

MCH EPI Conference

State Title V MCH Needs Assessment Practice

December 8 – 11, 2008

WILLIAM M. SAPPENFIELD: In other words, if the group doesn't buy in to how you choose your priorities, how much of a consensus in a political movement will you have at the end? In other words -- and if you're going to take your stakeholders and they're going to be advising you, they're going to give you input, and then you're going to off into another room and choose the priorities, and you come back and tell them what they were, and they don't look like what the advise you they're going to be, how much of the consensus building process do you have? Thank you. Thank you.

So that, I want you to think about -- so, how you choose is actually is important of a political process as choosing itself. Let's talk about some of these processes. One of these is Q-sort. I actually learned this from Donna and Greg in my first time. Donna, do you want to talk to them about Q-sorting?

DONNA PETERSON: Have you ever used it? Have you ever used it?

WILLIAM M. SAPPENFIELD: Not yet.

DONNA PETERSON: It's really a lot of fun, because what you do is you take from -- again, presumably you been gathering data and information and then you

(inaudible) folks, and then you can identify series of issues (inaudible) going to define your health problems. You can put them on index cards. And you give everybody in the room a set of these cards. So each one, it might say, low birth rate, it might say lead poisoning, it might say breastfeeding, it might say -- and (inaudible), but do you get the general idea? And then you ask people to sort them, just like this, where this one is the one you think that is the absolute most important, and this one is the one they think is the least important and you just group it.

So if you think breastfeeding is the most important issue, then you will put that one here. And if you think prenatal care and adolescent health is next, they both go here. There's no value to where you put them here. They're just next. And so on and so forth. And so you sort all of them in this way, turn all that in, they fill it out in a sheet. And if you have the capacity to do it onsite it's great. Add all of that up and (inaudible) program, you can put this right into your computer and it will tell you then very importantly very importantly where you have an agreement and where you don't. It's not so much important about what ends up being number one and what ends up being nine. It's where do you have an agreement and where do you not agree.

So if you got breastfeeding both here and here, that's something you're going to have to deal within the group. If everybody put child restraint, passenger restraint somewhere in the middle, okay, then you know what (inaudible) kind of agrees

where child restraint go on. Does that make sense? So it's a way to then facilitate discussion about where you really want to go with these things, and it is a way to move off the table when you got lots of issues which we keep talking about. And you all know this. (inaudible) and said, you know, we're dealing with this huge array of issues. We'll here's one (inaudible) off the table, those where there's general agreement, and then you can focus on the ones where there's not.

If everybody agrees breastfeeding should be number one, you don't need to about it anymore. Right? But if there's wide discrepancy about whether or not breastfeeding should even be on the list, that's what you need to talk about. So, it's a way, as Bill says, not only it will get you in the answer (inaudible) set of priorities, but a way to manage that process. So that is inclusive and respective of all the different values of (inaudible).

WILLIAM M. SAPPENFIELD: And the key is it is that process, it is that having that discussion and people buying in. The other thing is –

I would say in (inaudible), the hardest thing for us to do is what goes here -- we never want to talk about this. We used to, in some in the places I've been, try to rate things as high, medium, low, or extra high, medium low, extra low, and everything would end up being high or extra high. If it was medium, it was dead. And if we didn't do that, the other thing we like to do is we would roll it together.

Well, somehow breastfeeding and (inaudible), those are all education to those all young mothers. Maybe that's all in one (inaudible). So we'll sort of crump them together so -- and they're not really close, but it allows us, since we can only have so many (inaudible), but it allows us to make sure that all 28 priorities fit into 10 that we turn it to the Feds. But the challenge gets to be that it gets spread so thin we don't do any of them well. And it's not because you put something down here that you may not do it, it may mean, this time, it's not the priority that needs to be addressed. Because the idea is you only have so much energy, leadership and vision and time. And the key is you want to do a few things well that make a difference. Are you still trying to be so thin and then complaining that you can't accomplish it.

So I really like the idea that somebody has to spend as much time figuring out what am I not going to do is what my top priority is. And how many have done that? That is actually hard in MCH. The other process we talk about is the idea of selecting by criteria. The idea is instead of letting people vote for the popular. We invite -- (inaudible) kids' people to our group. So, I wonder what they're going to vote for is their priority. So, what you try to do is have a criteria based process where you'll take the magnitude of the problem, what the trend is, the consequence, (inaudible) preventability, national stakeholders, what is the agency's capacity to address it? Is it politically (inaudible) to be acceptable?

There may be other criteria. And then what you're going to do is -- of course, let's be clear, we have criteria base. There's the official criteria and there's the undercurrent of criteria, like (inaudible) the priority (inaudible). So we have a new criteria. I love it. Well, this is an impartial process 'cause this is criteria based. It's like -- and how many people in the room worked the system? Be aware. But the idea would be is you take those priorities, you put them in a listing here, and you'd have got magnitude, trends, severity, preventability. And who said that those criteria all have to be in the same way? You may choose, that -- meeting the national goal is nice, but it's not essential, community acceptability. Regretfully, not everything we do is what community perceives is as most important, but do we have the capacity, severity.

Then, what you do is you come back and then rate each of those areas. So for example, with magnitude, if something is (inaudible) prevalence, you might get a one, if it is moderate in some subgroups you get a two, moderate in all subgroups you get a three, high in some subgroups you get a four, and high in all groups gets a five. So then you go back, you look at your data and you try to score each of your problems apt, and you put each of these problems into this multiplication matrix and you come out, since you can actually take each of the problems identified based off of your criteria and get numerical scores.

Why do you like this? Because it does automatically put some things high and some things low. As Donna said, though, the number is not the final decision-

making process. The key is the numbers give you a starting place of where does everybody fit out, where do we agree, where do we disagree, what comes out high, what comes out low, what did we rank fairly, what did we not rank?. So this is another way to do it. The key that I want to (inaudible) with though is when I talked to Greg and we -- I always enjoyed my conversations with Greg, the bottom line is, he said, most places should probably end up doing some or both of these, because most people, when they start (inaudible) problems in MCH are going to end up with a hundred things on their list. So you start out with a hundred, you use something like a criteria-based process to figure out what your 25 is. And instead of clapping those 25 into 10, use your Q-sort to help you maybe round out those last of your highest priorities, so that your discussing and debating those last most important.

The key gets to be is, these are all tools, no one is perfect, but you are trying to develop a consensus around the values in where we can move ahead. If in this process, you don't have buy in to those priorities, how far are you going to get in your plan, that sort of that memory piece? How about questions, Donna covered a lot of the first piece in terms of the different data sets you needed to go out of and the people that may be included. And I've tried to talk about it for more of the steps pieces. Does this make sense? Issues, Ken.

UNKNOWN SPEAKER: What happens to something like preconception care, which is, in effect, an emerging issue where public -- if they know what it is at all,

clearly doesn't see it as a high priority? And maybe our priority is to educate people, but wouldn't it fall off in this nature?

WILLIAM M. SAPPENFIELD: Well, I love that question because the first question you would say is, is preconception care a health issue, or is it smoking prior to pregnancy, or lack of primary care for women. So, part of the question gets to be is how do you even -- do you take all the preconception care and health and can you consider that as one issue, or is that a variety of issues? So part of that discussion you need to have is how do you want -- what do you even put under your level of issues. For example, is infant mortality one issue, or you take all the components of infant mortality and put it underneath? Or prematurity or if you got prematurity here but then you also got prenatal care, are those separate priorities or they're similar priorities? Ken, those are not easy questions. Donna, you want to -- I'm going to make this interactive, so Donna --

DONNA PETERSON: Yes, I think, (inaudible) and I wish we had more time. One answer to that might be that's the strategy, the response to whatever it need is. The other thing though is I always try to get people to keep backing up. And when you are dealing with lots of stakeholders and they come in with their issues, their issue is usually a solution issue. They're there because they want to be hit (inaudible). They're there because they want, you know -- and let's back up to this -- this part of the exercise really has to be problem identification not solution competition.

So what is, you know -- so if you're there and you're the preconception care advocate, okay, what it is you are trying to accomplish with preconception care. Let's back up. Is it smoking? Is it weight? Is it of the things that Bill mentioned? And that's also important in this context when you get to evaluation and monitoring is that you start with solutions and you have it -- linked it back to a particular problem. And what is your evaluation, in a way, as an outcome? And then you're only looking at a process. Did we or did we not change the dynamic of preconception care? But if we didn't know why we were doing it, then we have nothing to measure. Did I make (inaudible)?

WILLIAM M. SAPPENFIELD: Well, to pick up to why we're doing that, the other thing is like we started out and say the problem can be (inaudible) helmets --

DONNA PETERSON: Right.

WILLIAM M. SAPPENFIELD: Well, then your -- selecting the problem had, in fact, leads to your automatic solution. So this, the whole discussion about what is included in your range of the problem, what is the solution, what is the capacity and more importantly, what should be separated out and what should be rolled together. And that, that's going to be a part (inaudible).

DONNA PETERSON: The other thing on this list -- I had a conversation at the break with somebody -- there are things that you are going to do whether they ever get brought up in these processes or not, either because you have to from the Feds, like doing a screening at all of the newborns. It doesn't matter if you (inaudible). Or there's those things that the First Lady goes to (inaudible) as we're doing this. Or the example (inaudible) the grandson of the governor has a rare disease. You're going to do that. Now, that's just reality. You don't have to confuse this process with those things. So, you don't have to say, well, I got to make sure that newborn screening or (inaudible) is on the list. No, you don't, because you're going to do those things anyway.

You want to keep this process short, if you will, really thinking about what are the issues and the means and the problems, and what do people collectively think. And I like the way Bill describes this because using something like a criteria scoring system, people don't like it necessarily but it does force some discussion about how important are these things really. And that's something like a Q-sort. You let people -- it's their opinion. You let them (inaudible). Working the two together is one way that you bridge the data with the policies (inaudible).

WILLIAM M. SAPPENFIELD: The other (inaudible) because you got people (inaudible). And some people are rationally based decision makers, and they love the idea of the criteria. That's me, I am a rationally based decision maker. There are others who have contextual and qualitative and emotion, or other

parts, and they feel like this is stripping them bare. But this is not really real (inaudible) so it does let you have a little bit of both process that takes place and it is not necessarily easy.

So I think it's -- (inaudible) answer the question. I guess, the first question is assigning what is wrong, and then realizing that somebody is going to have to have a reason to shape those up into comparable things that you can actually write and choose, but figure out how to build those together. And if you got (inaudible) that you're not trying to just to preserve that. Other questions? Yes sir?

UNKNOWN SPEAKER: How do you feel about prioritizing public health problem using cost benefit analysis (inaudible)? That's not mine.

WILLIAM M. SAPPENFIELD: How could anyone do this to a speaker? I mean, you could be any more rude than if you would. I think the key on a cost benefit analysis is that's usually related to a strategy. Usually, cost benefit that is related to an intervention, and that should come under the -- what I call the capacity assessment, strategy development approach, where you trying to say, okay, how am I now going to choose which problems to address. So that that's really a part of the planning process for actually what's going to happen versus the actual needs assessment.

Now, you may use cost as part of your criteria here because you can actually talk about what is the total economic cost, let's say, prematurity that IOM report came up with. The problem is for many of our health problems, we don't have that level of cost data to help become a quantitative measure. Other questions? Yes, ma'am.

UNKNOWN SPEAKER: I don't have a question, but I just want to give a real-life example. In (inaudible) last time in needs assessment, we used this model. And what we did was we created three internal workgroups for the three subpopulations that were part of the (inaudible). And what we did was we had program person and an epidemiologist as we (inaudible) groups, then invited people to come and they have to present those areas, the topic that they thought was an issue.

So then the discussion started, and what people would do is when they had their own topic and they (inaudible), they became passionate. So you to have kind of recognize your passion, but the rest of the workgroup could kind of balance their passion against the other, and then through the rating process that occurred, and it became numerical with kind of -- was able to sit through that.

WILLIAM M. SAPPENFIELD: It can be helpful elucidating. I mean, there are some people that help the data people. I mean, magnitude of the problem, the trend of the problem in severity, you could say (inaudible) are things that are

fairly objective. You could actually pre-score those and try to make it easier. But, also you have some who'll say, oh, no, don't you put my score down for me. So, yeah, if they doesn't allow that dialogue of -- where you are coming from could be very different and I appreciate that, because that's exactly what this is to do is to move us from my issue to where does it set everyone. And I don't find the Q-sort often does that is well. I do agree the idea of Q-sort helping. Once I have my shorter list, it does help me to sort of weigh through that.

UNKNOWN SPEAKER: So that's what happened is you should bring internal workgroups had you come up with I think -- I can't remember, I think five or six that came to the, a central group, and that's when I'm thinking, this year, whether I'm going to suggest is then we go to the Q grid to try to figure out how to take the five or six from the three workgroups and wheedle them down to something under 10 or seven or nine, whatever it is.

WILLIAM M. SAPPENFIELD: Well, now is the time -- actually, if you are going to go to case study one. I apologize, and do within the group to the table that you have. Hopefully, I know there are some tables have more people than other, if you feel like you're too large for a group you may want to reshuffle. If not, stay where you are. This one should take you roughly about 30 minutes.

We're going to talk about the exercises for a second or two and answer questions. I know you may not have finished it fully but it's going to be one of

those days. You may not make it through all the exercises fully, but we wanted to give you a taste. So, that first question, does that seem like a very important question? I'm hoping that's the question that you're asking yourselves when you're going back and doing your needs assessment. The bottom line is what's going to be different tomorrow because you did the needs assessment today and why is it going to be different and how did you get there. And so that first question that you should be asking as you start your needs assessment is, how do I make sure that I want to really get the result that I need? So, I'm hoping that that discussion you had at a small level here at your table, you take it to the big level when you go back to where you are.

The third question, who's ever done this give-get exercise? When you put people in a committee and you talk about giving and getting, have you done that before? Many of you? How many of you got invited in a meeting and it's a very large meeting and everyone shows up, and the next meeting you get about half the people, and the next meeting you get about a third of the people? You been through that experience? Why does that happen? You invited them to help you get something out of them, why in the world should they come back to your meeting? As long as they went to the meeting and found you're not going to hurt them, and they don't see any benefit to them, there's no reason to come back. You got to make the first meeting because you're always worried that the first meeting you might have something that's going to hurt you or might make you better off. But once you've done that scan, I don't need to come back again.

This idea of giving and getting is extremely important with your stakeholders. If you're talking about the Title V needs assessment, they need to know that the message is more than you're going to meet your Federal requirement and turn your block grant in. They need to figure out in that first meeting, so what am I going to get out of this, why should I be participating, what value does it have. Now sometimes, that giving and getting may not be money to their program. Some people need recognition. March of Dimes always likes to be recognized that they played a major key role in state leadership in choosing priorities. It's not bad, that's important for them. We make sure they get that recognition.

Sometime, frankly, you cannot figure out why this person should come back again. That's when it help they're really good friends and you maintain your real good personal contact with them so they feel guilty if they don't come back because it's your meeting that you're sponsoring. But I think you need to make sure in your dynamics you think about that, and that's why that transparency and being honest about what will happen when so they realize that trust is there, all those are factors. Otherwise, your needs assessment will not really have their input. Does that make sense? So what about this idea of waiting and criteria-based, problems, issues, questions?

UNKNOWN SPEAKER: We decided or I recommended to change the way for magnitude to three being the highest for the magnitude.

WILLIAM M. SAPPENFIELD: And why you think magnitude should be a three?

UNKNOWN SPEAKER: Because that kind of -- well, it kind of brings in (inaudible). It's kind of an overarching thing here, the magnitude of the problem.

WILLIAM M. SAPPENFIELD: Is it the magnitude? I thought it was severity? Isn't death more important than you not getting into school quite as quickly?

UNKNOWN SPEAKER: If one person dies of a disease that have ultimately severity, but only one person in your state has that, a disease where 50 percent of the people die, 50 percent of your state has that disease, it has less severity but more magnitude, so I put magnitude at the top of the (inaudible).

WILLIAM M. SAPPENFIELD: But if I have four percent, then I have four percent who are going to do poorly in school and not reach maximum potential because they have developed mental problem, isn't that more important than just the magnitude? I mean not everything is death. I realized death is rare but there's other (inaudible).

UNKNOWN SPEAKER: I would (inaudible).

WILLIAM M. SAPPENFIELD: You hear the discussion. The key here is one right or one wrong?

UNKNOWN SPEAKER: No.

WILLIAM M. SAPPENFIELD: Is this a data discussion?

UNKNOWN SPEAKER: No.

WILLIAM M. SAPPENFIELD: This is the key. This is all about values. Donna and I want to have this debate. Donna, what should the acceptability be?

DONNA PETERSON: Three.

WILLIAM M. SAPPENFIELD: Why?

DONNA PETERSON: Because if it's not acceptable to the community, it doesn't matter.

WILLIAM M. SAPPENFIELD: So if the current administration doesn't think contraceptive use is very important, so I should pay a high attention to that.

DONNA PETERSON: (inaudible)

WILLIAM M. SAPPENFIELD: I mean, these are all real important discussions. Even if you don't score, let's be clear, even if you don't go through this whole mathematical exercise, this type of discussion with your health problem is going to do what to your group? It's going to really be enlightening of where to balance and how do I fit, because even if you only get Q-sort, you still may want to have this sort of discussion so that before they start voting in Q-sort, it's not all just preset thoughts. Does that make -- Ken?

KEN: First, to comment, I would say preventable should be (inaudible). If it isn't preventable, why are we doing it? But more important is, the discussion that we had, one of the things that came up was the difficulty of identifying problems because they come in different frames and framing what should we call this problem, and we had several different ways of framing things that may or may not have been able to be -- separate different strategies.

WILLIAM M. SAPPENFIELD: The other problem is capacity. We have this tension in our state between, do we provide health services or do we do real public health? And right now, our capacity to do services, so should we -- should capacity be one of this if we really aren't moving to what real public health is. All real important value judgments. These numbers up here are more pretend and fake to give you a chance to have a (inaudible). Now one of you (inaudible) have problems with numbers? Be clear. Your -- people you bring in are going to have

a lot of problems in numbers. You may have to (inaudible) it down, like, instead one, two, three, high, medium, low, or some otherwise so that they don't get lost in numbers? Okay? Yes.

UNKNOWN SPEAKER: I want to be concerned with people trying to create too many weight levels because if you end up like the one-to-eight scale there, you got to find out whatever you got an eight weight on, (inaudible) is going to make that completely subdominant and it's going to be the only thing (inaudible).

WILLIAM M. SAPPENFIELD: (inaudible) a lot of things with numbers and their recommendations for writings was one to five, that after that one to five, it losses its real strength. But they would say on the scores over here about one to ten, but the problem gets to be, for some people, that's way too many numbers. So, this is where, again, the whole idea is get consensus political will by the time you finish so you don't want to -- it's getting through the process together that's as important as whether it's one to five or one to ten.

UNKNOWN SPEAKER: Could you maybe justify that all the weight have to add up to a fix number like 20, so then you have to divide the weights accordingly. You can't give them all the same number.

UNKNOWN SPEAKER: Yeah.

WILLIAM M. SAPPENFIELD: Well, you could do that but the other thing gets to be, if I write them all to three, does it matter?

UNKNOWN SPEAKER: No.

WILLIAM M. SAPPENFIELD: I'm just saying they're all equal. So, the whole idea on weight is, really, what all is important is the relative value. Many people will have a long discussion in the weight; you know what you ultimately do? You don't weigh. You finally agree, we have enough of disagreement, enough -- there's not that much different, guys, weighting is not important. But my experience is if you don't have discussion about weights, you're going to have that -- now you can complain, well, this is really boring. If we had scored this more, we would have chosen.

So, you have to have the weight discussion upfront, but I would say about half the time we end up dropping weights, because after we've had enough discussion about, it's magnitude, no, it's severity, no, it's preventability, no, it's acceptability, you finally say there's not that much difference. And again, the numbers don't make the final choice. The numbers give you the ranking out where the disagreements are, and then your discussion from there helps.

Okay. We -- they're going to start lunch at 12, so we're going to walk through the next piece. What I'm hoping is we'll make it to the lecture on problem-oriented

needs assessment, and then when you come back after lunch instead of, complicating, I guess we'll give you a start. You'll be back in doing case study two right after lunch.

Problem-oriented needs assessment -- this is one of my favorite cartoons. Teen pregnancy is caused by family breakdown. Teen pregnancy is caused by welfare. Teen pregnancy is caused by sex education. And there's teen mom saying in here, "I thought teen pregnancy was caused by teenage sex." The reason I like the cartoon is not only that it's humorous, it really points out to what a lot of our discussions about what is causing what. And frequently, we're all over the map as to what's causing what and what we should do.

This is where I'm going to get up on my self box. One of the things I discovered is we oftentimes don't do the second part of the needs assessment. We'll spend 90 percent of our time and energy figuring out our priorities and then 10 percent understanding our problem. We'll figure out our problem as prematurity, and so instead of investigating what may be contributing to our prematurity -- well, if it's prematurely, I know we need to do prenatal care, family planning. We have automatic answers. And the idea is we haven't really understood the problem.

I will tell you I've been in MCH now for 20-something years. There are so many MCH priorities, and there are insufficient resources to address any of them. My challenge would be I would love us to choose a few and succeed. What I find is,

frequently, when we choose everything and we sort of slowly move along with wherever we're going to go because we have so many priorities that our efforts are diffused and not necessarily targeted. And in that process, if I spend all my resources figuring out what my problems are, I really cannot move forward.

So I would challenge you to reverse this equation. I think it should be almost 10 percent on priorities and 90 percent on understanding the priorities you selected because I think you'll be more effective at addressing those problems, especially since -- I'll bet you, if you look over your last three needs assessment, many of your priorities have not change but maybe your knowledge level of priority has not also changed very much either. And I would hope after two or three times through it your knowledge levels on those priorities would substantially improve.

So, we're going to spend some time talking about health problem analysis because in many ways most needs assessment boils down to priorities. So, almost all of them have this idea of better understanding what the problems are and then what are the potential strategies, what's our capacity to address those issues. Now one of the things you need to do a problem-oriented process is you need a map that really defines that idea of what is the problem. Here's a very simple problem-oriented map that many people (inaudible) talks about, which is, you've identified the problem -- we just talked about how would we define a problem -- and you look at the precursors before and you look at the

consequences afterwards. The idea is we can figure out what leads to it and we can also figure out what happens because of it.

From a problem-oriented map, you talk about those things as the problem, and you talk about those things that are direct effects to that problem. So, for teenage pregnancy in going to back to that cartoon, we're talking about the initiation of sexual activity, the continuation of sexual activity, and the use of contraceptives (inaudible) most directly related to having teen pregnancy. And that, in terms to that, there may be secondary factors like partner age disparity, unsupervised activity, access to confidential services, and there you might have social norms and after-school programs and health policies. So, you almost have a -- I like to think about it as a domino effect of what's leading to what that leads to what that gets to be where we are.

And then you can take that map and you can complete it and you might even update it. For example, on this map, things that are missing now are text messaging and the role that text messaging may play. There are variety of things that can be sort of updated in this. But the whole idea is we can lay out some of the risk factors. Why is this helpful? When I go out and I start doing a data analysis, if I have a map of what I need to look for, I now know what data I need defined. More importantly, which frequently happens is we look at the data that's available and we don't talk about, so what's missing? If I lay out a problem map, I

can then talk about what's missing. I may not ever get the answers, but by talking about all of the risk factors I know the type of information I need. Ken?

KEN: So this is what you do after you've selected --

WILLIAM M. SAPPENFIELD: A problem.

KEN: (Inaudible)?

WILLIAM M. SAPPENFIELD: Yes.

KEN: Okay. So, this is how you develop a particular problem (inaudible).

WILLIAM M. SAPPENFIELD: Very correct. We're now stepping in. Once -- thank you, Ken. We'll go back to that. Once I've had this process, once I prioritize my process, once I've identified the 10 priorities or whatever I have to do, this is what needs to happen next. And these needs to happen before you start doing heavy planning, or you could say this is part of my planning process, so it's not one or the other.

Again, what I'm saying is, if I have my 10 priorities, this step is as important, in my opinion, as the 10 priorities I chose and I'm going to this process to do that step. Now I'm going to start talking about consequences. Well, teen pregnancy

may lead to abortion, fetal death, live birth, it may lead to abortion consequences or birth weight prematurities, school dropout or delay, impaired economics. Why are consequences important? Why should my problem analysis also focus on consequences? Prevention is not related to consequences. Or is it?

UNKNOWN SPEAKER: Yes.

WILLIAM M. SAPPENFIELD: Oh, I might have different prevention that focuses on consequences. Why else may I want to look at consequences? Again, we talk about health problems being a value. Is everyone going to see the value of teen pregnancy?

UNKNOWN SPEAKER: No, there is the value of the consequence.

WILLIAM M. SAPPENFIELD: But they will start seeing the value of the consequences. They may not be as worried about what baby this teen has, but if it starts impairing my economic activity, if they discover that 90 percent of these teens are on Medicaid in terms of delivery, if they start realizing the thousands of dollars that is causing them in taxpayer's dollars related to teen pregnancy, they may start to understand and value that as your health problem.

So, part of the reason consequences are important to studies is you may have prevention related to consequences, but also you may be better able to describe

to all the audiences the consequences that they need to understand related to that priority. Yes, sir?

UNKNOWN SPEAKER: I'm getting confused or concerned about (inaudible) again --

WILLIAM M. SAPPENFIELD: Please.

UNKNOWN SPEAKER: -- because this seems to be a discussion that you have before you set the priorities because this relates to the severity, and severity is one of the criteria that you may want to consider before you set the priorities rather than after you (inaudible). Or are you saying (inaudible) you have a brief discussion of the severity but that severity (inaudible) and then this is (inaudible)?

WILLIAM M. SAPPENFIELD: That's an excellent question. Make sure you all heard that. He's saying, "Wouldn't we really want to know this even before we chose our priorities?" Well the challenge gets to be there is, in an ideal world, that'd be nice, but do we have all this information available for the 98 priorities that are submitted in to us? And do we have the staffing levels to be able to do this sort of problem mapped for all 98 priorities? So, the challenge gets to be here is what I call a screening process, where I only have so many resources and I don't have enough data people to do it all. And so, part of it gets to be is

deciding what information I need to have, because you are right, if I'm going to score those, I have to have equal information.

And so, I need to make sure in my problem definition in describing what it is that I make sure I have equal information which, to be honest, it doesn't always happen. Sometimes we end up selecting our priorities because we already have more information on our priorities and we know nothing about the new things. So, the new things miss out. And so, you got to weigh the messiness of those pieces. But the challenge gets to be is people don't do this for their priorities, let alone for the selection of their priorities. I'll say it again, I don't believe most people will do this for their priorities, let alone for the selection of priorities. Donna, do you want to add?

DONNA PETERSON: Yes, just the other (inaudible) is that, I agree with Bill because you can't possibly, even though you (inaudible), you can't possibly do this for everything. But I think what this allows you to do, you could always go back then and after you do this analysis, you know what, this shouldn't be a priority.

WILLIAM M. SAPPENFIELD: Correct.

DONNA PETERSON: Okay? We've now figure out and my favorite example of that -- and I'm sure you've all experienced this -- you get everybody together and

their number one issue, access to care. And I go to this analysis and tell me what you're going to do as the (inaudible) director outside of the kind of applicants your leadership role talk about. Tell me what you're going to do about that. When you get a room full of people to understand that's not really the right priority. Do you—it allows you to either reframe the priority or what I said in response to the question Ken asked earlier, move up and down this precursor consequence continuum and maybe choose a different problem on that continuum that you can actually do something about. It's an intermittent process.

WILLIAM M. SAPPENFIELD: Now, many people are telling me, Bill, this is energy intensive and a lot of time, and I can't always get this done for my needs assessment. And I say, that's fine. And how many years has it been since you selected that priority and have you gotten to it yet? And how many times did you selected that priority and have you ever done it? If you think about it, our priorities don't often change that much. So, once you start these maps, they not only become your needs assessment, they become part of your evaluation. They become part of your strategy involvement. They become part of your monitoring system so to me it's the way we built institutional knowledge about an issue so that when we come out in the next set of PRAMS questions come out from states, how do I figure out what questions I need. Or my BRFSS questions what questions do I need to be thinking about. Or I need new grant, does this relate to what we're doing. So, in some ways I'm talking about this from a needs

assessment perspective, but in some ways this becomes sort of your core problem knowledge about the priority that you're planning to work on.

Now, some people will come back and say Bill I much prefer the (inaudible) model, I think it's really theoretically better, fine with me. The literature Dr. So and so has just published and this is a better map. And it's like, great. The idea here is, I am not selling this sort of simple problem map. What I am selling is, you need a map. You need a framework, because otherwise, what you're going to do is you're going to talk about what you have. And you're going to talk about what you know and you're not going to talk about what I don't have and what I don't know and what maybe factoring what's going on.

Now, the other thing in the needs assessment, there's always this characteristics on services. And so, I covered it to make sure that we talk about it. When we talk about need and need for services, they like to talk about five categories of needs. And this can be built into your map or this may actually be your problem. Need for services can be defined by professional or consensus, American and—gynecology recommends certain visits for prenatal care. That would be a standard we can use, measures like the (inaudible) or other index as to try and measure that.

Another way to measure need is demand for services. You can look at waiting lists and see how long. I look at appointment waiting time and see how long it

takes to get in. Sometimes, you don't have a lot of data, so you may choose to look at the at-risk group because the at-risk group people are in need of services, then that may reflect that everybody is at need of services. You may want to look at a relative basis and you may want to look at it based off of perception.

But what's the problem with perception? We talk about need and need for services and you do it based on perception. What's the underlying problem with perception? When we did part C in South Carolina it was just starting out. They had every fears of entitlement program that we had nine categories of services, and if we offer all nine and as an entitlement that we would break the bank. And what we found was the most number of services the family would ever use was three. And most of the time, it was always just two even if they needed six.

The problem with perception is people don't always do what they perceive they need. And the services that they perceive that they want usually greatly outstrip what they will utilize. So, be careful when you talk about need using perception. So, when you talk about need and needs assessment, you talk about need for services, you do need to think about these pieces as you think about your maps. Am I going the right direction? Okay.

So, why do I need the problem map? Again, there are many causes and many risk factors. There are many levels of influences. There are different opinions about causes and solutions. Part of the reason I like a problem map is people

come to the room frequently with their own agenda for an issue and it may or may not be evidence based or it may be personal philosophy. When I do a problem map, I can put everything up on the map. Then I can come back and say, okay, we need to look at the literature or data to see if there's any support. So then I can have those things on the map that are supported and those things that are unsupported. But at least the audience then feels like I've heard what they had to say. I recognized it's there. If there's no data, I may not move on it, but at least they had the opportunity to speak.

There's a vast amount of scientific knowledge and you need to figure out how to condense it in a way that it can be manageable and then you can get stacks of local data. And I use this map to help me sort of develop my thought process about what the problem is and not having all the data overwhelming when I go from page to page to page to page. I now know what the problem map what it is I'm trying to see.

Now, I'm going to do a test for you. This is a fun thing for me. When we move to Omaha and I went to CityMatCH, we went to look for a house. We couldn't find, when I came home a household. My wife said we need a new house. So, I sent her out by herself with her sister to choose a house. She did a wonderful job. I had only one major road all the way to work. It was lovely except that one major road was the busiest road in Omaha, and had only the three of the top ten worst intersections in the state, but otherwise it was a great selection. Well, she's

driving along as she comes to the sign and I need your help in interpreting the sign, okay? I'm going to show you the sign if you believe she should turn right at the count of three raise your right hand. If you believe she should turn left, raise your left hand. Some of you had seen this, and so it won't matter. Here you go. One, two, three. Just to let you know, this is actually a real sign down the street from the CityMatCH office. So, my wife goes, what day is it? What time is it? Of course, what's the biggest thing? What is the most important message here?

UNKNOWN SPEAKER: (Inaudible).

WILLIAM M. SAPPENFIELD, M.D., MPH: Of course, she see that last. And if you think this is confusing, I would say one day out of ten, I always found a car going the wrong direction because I have to go down this road. One day out of ten. The idea here is many times our problem maps and the way we organize our thoughts look like this. It's very complicated. On this day of the week, it's this issue. At this time of the day, it's this issue and on and on. So, in this process and never mind the date, I'm not trying to make it so complex, so overwhelming that people can't understand what we're trying to say. So, you do need to keep it simple and useful. And so, say that upfront because this will overwhelm some of the audience. But if you take them through it slowly, they can follow along with you.

Again, a problem map is oriented around the health problem. It shows causes and solutions. It shows consequences. It can be used to develop a consensus on opinion, knowledge and information. It defines a boundary of what's known and it helps us go find the data and what we need to look at. Where are the steps? To me, when I'm trying to pull my partners together, I actually like to start out with everybody's thoughts, because I may put people agree with me and disagree with me in the same room. But the strategy is to get us all to the same page using the same frameworks and understanding. So, I start out with where they come from, then we review the scientific information, then we obtain local information, and then we develop consensus. And that consensus may be we disagree or inadequate data, we can't move forward. And your job is to go find more information, but at least it allows us to put everyone down there, then I can determine the potential actions and action plans.

In this slide should have been earlier and would have add to what Ken is saying. So, what I'm talking about here is (inaudible) the seven step of a problem oriented assessment that I'm talking about. The first thing I talk about is that need for a theoretical framework, and we just talk about that. And (inaudible) if I can't have a framework for that problem, there's no way I can assimilate process and use all that data. And as a program policy person, if you're data person comes in and doesn't start out with some framework that you can understand the data they're about to give you, then you should stop them and say, "Wait, I need help. Tell me what I'm going to be starting to look at." Ken?

KEN: Say a little more about theoretical framework; give some example.

WILLIAM M. SAPPENFIELD: The problem map is a theoretical framework. Ken, these are the risk factors I think that are causing it. A (inaudible) model may be -- there are may be something that's actually published, but it's something that describes the problem map. So that when I start giving them data, because (inaudible) an epi will give you a logistic (inaudible). These are all the risk factors I considered and these are the ones I selected. But I may have no understanding of how any of those risk factors relate one to the other and how one contributes to the next. So, I'm giving you so many information about associations, but I haven't help understand the whole problem. And so, I don't know if any of this as well as I need to. Chris is here in the room and she can tell you that. But I do think starting out with that theoretical framework and making sure that people understand what you're talking about and where you're coming from this helpful. Then I can gather information, then I would like to do in my needs assessment is to try to focus in on critical questions, developing methods and analysis. And I want to go through those steps with you.

I had someone invited me to a meeting in the agency where I was at. He determined that all these grants now require needs assessment and he got the idea that maybe we could all get together and do one large needs assessment

together to meet all of our needs. How many of you like that idea? How many of you want to go to that meeting?

UNKNOWN SPEAKER: Well, the practical way to do that because we had a meeting in Vermont a month or so ago, everybody is doing needs assessments and for me it was, who is doing what, where (inaudible) and not repeating what everybody is doing.

WILLIAM M. SAPPENFIELD: And you're trying to remove duplication with effort and you're trying to figure out all the possibility. Then that's very appropriate. His idea was (inaudible) one great, big needs assessment. And the whole idea there is the needs assessment is tied with the planning process. And so, what works as the needs assessment for one may not actually fit very well with somebody else's. But I can take those other needs assessment and plug it in here once I have my problem map. So, I can go over to my HIV people and my immunization people and my (inaudible) people and other things and family planning, look at their needs assessments and see how they fit in with the data that I have. And I can go at the data reports. Not everyday that you need is out there and published, so you need to talk to key data people and community people to make sure you have all the data sources of what is out there.

But once I have that framework, to me, it's much easier. I now know what I'm looking for, I can go find it or try to find it. Then what I like to do is once I have

that data is, you know what I find? Huge holes because no one has ever done it before. No one has map out the problem, so no one's ever talked about what was missing. They've always talk about what they've had. And so, now I have remaining questions. And so, then I need to decide what the answer. Now, the problem I said in the 20 something years as an epidemiologist is there are never a lack of questions. When I ask people, I get tons of questions.

The problem is not resources to investigate all of them, so what I like to do is I like to go through an exercise to figure out how important it is. So, frequently what I do is they'll ask me a question and I won't know the answer but I have some ideas, and I say, "Okay. So, if I do this and I go back and then found out the problem is X what are you going to do?" They say, "I'm going to do, A." Okay. Now if I go out and I figure out that the problem was Y, what are going to do? Well, I'm going to do A. Okay. And if I go out and I figure out the problem is C, what are you going to do? I'm going to go to do A. And it's like, so no matter what I find you're still going to do the same thing. The answer is, yes. So, okay, what's your next question? The whole idea is there's not lot of time and resources. The critical question is, if I answer this what is really going to be different? What am I going to do differently, because you're going to come out in these questions, it would have been easily 10 to 20 questions and it's going to like those problem analysis that you wish you had before you rank your problems.

There's not time to go investigate all the questions. So, the questions gets (inaudible) I've got to prioritize and choose my critical questions. And I can tell you that most of the time about nine percent of the questions following to this, what I call, really nice to know questions. Really helpful, thoughtful questions but it's really not going to change my action. Once I know those questions and I know that they can be answered and, believe it or not, they're actually questions that you ask that I cannot answer and I got to recognize that and what it will cause.

And the other thing is I want to make sure that when I'm doing adds to the big picture. Sometimes you drill down and you're getting into the great detail and you step back and you get that greater detail, but it doesn't really add to what it is you going to do overall. And you need to be watching that big picture, because remember it's supposed to lead you to action.

Once I have those questions, once I know what those methods, I can choose methods. I mean sometimes what policy and program people do -- I think which is top is they turn the questions over to the data people and then the data people bring you back answers and you go, that's not what I wanted. That's not helpful, that's not useful. By turning the questions over to the data people, you're giving them the power to decide what you're looking at. You need to work together to define those questions, so that when they come back, they're questions that you

want and questions that are useful and answers that they give you back that will help you and that they can sure that our data are related.

But once you have that, you can determine your methods. The reason I say that is what many needs assessment people say, well here's the define method, you should go out and use this method every time you do your needs assessment.

What's the problem with the cookie cutter approach? It may not answer the questions at all. It may not fit. You may not be able to afford it. You may spend all your resources doing the standard approach versus getting the information that you need.

The next thing is most people have a lot of problems summarizing the problem. They do it on pages and pages of tables or pages and pages of paragraphs and prose. When I gave you the problem analysis for the underreporting in prenatal care visits, and access penal care in the beginning of my talk, how many numbers did I give you?

UNKNOWN SPEAKER: None.

WILLIAM M. SAPPENFIELD: None. Absolutely none. And how many of you doubted the accuracy of my information? How many of you challenged it? How many even asked what were the numbers on that? Part of what you need to do in a problem analysis is you do need to come down with -- after all the man and

data and the waiting and all the pieces, you need to come out with some clear statements that summarize the problem as best as you know it now. It may change tomorrow, you may get information later. But the problem is, if you cannot summarize what the problem is, how well can you plan? Because are you going to have to plan something? Are you going to have to do something? The answer is yes. So, you got to come back to the clearest statement as you can with the information you have, and you need to present those results back. The idea that will I get—did you read the report I sent you? That was on memo such and such. You really need to make sure that you present the results and the results are understood.

This summarize the problem, talk about a problem statement, talk about a trend. The individual contributors, community contributors, strengths, community strength, you should be able to take each of your problems, in my opinion, and summarize them as concisely as you can in about a page. And boy, that's painful. And boy, that's hard. But remember, your epidemiologist took a 20-minute presentation and submitted an abstract in the paragraph and we could choose which presentations we wanted to hear on that abstract. It may be painful, you may not be able to get it in there. But if they want to present, they will get it in that space. The bottom line is, it's going to take some of that pain and effort to get those concise statements.