Title V Maternal and Child Health Needs Assessment Plan
DIVISION OF CHILD & FAMILY HEALTH
Title V Maternal and Child Health Needs Assessment Plan

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Overview

What is the Title V Maternal and Child Health Block Grant?

The Title V Maternal and Child Health (MCH) Block Grant Program is a federal-state partnership that is a key source of support for promoting and improving the health and well-being of the nation’s mothers, children, including children with special needs, and their families.

As a part of the Title V MCH Block Grant Program, every five years Minnesota is required to complete a comprehensive statewide needs assessment on the health and well-being of mothers, children and youth, including children and youth with special health needs, and their families. This assessment helps identify state MCH priority issues and provides direction for Title V MCH Block Grant activities.

To learn more about the Title V MCH Block Grant Program visit our Minnesota Title V MCH Block Grant Program or the federal Health Resources and Services Administration’s (HRSA) Title V MCH Block Grant Program website.

What is a Needs Assessment?

Needs assessments are used to confirm current target populations and focus areas, as well as to identify new target populations in need of services. Needs assessments provide the information needed to develop goals, define objectives, and design program activities. They “provide and disseminate scientifically-credible information to the public, programs, and stakeholders, and policymakers that can be used to identify existing and emerging needs and to advocate for and ensure that, when possible, effective and accountable programs, services and policies are available to meet those needs.”

In general, needs assessments should answer the following questions:

- Who is the target population and what are their needs?
- What are the unmet needs of the target population?
- Which groups within the target population have these needs, and where are they located?
- What is currently being done and how effective are those interventions?
- What has changed since we started?

The Title V Maternal and Child Health Block Grant Needs Assessment (hereon referred to as Title V Needs Assessment) is a systematic process to collect information about the State’s public health system and service provision to pregnant women, mothers, infants (up to age one), children, adolescents, and children with special health care needs. The information collected through the needs assessment is used to identify statewide priorities, drive strategic planning, and allocate funds.

The goal of the statewide needs assessment is to improve maternal and child health outcomes and to strengthen partnerships for ensuring the effective implementation of strategies designed to address the needs of the MCH population.

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Who Participates in the Title V Needs Assessment?

The Title V Needs Assessment is an ongoing, collaborative process that includes the following stakeholders:

- Minnesota’s families, service providers, and community-based organizations
- Local Public Health
- Policymakers, service funders
- Minnesota Department of Health
- Other State agencies
- Health Resources and Services Administration’s (HRSA)/Maternal and Child Health Bureau (MCHB)

A Title V Needs Assessment Stakeholder Engagement Tracking Tool is under development and will provide more detail on the individuals and organizations involved in the work and engagement that has occurred.
Needs Assessment Leadership Team

The Needs Assessment Leadership Team consists of The Maternal and Child Health Advisory Task Force and our Internal Needs Assessment Leadership Team. The responsibilities of the Needs Assessment Leadership Team include:

- Provide feedback and guidance throughout the Needs Assessment Process
- Apply criteria-based ranking to narrow the cross-cutting potential priorities for community-based selection
- Apply criteria-based ranking to select final domain-specific Title V priorities
- Approve and review Minnesota Title V Priorities

Maternal and Child Health Advisory Task Force

The Maternal and Child Health Advisory Task Force was created by the Minnesota Legislature in 1982 (MN Stat 145.881) to advise (by reviewing and reporting to) the Commissioner of Health on the health care needs of mothers and children throughout Minnesota, priorities for funding the essential MCH services in statute, and more. The Task Force consists of 15 legislatively authorized members with equal representation in three statutory-defined categories: 1) professionals with expertise in maternal and child services, 2) representatives of community health boards, and 3) consumers representatives interested in the health of mothers and children, appointed by the Commissioner of Health to four-year terms. Eight of the terms are coterminous with the governor’s term (ending in early January) and seven terms end one year later. Applications are made through the Secretary of State’s Office of Open Appointments. You can find the complete list of members on the Members of the MCH Advisory Task Force webpage.

Internal Needs Assessment Leadership Team

<table>
<thead>
<tr>
<th>ROLE</th>
<th>NAME</th>
</tr>
</thead>
<tbody>
<tr>
<td>DIVISION DIRECTOR*</td>
<td>Joan Brandt</td>
</tr>
<tr>
<td>ASSISTANT DIVISION DIRECTOR*</td>
<td>Kathy Wick</td>
</tr>
<tr>
<td>TITLE V MCH DIRECTOR*</td>
<td>Position Currently Vacant</td>
</tr>
<tr>
<td>TITLE V CYSHN DIRECTOR*</td>
<td>Barb Dalbec</td>
</tr>
<tr>
<td>TITLE V MCH COORDINATOR*</td>
<td>Judy Edwards</td>
</tr>
<tr>
<td>TITLE V CYSHN COORDINATOR*</td>
<td>Sarah Cox</td>
</tr>
<tr>
<td>TITLE V NEEDS ASSESSMENT COORDINATOR*</td>
<td>Blair Harrison</td>
</tr>
<tr>
<td>TITLE V DATA COORDINATOR*</td>
<td>Molly Meyer</td>
</tr>
<tr>
<td>STATE MATERNAL &amp; CHILD HEALTH EPIDEMIOLOGIST</td>
<td>Mira Sheff</td>
</tr>
<tr>
<td>WIC SECTION REPRESENTATIVE</td>
<td>Kate Franken</td>
</tr>
<tr>
<td>FHV SECTION REPRESENTATIVE</td>
<td>Dawn Reckinger</td>
</tr>
<tr>
<td>MATERNAL/WOMEN-PERINATAL/INFANT DOMAIN REP</td>
<td>Katie Linde</td>
</tr>
<tr>
<td>CHILD/adolescent domain representative</td>
<td>Maureen Alms</td>
</tr>
<tr>
<td>CYSHN domain representative</td>
<td>Sarah Mapellentz</td>
</tr>
</tbody>
</table>

*Member of the Title V Leadership Team
Guiding Principles of the Title V Needs Assessment

A set of guiding principles have been developed to be utilized needs assessments conducted by the Child and Family Health Division. These principles provide guidance on the implementation of needs assessments in the Division, and also provide a conceptual framework toward conducting needs assessments. The guiding principles are as follows:

- **MCH Target Population:** Focus on target MCH populations, which includes families, women, mothers and fathers, infants, children, adolescents, young adults, and children and youth with special health needs.
- **Health Equity:** Integrate health equity throughout process using the MDH Triple Aim of Health Equity.
- **Trauma-Informed:** To adhere to best practices and trauma-informed approaches when conducting stakeholder engagement and needs assessment activities
- **Quality Improvement:** Use a continuous quality improvement approach to increase assets and protective factors and to address challenges as opportunities to advance population outcomes.
- **Community Engagement:** Actively engage with community stakeholders utilizing the principles within the MDH Community Engagement Plan.
- **Transparency:** Communicate with needs assessment participants, the MCH community, and stakeholders so that information used in needs assessment is shared, and that decision-making processes are clear and understandable (also to support accountability)
- **Accountability:** Be answerable for the consequences of decisions that impact families, communities, and stakeholders.
- **Data-driven Decisions:** Use quantitative and qualitative data to inform decision making.
- **Evidence-Based and Informed Practices:** Apply evidence-based and informed practices to methodology and planning efforts related to the needs assessment.
- **Adaptability:** Demonstrate willingness, flexibility and agility throughout the needs assessment process.
- **Collaboration with Systems Partners/Customers:** Focus on both internal and external partners as key collaborators to achieve desired outcomes.

Appendix A includes further information on the guiding principles, including activities for operationalization.
Methodology

Child and Family Health (CFH) will use a mixed methods approach, informed by best practices and evidence-based research, to conduct the needs assessment. In conducting needs assessment activities, CFH will operate from a trauma-informed intersectional framework that aims to advance health equity and acknowledge the strengths of our state’s communities. The needs assessment and its activities are rooted in the social ecological model (SEM), a systems model in which multiple levels of influence (individual, interpersonal, organizational, community, and policy) impact the health of communities.

Stages of the Needs Assessment Process

CFH utilized Donna Petersen & Greg Alexander’s book, “Needs Assessment in Public Health,” to develop our process. Discrete stages of the needs assessment are identified, with evaluation of the process ongoing throughout. These stages are listed and then described in detail below:

Planning Stage

Start-Up Planning

1. Establish the organization structure for the needs assessment
   a. Who will direct the day-to-day activities of the needs assessment
   b. Who is on the leadership committee
2. Identify the types of needs to be assessed and the potential uses of the needs assessment
3. Identify the stakeholders & target population of the needs assessment
4. Create a Community Engagement Plan that specifically outlines how families, tribes, and others will be represented throughout the needs assessment process
5. Meet with the Center for Health Equity at MDH to vet the Community Engagement plan
6. Work with Communications for how data and information will be shared with stakeholders throughout the process

**Operational Planning**

1. Establish who will help determine the indicators and data sources to be support prioritization
2. Establish who will produce the data stories
3. Determine methodology to be used to prioritize needs in terms of importance in Rounds 1-3
4. Determine strategies for facilitating meetings, managing conflict, and reaching consensus
5. Determine a strategy for ongoing needs assessment work and maintaining relationships formed during the needs assessment process

**Data and Capacity Assessment Stage**

In 2018 the Title V Data Team will begin the data and capacity assessment stage (see Appendix B for timeline). Minnesota’s Title V Data Team includes the Title V Needs Assessment Coordinator, the Title V/SSDI Data Coordinator, and MCHB interns, fellows, and students.

While engaging in data activities, the Title V Data Team will utilize Petersen’s guidance. As such, data should meet the following criteria:

- Simple – well-defined, valid, reliable, understandable to stakeholders
- Stable – should provide stable estimates (e.g. large enough n)
- Available – timely and readily available
- Logical, Relevant, Important – should reflect conditions and service patterns thought to correlate with changes in health status outcomes of interest
- Has Broad Representation – should reflect potential health status concerns of a majority of the target population, as well as high-risk groups
- Political Feasibility – Should consider political will, though remember the potential impact of the problem on community health is the most important

**Needs Assessments typically use four types of data:**

<table>
<thead>
<tr>
<th>Type of Data</th>
<th>Primary</th>
<th>Secondary</th>
<th>Quantitative</th>
<th>Qualitative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population-based social indicator data</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Survey Data</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Structured Group Data</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Program-based data</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

A need is a “discrepancy between a target state and an actual state”\(^4\). The table below outlines the types of needs that might be identified by stakeholders during four primary data collection activities.

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<table>
<thead>
<tr>
<th>Type of Need</th>
<th>Defined By</th>
<th>Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comparative</td>
<td>Experts</td>
<td>Most commonly used</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Based on a target state defined by experts</td>
</tr>
<tr>
<td>Expected, Wanted, Desired, Felt</td>
<td>Target Population</td>
<td>Reflects dissatisfaction with the disparity between where the population sees themselves and where they would like to be</td>
</tr>
<tr>
<td></td>
<td></td>
<td>May not be supported by scientific data</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Demand for action may still be significant</td>
</tr>
<tr>
<td>Expressed</td>
<td>‘Demand for Services’</td>
<td>Derived from marketing and economics</td>
</tr>
<tr>
<td>Extrapolated</td>
<td>Existing data</td>
<td>Derived from applying data</td>
</tr>
</tbody>
</table>

### Activities of the Data and Capacity Assessment Stage

- Examine strengths and capacity
  - Analyze quantitative data
    - Minnesota-specific data
    - Federally available data (FAD) data
  - Gather available reports, other Needs Assessments (including local public health’s community health assessments), literature, national benchmarks and goals (Healthy People 2020), and other relevant factors that influence the maternal and child health climate in Minnesota including agency capacity and political will
- Engage stakeholders & collect qualitative data
  - Hold internal listening sessions at MDH to collect information about perceived needs, existing partnerships, and data sources:
    - Maternal/Infant – 2/5 10-11:30
    - Child/Adolescent – 2/6/2:30-4
    - CSHCN – 2/15 12:30-2:00
  - Connect with subject matter experts at the Minnesota Department of Health
  - Conduct the Discovery Survey
  - Hold regional stakeholder focus groups (as capacity allows)
  - Conduct key informant interviews
  - Engage MCH Advisory Task Force and Title V Needs Assessment Leadership Team throughout
- Compile a comprehensive list of maternal and child health needs reported through all activities (outlined above) in 2018.

In order to provide the community and Need Assessment Leadership Team with data and information to inform prioritization (see prioritization stage for more information) we plan to create data stories for each priority being considered and documents outlining agency capacity, political will, and stakeholder input. The comprehensive list of needs will be evaluated by the Title V Data Team to create a list of possible priorities being considered for prioritization. The following methodology will be employed to develop this list of priorities to be considered during the 2019 prioritization rounds:

- Similar priorities will be combined into larger maternal and child health topic areas
- Minnesota’s current Title V priorities were initially included by default
- If a possible priority is not mentioned during an internal MDH listening session or in a key informant interview, and is mentioned less than 10 times on the Discovery Survey, it will be removed from the list of priorities being considered
- In anticipation of higher response counts related to cross-cutting needs, we will cap the number of cross-cutting priorities under consideration to 15 (based on Discovery Survey results)
End Products of this stage:

- Set of priorities to be considered during the 2019 prioritization rounds
- Data stories for the set of priorities under consideration
- Documents on agency capacity, political will, and stakeholder input
- Stakeholder Engagement Tracking Tool

Prioritization Stage

Minnesota will follow both a criteria-based ranking approach and a community voting process through three rounds of prioritization.

<table>
<thead>
<tr>
<th>Prioritization Stage</th>
<th>Round 1</th>
<th>Round 2</th>
<th>Round 3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Who is Involved</strong></td>
<td>Needs Assessment Leadership Team</td>
<td>Community</td>
<td>Needs Assessment Leadership Team</td>
</tr>
<tr>
<td><strong>What is the Method</strong></td>
<td>Criteria-Based Ranking Approach</td>
<td>Community Voting Process</td>
<td>Criteria-based Ranking Approach</td>
</tr>
<tr>
<td><strong>Where does it happen</strong></td>
<td>In person</td>
<td>In person meetings metro and an all-remote option for each forum held</td>
<td>In person</td>
</tr>
<tr>
<td><strong>When does it happen</strong></td>
<td>June 14, 2019</td>
<td>August 2019</td>
<td>September 13, 2019</td>
</tr>
<tr>
<td><strong>What is the outcome &amp; next steps</strong></td>
<td>Evaluates cross-cutting priorities for final selection by the Community</td>
<td>Final selection of cross-cutting priorities</td>
<td>Final selection of domain-specific priorities</td>
</tr>
</tbody>
</table>

Timeline of Prioritization Activities

Criteria-Based Ranking Approach

Each member of the Needs Assessment Leadership Team will score each potential Title V priority area from 1 (low priority) to 5 (high priority) based on the provided data stories – they can also consider information beyond what is provided by the Title V Data Team.
Criteria-Based Ranking Prioritization Criteria includes:

- Magnitude
- Trend
- Health and racial equity
- Impact/severity
- Perceived preventability
- Effective Interventions
- Agency capacity
- Political will
- Stakeholder Input

This method will be employed during round 1 and round 3. In round 1 the needs assessment leadership team will evaluate the list of cross-cutting priorities for final selection by the community. In round 3 they will select the final domain-specific priorities.

Before tallying final scores to determine rankings, the Title V Data Team will apply weights of to each criterion as determined by the Title V leadership team (example: health and racial equity will have greater weight). Total scores will be stratified by Title V Domain. Score sheet template can be found in Appendix C.

**Community Voting Process**

Four community forums will be held in-person during the months of July and August (with corresponding all-remote events). A community voting process will be utilized that will include a gallery walk of poster presentations of the data stories and voting using a scorecard. The community voting process is round 2 of prioritization: they will be prioritizing the domain-specific priorities and selecting the final set of cross-cutting priorities.

The MCH Advisory Task Force will approve the final set of Minnesota’s Title V priorities in December of 2019.

**Public Comment Stage**

Once the MCH Advisory Task Force has approved the final set of priorities, a report of those priorities with supporting data will be published for public comment. There will be a 30-day public comment period through which MDH receives additional community feedback about the needs assessment process and the final set of Title V priorities.

**Manuscript Stage**

Write up work will be ongoing throughout the process, with January – May of 2020 dedicated to writing the 2020 grant application.

**Final Results Dissemination Stage**

The Title V Needs Assessment Coordinator is working with agency communications experts on developing a communications plan that will outline how results of the needs assessment will be shared with participants and the general public.
Ongoing Needs Assessment

- Detailed data briefs on selected state priorities will be updated as often as new data is available
- A dashboard of progress towards goals related to State priorities will be developed by the Title V Data Team
- The Title V Leadership Team will develop a plan for ongoing assessment and evaluation
## Appendix A: Guiding Principles for CFH Ongoing Needs Assessment Process

<table>
<thead>
<tr>
<th>Key Principle</th>
<th>Activities to Operationalize</th>
</tr>
</thead>
</table>
| **MCH Target Population:** Focus on target MCH populations, which includes families, women, mothers and fathers, infants, children, adolescents, young adults, and children and youth with special health needs. | All populations have commonly understood/agreed upon definitions within the division  
All populations are included when collecting data  
All populations are included in fact sheets/snapshots presented to community/stakeholders |
| **Health Equity:** Integrate health equity throughout process using the MDH Triple Aim of Health Equity. | Implement Health Equity as the goal  
Expand our understanding of what creates health  
Strengthen the capacity of communities to create their own future  
Reference/utilize data on health and health disparities, MDH reports, and policy briefs  
Collaborate with partners/communities to ensure health equity is discussed and community suggestions are honored |
| **Quality Improvement:** Use a continuous quality improvement approach to increase assets and protective factors and to address challenges as opportunities to advance population outcomes. | Together with both internal and external partners, identify assets, protective factors, challenges, and opportunities specific to MN’s MCH population  
Utilize continuous quality improvement expertise within the CFH Division  
Utilize quality improvement processes and tools appropriately throughout the needs assessment |
| **Community Engagement:** Actively engage with community stakeholders utilizing the principles within the MDH Community Engagement Plan. | Utilize MDH Community Engagement Plan with focus on intentional efforts to learn from MN’s MCH population, with special effort to include those from racially, ethnically, culturally, and geographically diverse backgrounds.  
Actively seek, consider, and rely upon MCH community and stakeholder expertise to inform efforts and results. |
| **Transparency:** Communicate with needs assessment participants, the MCH community, and stakeholders so that information used in needs assessment is shared, and that decision-making processes are clear and understandable (also to support accountability) | Document sources of data and methods used in needs assessment  
Document meeting proceedings and decision-making processes  
Communicate with all participants and stakeholders on a regular basis throughout the needs assessment process |
| **Accountability:** Be answerable for the consequences of decisions that impact families, communities, and stakeholders. | Evaluate effectiveness of processes and programs  
Follow-up and/or act on feedback received  
Consistently report to the MCH Advisory Task Force |
| **Data-driven Decisions:** Use quantitative and qualitative data to inform decision making. | Identify and collect valid, relevant, and updated data to describe the MCH population and its needs  
Use the best available data and understand its limitations  
Utilization of prioritization process  
Balance data with stories, including lived experiences |
<table>
<thead>
<tr>
<th>Key Principle</th>
<th>Activities to Operationalize</th>
</tr>
</thead>
</table>
| Evidence-Based and Informed Practices: Apply evidence-based and informed practices to methodology and planning efforts related to the needs assessment. | Create MCH/CYSHN Topic Inventory Crosswalk  
Qualitative and quantitative method design and implementation  
Apply a systematic framework to the prioritization process |
| Adaptability: Demonstrate willingness, flexibility and agility throughout the needs assessment process. | Remain open to change and compromise in an effort to enhance the process  
Consider and integrate new guidance throughout process |
| Collaboration with Systems Partners/Customers: Focus on both internal and external partners as key collaborators to achieve desired outcomes. | Identify internal and external partners.  
Develop nontraditional partners  
Seek input, guidance, and collaboration from identified partners, including local public health, in addition to other key stakeholders.  
Construct mutual goals and objectives to best utilize the synergy of all partners.  
Coordinate and track strategies and deliverables from all sectors.  
Building long-term relationships |
Appendix B: Timeline with Activities

2018: The Data Stage

**Stakeholder-Driven Activities**
- MDH Meetings
  - Infant/Woman – Feb 5
  - Child/Adolescent – Feb 6
  - CSHCN – Feb 15

**Data Team Activities**
- January-April
  - Collect/Obtain Quantitative Data
- May
  - Create Data Story Template
- June-August
  - Discovery Survey Open
- September-November
  - Analyze Discovery Survey data
- July-December
  - Data team starts to create data stories for domains and analyze/collect data
- Fall 2018
  - Stakeholder Key Informant Interviews
- Title V Leadership Team Reviews
  - Results of Data Collection Activities

Data team assembles indicator list
Data team analyzes additional qualitative data
2019: The Prioritization Stage

Prioritization Activities

Data Team Activities

Jan: Data team completes data stories and preparing for prioritization
Feb: Data team summarizes Prioritization Round 1; prepares data sheets for round 2
Mar: Needs Assessment Leadership Team narrows list of cross-cutting priorities
Apr: Community final selection of cross-cutting
May: Community narrows list of domain-specific priorities
Jun: Needs Assessment Leadership Team final selection of domain-specific priorities
Jul: MCH Advisory Task Force Approval
Aug: Data team summarizes final priorities; prepares public comment document
Sep: Oct: Nov: Dec:
## Appendix C: Criteria-Based Ranking Scoring Sheet

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Criteria Explanation</th>
<th>Scoring Guidance</th>
<th>Possible Priority 1</th>
<th>Possible Priority 2</th>
<th>Possible Priority 3</th>
<th>Possible Priority 4</th>
<th>Applied Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Magnitude</td>
<td>The number of people who are impacted.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Trend</td>
<td>A pattern of gradual change or general tendency of a series of data points to move in a certain direction over time.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Health and racial equity</td>
<td>Attainment of the highest level of health for all people. Inequities are differences (i.e. disparities) among different groups of people that are avoidable, unfair, and unjust.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Impact/Severity</td>
<td>The impact/effects of the utilization of resources (financial cost), morbidities, comorbidities, and mortality.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Perceived preventability</td>
<td>Able to be prevented, avoided, or stopped in its tracks.</td>
<td></td>
<td></td>
<td></td>
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<td>1</td>
</tr>
<tr>
<td>Effective interventions</td>
<td>Effective intervention or evidence-based/informed strategy is available (efforts will make a measurable impact in 2, 5, and 10 years).</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Agency capacity</td>
<td>The ability for Child and Family Health, in partnership with stakeholders, to dedicate resources to address strategies to improve priority.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Political will</td>
<td>The collective support from state administration, politicians, and the public.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Stakeholder input*</td>
<td>Contributions from community members, stakeholders, internal staff, and other</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Criteria</td>
<td>Criteria Explanation</td>
<td>Scoring Guidance</td>
<td>Possible Priority 1</td>
<td>Possible Priority 2</td>
<td>Possible Priority 3</td>
<td>Possible Priority 4</td>
<td>Applied Weight</td>
</tr>
<tr>
<td>----------</td>
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</tr>
<tr>
<td></td>
<td>partners throughout Needs Assessment process.</td>
<td></td>
<td></td>
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<td></td>
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<td></td>
</tr>
</tbody>
</table>

*Stakeholder input score will be combined with results from community forum.*
Appendix D: Needs Assessment Required Elements

The Title V legislation (Section 505(a)(1)) requires the state, as part of the Application, to prepare and transmit a comprehensive statewide Needs Assessment every five years that identifies (consistent with the health status goals and national health objectives) the need for:

1. Preventive and primary care services for pregnant women, mothers and infants up to age one;
2. Preventive and primary care services for children; and
3. Services for children with special health care needs.

States will report on their next Five-Year Needs Assessment on **July 15, 2020**.

**Required Elements of the Five-Year Needs Assessment**

<table>
<thead>
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<th>Required Element</th>
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<tr>
<td><strong>Process Description</strong></td>
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<tr>
<td>Goals, framework and methodology that guided the Needs Assessment process</td>
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<tr>
<td>Level and extent of stakeholder involvement, including families, individuals and family-led organizations;</td>
</tr>
<tr>
<td>Quantitative and qualitative methods that were used to assess the strengths and needs of the MCH population in each of the five identified population health domains, MCH program capacity and supportive partnerships/collaborations</td>
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<tr>
<td>Data sources utilized to inform the Needs Assessment process; and (v) Interface between the collection of Needs Assessment data, the finalization of the state’s Title V priority needs and the development of the state’s Action Plan</td>
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</table>

| **Findings** |
| MCH Population Health Status - The state should clearly describe the health status of the MCH population within each of the five population health domains (i.e., Women/ Maternal Health, Perinatal/Infant Health, Child Health, Adolescent Health, and CSHCN), based on the quantitative and qualitative analyses conducted. Specific discussion points should include: |
| (a) A summary of the noted strengths and needs in the overall MCH population and in specific MCH sub-population groups; |
| (b) A concise description of the state’s successes, challenges and gaps related to major morbidity, mortality, health risks or wellness for each of the five population health domains. At a minimum, the discussion should include the major health issues reflected in the state’s priority needs relative to the MCH population as a whole or specific sub-populations when stratified by age, income, geography, frontier/rural/urban status, or other relevant characteristics. |
| (c) An analysis of current MCH Block Grant efforts in addressing the needs of its MCH population to determine areas of success and areas in which new or enhanced strategies/activities are needed. |
| Title V Program Capacity - A state’s assessment of its Title V program capacity should examine current resources, staffing and organizational structure, state agency coordination and family partnerships. States should summarize the findings from their Five-Year Needs Assessment relative to each of these categories in the following sections. |
| (a) Organizational Structure |
**Required Element**

In reporting on the organizational structure of the Title V program, the state should:

Describe the organizational structure and placement of the Governor, state health agency and the Title V MCH and CSHCN programs in the state government. Clarify how the state health agency is "responsible for the administration (or supervision of the administration) of programs carried out with allotments" under Title V. This description should include all of the programs that are funded by the federal-state MCH Block Grant.

(b) Agency Capacity

In summarizing the state Title V program capacity, the state should describe the state Title V agency's capacity to promote and protect the health of all mothers and children, including CSHCN. Included in this description should be a discussion of the steps taken by the MCH and CSHCN programs to ensure a statewide system of services that reflect the components of comprehensive, community-based and family centered care. The state should also describe the extent to which the Title V program collaborates with other state agencies, health services entities and private organizations to support health services delivery at the community level.

Specifically, the state's summary on Title V program capacity should include the following:

- A description of the state’s Title V capacity to provide and assure services within each of the five population health domains.

An expanded discussion on the state’s capacity for serving CSHCN, which includes the Title V program’s ability to provide rehabilitation services for blind and disabled individuals under the age of 16 receiving benefits under Title XVI (the Supplemental Security Income Program), to the extent that medical assistance for such services is not provided under Title XIX (Medicaid). If applicable, states may describe their capacity to serve CSHCN and their families by referencing the National Consensus Standards for Systems of Care for Children and Youth with Special Health Care Needs as a guiding framework (AMCHP, 2014).

**MCH Workforce Capacity - State Title V program efforts to implement the core public health functions (assessment, policy development and assurance) and to achieve increased accountability through ongoing performance measurement and monitoring require an adequately sized and skilled workforce. In reporting on their Title V program capacity, states should describe the strengths and needs of their MCH and CSHCN workforce. Specifically, states should include in their MCH workforce summary the following information:**

- Number, location and full-time equivalents of state and local staff who work on behalf of the state Title V programs;

- Names and qualifications (briefly described) of senior level management employees who serve in lead MCH-related positions and program staff who contribute to the state’s planning, evaluation, and data analysis capabilities;

- Number of parent and family members, including CSHCN and their families, who are on the state’s Title V program staff and a brief description of their roles (e.g., paid consultant or volunteer); and

- Additional MCH workforce information, such as the tenure of the state MCH workforce and projected shifts in the MCH and CSHCN workforce over the five-year reporting period, that aligns workforce capacity with the achievement of Title V program goals.

**Title V Program Partnerships, Collaboration, and Coordination - Title V programs partner with a range of federal, state and local entities to further supplement state agency capacity in meeting the needs of its MCH population. In summarizing these partnerships as well as the engagement of stakeholders in programmatic decisions, the state should describe relevant organizational relationships that serve to expand the capacity and reach of a state Title V program in meeting the needs of its MCH population, including CSHCN. The state should reference formal and informal collaboration processes and partnerships with the public and private sector and with state and local levels of government. In addition, the state should describe the process for involving stakeholders and their contributions to the Title V program.**

In summarizing the strengths and weaknesses of its partnership building and collaboration efforts, the state should describe its partnerships and relationships with such programs as:
## Required Element

(a) Other MCHB investments (e.g., State System Development Initiative (SSDI) Grants, Family-to-Family Health Information Centers; MCHB investments related to newborn and early childhood screenings, epilepsy, genetics, and blood disorders, Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Grants, Healthy Start Grants, Early Childhood Systems of Care (ECCS) Grants, MCH Training programs and other MCHB efforts relating to injury prevention, autism, developmental disabilities, adolescent health, workforce development, oral health, bullying and emergency medical services for children);
(b) Other Federal investments (e.g., ACF, CDC and USDA-funded programs, such as immunizations, infant and child death reviews and WIC);
(c) Other HRSA programs (e.g., community health centers and HIV/AIDS/AIDS programs and Area Health Education Centers);
(d) State and local MCH programs (e.g., local health departments and urban MCH programs);
(e) Other programs within the State Department of Health (e.g., chronic disease, prevention and health promotion, immunization, vital records and health statistics, injury prevention, behavioral and mental health and substance abuse);
(f) Other governmental agencies (e.g., Medicaid, CHIP, Education, Social Services/Child Welfare, Social Security Administration, Corrections and Vocational Rehabilitation Services);
(g) Tribes, Tribal Organizations and Urban Indian Organizations;
(h) Public health and health professional educational programs and universities; and
(i) Other state and local public and private organizations that serve the state’s MCH population.

### Identifying Priority Needs and Linking to Performance Measures

Consistent with Figure 4 on page 14, findings from the Five-Year Needs Assessment should drive the state’s identification of its seven to ten highest MCH priority needs for the five-year reporting cycle. The selected priorities may address the defined MCH population groups and/or cross-cutting/ systems building areas, and they should reflect the unique needs of the state. In addition, the identified priority needs should address areas in which a state believes that targeted interventions can result in needed improvements to its health care delivery systems. Once identified, the priority needs inform the selection of a minimum of five NPMs, one in each of the MCH population health domains, and the development of SPMs. Collectively, the NPMs and SPMs should address the state’s identified priority needs.

States list their seven to ten priority needs on Form 9 of the Application/Annual Report. For each of the listed priority needs on Form 9, states should indicate if the need is new for this reporting cycle or if it is being revised or continued from the previous reporting cycle.

The narrative discussion supplements the listing of the final priority needs by providing a rationale for how the priority needs were determined and how they link with the selected national and state performance measures. Specifically, this discussion should include:
- Methodologies used to rank the broad set of identified needs and the state’s process for selecting its final seven to ten priorities;
- Emerging issues or other frequently cited needs that were not included in the final list of priority needs and a rationale for why they were not selected;
- Factors that contributed to changes in the state’s priority needs since the previous five-year reporting cycle; and
- The relationship between the priority need and the selected national and/or state performance measures in driving improvement.
Appendix E: Definitions

**Needs Assessment:** Systematic collection and examination of information to make decisions to formulate a plan for the next steps leading to public health action.

**Stakeholder:** Any party with an interest in or is being affected by the implementation or outcome of a particular service, practice, process or a decision and participate in group decision-making to resolve problems or define solutions to achieve a common goal.

**Community:** A geographic location (place) or a group of people with diverse characteristics who are linked by social ties (e.g., skin color, sexual identity, culture), share common interests or perspectives, and engage in joint action in geographical settings (e.g. neighborhood, rural, watch over or look out for one another).

**Evidence-based and evidence-informed practices:** Any concepts or strategies that are derived from or informed by using objective evidence from well-defined valid research findings and scientific studies to improve health outcomes or services. The approaches to these practices integrate the state, needs, values, and preferences of those affected.

**Partner vs. Customer:** A partner is a person or organization working together collaboratively and in a transparent manner with a common goal and shared vision to maximize their resources and to realize an increase in number or value of benefits and services provided or offered. A customer uses or is a recipient of the benefits or services offered. A customer can also be a partner and in certain circumstances, we listen to their concerns and expectations and treat them as partners.

**MCH Populations:** Families, women, mothers and fathers, infants, children, adolescents, young adults, and children and youth with special health needs.

**Health Equity:** Health Equity is achieved when every person has the opportunity to attain their health potential, and no one is unjustly kept from achieving this potential.

Healthy People 2020 defines health equity as the "attainment of the highest level of health for all people."

American Public Health Association definition of health equity: By health equity, we mean everyone has the opportunity to attain their highest level of health.

**Protective factors:** Conditions or attributes (skills, strengths, resources, supports or coping strategies) in individuals, families, communities or the larger society that help people deal more effectively with stressful events and mitigate or eliminate risk in families and communities.

**Title V Domains:** Maternal/Women’s Health, Infant/Perinatal Health, Child Health, Adolescent Health, CYSHN