

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

SHAVIR AMAD: Thank you, Vivian. I thank the bureau to give us the opportunity to share our experience with you as far as a five-year need assessment and the ongoing implementation plan, as concerned. The title was picked, actually very smartly by Vivian, I would say. And the process is very important, as we experienced in our five-year need assessment. What I am doing is I am representing a big group, from state, of our local health department staff, UCSF Family Health Outcome Project Staff. Many, many stakeholders, both at local level, as well as state level, and others. So, also, I am going to focus more on the maternal child and adolescent health need assessment process because we are two separate branches, both programs, MCH and the Children with Special Healthcare Needs. They are administered separately, but we have good coordination. Both processes went parallel, and they are very intensive.

And we took some different approach, based on some of the challenges. And those challenges are actually our (inaudible), that they are at 37 or about 36 million people. There are over a half million births every year in California. The population is diverse. The geography is very diverse, both rural as well as urban.

The concentration of population in the South and in the Bay Area and their needs as compared to some of the mountain counties and the North Counties, and some you will see here, some of the, on your right, there are only like 15 births in a county, as compared to over 150, 000, over 150,000 only in LA. So, there is a big diversity. So we at the state level for the Steering Committee, or the Advisory Committee, which was mostly the Abbey Staff, along with the program staff policy staff, they decided that we need to move the need assessment process more at the local level and decentralize, if you can take the word or the message from California, that was the strategy we took that we decentralized the whole process and that these were our various compartments working on the need assessment in California state, of course was the oversight. Sixty-one local health jurisdictions. They did their own that need assessment.

So in (inaudible) you can say, California did 61 separate need assessments. Of course, we did not receive the report from all. We received the report from 57. So that was a good actually. And before we did not receive those having very low birth, and, I mean, the low number of births, or their resources were not adequate. Just to tell that California provided, the state provided \$10,000 for each county to conduct the need assessment, I know this is not enough money at the local level. But it was at least some support to conduct meetings with the stakeholders, some travel involved. So the locals were at least partially happy that they received something.

What we did that we asked of our local health jurisdictions, which are 61, to conduct their need assessment, and Title V agency at the state level, summarize those needs and priorities, and you will know how many we received from all of them. Analyze both local jurisdiction, qualitative as well as the quantitative data, and that is important because I will give you one example that was not available, and the information came from the local stakeholders' local data and the local needs.

And then assess the Title V agency capacity and involve extensive involvement of stakeholders at the state level, state administrators, other branches, other programs in the state. And then at the end, we posted for public input at our Website. So, the conceptual framework was decentralized, and built 61 local need assessments as I mentioned earlier. And we gave the task to each local health jurisdiction to come up with two to seven priorities from the local level. Our key collaborators, as I said, that the state was overseeing the overall process, the local MCH programs were the driving force for California need assessment. And UCSF effort project. They provided, we had a contract at the task and the contract was that they were going to provide all what is needed for need assessment to the locals. The locals were not required to do any data analyses. They were going to give their data requests to EFOP. EFOP would provide all the information too. So we centralized the capacity as far as data analysis, information gathering needed by locals. Although, local health jurisdiction, they

did use their local reports, local information, local interviews, all that was used for need assessment process.

So, we provided individual training, the TA to local health jurisdictions on this. And, we also provided the specific guidelines, just to start the process. There was a list, and these guidelines are on our Website, and also, Vivian put it in the appendix in the report. I would like to say that the report HSAR put, that's very good. There are very key messages in that report. I would encourage those who would be involved in the next five-year assessment, they should read. It's pretty much they captured most of the strengths and weaknesses of the process. It's very good report. And then, after the reason we provided these guidelines, to have a uniform report from the locals so that at the state level, the assessment is more uniform and it's easy for the team at the state level. Although it was a lot of work. What we asked in those guidelines from the locals, that convene a planning group.

And emphasize on stakeholders, consumers, local MCH programs, providers, health, social services and educational providers, complete community assessment, and under community assessment, community health profile, and resources assessment, the view required, and other health service indicators, assess local MCH program capacity. And then identify MCH publish needs. And therefore, those needs, they need to also emphasize on the capacity at the local level. And conduct a preliminary problem analysis for at least one priority area.

Now what we did, I just want to mention that out of this five-year need assessment, we are asking now local health jurisdictions to provide us the action plan in every annual progress report which we received were, like 2007, 2008, 2009, they are going to provide the action plan for each priority because there was a resource issue and they could not do altogether at one time quiet.

So, at the local level, they did use the secondary research data. And reports. And what we gather, that out of those 57 need assessments, we received reports, they used almost 1500 plus citations. These were academic generals, state federal agencies, data reports, interest groups, report from other local health and social services group. They also used local program and jurisdiction data about over 100 citations, and the local service in all of those 57 need assessment.

About 5,000 individuals were surveyed, and those including school administrators, clients, providers, and family members.

And, at the planning committee level, these were the stakeholders. And altogether in all California, these local health jurisdictions almost invited 1600 stakeholders. So, in some county, 10, some 50, some 40, depending on the group and resources. So, and this is the list of those stakeholders who worked at the local level, with the local MCH programs.

Now, I want to give you one example that, where state MCH program did not have enough information or enough data. And they, the locals, they used the

provider surveys, the foster care placement information, and the key informant interview then stakeholders input. And they came up that the substance, the perinatal substance abuse is one of the top priority. All those states or UCSF did not provide much of the information. This is something that emerged from the local process, and that emphasized the title of today's session. The other one, where we have very good information at the state level. But that even is so rare at the local level that it did not emerge as one of their priority areas. Although, at the state level, that is one of our top priority. That is the maternal health improvement. And, the state is about four times of 20/10 objective we have, over 13, that's per 100,000 births. So this was one example where we had the data, but from local level, we did not hear much.

We, just to, just briefly that at state level, you can see that those huge four binders, with the four-inch thick, that came on my table and said, "What to do with it now?" Yeah. So, the staff was already, they were quite busy. And if you know also, when we were doing this need assessment, there was competing assignments at the local level. You know, HRSA and CDC, bio terrorism (inaudible) that were going on. So, there were a issue of resources, both at state level, as well as local level. So we did a quite intensive analysis. We received almost 122 specific problems. As Jen said, the list. So, and when we grouped them, we came up with some like 20. And out of 20, we presented the 13 to our stakeholders at the state level. This is like months of work, I'm telling you.

Now if you go and adjust the timeline quickly, the process at state level started in the January 2003. And I am totally supporting Vivian's comment that if you want to do need assessment, please start thinking two years ahead of the deadline. So, your July 15, 2008 is the deadline for having the plan ready what you're going to do next two years. So, this is, you have the handout, I will not go over in the detail. But, just to say that we provided information, data, all the trend information, trend data to the locals on the 27 MCH indicators. And this came out of a survey which we did in January 2003.

So, at that time, we were not taking a five-year need assessment, but we had that information, which we used for this. Now, these are the seven priorities we provided, reported to the bureau. And the one which are highlighted below, for these, we have already done in 2006, we developed the implementation plan, and Kate Murray, Kate Murray, can you raise your hand? She is the one who is leading the effort, it's a big team on Program EPI and policy side, developing the implementation plan. And currently, we are doing for the other three, the one in black color, we are developing the implementation plan at state level.

And at the same time, we went over our old state performance measures. And if you look at state performance measure number three and number four, that's, those are brand-new state performance measures, based on our action plan, which is based on the five-year need assessment process. This is the Phase 2 implementation plan that is going on. Currently, I will not go over the timeline.

And this is going to be a last stakeholder meeting we had almost every year at state level. Stakeholder meetings, and there is a complete list. And this need assessment, we have a hardcopy. All of it can be downloaded from California Website. This is www.mch.dhs.ca.gov. And there is almost 54 various organizations who are invited, private-sector providers, advocacy groups, state departments, state programs, to this meeting. The take home message, it's a continuous process. It's not July 15, 2005. This is not the game. The game is that you start two years, 18 months ahead of this deadline, and then you continue for your implementation plan for the following years.

And the recommendations, I have those on your handout. But, what, I think I'm going to give a message to our bureau staff that we would need some training at the state level, how to blend the capacity and the need. That is where I think we were slightly weak. And I should not confess it in front of Cassie Lauer, but, I think it's good to bring the weaknesses of our processor. I think, if we can have some TA on that. And the bureau did an excellent job in providing us training when we started this need assessment, to all. And, I thank you all for your attention.