AMCHP 2007 ANNUAL CONFERENCE

HEALTHY COMMUNITIES

March 3rd to 7th, 2007

MCHB/Division of State and Community Health Block Grant Training – Providing Data to Tell the MCH Story

JAN FLEMING: Well, thank you. And I'm not leaving the agency just to be leaving the agency. I'm ready to retire in July. So, I'm wrapping things up. I'm very happy to be here, and I'm really pleased that we are part of this panel. We took a very unusual approach to our needs assessment this time, and it's really paying off for us. So I'm very anxious to share that with you. So just to get started, here we are in Washington State. And maybe I should say, before then, you have a handout of the PowerPoint, and attached to it are two documents. One, this kind of a short description of our priority setting, another that looks like this. Some of you may not have it, that lists the priorities and then an example of an issue brief that I'll talk about. This is all on our Website, very nicely described, and you can get it there too.

So here we are in Washington, and I'm going to talk just a little bit about how we decided to approach our needs assessment process, the conceptual framework. I'll talk about our leadership team, how we use stakeholders, use of logic models as a tool to get us to be thinking about outcomes, and then the development of

issue briefs as concise documents about each of our priorities. And then I will talk a little bit about how it's working for us and some take-home messages.

Let me just explain very briefly what our office looks like. We're an office of about 84 FTEs in the division of community and family health. So our office is the Office of Maternal and Child Health in a larger division. And I have six primary sections. One focuses on maternal and infant health, one focuses on children with special needs, one on child and adolescent health, one on immunizations and health promotion for immunizations, and a registry. Another on genetic services, including newborn hearing screening, but not newborn screening. That's in another part of our department. And then finally, a nicely growing units on MCH assessment. And we have a budget in contracts managers. So those six sections, plus the budget and contracts manager each have a manager, and that's our core management team.

Some of the sections are large enough that they have secondary level supervisors. They join us in our meetings, and we call that group together the extended management team. So it's the extended management team that was our leadership team for this effort.

We've always had a team approach to the way we do our work, whether it's section by section or cross sections, cross division, cross department. It's a very collaborative way of working. So, we approach this needs assessment process in

the same way. Each of the sections in MCH has multiple stakeholder groups, and they have regular meetings with them. And this time, instead of pulling from those stakeholder groups and others and bringing people into another meeting, we decided to use the existing stakeholder meetings that we have throughout the year to get their input and involve them in our needs assessment process. We prepared them ahead of time, said, “Remember the last needs assessment?” “Oh yes.” “Here's how we're going to get started and here's how will engage you.” So they had a sense of what was going to happen. What we wanted this time around was a really comprehensive and integrated approach. Our needs assessment in 2000 was enlightening to me and to others in that many people were saying, "Well, if you're talking about care coordination for children with special healthcare needs, pregnant women also need that." And over the five-year period, that notion kind of grew over time, that what one part of the MCH population might need, probably is true for another piece of the MCH population. So we wanted to try that approach.

We also wanted a strength-based approach versus a deficit approach. And I remember the day this came up, and the manager of our Child and Adolescent Health Section said, "Why can't we just flip it? Why can't we just work on what it takes to have a healthy child or a healthy pregnant women, rather than, what's wrong with them and focusing on what's the deficit?” And I know that that notion came from the youth development framework that they're using in their sections. So, it was like, well, okay, we could try that. The other thing we wanted was, the

needs assessment to be part of ongoing strategic planning. Not all of the work in our office is funded by the Block Grant. And so we wanted this to work for all of the MCH work, not just be an assignment for our Block Grant. And then finally, we wanted to have some clear and simple documents that use data that could describe what we do at the state level and what our role is.

I have to say, we didn't know what it was going to look like when we were talking about this. The leadership team agreed, we need to own this, and we need to drive this. But in the way that we work in our office, we wanted to involve everyone. So we created the steering committee with a representative from each of the six sections. And they worked with the assessment staff on looking at the data and working that way. But then we created four work groups, one for pregnant women, one for infants, one for children, one for youth and adolescents. We did not create a separate group for children with special healthcare needs, and that's my background, and I was okay with that. What we felt was that for each of these little subgroups, someone from the Children with Special Healthcare Needs staff would sit on each of them and bring the children with special healthcare needs issues to the infant, the child, the adolescent, the pregnant woman.

And we also had genetics staff on each of those groups, and immunization staff on each of those groups. So the steering committee got started by saying, well what do we already know, and what do we need to know? And they looked at all

the existing data that we had, all the needs assessments that had been done in the past five years by other people, the data reports, issue briefs, they gathered it all together and compared it to national measures and feedback that we had gotten from stakeholders.

And then we asked, so what does it take to have a healthy pregnant woman or infant or child, adolescent, or family. And we got the steering committee and the subgroups to begin looking at it population by population, what are the attributes, what are the preliminary needs, what are some indicators for these groups? And they just created lists. And then we drafted a little note and sent this out to stakeholders and said, "Please take a look at these lists, and tell us what you think. Do they resonate with you? What did we miss? Could something be collapsed? Could you prioritize it?" The information we got back from all of them was, "These are the right ones." And, "No, we can't prioritize it."

So then, (laughter) so then the real work for our needs assessment was creating logic models for everything that was on these lists. And there were about 33 to 40 issued. Some of them got combined early on. And the small workgroups did, the staff in the office did the logic models. And our secretary of health has said, our work will be based on logic models. So, she was pushing us all to do this. So we had some training and did some hand-holding, and people created logic models. And these are on our website, but let me just use one here. So it went, some people started from the inputs and the resources that we had, and worked

all the way to the outcomes. Some people started from the outcomes and worked back. But what we ended up with were 33 logic models. Okay, what do you do with that? Well, the steering committee took them, laid them out, and lo and behold, the issues for pregnant women were very similar to issues. They need to be emotionally healthy, they need to be drug-free, they need to have healthy environments, they need good nutrition, care coordination, all of that. Started grouping things, and came out with nine groups.

And my assistant manager came to me one day and said, “Jen, I think we have our priorities.” And I said, “Well, that was quick." And, but he said, here's what happened. And it really did show a lot of overlap across all the population groups. So it really validated that we could do this integrated approach, and what was probably good for one piece of the population was good for the other. So then the leadership team, got to get my next matrix, reviewed each of these nine priorities in depth. And this took a lot of time. We started in about September, must have been 2004, and spent a whole day, a day and a half on some of them. And what we did was we said, okay, we pulled together the logic models that fit with each priority, and then the manager actually tried to roll that up, in terms of what is the work that I do in maternal and infant health? What is the work that our section does? What would we like to do? So for each priority, we had a little bit different of a matrix to put together. And the one for quality screening, identification, intervention looked like this. We just had the population group, and then for each of the pieces of the priority, what was happening there. And then the biggest part

of it was, what data sources do we have to support this, and what best practices do we have?

And then the last column was, what performance measures fit with this, the ones, national or state, and, are they the right performance measures? So these were very rich discussions, and it actually vaulted us, as in office, to a new level of thinking in terms of, we always thought we were sort of integrated and worked across, but people were like, “Oh my gosh, I could be talking with you about this.” And so, more integration happened immediately.