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HEALTHY COMMUNITIES

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

VICTORIA FREEMAN: Okay. I had to unplug the mouse here, so I'm going to have to see if I can get this going. Oops. Okay, where is the slideshow? Down here?

UNKNOWN SPEAKER: Try F5.

VICTORIA FREEMAN: F5? Thank you. Okay. I'm a Mac user, so I get a little confused. Well, I'm really happy to be here. I'm happy there are so many of you who are still here. It's getting close to 4:00. It is a beautiful day outside. But it will hopefully still be nice when we get out. I'm here with my colleague, Priscilla Gild, who, probably any of you who are here from Region 4, particularly you know Priscilla, she's worked in MCH for a long time. And I'm here to talk a little bit about setting new priorities for 2005 to the year 2010, what's changed since that year, 2000.

You've heard a lot about the Needs Assessment. You all probably participated in the Needs Assessment. And basically, I want to boil the Needs Assessment

down to the priority needs that came out at the end, because that's what we're focusing on, as part of our work for the Bureau. Let's see. The purpose of, of the contract that we have with MCHB over the next year is to review the priority needs as a whole, and see how they've changed since 2000. And then we'll also be reviewing selected needs, state needs assessments to look at, you know, how you chose your priority needs and what you didn't choose from needs that were identified, and how you identify priorities. And then the final part will be to review the performance measures. But for this part, I just want to talk a little bit about how we reviewed the priority needs and how we came up with a categorization scheme, and kind of what were the, the big themes, you know, at the end of the day.

We started, this was not to look at within an individual state, but to look across all 59 states and jurisdictions. So we started with individual priority needs statements. We started with your words. And as clear as you were is how we were able to categorize them. We took, as you know, there are seven to 10 needs for each of the 59 states of jurisdictions. You all averaged about 9.4. We looked at not only the 2005 needs, we looked at the 2000 priority needs statements. So that totaled 556 needs statements, plus 559 needs statements for a total of 1115 needs statements that we reviewed. These statements ranged from the simplest two-word priority need--I don't really easy think anybody had one word, but the two-word, you know, something like reduce injuries—I really like these states—this was for us, to things as complicated as a priority need that

said something like, and I made this one up, no, but this isn't anybody's real need. But, work with healthcare partners to improve access to care and quality of care for all MCH populations and all aspects of care, including issuing cultural compliments and a prepared public health workforce. So, then we have to distill that down. So, it went from the really, really simple in terms of wording, although maybe not simple to implement, to the complex.

So we had to develop a scheme to look at these priority needs and somehow classify them and categorize them. So, this is what we did. We looked at each priority needs statement, we said, what is the health of healthcare issue? Is this issue further described or delineated? What MCH population is the target of the need, and are there specific subpopulation whose needs are being addressed?

So, for example, this is a fairly typical priority need, is to reduce the low-birth weight births among African-American women. So, we said first of all, one issue here is pregnancy outcomes. The issue detail is low birth weight. But there's another issue that we identified here, and that's disparity reduction. The population is maternal and infant. We wanted particularly to look at the different populations for the needs to at some point be able to look at them by population, so we know that children with special healthcare needs had needs represented by all the states or how ever many states. And then sub-population is African American women.

So basically, we did this 1115 times. And we ended up with, once all 1115 priority needs statements were classified, we created a database of priority needs, we looked at the health, our healthcare issues that were mentioned the most often. We de-duplicated by state. We wanted to make sure that we only counted a state once, even if it had multiple needs addressing one issue. And that was fairly common, to have more than one, say, pregnancy outcome need for a state, or disparity reduction need for a state. So we de-duplicate it by state, because we wanted to talk about the number of states that identified a particular issue in their priority needs for 2005. What were the issues identified by most states in 2005, and then how did those top issues in 2005 compare to 2000 in terms of the number of states specifying such a need? So here is the list. The most common needs in 2005, and on the left, you see the categories that we created, whether or not it went up, and the number of states that identified these issues as a priority need in 2005 versus 2000.

Healthy lifestyles zoomed right up to the top. And I'm going to talk about some of these in more detail, the little bit about what kind of priority needs fell into this category. Next, with a tiny little arrow up, because technically, it went up by one state, but it's, essentially it was flat, was health improvement and access to healthcare. And these were basically two sides to the same coin. A state could specify their priority need as improving the health of children, but also, they could specify it in terms of proving access to healthcare. So we'd lump the two together as different ways to approach the same goal, which is improving health. But the

priority need itself might say improve health. It might say improve access to healthcare to improve health, or just improve access to healthcare. The next one was oral health improvement and access to oral healthcare. Again, it went up a tiny bit. Injury prevention was mentioned less frequently by states in 2005. And this included intentional and unintentional injuries and sometimes specification of specific injuries. Adolescent suicide or motor vehicle crash mentality. Child abuse and neglect and domestic violence was frequently mentioned. Mental health improvement and access to mental healthcare was another one that went up. To the next page, medical home and care coordination. I'll talk a little more about this one because it went up and there were some interesting changes in this group. Legal and illegal substance use went down, even though it still was mentioned by more than a third of the states. Pregnancy outcomes went down just a little bit as to disparity reduction. Also down were priority needs mentioned in regard to pregnancy, fertility, and birth weight birth rates. And up a little bit was prenatal preconception and inter-conceptual care. And I'll talk a little bit more about that one because there were interesting changes within this category. Looking at these a little bit in a different way, just so you can see, instead of having them listed, you know, not chronologically, but by order of the most states, the things more states talked about, healthy lifestyles, mental health, and mental healthcare, medical home and care coordination pretty much unchanged were prenatal care, pre-inter-conceptual care, health and healthcare, oral health, disparity reduction pregnancy outcomes, and then fewer states had

specified needs related to injury prevention, legal and illegal substance abuse, and pregnancy for fertility and birth rates.

Healthy lifestyles. Forty-four states had a priority need related to healthy lifestyles in 2005 versus 21 states in 2000. Some of these priority needs statements were very broad. And they specifically said, promote healthy lifestyles. Some of them got into more detail. But the areas that we looked in specifically here were reducing obesity and overweight, which went up, more than doubled in the number of states, and promoting nutrition and/or exercise. So those were frequently mentioned. Sometimes promoting healthy lifestyles, including reducing overweight, obesity and overweight. But there were other things. Sexual health was included. Computer and TV time sometimes was included in healthy lifestyles. And so this was a big, big increase and new focus for a lot of states in terms of identifying it as a priority need.

Mental health. Again, 27 states versus 14 in 2000, again, it could, like any health issue or healthcare issue, states related to improving mental health or improving access to mental healthcare. It was not related, not limited to one MCH population, it crossed populations, pregnant women, children, families. Even in some cases, citizens of the state. So this was another one. Medical home and care coordination, 27 states in 2005 versus 18 in 2000. In 2000, medical home care coordination was almost exclusively related to children with special healthcare needs. But not in 2005. There was an increase in emphasis on

medical home, for care coordination for populations other than children with special healthcare needs, which I think is in keeping with what you said about Washington, that, and I know there's been an emphasis in a lot of maternity care, in terms of care coordination. So, states have broadened their emphasis on care coordination in the medical home to include other populations.

And prenatal care, pre-conceptual care, and inter-conceptual care, in this particular area, prenatal care was actually down. But it was, there was an increase in emphasis on pre-conceptual care and inter-conceptual care. So I know that's been an emphasis for a lot of MCH activities and moving beyond just the time when a woman is pregnant and moving out into preconception and an inter-conceptual period. So it'll be interesting to see how that changes over in the next 10 years, the next five years.

Not only did we look at, just, I want to say a little bit about the other area that we looked at, that we're going to continue to kind of refine. Not all needs were targeted at specific MCH populations. Thirty-eight states in 2005 specified needs that we called local MCH agency needs. And it was about the same number in 2000 as well, actually. Probably the most common in 2000 were needs for data, and improving data systems, planning data systems, developing data systems, obtaining baseline data for whatever program, for program and planning and implementation. Data assistants were less frequently mentioned in 2005. But there were lots of it. It was kind of hard to categorize, cause they were kind of all

over the place. And these were some of the really complex needs statements, which included integrated systems of care, interagency collaboration, cultural competence, public health workforce preparation. You name it, there were priority needs for, what we considered to be considerable work within the agency itself to develop their capacity. And so we'll be looking at this a little bit more to see.

So that's basically a summary of what we found. There's my contact information, if you want more information. I tend to talk much faster when I get up here, and so I probably maybe made up some of the time that we were running behind. So, but I'd be happy to answer questions as well. So.