

MCH EPI Conference

State Title V MCH Needs Assessment Practice

December 8 – 11, 2008

DONNA PETERSON: : --technology, are our constituents engaged, have we kind of let that fall, can we pick it back up again, how well are we doing on the things that we implemented over the years, and then think about where we're going in new. So, it's really just a point in time to refocus, but it should not be a new exercise every five years. It should be an escalation of an ongoing effort because these are ongoing processes.

And again, in the intervening years, it shouldn't be just, well, we're just kind of sliding along here, but you should have identified things in the five-year needs assessment that need a more in-depth examination. So, if you're doing the five-year thing right, you will learn of things that are perhaps emerging or something that's changed and we don't understand it well enough, so the intervening years, we can do focus assessments. It might be a new population group that's moved in to your state, it might be a new industry that's moved in to your state and it's affecting things, it may be somebody that has moved out of your state, maybe it's significant job loss that's going on everywhere, or a new health concern, a new drug, a new policy that seems to have had unintended consequences, the opportunity to focus within that five years. So, and you know this already, and how many cycles ago, is this the fourth?

UNKNOWN SPEAKER: This is the fourth.

DONNA PETERSON: The fourth. Okay, so the first time around, doing trainings like these, there'd be a lot of people sitting there looking at me like, "All right, I'll do it but only because I have to." No, that's just not acceptable. That's not why we do it. Yes, you have to but that's not why. It's like your kids. Yes, I know you have to clean your room, but it's also because you don't want to live in squalor. We don't do needs assessment simply to justify what we're already doing. What would be the point? If what we're doing was fine, then I can only assume that nothing has changed in your community and your state. And we shouldn't do it if we don't intend to act on what we learned because that's a false promise that we make to the people we engage in this assessment. And this is a scary part. You know all this, you go out in your state, you start talking to people and asking them what's on their mind, and then they'd get all excited because they think you're going to do something about it. That's the scary part because sometimes you really can't do anything about it, but sometimes you can. And we're going to talk about that over the next two days because that's the scary part but it's also one of the most important parts of what you do. So, if you really have no intention of acting on it, then maybe you shouldn't do it and I guess you can call Cassie and say, "You know what, I know I have to but I'm not going to do anything with it, so it's a waste of everybody's time," and she how she responds.

We do do them because we understand it's part of who we are, we recognize the dynamic nature of the population that we're working with, we do want to be good stewards of the public's trust, we are public servants and we understand that, and because we know we have to do the best we can with very little in the way of resources, and we don't want to waste them. And you don't want to be busy working on A when you really could've had a bigger bang if you worked on B, right? And that demands then that we have good understanding of what's going on in our communities.

Now, it's a data-driven exercise, certainly. It's a data-driven exercise. We are part of a scientific field, and we work on the notion that what we do is evidence-based and evidence comes from the data and the research knowledge that's out there, but we also understand that this is ultimately a political exercise. It's not simply a data exercise. If anything, it's more of a political exercise than a data exercise, and so we have to understand the politics of policy making and program development and resource allocation. And that means we've got to engage our stakeholders, and our stakeholders are our direct partners, the people we fund, the people we partner with in some formal programmatic way, and they're also the people that care about the outcome of what we do, recipients. I'll talk more about that in a minute.

So, what good needs assessment allow us to do is bridge those two worlds--the data world and the political world--the science and the politics, the data and the

values of the community, the needs and the strategies for their solutions. And that's why it's not really okay just to bring the data folks into a room and talk about needs assessment because that's only one part of it. It's why we have to have program leaders with data people together so that you both understand how this happens because what we're talking about here is change. And just gathering the data, however exquisitely and comprehensively you do it, doesn't lead to change. It's that policy process, the political process that ultimately results in change.

But just to make sure we're all on the same page here, quickly go over where we get all these data. We know we get it from our population-based data systems that I mentioned before, those that live on despite us, the census, all the vital records, our surveillance systems and survey data that we may have, the data that we derive from our programs and those of our sister agencies, and what we (inaudible) from the public very deliberately. And what we're looking for when we do this is what are the gaps, the needs, where are the assets and the strengths, where are the resource capacities that we haven't tapped or that are maxed out, and where are the success stories. We're really trying to look at all of those things.

So, again, you know all the vital record data that we utilize, you know the surveillance data that's available out there, not a comprehensive list where most of us are participating in these surveys that come from the Federal government,

others of us run our own. We know, within our programs, we collect lots of data. The important thing to remember with program databases, service databases is they capture our clients. They're not population-based per se, but they tend to be deeper. So, on that client population, there's going to be more information than it might be what we collect directly through our contractors, through our sister agencies, and that's just a list, a long list. Look at it at your leisure, but remember that lots of folks are collecting lots of data that may be of interest to you when you're thinking about what affects the health of women and children.

And then we're getting much more sophisticated at qualitative data assessments, where we hold public forums or public hearings or we conduct focus groups or we actually formally catalogue and chronicle what we learned from the public, what does the media seem to care about because that's often a reflection of what the public care is about, we talk to our elected officials, we monitor what's going on out there. We get--we're getting far more sophisticated at taking that kind of data and linking it back.

Okay. But all that stuff are sources of data, but is it data, as I hear somewhat rhetorically. Again, the data is necessary but not sufficient to this process. We need all that data but it's not enough to move an agenda for change. It's public health, it has to involve the public. It's what public health is about. And what matters to the public is really ultimately what matters to you at the end because if the public doesn't buy what the data's telling you, in effect, it doesn't exist.

Unless the public agrees with you that these are, in fact, the issues that are affecting your state, it doesn't matter. You will not be credible if you don't engage them and get their buy-in to this, which just gets back to this notion that needs our reflection of the values that the public hold.

Need is simply--it's a value statement, right? It's not a--you look at your data and say, "Well, no, you're wrong, this is a fact. No, it's a fact--yes, I realized the data says it, but if the public doesn't care about it, it doesn't matter. Doesn't matter. Doesn't exist. So, for needs as value statements to be useful, there has to be some agreement. Okay? And you know this. Your data is very clear, public doesn't care about that, vice versa. The public is going to tell you about things that your data don't reflect. Do we collect data on every single thing that affects the health? Oh, thank God, but no, we don't. And because apparently the collection of data is itself a political exercise. Read through Healthy People 2010 and look at what's not there. These are political exercises in and of themselves. What we collect, how we collect it, how we ask questions are political exercises. You can't just rely on the data you collect. It's one important element but it's not sufficient because there's always a political side to this.

So, again, back to stakeholders. Who are they? Anybody with a stake, it's where the word comes from, anyone that cares about this process, anyone that care about your outcome, anyone with a vested interest. Lots of folks out there, and they're not going to agree amongst themselves, okay? We know that. But

because this is about change, people get interested in this. They get excited about it. They want to know what you're doing because they know. You start looking and you're going to find things and that's going to lead you to act. That's why the '80s were so much fun because we had no data and, therefore, there was nothing wrong and there was nothing for anybody to worry about.

But you start looking for things, you're going to find things. And then once you know, it's very difficult not to act because we're good public servants, good public health professionals. We are compelled. Once we see something, we're compelled to act, so people are going to want to know what you're up to in that assessment. It's far better to get them engaged early than have to fight them later. Okay?

Now, if you do this well, you're take the broad population focus, system focus, preventive orientation, all that stuff, and you will identify things that have nothing to do with what your agency does. You go out in the community and ask them what's on their mind, they don't say, "We'd like more PPOR and FIMR." No, they're going to tell you, "I need a job," or, "I need a grocery store." We had a guy come to the university to speak, and I won't bore you with all the details, but he put up a slide and showed that in the city of Detroit, inner city Detroit, and it was like 22 square miles, not a single grocery store. So, he thinks, well, yeah, those people do need a grocery store. I can put up billboards all over the place that

say, “Eat five a day,” or 10 a day, whatever it is now. If there’s no grocery store, thanks a lot, health department, smarties, right?

So, if people tell you they need a grocery store, that’s probably what they need. Are you in the business of establishing grocery stores? No. But do you know who is? Yes. Or you could find out. You’re going to learn things that you--you don’t deal with housing, you don’t create jobs, you don’t work on transportation, you don’t deal with crime. But you know the people that do, or you can find them. And that’s part of our leadership responsibility. If we’re here to assure the health of all women and children and what those families need are jobs and transportation and a grocery store, all right, how do I help make that happen?

It might not show up in your list of priorities that you send to Cassie but it better be part of what you do as a leader for this population in your state. Who should be taking the lead on this issue? How can you engage them? Well, the first thing to do is engage them at the beginning. So, when you think about what am I--I’m going to move in this--I’m going to move now, I’m going to think about my comprehensive five-year needs assessment, I got to start thinking about what I might find and who might need to be a part of that conversation now rather than later. Because that’s what--that’s really what we’re about, is how do we make things easier for families in our communities.

So, stakeholders help you do lots of things, identify the full scope of what's going on out there, helping interpret the data that you collect, helping you collect new data. It doesn't always have to be you collecting data. Lots of other people are collecting data out there, and maybe if they just added an item or two that would be of help to you, that's a lot easier than you having to mount a whole new system. But I put in bold here these two, which is helping sort out priorities and helping identify and select solutions, because I think where we often fall down in this process, we're going to talk about this later today and tomorrow, is we do a good job, and you all have done a much better job over the years, at gathering the data, and you've got partners that share data with you, and you go out and really get some depth into some areas. And then when it comes time to figure out what the priorities are, somehow, when we reach our block grant applications, they don't change a whole lot over the years. And we understand why that is. But if you had a larger, wider group of people helping you sort through those priorities, you might come up with a different set and you might get more creative about what some of the potential solutions may be. And remember, they don't all have to be yours. Other people can be doing things.

Continuing on, they help build awareness of your program, help build a consensus, help you advocate for what needs to happen and then support overall efforts. It's far better if we come together and understand what we're all doing than if we try to work in isolation. Okay? So, needs assessment isn't done when you've collected the data, it's not done just because you've established the

priorities, it's not done until you figure out what you're going to do, you've planned your program, you've written your objectives, you've allocated the resources, you've got your performance measures, right? The needs assessment part isn't just the data report. And binding it and putting it on the shelf doesn't mean you're done. You might as well not have done it because needs assessment is about change. And once you go out and gather all that and learn, now the work began. Now we got to figure out what we're going to do about it.

We know that we are required to establish performance measures, but again, think of it as a gift. It's a good reason to have to come up with things that you can hold yourselves accountable to, your grantees, your partners. You can evaluate what you do. We've got to be doing a much better job evaluating what we're doing, otherwise we're just doing the same old thing and not making changes. So, state performance measures are one really important tool that we use, and we do that from the needs assessment. We have to have a baseline, where did we start from, where are we going. You can't do this without a good needs assessment. Very difficult to allocate resources without the data, again, that you derive from your needs assessment.

You have to figure out, okay, I got limited money, how am I going to get it out there, what are parameters I'm going to use, what are the measures I'm going to use, because what happens if you say to your counties, "Okay, I'm just going to give this out evenly. Every county get the same amount of money." Will that go

over well? Why not? Isn't that fair, everybody gets the same amount of money? What's wrong with that? Oh, okay. All right, well, then--all right, then I'll give the bigger counties more money and the little counties less money. Okay, it should be based on whatever need they have.

All right, well, I think you have this need, and Cassie thinks you have a different need, and you think you have the other third need. How do I sort that out? My needs assessment, the data that you participated in and helped me collect, so now we all agree and this is what we're going to use. It doesn't mean you'll stop all the arguments, but it makes it a heck of a lot easier for you to say, "This is how we're going to do it," because they participated in it and they know--they understand. They might not like it but at least they understand. It was transparent. And again, the way you create your work, your agenda, who's doing the work, how are you organized, again, the data can help drive that.

Too often, it's too easy to go back when you're setting those priorities and look at your organization chart and say, "Well, I better have a priority for Sally, and I better have one for Jim, and I better have one for Charlie because they'll be upset." No, that's not how we set priorities. But if you look--and I don't know how many of you have ever--because it's gripping reading--read another state's (inaudible) application. But you might one day. Just pick another state and read it because you'll read it fresh and you'll read it and you'll say, "Wait a minute, it's very clear that they should be working on A, B and C, but when I look at what

they're doing, it's X, Y and Z. And then go back and read your own and see if you aren't doing some of the same. Data can help you do this. Data is your friend.

And then, evaluating.

We all know we need to be doing a better job evaluating, but if we don't have the data in place, if we don't have baseline strategies, if we didn't set objectives, if we don't have a monitoring data-gathering system in place to allow us to do that--very difficult--can't evaluate after the fact. You can't come in later and say, "Oh, we better evaluate that," and then find that you don't know what you wanted to do and you don't have any other data in place to know if you've done whatever it was you didn't know you wanted to do because you didn't lay that out at the beginning. And we all know this, but again, the needs assessment can lead you there. It can drive you to that point.

I'm doing great. All right. So, the so what, okay, so what? Why do I have to do this? Because it's part of our heritage. It's one of the greatest things that we were left by those leaders of the Children's Bureau on 1912. This notion that it is our job. This is not anybody else's job. This is ours. To investigate and report on all matters relating to child welfare and child life among all classes of our people, that's a great line. Remember it. When you're down and you're aggravated, remember what that says, how important that is. Because if you really do this well and you gather your data and you do a good job and you engage the communities that you're gathering information and building knowledge, then you

build “strength in numbers”--I put that in quotes--because it’s the data numbers and it’s the people numbers that you bring together and assemble. All of that then allows you to move forward and affect change, which is what we’re going to talk about the rest of the time, okay?

So, as leaders in your states--and I argue that everybody in an MCH program is a leader, I don’t care where you are--you need to manage this effort, you need to participate in this effort, understanding how complex it is as leaders of the unit. Those of you that are in the room--yes, obviously, you will assign tasks to different people, but it’s got to come back to a larger, integrated focus. This cannot be assigned to the data guys and then not brought back into the fold. It’s not a data exercise. It’s a leadership exercise. Go back and talk to people who lived through this in the ‘80s. They’ll tell you it’s a survival exercise because maybe it’s about change. So what--it’s about change.

Now, it’s important to remember that whatever you come up with, you’re likely going to need something to move your agenda forward. You’re going to need the resources, perhaps. You might need new authority. You might need the authority to stop doing something. You may need to be able to maneuver within your own agency, forgetting going to the legislature. It’s hard to argue with that powerful combination of data and advocacy, data and politics. The numbers and the consensus of your constituents, together, make a very powerful argument. So, in fact, good needs assessments really are a tool for your success. You do this

well, it's a tool for your success. It sets you free. It's your friend. And with that, I'm going to turn it over to Bill. So, I hope that provided you a little bit of a context, kind of get your head around the fact that this is really something very important.

Yes, sir?

UNKNOWN SPEAKER: (Inaudible) evidence-based interventions usually are?

DONNA PETERSON: Evidence-base interventions, that part--well, I'll say two things. One is while you are determining your priorities and coming up with strategies, that's where you'd look to. What does the evidence suggest we should be doing here? And I would argue that you shouldn't select something as a priority if you don't know what you're going to do about it. So, if there's not a clear strategy or you're not quite sure, then maybe the strategy is helping contribute the evidence base. So that's the second part of it.

The part of it--part of our job in doing this kind of ongoing assessment is building the evidence to support all the rest of us, which was my point about research. And we know this is a whole interesting – whole different discussion about what happens when we have no evidence, what happens when it's mixed, what happens when we have it and we can't get anybody to get excited about it. But in all cases, we want to be bringing scientific knowledge and evidence to whatever we do. Other questions?

UNKNOWN SPEAKER: How do you (inaudible)?

DONNA PETERSON: I can't hear you.

UNKNOWN SPEAKER: (Inaudible)?

DONNA PETERSON: Changes at the federal level.

UNKNOWN SPEAKER: Yeah, funding, things like that.

DONNA PETERSON: Well, we'll talk more about that tomorrow. But certainly, one of the ways we change is because things change around us. And we are hopeful, if you've been following the news, we are hopeful that there will be some relief to states, maybe in the form of new dollars. Maybe not--Cassie can speak to this. It might not come to us directly, but if it comes to those agencies that provide services and supports to our families, then that's a good thing. But we need to be prepared to advocate for how those dollars get used the right way.

So, one thing I wish we could talk more about here, we don't have time, is the whole policy development process and how we've got to be prepared for those windows, policy windows is the term, because they're coming soon. And in fact, the timing of this is pretty good because you're out there figuring out what is needed in your communities. And if there is a (inaudible) of some money for

Medicaid or if CHIP is suddenly reauthorized and expanded, and you've got folks in sister agencies making decisions about eligibility or covered services, you ought to be at the table arguing for what you think based on your data, not just your opinion.

So, whatever you can say about that, if they're going to do something to WIC, if they're going to do something to early childhood education, if they're going to reauthorize or expand (inaudible), if they're going to work on use transition, I mean, there's all kind of things that are being debated, you've got to be ready at the state level to move that agenda forward based on the best evidence that you've gathered through this needs assessment. So the timing is actually pretty darn good.

You shouldn't be in this room. You should be home doing your needs assessment. Bill, do you want them to take a stretch break?

WILLIAM M. SAPPENFIELD: Let's go ahead and take a break.

DONNA PETERSON: Let's take a stretch break. We'll let Dr. Sappenfield get set up and we're going to get in some of the nitty-gritty nutsy-boltsy stuff. Ten minutes.

WILLIAM M. SAPPENFIELD: I've noticed that some people are not sitting together with their fellow state people. And so, for pretty much the rest of the workshop, we're going to want you to sit together. The reason we brought data and program together was for you to learn together and learn to work together. And if you're in two different spots or three different spots or four different spots, that doesn't work very well. So, please get together with your state people.

Is that--obviously, it looks like that's not an issue. People are together. We want you to sit next to each other and say, "Oh, yeah," and, "Oh, no," and, "Oh, my," so that you can learn together. We're slowly getting people back. Is that it?

Again, please sit together with your state. For those who just came in the room, we're going to want you to sit together and learn together.

Let's get --it would be helpful to me, how many of you all have done a previous Title V needs assessment who's in the room? Done one, but to actually participated fully, not partially, not attended one or two meetings, but actually participated fully in the development of a needs assessment? Oh, about half the room only, interesting. Okay. And just to get some idea of balance, what proportion of you would claim to be data people? And what proportion would kind of be policy program people? So we're about evenly split, that's good. We're now going to, sort of, move on to needs assessment. And even though this is a large group, I really would like this to be a conversation. And I know Donna and Juan want it to be a conversation as well. So as we start to talk and walk through this,

and even though we're 120 people, pretend like we're just talking with you. And if you have some questions, and more importantly if you have some disagreement or different ideas, please stop us and go through. We're actually doing quite well on time. We're not going to be rushing through things. So we actually do have some time to talk through things.

I am Bill Sappenfield. I'm now the state MCH epidemiologist at the Florida Department of Health. It's interesting--I guess we don't call the needs assessment we did in 1989, 1990 officially a needs assessment, but I do remember our first opportunity to submit data to the bureau. And it's been interesting to watch needs assessment evolve. And when I finally got out of the state and went back to CDC, it was fun to coach states. It's even more interesting now to go back to a state and go back to trying to do it all over again. So, something stays with you. So this will actually be my--I will say, Cassie, I think it's my fifth time that I've actually been through a process.

UNKNOWN SPEAKER: (Inaudible).

WILLIAM M. SAPPENFIELD: Official, okay. And what's really interesting is back when we started as the epidemiologist, I remember Lisa saying, we're doing needs assessment, so, Bill, this is what you as the epidemiologist need to worry about. And it's nice to see that we've really changed and evolved since that time point, and it really has been an evolution for all of us. I do want to start out with

some acknowledgements of people who I used to help shape some of what we're going to cover today. One, Mary Peoples-Sheps, Anita Farel and Mary Rogers did some initial work on needs assessment. It's actually--it's still out on the Web, and we use a lot of their problem analysis focus that they developed.

So, my experience with the South Carolina days, and my (inaudible) days. And then (inaudible) Greg Alexander and Donna Peterson: have added a lot to the thoughts. I think the first thing to do when we start talking about needs assessment--is Donna says, an MCH, we think, we back up, we talk about the bigger picture. And she talked about how MCH is a part of a bigger picture of public health. And I realized we talk about the big three being assessment, policy development, insurance, but from that assessment side, I really see that bigger assessment piece also included what I call the larger planning piece, and that planning is a big piece of assessment.

And when I think of needs assessment, I see it as part of this larger planning process. And I think that's important because in MCH, I think some of the areas that we really struggle on is really developing plans that we're able to carry out and carry out effectively from beyond a single program level. Now we do program plans that we can do fairly well, but when we get into multiple levels of planning, it's harder.

I actually thought--think about planning in terms of being effective in public health. In fact, I would challenge many of you in the audience to just think of a time that we've been effective in public health, where we actually haven't had quality planning? Think back to your own state. Think at a national level. Think at a time where we really did a major job of being successful in public health, and we didn't have a strong planning effort related to it. So that in my opinion, good planning is essential to being effective in public health, and that without it we cannot succeed.

So when I started out with the problem that I think that we have, which is planning across broad programs, it identifies that we may have some problems with being effective. And when I think of planning, I do like this idea of plan, do, act, or this idea of planning and doing and really like to think about it from that process. Well, we talk about assessment as a part of a--this first step in the planning process. Like now, how we talk about capacity assessment and strategy as a stage, we actually develop a plan, we implement it, we monitor and we evaluate.

However, I think most of the time in Title V, I see your planning process more like this. We do assessment and we evaluate our capacities and strategies, and we'll have a plan. And please don't confuse it with the budget. We will implement, we will review. And if they require us, we might actually evaluate. However, if they don't require us, we may not actually get to it. And what happens here is we also

have different people and different units doing each of these so that we almost carry them out as independent functions and not one process that actually reaches to the end. Well, then you don't have a planning process. And that's where your seams can start to break down. And so I think it's really important that we think about how we accomplish what we do. Now, I realize that sometimes we have constraints that make it difficult, take for example budget.

Sometimes, I notice there are some states where the legislature actually budgets the block grant dollars. So it sort of defines exactly how those dollars are going to be spent. But we do need to be clear about what the process is and what we need to do to create the change that needs to be happening, because if we don't define it together in some sort of process, we'll never actually get there. Well, that was interesting, isn't that one? The other thing is in Title V is sometimes we think about this because the block grant requires needs assessment every five years, that somehow this is a linear process and that you actually move from one stage to the next stage to the next stage, and that you actually do it on a five-year cycle.

The nice thing about now being older is I don't think I actually do anything on a five-year cycle except actually turn reports in. Data doesn't come in on every five-year basis. The systems we develop, the information that we need, our needs don't just pop up on an every five-year basis. Our planning, our budgets, our programs need to change--don't happen on that basis. So the key that I like to

think about is that we really need an integrated process. We need to be thinking about how do we do these functions well. We do them integrated, and then on every five-year basis we stop and we pull those pieces together so that we have what we turn in as required, as part of the block grant. But that the block grant in every five years is not an all of sudden gear up. I still see states where all of a sudden, they'll hire staff and bring on people to get the needs assessment done. About two years or to one year out from the block grant because now we need to staff up to get this done as if you can, all of a sudden, accomplish all these steps and pieces effectively in very short time period. And then afterwards, (inaudible) staff turns over. Well, we don't need to fill those positions. We don't need to continue that, or we can now redefine those roles. Or, in fact, I will tell you that you got a lot of needs that you needed to define better. You know that you needed to--and those people need to be around to actually help get that data, so that the next time around it's actually there and useable for your process. So that you need to think about where you are in each of these steps and what that process is and be clear, because again, I go back to the idea that needs assessment is part of that planning process. Let's give you an example from some of my South Carolina days. I was hoping they'd bring a (inaudible) here so that we don't stand up in front here the whole time. But, did you?

UNKNOWN SPEAKER: (Inaudible)

WILLIAM M. SAPPENFIELD: No. No. This is the take-mic. This helps make sure the TV camera has it. (Inaudible) right now is this one. Well, there's being (inaudible) here. I actually asked. So this is an example of late prenatal care and-entry into the South Carolina. Starting back almost to some of the time frame that Donna was talking about, in terms of 1981 up to 1989, and the changes that needed to take place. In this, you can see the percentage of late entering into prenatal care. That's prenatal care after the second trimester or no care at all, going from zero to 50 percent, from 1983 up to 1987. The blue line is that of South Carolina. The black line is--the region black, the red line is that for white. We've gotten together to work on prenatal care in this late entry. It was a problem that was there. We weren't making headway.

We decided at that time that we needed to start a planning process, so the first thing that we did was started a needs assessment. In that needs assessment, we found out that we were under reporting prenatal care visits. We were one of the few states that literally train and require the visits to come off the medical records, so that not all the visits were being counted because of records that weren't complete or things that were being done.

We discovered that we had physicians who actually told women when they call in to not schedule an appointment until the second trimester. It's actually hard to have first trimester prenatal care when you're not to schedule your appointment to the second trimester. Even though WIC was not supposed to have waiting

lists, so we officially did not have waiting lists, sometimes it actually took a while to get in to WIC. And in South Carolina, WIC and prenatal care, at that time, was integrated, and so you couldn't start prenatal until you were into WIC.

We actually started to try and work on this problem at a community level, and a lot of response was--in the community level was, so what, what's the problem here? So that it's hard to engage people to create change when in fact it's not even recognized to be a community problem. Of course, we had the traditional problems that continue to be brought up with transportation and child care. And then what we actually figured out that one of our worst risk factors for, earlier into prenatal care was, in fact, unintended pregnancy.

And that from analysis that we did, it counted for almost two-thirds of the late entry into prenatal care was because women who had mixed feelings about their pregnancy at the time they got pregnant, and we had not figured out how to crossover some of those issues. So in that process, at that needs assessment, one of the areas that we focused in on, we took some--each of these as areas that need to be addressed in our plan, one of them was on prenatal reporting. Yeah, so I'm gonna talk about that one because that one is easy for most of the audience to understand. Well, we--in our needs assessment, things like in our problem analysis, we--our vital registration manual actually hadn't been updated in 10 years. And, oh, by the way, we had implemented electronic birth certificates

within that 10-year period of time, but didn't update the manual at the time we did the electronic birth certificate.

Our clerk training was done in an as-needed basis, as we found out there was a new clerk in the hospital that was collecting the data. And we figured out they needed training, we would send somebody out. Health Department records, well frequently, actually not considered to be prenatal records, so sometimes they weren't being put on to the chart, and sometimes we weren't making them over from the Health Department to the hospital, or some of the later records were not being made. We did this (inaudible) for the physician records that many of them got the early prenatal care records and none of the later records. So all those visits that occurred much later than prenatal care weren't counted. We had women who would go between two and three prenatal providers. They would all start with different records, because they all like to collect it differently. And the idea was that maybe if we all used ACOG's record or standardized record that we might actually just be able to transfer one record to the other and have more complete information.

There was absolutely no physician or hospital education about prenatal care, the importance of prenatal care, monitoring prenatal care, or the need to address the issue. We reported prenatal care when the birth certificate files were completed, which was about six months after the end of the calendar year. So she only knew how you were doing in your prenatal care problem on an annual basis, which for

a feedback mechanism to improve, prenatal care participation is a very long feedback mechanism.

There were hospital standards actually require some of the prenatal pieces, but no one had thought about how to build in the prenatal pieces to the hospital standards. And we actually gave no incentive at all to the hospitals to report on birth certificates through poor prenatal period point accurately. They were supposed to do it because they were required to. So we looked at all those potential needs and strategies and had debates. We look at what we could do, the capacity that we had within the Health Department, what strategies we thought would be successful, and we then identify the five of them in red and develop specific plans to work on each of those five areas we've measured to talk about when we got those done.

We did that through all six areas of the needs assessment that I showed you, so that we had very detailed analysis in each of the six problem areas with detail plans, each other groups, work on each of those areas. And we launched those plans and started our monitoring evaluation process. In over the couple of years that we continue to watch, we did drop or white rates continue to improve or black rate continue to improve. It so did it, for the region as a whole, for blacks. So, were we successful, were we not successful? That's an interesting question.

Yes, we were successful. In proving so we're--others, we're not sure which part of what we did actually made the biggest difference. However, compared to our previous track record, we were happy that progress was being made. And in the process of doing this, what we discovered is we--I had to formalize planning process. We have been actually working on this issue for several years and that we needed a really strength in our planning process to understand how we were doing (inaudible). Back in 1983, we are only serving 26 percent of the poverty for Medicaid. In 1985, we went up to 100 percent. In '87, it was 150. And then '89, it was 185 percent of poverty. We discovered at that time that we were (inaudible) so we increased the prenatal and obstetrical payments. We started to just become the tertiary center or the triage center that signed women up for Medicaid. We form out to private doctors. We started to work on a variety of systems issues, so that when we've learned that it wasn't really any one strategy that it was repeated strategy to make a difference.

In fact, most things with public health, you know, discovered that you may not get it right the first time. And our first answers may not be the best answers, and it's an essential part of a planning process is to make sure that we plan, we figure out our best strategies. We implement them. We evaluate them. We see whether they're working, whether they need to continue, whether they need to be revised or changed.

When we looked at our Title V block grant in most estates I've been at, we've not been able to make the full loop of the planning process. We get geared up. We get the needs assessment going. We get people excited. We get them interested. We started on our plans. Our plans are probably not quite as good as our needs assessment because time ran out and we had to turn something in. And we didn't always go back to it because once it's in and submitted and the bureaus accepted it, we know we need to improve it but we have other things that we need to get done. And with our data people, we have them on board, so we start that monitoring process. But by the time the five years wears out, I think in most of the time, if you actually tested people what our priorities are, what our planning elements were, and what we needed done, the number of people who may still be in those positions in those places who knew what they were probably are not as good as they need to be. And then the evaluation pieces starts to being a problem.

So why doesn't the planning process happen? If we can only be effective by actually planning and planning well, why don't we do it? Well, when I talk to states and consult with states, the first thing we hear is, "Well, my staff are overcommitted." They really don't have time to do that. What is the problem with overcommitted staff and not being able to plan? How do you ever not have overcommitted staff? I mean, it seems obvious. But if you're overcommitted and you're too busy to plan what it is that you need to do to be effective, then you got some issues that you need to be thinking through.

Second is the lack of political will. It goes back to some of what Donna change-- said is, do we really want to change? And have we really created the process that leads to change? And if there's not that change process behind the plan, and the plan's not proceed as a real-life instrument to create a change that needs to happen, then it doesn't go very far. You have a variety of people who are committed to the present activities. We're doing what we know we need to do. We're doing it very well. Please, leave us alone. Let us get those done.

How many people have been participating on a planning process that didn't work? How many feel like most planning processes that they're in don't work? Part of the reason that plans are not successful is we've all been parts of one and they've really not been designed to be successful from the start. And so, in fact, the reason you have problems in your plan is because you have a history of not being successful. One of my favorite is I think people feel like some people are just supposed to be born with planning expertise. That it's innate, it's built into the DNA.

Plan is actually a skill. It's actually a training. It's actually a form of undergraduate and graduate degree. It really does take the right skills and the right people. And frequently, what we do is we assign planning responsibilities over to staff to do who have little planning expertise or process. Insufficient resources, there's not the resources we need to do what we're doing now. The idea of doing other

things seems foreign. Or you actually have competing priorities or desires at the time of the planning process. So, there's a lot that really inhibits that planning process. And if you don't start upfront, recognizing each of those, these things and addressing them, as you start to get ready for your next needs assessment, be prepared for some of the same results.

So, the idea is it's an integrated process that needs to be done. But I really like is they always say, "Well, Bill, who should do the needs assessment?" And I always say that that's immediately the wrong question. We just talked about being effective is about planning. So, the key is, who's doing the planning process? Who's responsible for the overall piece? What is the--what's going to happen when, where, how, what are the resources? If you can't start out by defining your overall planning process first and talk about how needs assessment is part of it and how it fit in, you're automatically going to start out with an un-integrated process, and you're going to go back to that diagram where we do everything separately.

I mean, frequently, "Well, we need to get these done, so, Bill, your data, so you do the needs assessment. You're the program. You all had--go ahead and start the planning now, and when we get back together and get them both done, we'll put them together and submit them." No chance for the needs assessment to really affect at all that planning piece. And the budget people don't even want to come to the meeting. They (inaudible) just take care of the budget. So, the key

gets to be is anyone who turns to the data person and say, "Well, this is a needs assessment, you're now responsible," you're already starting off wrong. Needs assessment is a planning process of which you will use data to help choose priorities. And if you don't recognize that in the "who, what and when" as your planning, you're going to start out in the wrong position.

What we're going to do now is break you in to the first case study. This is going to be an ongoing lecture of mine today that we're going to do. The case studies are in your packet. It's case study one. And what we're going to do is encourage you just to stay at the tables that you're at right now and work collectively together. Now, I realize you're from different states, and we're going to start--well, maybe, let's--no, let's go on further. I'm sorry, I'm starting (inaudible). Forgive me. (Inaudible) is where we start. So, let's go on to needs assessment.

Again, needs assessment is a step within the planning process. And if you don't recognize that from the start, you're in problem. So, the definition, this is my definition. I suspect Donna and Greg in their book have their own definition, and Donna may want to share that to us. But I think about it as a systematic collection and examination of information to make decisions to formulate a plan for the next steps leading to public health action. Now, in that, I recognize the examination of information decisions is priority-making and it's a value-driven process. But what I'm trying to emphasize here that needs assessment is really what's supposed to help you make decisions in a plan that's leading to that public health action.

And it really--and the point I'm trying to make is it's all about the next steps. If needs assessment hasn't lead you and set you up for the next steps related to planning and determining strategies and evaluating the capacity of your department and what you need to be able to do, then needs assessment hasn't helped you. If it's a data exercise that's left you with more data than you know what to do with and you cannot distilled it down to the priorities, you cannot develop the cohesive nature that you need to get everyone on board to formulate a plan, your needs assessment will not be successful. The whole idea is what should the needs to be? One is, needs, in my opinion, needs to be conceptual. You need to have a real framework of why you're doing it.

I will have to chuckle. Earl Fox, who's former HRSA administrator, and I just heard he's now helping with the transition team there at HRSA in terms of what needs to happen again, invited me to come to Mississippi. He had just got through linking his birth and death files, put them all together, and he literally told me he had a room that was eight-by-eight-by-eight that was about six-foot from the floor up full of printouts of all the data that he had asked his vital records people to run on the link file. And he wanted me to come from CDC to help him interpret all those printouts to decide what he needed to do to address his infant mortality problem. How many of you want to sign up?

The whole idea is if you don't have a concept and a framework of how you're going to take all that information and interpret it, use it, and come out to a conclusion, if you don't have that framework up start, upfront at the start, you're going to drown. I can't tell you how many--even as an epidemiologist, I love numbers, and I sit in and they bring me the book, and you sit down and you're now supposed to have a conversation, and I'm just totally lost. And then we'd put people who are not data people into this planning process and they can't see how data is really useful. I mean, I can remember when they said, "We'll just don't invite the data people to the meeting." It needs to be visionary. The needs assessment is not about where you've been. It's about where you need to go.

Before the bureau actually started the random-digit-dialing surveys for children with special healthcare needs and for children's health, we were in South Carolina, for years, we've been struggling with special needs children to actually figure out what their needs are because there really wasn't the datasets to do it. So, we actually, in South Carolina, got (inaudible), identified children with six-marker conditions across the spectrum of children with healthcare needs. We went ahead and identified every state we could to providers and systems to identify the names of children we randomly selected. And we went out and interviewed almost 850 women either in person or by telephone to identify all their needs. We had the special needs director with me the whole time, helped develop the instrument, figured out what we really needed to know. We worked. We got the results. We got it done. We actually got it in time to actually have a

plan, develop a plan for the block grant. And the special needs director actually backed up and said, "Bill, I see these needs. These are really clear. We really need to address these." We're not ready to address these. We're not at a stage that we can even begin to address these needs.

And so, (inaudible) plan that was unrelated to the needs assessment that we just completed. So, we were visionary, but in some ways, even with a detailed planning process and working together, we overshot where we wanted to be. Now, the good news is (inaudible) came involved, she got more money, and for the next five-years needs assessment, actually that needs assessment did tell her what the new issues that she needed to be working with, and in fact, incorporated those pieces into her second five-year plan after that. So it wasn't a total loss. But there is this need to be the future, but it's got to be a future of where you can go and be realistic of where you can go. And everyone needs to understand those limitations.

I mean, one of the things, when we bring our partners and our stakeholders in, sometimes we're uncomfortable just telling them how decisions are made and what's going to happen. But if you don't have that realism when you meet with them and you build all of the expectation up, what's going to happen when you go ahead and do what you're going to do anyway? So, you need to have some of that vision for the future, but you need to come back, as I'll say here, and be pragmatic and be open to what can be done.

The other two things that I want to emphasize is, believe it or not, data can actually be action-oriented. It does not need to lead to paralysis. And you need to make sure your needs assessment is structured such that by the time you finish, you're actually compelled to go forward and that it's led to a cohesive effort.

There are a lot of different types of needs assessment. You can do communities, you can do populations, you can do health systems, programs, health services, health problems. But what I'd like to think about needs assessment is having sort of two parts to them. The first part is that health problem identification, measurement and prioritization. That includes that stakeholder process that Donna did a great job of covering. And then the second part is to actually analyze those priorities that you talked about so that you can connect them up to strategies and capacity and what it is that you can do. And I want to talk about these two parts because I think sometimes we don't get both parts done well. And I'm going to add on to some of what Donna talked about with that first part.

I think the first thing to talk about is, what is a health problem? And that seems strange to talk about what that is because many of us epidemiologists, we immediately say a health problem as an outcome. Well, that's not true. A health problem can actually more than an outcome. It can be a service. It can be an issue. It can be a risk factor. And we do all of those things. You may also find, as Donna brought up, the community's perceptions may be different from yours.

There may be measurement issues. There may be comparison issues. But it is about helping understand what is a health problem because each of these could be quite different. And as you get to your needs assessment process, you need to have some agreement as to what is considered a health problem because your discussion and debate, your prioritizations will be all affected by what is your definition.

Donna talked about the stage of stakeholders and partners and reports in problem identification and verification. This is that first phase where you go out and try to figure out all the problems that can be identified that you think need to be addressed. That can be through the key stakeholders, that can be through partners, that can be through reports. It can be through the different data that you have available. And I do say verification because, as Donna said, some people would bring problems up and they may not be data. Some people would bring problems up and they're not really as bad a problems as they thought they were or not defined. And so you'll have that process of verifying.

And then you'll go to the idea of defining it in such a way that you can start prioritizing. You'll talk about the extent, the duration, the expected future course. Does it have variation? So you'll take those stakeholder pieces and then start trying to describe them and work with them in a way in which you can actually start to prioritize. And this is when the data pieces start feeling heavy. A lot of this here is actually is much qualitative as it is quantitative. So your epidemiologists

may not always be the best at helping you through all these stages. This is a place where bringing in your epi and your quantitative as well as qualitative pieces in can start to help.

The key gets to be, at some point in this political process that you just talked about, we've got to decide. And I do think we need to realize that, as Donna said, this is all about values. It's amazing to me how many people think that needs assessment is truly a data process. And it really is a value process. Even choosing what is a health problem is, in fact, a value because you're saying, "I now value this." How you measure is important.

We consider, for example, infant mortality in this country to be an important and a major problem. There are still communities in the world where infant mortality is not considered a problem. They're expected, that's why you have more children because some of them will actually die. There is this idea of what do we perceive as a problem or not. And so what happens when you start choosing priorities and how you choose them, you've got to realize the choice process are a value-driven process. You say, "No, Bill, we can put scores and numbers and all these pieces to them." But all those scores and all those criteria and all those numbers are chosen based off of values.

Let's talk about it, for example, group consensus. The idea of group consensus here is your valuing that all of us can agree that these are our priorities.

