some states did spend time talking about the need for insurance, they need to improve insurance for children coverage for children and also the relationship between insurance and access to care and health. The second area that we saw that listed needs were areas related to child care and parenting support. States acknowledged the needs of families to help themselves healthy that child care was included by some states as well as health care consultant in child care but this was a need that was often discussed but did not end up on priority needs. But then the third area was basic needs. For housing, transportation and education. These are needs that we recognized as being important for health that may be out of the purview of the M.C.H. Department or may have called for interagency collaboration. I think it's a credit to the states when they are doing their needs assessments that they are looking broadly at the problems that face families. There were other categories of needs that were not included but were just as likely to have been included by other states. Oral health, it was included by a lot of states but not by some states. Mental health, injury, pregnancy and maternal health, substance abuse, morbidity and mortality. As I said before, why needs are not included is not always obvious. It could be for the needs listed, it could be there's a national performance level that covers it. This is a good time to talk a little bit, to say a few words about the needs for children with special health care needs. This is an important group and why their needs show up in this

group as unlisted needs is important to explore. Many of the needs assessment documents that we review showed a different process that states used or a separate process to examine the needs of children with special health care needs. First of all, a typical state is divided into several groups that focus on the needs of children, the mothers and infants, mothers with special health care needs and x number of needs, usually two or three, needs would come from each group. It was also typical that children with special health care needs need a group, may not have followed the same process as the rest of the group. Not that it was a better or worse process. It was just different. So frequently the five or six aspects of care for children with special health care needs that were identified as needs, for example, medical home, satisfaction with care, transition care, were listed but only two or three can make the final list, leaving the rest as unlisted.

Next slide. The third part that we did was looking at how states are measuring their success in meeting their priority needs and I'm only going to touch on this briefly because this is another place to get more information from our report.

These are examples and I chose these states because of how clearly in their documents they linked their priority needs with their performance measures. This was not always the case for some states but Alabama, for example, did a great job and this is how -- an example of how a state has somewhat a broadly worded priority need but multiple ways of measuring success and meeting that need that included both national performance measures and state performance measures.

The next slide? I believe it's Indiana. Exactly. Indiana provides a good example of using a proxy measure to measure success in meeting a priority need. Their target of population is very broad as you can see for these two needs but they used measures, proxy measures

from the populations that they observed. So to decrease obesity in Indiana, to reduce obesity in Indiana, they're looking at reducing overweight in the MCH population.

Then the third example comes from Pennsylvania where they have a priority need that is very specific. To reduce motor vehicle crash mortality in teens associated with alcohol involvement. They have a very specific performance measure to measure success in this case.

Generally the topics of state performance measures mimic pretty much the priority needs that we saw among the -- all of the states. Looking generally at the problem for which states have developed state performance measures, this list is in descending order and includes only those topics for which one half or more of states had a performance measure. What I want to point out here are the two in orange. You can see that many of the, quote, new priority needs back to my slide from about 10 slides ago, are on this list. Obesity and overweight and nutrition and exercise. And you can see a little farther down the list that many states now have a mental health performance measure that goes along with their increase in identifying mental health as a priority need.

The next slide is some of the sources of data for measuring progress. I'll talk about this a little bit just briefly but there's more detail in our report. I'll tell you how to get it at the end. States are using many national data sets many of which provide comparable data across many states. While both the states and the bureau do comparisons and also have a lot of longitudinal data. Some are listed here such as file records, such as BRFSS. It's a testament to the states and the capacity the states have developed over the past few years to collect their own data because many states are using their own data, data that they're doing for special surveys, through programs in the schools to collect data, to do

state performance measures, to look at success in their programs. 38% of the state performance measures that we looked at use unique state data and only two states do not use some form of their own state data.

Next slide. So let's, for the next few minutes, go back to some of the new topics, some of the things we talked about earlier.

And on the next slide, you'll see some of the new ones. Obesity and overweight and nutrition and physical exercise and on the next slide you can see a map.

I'm looking at a television set and hope the map is a little more clear for you all looking at a computer recall obesity and overweight or nutrition and exercise really increased from 2000 to 2005. The states shaded in gray have a priority need to address obesity and overweight and that includes two of the jurisdictions. And states with stripes have one for nutrition and physical exercise. Some states talk about both. North Dakota and Nebraska, Wisconsin, Virginia. So combined that's 41 of 59 states and jurisdictions have a priority need to address obesity and overweight and/or nutrition and physical exercise. For a very specific topic, that's a lot of states.

The next slide, again, this is, you know, twice as many states or even more. The needs statements are very specifically and narrowly worded. Most people, most states have worded their priority needs statement as to reduce obesity among children and teens or among adults, occasionally to promote healthy weight but these are generally very, very specifically worded needs which makes it a little bit easier to measure. Everyone is reporting on the new national performance measure to reduce B.M.I. so that's one way states are measuring success and they're also using state performance measures that

use YRBS for teens, BRFSS for women. A lot of states are doing surveys in the schools so there's a lot of different ways. This will make it very interesting to see how successful people are but also hopefully there are enough people using the same data source so we can look at some trends over time and some comparisons among states.

The next slide is promoting nutrition and physical exercise. The fewer states with the priority need to improve nutrition and physical exercise and their approach as opposed to obesity and overweight is much more broad with a focus on many populations, including developing a program to promote nutrition and physical exercise. Probably the majority, 90% of priority needs are worded in terms of the agency's ability and to develop programs to promote nutrition and exercise. Occasionally, very rarely, they talk about specific guidelines such as promoting 30 minutes of exercise or five servings of fruits and vegetables, the kinds of things we talk about in terms of specifics. Similarly, though, you have very broadly worded measures like this, it's much more difficult to develop performance measures and more likely states will have to rely on proxy measures.

The next slide is mental health. Again, there was twice as many states and the next slide is a map, again, of the states with the mental health priority in 2005. This is either to improve mental health or to improve access to mental health care. The states are indicated here in gray. I want to say specifically, and this is also in the report, that we did not include suicide, child abuse or domestic violence here unless it was framed in the context of mental health. And by and large, it was not. Most states have talked about suicide, child abuse, domestic violence, talked about it in terms of injuries prevention. We would have counted it in injury prevention. We did not count your state here if you talked about reducing suicide unless you said something about improving mental health care. Even if we had added suicide and it would have added only one more state here. We were

focusing on the use of the terms mental health. A little bit about the details of mental health priority needs. A lot of priority needs for mental health involve changes to the health care infrastructure to improve the services. There was recognition that this area may require a lot of system change. When states did talk about specific mental health problems, it was most likely in terms of perinatal depression. It may be difficult to measure success and proxy measures may be needed and probably developed by the states. I'm going to end -- I'm almost done here. I'm going to end with a couple more maps that we found to be interesting. First is a map of states with prenatal care as a priority need in 2000 and in 2005. States with prenatal care has stripes on them and 2005 are gray. A number of states remained virtually the same from 2000 to 2005 but the states themselves changed. The most notable exception were four of the jurisdictions, consistently identified this as a need but only two states did.

The next slide is a map of care. Many states added it as a priority in 2005 and note that the gray states. We defined preconceptional and interconceptional care fairly strictly. If you talk about well woman care, improving assets to care for women, we did not count that. That would fall into another category. This is where we talked about prenatal vitamins, about folic acid, pregnancy spacing, that's what you had to have to get counted in this category. We asked, maybe you might ask, I think, MCHB might be interested, aren't states moving from a priority, focusing on prenatal care to a priority of pre and interconceptional care? We did another map, it was a very busy map that was hard to read to look at that and basically the answer is no. The 31 states would be a prenatal care or preconceptional care and in either time period, there was only one that went from prenatal care to interconceptional care. That's about the extent of my presentation in a nutshell. I'm happy to share this with you. I'm anxious to take questions. If you want more information, you can contact me at victoria.freeman@unc.edu. We will be mailing this

report, hopefully probably the first of next week so anybody who is an M.C.H. director or health needs director will be getting a report and as promised, you can download it from our website at Sheps Center.unc.edu. www.mchta-project.com, you can find it under resources. So I am happy to answer questions.

>> Thank you, Victoria, for the wonderful presentation. And now we'll see if we have any questions from the audience.

>> OK. Just a reminder, we encourage you to ask questions at this time. Simply type your question in the white message window on the right of the interface and select question for speaker from the drop down menu and hit send. We have several questions already. The first is, could you elaborate on the stadium agency infrastructure needs and how these changed between 2000 and 2005?

>> Yeah. This was a very interesting section for us because so many of the priority needs, you know, there were quite a few, where we look at the target population and they really were targeted toward the state M.C.H. agency and improving the interagency collaboration or whatever. And there were changes. I think the biggest change was that in 2000 there was a big focus on developing data systems for problem planning and for other purposes. There were 32 states that had that as a priority need in 2000 but only 17 in 2005. What we saw a lot of now was developing a system to care or the ability to integrate services or to promote collaboration in terms of working with other agencies. Improving coordination among health care plans, primary physicians and the pediatrician centers was an example of one that's in our report. Establish collaborative relationships at the state and local level so it's this sort of thing. I think the biggest change was probably to

see the states moving from a focus on data and data collection which I think has been accomplished in a lot of areas.

>> Thank you. The next question, you provided a nice discussion of the changes and identified priority needs between 2000 and 2005. Could you also comment on the priorities identified by the greatest number of states in 2005?

>> Combined, if you combined obesity and overweight and nutrition and exercise, that's probably the biggest area. Especially the biggest very specific area. It was -- everybody, you know, is focusing on that area now and it's certainly there's been lots of national attention. You can hardly turn on the news without hearing that discussion of the problem with obesity and overweight. The other areas are areas that don't change very often and those are access to care and improvement in health and they're very broad and very general. But that is kind of what M.C.H. is all about in terms of improving health. The other areas include -- let's see. Mental health, there was a fairly big area, oral health and also injury reduction. So even though injury reduction, you know, fell somewhat from before, it's still more than half of the states are talking about reduction of injuries. Sometimes specifically talking about intentional injury, about domestic violence, suicide and homicide and talking about unintentional injury.

>> OK. Thank you. Next question, did you do any analysis on looking at investment of block grant resources to new priority needs?

>> I did not. It would be interesting to look at. It would look interesting to look at to the extent it's been the needs assessment document. But that's not something we looked at.

>> Thank you. The next question, in extracting information from the needs assessment documents, are there some tips you can provide for states on how to best present their needs assessment activities and findings?

>> If I could say anything, it's like use more tables. Use more graphics. You know, I'm coming at this from the perspective of a researcher who wants -- is trying to see the road map of where you came from in your process and the process is very well described. I'm not saying there's not a lot of really, really valuable information there. But I think if there would be one thing that would help MCHB and also help states in terms of documentation of their process and their road map of where they're going is some sort of a table that says these were our priority needs before. This is where we stand. This is how we're going to continue this or this is why we are not continuing this and this is being replaced by something else. So that would be the one thing I would do. Generally I think that -- I mean, they're just really, really valuable. Some states are much more detailed than others but -- and I know it's a learning process and also states are somewhat confined by the circumstances. I think what I've heard from states, though, is that a lot of states are starting this process now way in advance and will be able to get a lot more done in their needs assessment. But the use of tables, the use of summaries, of where we've been and where we're going is -- I think would be really valuable.

>> OK. Next question, were there states that combined the priority MCH needs and MCH capacity assessment for developing action plan and policy?

>> I'm not sure I quite understand that. You mean they took their old priorities -- well, if that's the question, definitely there were -- there was reframing of priorities that took old priorities and combined them into more broad statements. That was -- you know, we saw

that quite a bit where before a state may have listed very specific priorities but in 2005 as they moved through their evolution of their needs assessment process and they're setting a priority need, they talked much more broadly in terms of system change, in terms of looking at the whole population and improving care whereas other states were just as likely to go from very broad statements to very specific statements. So, you see both and I think that has to do with the philosophy of the state and basically how they write their mission statements and how they direct their day-to-day work in terms of keeping their goals ahead of them and in front of them in terms of working toward their goals. I don't know if that answered the question exactly. But certainly there were needs that were combined.

>> OK. Thank you. This next one I think you've touched on a bit in previous questions but how can we make our needs assessments more clear so everybody understands the needs we have identified in our state?

>> Right -- write them all down. The lists. Having lists even though you may know the list and you may have talked about the list a lot but actually having the list in the document, it was really helpful. You know, MCHB recognizes, I recognize, anybody in this area recognizes that you can't do everything and you're not going to have everything there so just putting on the list doesn't mean that you're committed or obligated to address this. But having the things there and then having some sort of a -- even if it's a bulleted summary at the end saying -- or as part of your table saying this is a great problem, we want to do something about this, we will be working with this agency to develop this but it is not on our priority list right now.

>> Great. Thank you. How important is it to link priorities to state performance measures?

>> Well, I think it's very important. If you're asking me if it's important to link them, absolutely because you have to be able to measure success. And many of your -- much of the ways that you measure success is using state performance measures, although outcome measures also work in that regard and also national performance measures. In terms of would it make reviewing these documents easier, it definitely would and a lot of states did not do that. So it would be up to me to say, well, let's see. This address this needs that deals with obesity and they have this performance measure that looks like it could go with it or it may be a proxy. It's better if you tell me what you're going to measure or what the state performance measure is to measure success and meeting a priority need. I think probably most states are doing that but it's not always obvious from the documents.

>> And finally, the last question that we have, is there a parallel between state needs assessments and helping people 20/20 objectives?

>> Sometimes. I didn't look at this in detail but definitely states did discuss a 2020, 2010 objectives in the discussion of their needs assessment so that's another -- you know, that's another great length, another great -- you know, I hate to use the word justification but an explanation of why or why not you included a priority need, especially if it's healthy people 2010 need or if it's a priority of your state health department. And I did see that a number of times, that M.C.H. is part of the state health department and if the state health department has a list of mission statement and goals and objectives that sometimes drives what happens in MCH.

>> Can you provide any examples of states that are -- that did a particularly good needs assessment that other states might look to for some assistance?

>> I found California's needs assessment to be really comprehensive and easy to follow and include a lot of the things that I was looking at in terms of my needs as a researcher. Keep in mind that there were specific things that I was looking for so if you had them, I was really impressed. I liked your needs assessment. But I thought overall, California was very impressive. I think that one of the other ones that I really liked was Ohio. Ohio's was very comprehensive and had the kinds of information that I needed or that I thought -- I'm looking for -- I'm looking to be walked through the process in very explicit steps, you know, with a lot of bullets and subheadings and now they're going to do this. It's like telling a story and it's easier to read the more white space, the more bullets, the more subheadings that you have. Some of them are very long and very comprehensive but just somehow it seems the way you format it helps.

>> Great. Thank you very much. We would like to thank Dr. Freeman for her presentation and thank our colleagues in the division of state and community health for organizing this webcast. I want to thank you also, our audience, very much for participating in our monthly MCH webcast. Also we would like to thank our contractor at the University of Illinois for making this technology work. Today's webcast as if all of our webcasts will be archived and available within a couple of days on the website, www.mchcom.com. We would like to make these webcasts as responsive to your information needs as possible. If you have suggestions for topics that you would like addressed on future webcasts or have comments in general, email them to us at [info @ mchcom.com](mailto:info@mchcom.com). Thank you and we look forward to your participation again next month.