MCH EPI Conference

State Title V MCH Needs Assessment Practice

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DONNA PETERSON: Thank you. Good morning.

GROUP: Good morning.

DONNA PETERSON: How's everybody?

GROUP: Great.

DONNA PETERSON: How many of you are from the West Coast? How many of you are from the warm West Coast? It's particularly cruel, isn't it? We drag you here and make you get up early. Well, we're glad you're here. As everybody said, this is something that we've gotten used to doing now every couple of years, we come together and we talk about this. And every year, we see progress. Every year, we see people eager to move to the next step. Okay, I mastered that one, what's next?

And so, in that spirit, we will both review some of where we've been while we work toward where we need to be in the future. I see a lot of friends in this room. A lot of you have been with me before, so you know what you're going to get here. But it's like when you go home for the holidays and you have to hear the

old family stories again, but they're still good. And it's good to be reminded of where you come from and your crazy old aunt or your great grandma and all that good stuff. So, we're going to go back and answer the so-what question because I think it's worth spending a few minutes to remember why we do these things and why we drag ourselves from across the country and come together. So, we're going to spend time talking about the so-what question this morning.

So, the first so-what is that we are part of public health, and those of you that know me know I always start here because I think it's important to remind ourselves where we sit. So, we sit in public health which, of course, is what we do together and big together, not just us as professionals, but what we do together with our communities to create those opportunities for people to enjoy a high quality of life and good health. That's what public health is about. We are part of that. We are part of that around the world. And we, in the United States in particular, have this focus in statute, in funding, in appropriations to states because it's in our collective interest to promote the health of our children because they are both our now and our future.

And so, we take on this task and we work together in a public health context to try to improve health for families and children in the country. Our focus in MCH, we're a part of public health, because of that, our focus is on the population. It's not on any particular group, it's on everybody. Our emphasis is a preventive one, and that's challenging because it's hard to argue for something that hasn't

happened yet. We all know this. Very difficult to get people excited about something that you kept from happening. Our orientation is toward communities. We know we have an effort to direct and move systems. And ultimately, we're talking about our role as leaders for this population--women, children, families, children with special needs, abused, fathers, however you wanted to find it, our role is ultimately a leadership role. It has to be.

It's interesting to hear one talk about all of the money we have. And when you think about it, it is a lot of money, but then we know, at the same time, it's not a lot of money because we sit in states and we work with other partners who have way more money than we do. They have way more clout that we do, at least feels that way to us. But the fact of the matter is what we have maybe isn't dollar currency, but they're other currencies. And we have very important currency in these emphases, that our focus is on everybody, prevention, systems, communities. And we must provide the leadership to then move all those other parts of that system along to really improve the health of the populations that we care about.

We know, hopefully, we know. I guess I should've asked you if you can name the core functions, recite them in the morning when you're brushing your teeth. Before you go to bed, you say a little prayer, okay? But because we're part of public health, we ascribe to these core functions. And though everyone kind of roll their eyes when these emerged in 1987, 1988, they work, because it really

what public health is about and it's what MCH is about. We continually assess what's going on in our populations. We use that information, the data we gather, the information we amass, to then consider programmatic and policy interventions that will then allow us to assure those things that need to be in place to improve and protect and promote health. That is what public health is about. It's what we do in MCH.

And of course, we've highlighted assessment here because that's the topic of this particular training. But as people have already said, you really need to think about needs assessment as an umbrella term because it really covers not only the data collection part, which is I think what a lot of us think of, but it covers everything related to that--why do we do it, how do we use it, how do we then affect change, how do we transform our agencies, our programs and our communities. That's all part of the assessment umbrella in this regard. So, it's highlighted just because that's what we're focusing today.

This is the definition. You have it in your packet. I won't read it to you. You can read. But you know what it means. And then, of course, after those core functions we've developed in the late '80s, there was an effort to say, well, they're not specific enough. And so, a group of people got together and wrote the 10 essential services. And then, because we always to MCH-ized everything because it never really works, we MCH-ized the essential services. And again, you can see this idea of ongoing monitoring and assessment and diagnosing

community problems and engaging our stakeholders, moving those partnerships along. Leadership shows up again, promoting and enforcing, linking, assuring, evaluating and supporting research.

And the last one I'll just comment on because I think it's the one that we don't recognize as much in state agencies. We don't see ourselves as research enterprises. That's what the academics do. And we like to partner with them. We appreciate the importance of research, but we don't feel like we do it. But that's wrong because you're doing it all the time. Everything you do you should think about as a little mini-research study or a natural experiment, if you will. Because every time you go out into a community and try something new, every time you think about how you want to redefine a program or change the components of what you're doing or change up the staff, you're actually trying something new. And one of the things we don't do very well for ourselves is share those stories. So, that's just a little paid political advertisement exhortation to you to take the time to write up what you've learned and share it with others. Apparently, why we come to this meeting.

All right. Leadership, I keep talking about this. What's interesting about MCH in public health--and you know because you all sit in health departments—is that for us in MCH, because of this very broad focus, we are--at the same time, we're sort of kind of all over the place, we have a very intense emphasis on what we do. So we are at once deep, if you will, and broad.

So, think about and talk to your friends when you're here. We all organize our programs differently. We all have different emphases depending on the state we may have responsibility for related programs, or we may not. So within MCH, you may have injury control, you may have lead poisoning, you may have dental health, or you may not. But you're still responsible to provide leadership for all of those things that affect children and families. So, you have that breadth responsibility no matter what. And then we choose to have, or we are mandated or we are required to have depth responsibilities. So it's an interesting, it's like petting your head and rubbing your stomach or something. We're doing all these across stuff while we're also focusing intensely at the deep stuff.

And that just gets back to this notion that because of our focus on populations and prevention and systems, in a way, we're responsible for almost anything and everything that touches the lives of the families who live in our states and our communities. And if we can do a good job for them, we'll do a good job for everybody. So MCH, in some ways, is public health, large, because what we do for that population of women and children, if we do it well, it affects everybody. Not that we claim ownership of the entire public health spectrum, but we probably could. Okay?

So, here we have this amazing responsibility huge, huge scope, very little money within any given states. A lot of money when you add it all up. But we know, we

have very limited resources to deal with. So, how do we do this? We've got to make the best decisions we can make about how to use those resources. And it's not just our dollar resources, it's our people resources, it's our network resources, it's our partner resources. We have got to do the best job we can. We can't afford to waste a dime. We can't. There's too much out there that needs our attention, needs our talent, needs our support. So, we've got to be meticulous and make the best decisions we can do.

So that means, again, thinking about this whole needs assessment and planning process, however you want to call it, at the highest levels of leadership within MCH. This is not just an exercise in collecting a bunch of numbers and sending them off to the Feds. This is how you do what you need to do. So, we've all got to be engaged from the highest levels all that way through the organization and pay attention to this process, pay attention to how we carry it out, what we learn along the way, and then evaluate the extent to which we've been successful in that process. And that's probably why we brought you here in the teams that we did this time around.

All right. So here's the fact. We are all required, every five years, to conduct a needs assessments, comprehensive, population-based, statewide. We are to conduct this assessment. We are to identify our priorities. We are to arrange our activity around those prioririte and we are to develop performance measures to monitor our success. And that sounds really easy. And it's really hard because

it’s a lot of work and it doesn’t always make sense. And we’ve got all kind of things going on around us while we’re doing this. The world doesn’t stand still while we’re doing this, right? And I think one said it earlier, you know, if you do a good job, which most of us do a much better job now than when we started this, we’re good now at gathering all the data and getting out there. But then, it’s almost overwhelming. And so, figuring out what the priorities are and then figuring out what to do now that we’ve established those priorities, that’s where it gets hard. That’s what we’re going to focus on over the next couple of days.

But, this is a Thanksgiving old family story. This isn’t new. It feels new for some of us, but this is actually part of our heritage. This is part of where we came from as a field. In 1912, when the Children’s Bureau was established, which was our precursor. Their mission, it stated very clearly, to investigate and report upon matters pertaining to the welfare of children and child life among all classes of people. I do recite that every night before I go to bed, because it is the essence of what we do. To investigate and report upon, that’s need assessment. That’s monitoring. That’s diagnosing. Report upon, that’s communicating, getting those partners engaged. Welfare of children and child life, everything among all classes of people, every body. This is what we do. That’s assessment, the whole process. So, this has been part of who we are since our very inception in 1912. So, this isn’t some new task somebody’s making you do. It’s not some new chore. This is absolutely essential to who we are as Maternal and Child Health. It’s one of the greatest things that we have, is that history of us.

And our mission today, to assure the health of all mothers and children, stems from that. This notion that we are about every body, everything that affects child life and welfare and families and everything around it, and that it's our job to know what's going on out there so that we can make the decisions that will affect the change that will allow those folks to lead the most optimally productive healthy live that they can. So, that mission demands that we do this, not just every five years, the every five years is a marker point. We'll talk about that. But that we do this all the time.

The five-year point should be a time at which we sort of take a look at our capacity to do this and make sure that we can do this in an ongoing fashion. Because you don't want to just shut the needs assessment window for five years and don't pay any attention and then come back in five years. This is something we've got to be doing all the time, looking at all these different factors that affect the health of mothers and children in our community.

All right. You're wondering when we're going to get to this. So, here's a chance for you to get to know who's sitting at your table. We don't have time for everybody to stand up and introduce themselves as much as we'd like to. So, I want--and you don't have the slides. So, I want you to take a moment, get to know who's at your table, and I want you to do that by answering two questions.

The first is, where were you in 1981? And why am I asking that? And then the second is, where--and if you don't remember where you were in 1981, because you weren't--I, of course, was a mere baby. Where were you in 1989? And why did I ask that question? So, say hi to your folks, meet everyone around your table. Where were you in 1981? Where were you in 1989? And why am I asking those questions?

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All right. Have we remembered or revealed where we were? Who was not in MCH in 1981? Not in MCH in 1981? How about 1989? How about now? All right. Why 1981?

UNKNOWN SPEAKER: Block grant.

DONNA PETERSON: Block grant. Did everybody get that right? It was the block grant. I'll tell you more in a minute. What was 1989?

UNKNOWN SPEAKER: OBRA '89.

DONNA PETERSON: OBRA '89. There was actually OBRA '81 to be technical about it. Okay? OBRA '81 and OBRA '89. You don't have these next slides. 1981, block grants, Ronald Reagan had just been elected president. And in the

spirit of, this is my quote, “Get the federal government off our backs,” the old formula MCH funds. And I won’t go into the whole history of this, but there was a way that MCH dollars were allocated to states. Those were then blocked with a group of categorical programs that states used to compete for. They were competitive grants. They were blocked into one big lump of money. Funds were awarded to states based on their proportional share of their total less 25 percent. Any of you that were around that may remember this?

The idea was, since we were going to give you the money and let you decide, you’d be more efficient, right? Because it wasn’t us telling you what to do. It was, “We’ll just give you the money. You decide. You’ll be more efficient, so we can cut 25 percent off the total.” Right? Because states were going to make far better decisions. And they could just do that like this, right? Oh, yeah. We’ll make all these decision. Huge change in the way MCH dollars were allocated and then programs were instituted.

So, what happened? And this is a very crude history review here. But in essence, because states were making their own decisions, there was no need for any interference from the federal government or oversight. And I remember, and see if that make you turn in the room, when I went to the Maryland Department of Health in 1984, I think it was, a guy that I worked with came down the hall one day and he said, “Okay, time for us to send in to get our block grant money.” And it turned out this was his annual joke because he was so appalled by this whole

thing. He would go to the men's room and tear off a piece of paper towel and write, "Send us our money." And that's about all you had to do, really. I mean, those of you that were around, that's about all you had to do. No plan, no anything. Just because this was, right? Send us the money.

So there were no reporting requirements, no need to submit a plan. So, what did I say? Twenty-five percent cut in the money, no data reporting requirements and no plan, who got let go? The data people. Who got let go? Okay, remember, you're now, all of a sudden, you're supposed to be making your own decisions, right? Well, what does the public want you to do? Does the public want you to change up everything you're doing? No. And the public likes, and this is something we're faced with today, the challenge of the public like seeing tangible programs and tangible services and they don't like you touching those things. So, those things stayed. The public didn't care about that. You say, "Boy, I got a great plan here, state of Georgia. We're going to put all our money into collecting more data." And the public's going to go, "Yes. Yes, it's about time. More data, more accountability." No. That's not what happens. So, who went? The data people went.

So then, what happens to the '80s? It's the dataless decade. (Singing) Don't worry, be happy. Remember that song? That's what it was. We were all so happy because without any data, you don't have any problems. There's nothing wrong. No data, no problems. It was great. What a great decade. No data. Except we did

still have one great source of data and that was the vital record systems in our states, which didn't go away. And they kept churning out that birth certificate data. And we were getting more technologically sophisticated. We could put those databases into real systems and we were starting to link what we had Medicaid and--because we had Medicaid data and we had (inaudible) data and we had--so it sort of became the decade of infant mortality reduction efforts because it was the one thing that we knew about and we focused on. And a lot of folks were getting together and states had infant mortality commissions.

And (inaudible) aside, when I was working for the Maryland Department of Health, we were going to have an infant mortality commission. And I did the letters and invited everybody and I somehow wrote the infant morality commission by mistake. So, I guess we didn't have a spell check then. And I got calls from all over the--"I had no idea that this was a problem." Always proofread what you're going to write.

So, what happened then was child advocates, Children's Defense Fund, March of Dimes and parents of children with special healthcare needs said, "Well, time out, guys." MCH is supposed to be about children and families and what happened. And again, this is a very superficial analysis of what went on then. But I think it's a fair assessment. So, these guys got very mobilized and went to Congress and said, "This is ridiculous. There's no accountability anymore. We have no idea where these dollars are going." And states were saying because

there was no requirement for plans and no accountability, it was very easy for higher ups in the organization to say, “Well, kids and families drive on roads, so why don’t we use that money over here?” And those of you that have been around awhile will remember this or can go back home and over the holiday dinner you can get them to tell you stories of how the MCH money started to trickle away in different states.

So, what happened then in 1989, big overhaul of the legislation to what we know and love today as I said up here. So, the annual reporting requirements where we store the application plan process was restored. There was new language specifying how the funds were to be distributed, so that’s where the 30-30-10 nothing language was put in there, nothing because we know what it’s for. And then, the requirement that we do comprehensive needs assessments. Well, why would they have put that in there? Well, for all the reasons that I just said, that that’s the--it’s really a gift, if you think about it. That’s how you know what’s going on in your community. That’s how you are compelled and able to act. When you have the data and the knowledge about what’s going on with precious resources, that’s how you know. And that’s why that all got put in there among other things, but those were the major things.

And when you get aggravated doing this, remember that it was your predecessors that actually begged for this because they knew what the alternative was like. When you don’t have these requirements, it’s very difficult to

have any ability, any authority to actually do what you know needs to be done. So, back to where you have slides in the packet.

So we need this. We need to be able to do this. It's good that it's a requirement because it allows us then to commit resources to it. You can look at the staffing patterns in your unit, in your organization and see how they've changed. Because who's back? The data people. They're back. That's why we can have meetings like this. You had a meeting like this in 1983, there'd be nobody here because there were only like two states that were able to hide somebody in the basement somewhere so that no one knew what they were doing.

So, this is an essential activity of what we do. And it's about change. And we're going to keep coming back to this theme because that's really what this is all about. And that's a good thing, because everything we do should be about change. And the reason we plan and think about where we're going and think about how we're going to use our resources is because things have to change. We may change direction, we may change our efforts, we may change our staffing, we may change our resources, what comes in, what goes out, we're ultimately about changing outcomes and changing lives, as one said earlier. That's what we're about, because nothing stays static, and so we can't either. It's wrong to think we can.

Again, the assessment is one part that we tend to use the term as an umbrella of this ongoing planning cycle. This is crude. You'll see in the new guidance that Cassie mentioned, a far more elegant depiction of this planning cycle. But the important thing to remember is it is a planning cycle and it is a circle without end because it's an ongoing effort. So, we continue to assess what's going on in our communities, both the negative and the positive. We look for solutions and we try them out. We figure out how to allocate resources. We marshal our activities and evaluate them. We monitor what we're doing. And in the doing, we learn and we keep going. It's a cycle. Assessment is part of it. Both of these are ongoing, okay? It's a circle with no end.