STATE MATERNAL AND CHILD HEALTH AGENCY PRIORITY NEEDS AND PERFORMANCE MEASURES FOR 2000, 2005, AND 2010

Summary Report
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BACKGROUND

The Federal Maternal and Child Health Bureau (MCHB) and State Maternal and Child Health (MCH) programs work in concert to meet the needs of women and children in all 59 States and jurisdictions. States conduct a comprehensive needs assessment every five years to guide program development and measurement of performance. In addition, grantees complete an annual document that is both an application for further Title V funding and a report on activities and performance. The Bureau has contracted with the Cecil G. Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill to examine the current focus of State MCH activity as expressed in statements of priority needs. In addition, this report explores areas of concern identified by States but not selected as priorities, State Performance Measures developed to measure progress, and trends in priority needs over three needs assessment periods: 2000, 2005, and 2010.

The specific reporting requirement that is relevant to this analysis is the Needs Assessment report each grantee prepares every five years as a product of the comprehensive needs assessment they conduct. The needs assessment processes can vary widely from State to State and from year to year for any given State. For example, the direction a State takes in meeting the needs of the maternal and child health population may be driven in part by the overall philosophy and goals of the State health department. Similarly, a State MCH agency may be reorganized or otherwise change how it approaches its mission, perhaps focusing on broad issues in one year and more specific ones in another. In the most recent needs assessment period (2010) it is noted that Life Course theory proved to be an important construct on which many States based their review and selection of priorities. The process is fluid and as varied as the States themselves and the priorities identified in Needs Assessment documents can change due to a change in mission as well as due to change in needs of the populations served.

OVERVIEW OF 2010 PRIORITY NEEDS

More than 90% of priority needs developed by MCH Title V grantees for 2010 fall into four broad categories of focus for State Title V agencies:

Access to Care and Health Status – All but one grantee include a priority need to improve health or health care. While many States have identified priorities for primary care, just as many have identified access to dental care, mental health care and pregnancy-related care as a need for their populations. Even more States have identified specific other health care priorities, particularly transition care for children with special health care needs (CSHCN) and others and developmental screening/early intervention services. Other specialized care identified less frequently includes specialist care, cancer screening for women, immunizations, newborn genetic, hearing and vision screening, and lead monitoring.

Healthy Living – The Healthy Living category includes the single most common priority need theme, i.e., healthy lifestyles in general, and healthy weight, exercise and nutrition, in particular. There is almost universal agreement on the need for programs to promote healthy weight.

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Healthy Pregnancies – Healthy Pregnancy priority needs are specified by 50 of 59 grantees. There is not a predominant focus among the major categories of priorities in this area; focus on poor birth outcomes, typically low birth weight and infant mortality, is only slightly more common than focus on preventive measures to reduce poor outcomes. Of nine grantees without a specifically stated priority need for healthy pregnancies, many crafted broadly stated priority needs and likely included healthy pregnancies in these priorities without stating such.

Building MCH Capacity – Some priority needs are not client-focused but instead identify issues to improve functioning of the Title V agency. Data and surveillance are the most common capacity priorities. Other priorities, such as strategic partnerships, availability of safety net providers, and education for providers and families, vary in response to the unique needs of each State.

Subcategories of Priority Needs in the Four Major Categories

PRIORITY NEEDS FOR 59 MCH STATE AND JURISDICTIONAL GRANTEES IN 2010		
IMPROVED HEALTH AND HEALTH CARE		**59 States**
Access to Care and Health Status		58 States[1]
Health in General and Access to Health Care	31 States	
Oral Health and Access to Oral Health Care	32 States	
Mental Health and Access to Mental Health Care	30 States	
Specialists, Screening, Immunizations, Other Specialized Care	45 States	
Healthy Living		56 States
Healthy Lifestyles in General, Nutrition, Exercise, Weight	50 States	
Injury Prevention	37 States	
Risk Behavior in General, Substance Use, STIs, Sexual Risk	34 States	
Healthy Pregnancies		50 States
Prenatal, Preconceptional & Interconceptional Health and Care	28 States	
Pregnancy, Fertility and Birth Rates	25 States	
Pregnancy Outcomes - Low Birth Weight and Infant Mortality	31 States	
Building Title V Capacity		32 States
Data and Surveillance	18 States	
Other	22 States	

Access to Care and Health Status - States are more likely to focus on access to care than on health outcomes. These priority needs statements are among the most broadly worded. Some States include medical home or care coordination as a strategy. Disparity reduction can also be included as a focus in this category.

Oral Health and Access to Oral Health Care - Oral health priorities are also most often stated in terms of access to oral health care and may include all MCH populations or specific populations as the target group.

Mental/Behavioral Health and Access to Mental/Behavioral Health Care - A priority need to improve mental or behavioral health and care is as common as a priority to improve health in general. Depression is most often cited as a priority need.

Other Specialized Health Services - Almost 75% of States have a priority need that falls in this category. Most commonly identified specialized care priorities include developmental screening and early intervention services, and transition services for adolescents. Other health care priorities identified include immunizations, cancer screening for women, and lead screening, among others.

[1] The single State not included in this category does have a priority need to improve prenatal or pre- or interconceptional health care which could be included in this broad category of access to care but is discussed separately below.

Healthy Lifestyles - The importance of lifestyle for optimal health is acknowledged by States in their selection of healthy lifestyles as the most frequently listed priority need in 2010 Needs Assessment documents. The most common focus within this category is on reducing overweight and obesity. However, prevention programs such as those promoting nutrition and exercise are also targeted by some States. Breastfeeding as a healthy start for newborns is included in this category as is improved nutrition in general.

Injury Prevention -The most common specific types of injuries on which States will focus include suicide, intimate partner violence, child abuse, and motor vehicle crashes.

Risk Behavior Including Substance Use - Many States specify risk behavior reduction in general while others target specific risk behaviors such as substance use and, less commonly, sexual risk behavior. Reducing the use of tobacco is still the most common specific behavior that is targeted.

Prenatal, Preconceptional and Interconceptional Health Care - Access to prenatal care was the target for some States, but more of them focused on ensuring preconceptional or interconceptional care.

Pregnancy, Fertility and Birth Rates - Most States specifically targeted intendedness of pregnancy although a few specified pregnancy spacing or repeat pregnancies.

Pregnancy Outcomes – *Low Birth Weight and Infant Mortality* - While some States frame their priority need in terms of access to care to ensure healthy pregnancies, it is more common for States to focus on pregnancy outcomes, particularly on low birth weight and infant mortality.

Data and Surveillance - Data needs may be specific or general.

All MCH Populations Are Included in Priority Needs

The priority needs for specific MCH populations were similar to those for the MCH population in general with the exception of pregnancy-related priority needs. An increasing number of grantees select priority needs that focus on women or on women of childbearing age not only in priorities which address pre- or interconceptional health care, but also in priorities that promote healthy lifestyles and access to all types of care for women. This increasing emphasis on women, regardless of pregnancy, is indication of the shift toward a Life Course approach to priority setting noted by many States.

States with Priority Needs for MCH Populations	
Maternal and Infant	53 States
Children, including adolescents	55 States
Children with Special Health Care Needs	45 States
All populations (implied)	33 States

Subsets of Core MCH Populations Priority Needs		**Other Populations Priority Needs**	
Adolescents	49 States	State MCH Agencies	32 States
Parents or Families	20 States	Citizens or Community	6 States
Women including those of childbearing age	33 States		

STATES EXPLAIN THEIR CHOICES

The guidance for the 2010 Needs Assessment document asked that States describe not only their process for selecting priority needs but how priorities changed from 2005 to 2010 and, also, which needs were considered but not selected as priorities and why. The following conclusions are drawn from a review of State explanations of the priority setting process.

Changes in Priority Needs from Year to Year: Of the 561 priority needs specified in 2005, almost two-thirds (n=361) were retained but most were modified in some way. Reasons for exclusion of 200 priority needs were not discussed by many States. Of the 536 priority needs specified in 2010, 36% were considered to be new by the guidelines for this review. Almost two-thirds were variations of previously specified priority needs. The majority of States revised or, in rare cases, completely revamped their 2005 priority needs during the 2010 process. A few States, however, retained their 2005 priorities unchanged.

The 2005 priority needs that were retained but modified fell into four general categories: priority needs that were reworded, priorities that were refocused, priorities that were encompassed in a new priority need and priorities that were split among new priority needs. The majority of 2005 priority needs that were retained but modified were rewritten with a change in focus, either a change in the health or health care issue addressed or a change in the population targeted. More than 50 priority needs from 2005 were encompassed in more comprehensive priorities in 2010, allowing States to include more issues in their 2010 priority needs and form a comprehensive plan for improving MCH health. Conversely, some 2005 priorities were split among new 2010 priorities.

Many States, however, did not explain their decision to drop a priority need. Those who did cited four reasons: a) the need ranked too low in the scoring process used, b) a lack of agency authority or ability to address an issue, c) the issue is an overarching principle that applies to all priority needs, and d) the priority need was not consistent with a new agency focus or process.

Issues Considered in the Needs Assessment Process but Not Selected: Twenty-five (25) States listed more than 200 issues that were considered but not selected. There were no specific health or health care issues that predominated among the list and topics covered all populations and all health problems. The reasons for exclusion varied and were similar to reasons States cited for dropping priority needs. States noted that topics not chosen had not ranked highly enough, the issue was either too broad or too narrow, or the issue was not in the purview of the MCH agency.

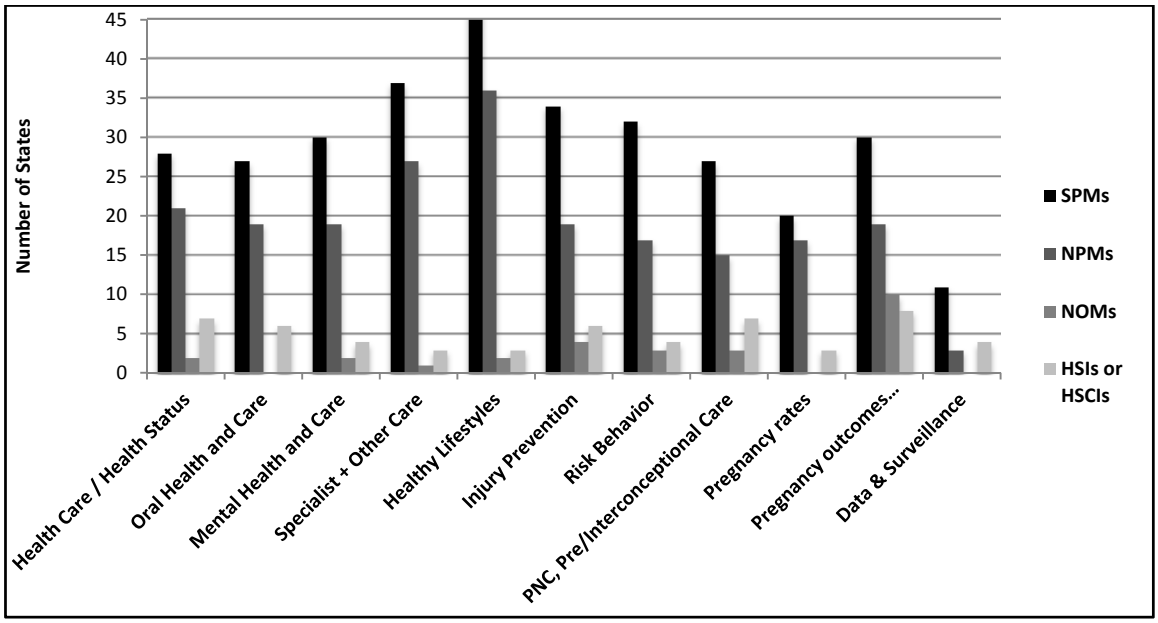
Almost one-half of States note using a life course perspective as a guide for their 2010 needs assessment process or for specific programs. Looking broadly at the needs of women and children led, in some cases, to more broadly focused priority needs statements rather than specific ones. On the other hand, this broad perspective that considers multiple influences on health also includes risk factors considered to be beyond the scope of influence of MCH agencies, issues such as education and poverty. This increased use of a life course perspective to evaluate the needs of populations is one factor that has contributed to the inter-relatedness of many priority needs.

GRANTEES LINK PRIORITY NEEDS TO MEASURES AND INDICATORS

The majority of grantees (47 of 59 or 80%) provided a “roadmap” that links priority needs to measures to gauge success in meeting priorities. State Performance Measures are the most commonly used measures of performance linked to priority needs but States may use multiple and varied measures of performance. Seventy-eight percent (78%) of grantees (46 of 59) developed an SPM for 75% or more of their priority needs. Almost 60% of grantees had multiple SPMs for at least one priority need.

Multiple performances measures for priority needs are the rule rather than the exception. While SPMs are the most commonly used measures for priority needs, the next most frequently used measures are the 18 National Performance Measures. It is not surprising that States use the broadest range of State or National Performance Measures and indicators for their pregnancy outcome priority needs and that Healthy Lifestyles is the category of priorities for which States are most likely to develop an SPM. Pregnancy outcomes are a long standing focus for State MCH agencies and vital records and specialized National datasets such as PRAMS have been available as measures to evaluate success in meeting goals. Newer areas of focus including the emerging focus on healthy lifestyles must depend on more creative use of existing data, often local, until National data collected in a systematic manner becomes the norm.

Figure 1: Types of Measures and Indicators Used by States for Priority Needs in Different Categories



TRENDS IN PRIORITY NEEDS – 2000, 2005, AND 2010

A distinct advantage of a continued examination of priority needs identified by the States is the ability to look at change in State-specified priorities over three needs assessment time periods. This longitudinal review of MCH priorities identified in the needs assessment process provides information on the changes in priority needs identified by States and can support the Bureau as it positions itself to assist the States in meeting State priorities.

Table 1: Change in the Percent and (Number) of State MCH Grantees with Specific Priority Needs Identified through Three Needs Assessment Cycles

	2000	2005	2010
IMPROVED HEALTH AND HEALTH CARE	**100% (59)**	**100% (59)**	**100% (59)**
Access to Care and Health Status	**98% (58)**	**100% (59)**	**98% (58)**
Health in General and Access to Health Care	66% (39)	80% (46)	53% (31)
Oral Health and Access to Oral Health Care	58% (34)	59% (35)	54% (32)
Mental Health and Access to Mental Health Care	29% (17)	53% (31)	51% (30)
Specialists, Screening, Immunizations, Other Care	59% (35)	53% (31)	75% (44)
Healthy Living	**93% (55)**	**98% (58)**	**95% (56)**
Healthy Lifestyles in General, Nutrition, Exercise, Weight	51% (30)	81% (48)	85% (50)
Injury Prevention	69% (41)	58% (34)	63% (37)
Risk Behavior in General, Substance Use, STIs, Sexual Risk	69% (41)	66% (39)	58% (34)
Healthy Pregnancies	**92% (54)**	**85% (50)**	**85% (50)**
Prenatal, Pre- and Interconceptional Health or Care	34% (20)	39% (23)	47% (28)
Pregnancy, Fertility, and Birth Rates	61% (36)	44% (26)	42% (25)
Low Birth Weight and Infant Mortality	51% (30)	47% (28)	53% (31)
Building Title V Capacity	**71% (42)**	**64% (38)**	**54% (32)**
Data and Surveillance	56% (33)	29% (17)	31% (18)
Other	46% (27)	49% (29)	37% (22)

Access to Care and Health Status - The number and percent of States with a priority need to improve health in general or access to health care has fluctuated over the three needs assessment periods but that fluctuation is likely due to changes in the way that States word their priority needs rather than a change in priority. The increase in focus on a medical home or care coordination from 2000 to 2005 was not noted in 2010, but expansion to populations other than CSHCN is still evident.
Disparity reduction, specifically stated, has decreased although it is discussed as an overarching principle in the Needs Assessment documents for some States.

Oral Health and Access to Oral Health Care - Identification of oral health and health care as a priority has changed little since 2000.

Mental/Behavioral Health Access to Care - The number of States identifying a priority need to improve mental or behavioral health and services almost doubled from 2000 to 2005 and is currently stable at one-half of States. The focus has switched from access to care to health status, particularly depression. Behavioral health is mentioned more frequently in 2010 than in previous years.

Specialists, Screening, Immunizations, and Other Care - The number of States identifying specialized health care services as a priority need increased notably in 2010, and two areas, transition care and developmental screening/early intervention, predominate compared to previous years.

Healthy Lifestyles – Almost all States have identified priorities to promote healthy living in all time periods but the specific focus of these priorities has changed with more States targeting healthy lifestyles and fewer focusing on risk behavior such as substance use, and to a lesser extent, on injury.

In 2000, only 51% of grantees identified healthy lifestyles as a priority. There was a notable increase in the number of grantees with this priority need by 2005, which continued in 2010 when 85% of grantees included one or more priority needs with a healthy lifestyle focus.

Injury Prevention - Injury prevention is cited as a priority need less often over the years but remains a focus for the majority of States. Specific types of injuries targeted included suicide, domestic/intimate partner violence, child abuse and neglect.

Risk Behavior - Risk behavior reduction remains a priority need for more than one-half of grantees and the focus has shifted to addressing multiple risks. Tobacco remains the most common single substance targeted.

Prenatal, Pre- and Interconceptional Health Care - Ensuring care for healthy pregnancies was cited as a priority by almost one-half of States, up from one-third of States. Care for healthy pregnancies typically includes assuring access and utilization of prenatal care but States increasingly promote access to pre- and interconceptional care. It is this focus on the health of women before and between pregnancies that accounts for the increase in the number of States with priorities to increase care to promote healthy pregnancies.

Pregnancy, Fertility, and Birth Rates - The number of States identifying priority needs that target pregnancy rates, fertility rates, or birth rates has decreased by 30% since 2000.

Low Birth Weight and Infant Mortality – Identification of these important outcomes as priorities has been relatively unchanged at 50% of States over the three time periods examined.

Data and Surveillance - Over the years, fewer States have included a capacity building priority need but still more than 50% of them do. The need for improved data and surveillance, the capacity priority need most often identified, has decreased from 2000 but remains a priority need for almost a third of the 59 States. Other priorities, such as strategic partnerships, availability of safety net providers, and education for providers and families, vary in response to the unique needs of each State.