MATERNAL AND CHILD HEALTH NEEDS ASSESSMENT SUMMARY
COLORADO DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT
FISCAL YEARS 2011-2015

1. Process for Conducting Needs Assessment

Goals and Vision:
The Colorado Maternal and Child Health (MCH) Program adopted the following Vision and Mission statements in 2007. Colorado's Vision is to foster Healthy People, Healthy Families…Thriving Communities. The Mission focuses on optimizing the health of women, children, adolescents, children and youth with special health care needs and families using public health strategies that support community action, facilitate capacity building, strengthen public health infrastructure, and enhance systems of care.

Colorado chose a conceptual framework for the needs assessment process that uses a strengths-based approach with the goal of optimizing health and well-being among the MCH population across the life course, taking into account that a complex interplay of biological, behavioral, psychological, and social factors (e.g., both risk and protective) contribute to health outcomes (e.g., the Life Course Health Development Model). In alignment with this model, the influence of early life events and critical periods across the life course were considered with attention given to the cumulative impact of experiences over time, which resulted in an emphasis on primary prevention and early intervention. The social determinants of health were also considered as factors that shape the health of individuals and communities. The state arrived at this view collaboratively by discussing the overall framework with the MCH Needs Assessment Steering Committee and by subsequently building consensus for this approach with the MCH Needs Assessment Advisory Committee. (Both groups are described in the Leadership Section below.)

For purposes of assessment and strategic planning, the MCH population was defined as women, children, adolescents, children with special health care needs, and families. The MCH population was further subdivided into women of reproductive age (ages 15-44), early childhood (ages birth-8), including children with special health care needs and child/adolescent (ages 9-21), including children and youth with special health care needs. In order to foster integration of efforts horizontally among core MCH Units in the division, staff felt that it was important to include issues pertinent to all children and youth, including those with special health care needs (CSHCN), as opposed to considering their needs separately.

The overall goal of the process focused on identifying a set of specific priorities that could be acted upon at some depth so that results, even preliminary ones, would be achievable and evident in five years. Strategies employed to achieve results were to be evidence-based/ promising practices or interventions grounded in sound public health theory or research and consistent with the mission and scope of Colorado's MCH program. A clear MCH public health role needed to exist for an issue to be considered as a potential priority. The process focused on meaningfully involving multiple state and community stakeholders/partners to enhance collaboration, while looking for opportunities to coordinate and integrate MCH efforts externally and internally across the MCH continuum. To this end, the needs assessment has served as a catalyst, fostering an integration of work activities across all MCH-related programs at the CDPHE.

The needs assessment has served as a vital planning process for determining where best to focus Colorado's MCH efforts to implement programs, policies and systems building efforts that will measurably demonstrate impact within five years. Colorado also employed a strategic planning process to examine how these new priority areas can be incorporated into the existing MCH scope of work. By identifying state mandates and statutory requirements, along with existing MCH efforts, planning will be initiated in the summer of 2010 to develop implementation steps for the new priorities. Part of this process will involve transitioning previous areas of investment, in order to resource efforts that most directly relate to the newly chosen priorities. Key to future implementation efforts is resource allocation, as the final MCH scope of work must align with existing funding and staff capacity.

Leadership:
Colorado's needs assessment process was guided by the MCH Needs Assessment Steering Committee (Steering Committee) which included the following staff members:

- Kathy Watters, Director of the Children with Special Health Care Needs Unit;
- Candace Grosz, and, following her retirement, Mandy Bakulski, Prenatal Program Director from the Women's Health Unit;
- Rachel Hutson, Director of the Child, Adolescent & School Health Unit;
- Barbara Gabella, Director of the Epidemiology Unit of the Epidemiology, Planning and Evaluation Branch for the Prevention Services Division;
- Gina Febbraro, MCH Program Manager;
- Sara Wargo, MCH Program Assistant and
- Karen Trierweiler, the Title V Director.
- The group was assisted by Jill Hunsaker-Ryan, from the CDPHE Office of Planning and Partnerships, who served as facilitator and process consultant.

With leadership from the MCH Director, this group established the overall strategic direction and methodology for the needs assessment while providing the ongoing project management and oversight for the process, The Steering Committee met bi-weekly beginning in February 2009, completing their work in June 2010.

The Steering Committee received support and counsel from the MCH Needs Assessment Advisory Committee, a group of external and internal stakeholders who served as advisors to the needs assessment process. This group convened twice during the during the 16-month project implementation period; initially providing critical feedback regarding the overall process methodology in August 2009 and participating in a pilot and set of focus groups to finalize the Phase II stakeholder survey in February 2010. The Advisory Committee, along with other stakeholders, will be reconvened in September 2010 to review Colorado's new MCH priorities in order to identify future collaborative opportunities. (See Appendix A: MCH Needs Assessment Advisory Committee Members.)

Methodology:
<u>PHASE I</u>
The Needs Assessment Steering Committee employed a three-phase methodology in planning and implementing Colorado's needs assessment. During Phase I, staff devised two strategies to solicit both qualitative and quantitative data to identify potential MCH priority areas. The first strategy involved convening three expert panels to identify potential focus areas for future MCH investment

(a list of members can be found in Appendix B: Expert Panel Summary). The expert panels were organized according to the key MCH population groups: women of reproductive age (ages 15-44), early childhood, including CSHCN, (birth-age 8), and the child/adolescent/CSHCN group (ages 9-21). Each panel consisted of 10-12 subject matter experts, with background and experience specific to the target cohort. Panelists participated in a series of three facilitated meetings, October through December 2009, led by Steering Committee members who served as state staff experts in the area. Panel leaders recruited members for the team and set a schedule. The needs assessment coordinator assisted the panel leaders by providing oversight and resources to all three groups. Panelists were presented with a series of background documents to inform the process and the panels were guided by a set of expectations regarding data-based decision making, prioritization criteria and desired outcomes. Prioritization criteria included considering potential issues in terms of the MCH/public health role, the existence of strategies for intervention, and the ability to demonstrate outcomes/results within five years using specific indicators to measure progress. These criteria were summarized as "DIP" (e.g., doable, important and a clear role for public health). The priorities that met the "DIP" criteria were eligible for consideration during Phase II of the needs assessment process. In addition to the input provided by the subject matter experts, panel members were asked to gather input from secondary stakeholders between meetings to bring additional viewpoints to the panel discussions.

The second Phase I strategy involved creating an updated version of the Colorado MCH Health Status Report, which served as a means for compiling and analyzing quantitative MCH population data. The new report, which was updated to include a life course perspective, also included new data, such as results from the Colorado Child Health Survey. Finally, the summary complements the MCH data sets developed under the auspices of the State Systems Development Initiative (SSDI) grant. (Appendix C: Colorado MCH Health Status Report).

At the end of the expert panel process, results were summarized from all three groups and presented to the Steering Committee, along with the preliminary draft of the Colorado MCH Health Status Report. As expected, the focus areas identified by the three expert panels overlapped due to the impact that many of the issues exert throughout the life course. Phase I, then, concluded with the identification of 21 potential MCH priorities, generated by the expert panels, spanning the three populations (Appendix D: Potential MCH Priorities).

PHASE II

The potential priorities identified by the expert panels were presented to key stakeholders, via an online survey during Phase II of the process, with the goal of gathering additional input to further refine and prioritize the issues. The survey was pilot tested with internal state staff, revised and then again reviewed by the MCH Advisory Committee before the final version was disseminated in February 2010. During Phase II, 265 stakeholders were invited to comment with 172 completing the survey for a completion rate of 65 percent (Appendix E: Priority Survey Respondents). Survey participants chose their top three issues for each population, while also identifying any important issues not reflected in the original twenty-one. Of the new issues identified, most had been considered by the expert panels or other stakeholders in earlier phases of the needs assessment process.

To gauge local capacity, local public health agency directors were asked to assess their organizational capacity to address the potential MCH priority areas. Out of 54 agency directors, only 24 completed the survey. However, since the responses were identified, analysis revealed that the largest public health agencies in Colorado were represented in the survey results.

The survey results were tabulated and a more refined list of key issues emerged for presentation to the Steering Committee in March 2010.

PHASE III

Phase III included the final prioritization process and state capacity assessment to determine the MCH priorities for FY2011-2015, including identification of the state performance measures. True to the guiding principles of the process, the Steering Committee focused on the goal of identifying fewer areas for MCH investment, so that a comprehensive set of interventions could be employed at more depth to affect five-year outcomes. In addition, the chosen priorities and the State Performance Measures needed to be tied to the MCH sphere of influence in order to assure ultimate impact. In order to do so, the Steering Committee was charged with connecting each potential priority to an intermediate or population-based outcome measure. To this end, MCH staff prepared a two-page justification for each priority highlighting the following: public health/MCH role; data to support the need (severity or numbers affected); effective interventions/strategies that exist to address the issue; local capacity score for the issue and specific indicators that could be used to measure success within the five-year period. These issue papers, along with the assessment of state capacity, served as key resources for discussion in determining the final set of nine priorities. Following these discussions, each issue was ranked, using a grid specifying impact and feasibility along an x and y axis.

To assure that the MCH Program could realistically resource the new priorities, Phase III also included the identification of all work being currently completed under the auspices of the MCH Program. The "MCH Scope of Work" (SOW) included all MCH-related statutory mandates and other required activities, such as the MCH National Performance Measures, as well as other efforts related to MCH, but funded by sources other than the block grant. These activities were recognized as needing to continue, regardless of the state's choice of new priorities. The SOW also encompassed discretionary MCH activities, e.g., current work that aligned with the existing set of MCH priorities that could be shifted in order to provide capacity (funding and staff time) to address the new priorities. The development of the SOW was critical in that, in the past, the state had defaulted to include mandates and discretionary efforts when identifying new priorities, even when these issues did not consistently align with the needs assessment results. Therefore, as the state moves into implementation planning, issues that fall outside of the MCH SOW will not be ultimately addressed or resourced through the block grant.

Realizing the dynamic nature of MCH as well as the depth and breadth of issues specific to these populations, Colorado will continue to systematically assess needs during the upcoming five-year time frame. In the fall of 2010, specific work plans will be developed for each priority with goals, objectives, activities and evaluation measures that will drive state and local MCH-level activities from FY 2011-2015. As noted above, MCH resources will be allocated and/or shifted to implement the new priorities which will include ongoing evaluation. Local MCH contractors and other partners will be introduced to the new priorities during a stakeholder meeting planned for September 2010.

Stakeholder Description

Expert panelists included representation from state MCH programs (including MCH Needs Assessment Steering Committee members), local MCH programs, family/youth serving agencies, and other key MCH community partners such as health care providers and community-based agency staff, along with representatives from other state agencies and academic institutions (see

Appendix B). Both the early childhood and child/adolescent panels included a family leader. Criteria used for selecting expert panelists included their area of expertise and workplace setting (e.g., geographic perspective), training and experience, knowledge of public health, and their ability to conceptualize at the strategic level, while not solely advocating for a single issue. Expert panel members solicited feedback from their own constituencies/ stakeholders in between panel meetings which greatly expanded the reach of this effort. In addition to the expert panelists, approximately 75 additional people shared their perspective on MCH needs and priorities through the expert panel process, including adolescents from the Youth Partnership for Health.

The 21 potential priority areas identified by the expert panels (Appendix D) and the Colorado MCH Health Status Report (Appendix C) were used to develop a stakeholder survey. Invited stakeholders included representatives from state and local public health and other governmental agencies (e.g., the Colorado Department of Education and the state Medicaid Program), staff from community-based organizations and advocacy/interest groups (e.g., The Autism Society, Colorado Association for School-Based Health Care, HealthyWomen HealthyBabies, Oral Health Awareness Colorado, The Colorado Children's Campaign, etc.) along with health care providers/organizations (e.g., The Colorado Community Health Center Network and Kaiser Permanente, etc.) and academic partners (LEND, The University of Colorado and The Children's Hospital.) A complete list is available in Appendix E. The Steering Committee noted that the stakeholders who participated appeared to be representative of the population at large as few issues were identified by survey participants as "missing" from the final potential priorities list.

The additional issues that were identified in the survey were classified in the following fashion. A number of comments were related to access to care for the MCH population and health insurance coverage; both of which should be impacted significantly by health care reform. A second group included issues that were either included as national performance measures or were adequately addressed by other department/community efforts and/or funding sources where MCH will continue to function as a partner, e.g., immunizations, second hand smoke exposure and child abuse and neglect. A third group consisted of strategies which can be employed in implementing the chosen priorities such as the inclusion of fathers into interventions, the impact of attitudes and beliefs on health and well-being and health equity. Finally a few, such as youth homelessness and the long-term implications of poor parenting, did not satisfy the criteria for inclusion into the final group of priorities, as outlined earlier.

Methods for Assessing Three MCH Populations:
The Methodology Section of this report included a review of the methods employed in assessing the strengths and needs of the MCH population. To summarize, the Colorado MCH Health Status Report served as a means for compiling and examining quantitative data relative to the various populations while the expert panel and stakeholder survey processes provided a qualitative view of pertinent data issues.

Methods for Assessing State Capacity:
Colorado studied options for capacity assessment extensively before choosing to utilize a modified CAST V approach. The Steering Committee incorporated a formal assessment of state capacity relative to the 21 potential priority areas into the Phase III final prioritization process. The following four components were utilized to assess capacity at both the state and local level for each of the proposed MCH priorities.

- Structural Resources: Financial, human, and material resources; policies and protocols; and other resources needed for the performance of core functions.

- Data/Information Systems: Access to timely program and population data; supportive environment for data sharing; adequate technological resources to support the use of data in decision-making

- Competencies/Skills: Knowledge, skills, and abilities of MCH staff

- Organizational Relationships: Partnerships, communication channels, and other types of interactions and collaborations with public and private entities.

The following scoring system was employed by both state and local staff in quantifying capacity to address each potential priority area.

Score	
1	No current capacity exists to address this priority
2	Some capacity exists, but it is not currently adequate to address this priority
3	Although there is always room for more, current capacity is adequate to address this priority
4	Current capacity is well-established to address this priority

For both the state and local capacity assessments, the scores for each of the four areas were averaged to give one state and local capacity assessment score for each potential priority area.

One of the goals of Colorado's needs assessment process was to reflect the MCH pyramid's emphasis on population-based services and infrastructure building. Therefore, the capacity to address the potential priorities was examined specifically in the context of the capacity to support population-based and infrastructure building efforts related to the priority areas. Capacity related to direct and enabling services was incorporated into the Access to Health Care sections throughout the Colorado MCH Health Status Report.

Data Sources:
For a detailed review of data sources used, please see Appendix C: Colorado MCH Health Status Report.

Linkages between Assessment, Capacity, and Priorities:
Information gathered in Phases I and II of the needs assessment process along with the state and local capacity assessment scores informed the final process for identifying Colorado's new MCH priorities and State Performance Measures. The final priorities reflect the guiding principles for the needs assessment, incorporating the importance of primary prevention and early intervention in facilitating a positive health trajectory for individuals and communities. The linkages between assessment and capacity and priorities selection process are outlined in the earlier section on Methodology, particularly in the Phase III discussion.

Dissemination:
The MCH program will host a large stakeholder meeting in September 2010 to share the results of the 2011-2015 needs assessment process and to introduce the new MCH priorities and state

performance measures to stakeholders and partners. Invited stakeholders will include members of the MCH Steering and Advisory Committee, expert panel members, participants in the Phase II MCH stakeholder survey, local public health agency directors and MCH staff, family leaders, members of the Youth Partnership for Health and the CSHCN Youth Leadership Council. In addition, senior staff from the CDPHE will be invited to attend. (Please see the Stakeholder Section under Methodology and the appendices for specific information on stakeholder representation.) This meeting will provide an opportunity to update stakeholders interested in the final outcome of the process, while providing a forum to discuss implementation plans and future opportunities for collaboration and partnership.

The Colorado MCH Health Status Report along with Colorado's new priorities and state performance measures were posted on the MCH website as stand-alone documents and as a part of the state's FY11 MCH Block Grant application. An announcement was initially featured on the front page of the CDPHE website and an email, noting the location of these core documents, was sent to all MCH stakeholders.

Strengths and Weaknesses of Process:
The MCH Director conducted a formal de-brief of the needs assessment process at the final meeting of the MCH Steering Committee in June 2010. (Questions used to guide the discussion are included in Appendix F: Debrief Questions). In general, the group indicated satisfaction with the process and the results. There was universal support of the initial decision to redesign the process and the group reaffirmed the relevance of the guiding principles in shaping the outcomes. Initial concerns around the loss of unit/program considerations were not ultimately realized, with general agreement that the process helped to connect the work of the three core MCH Units more intentionally in what ultimately was viewed as a very participatory process. There was general agreement that the intensity of the meeting structure and the discussions themselves served to integrate the group's thinking about different programs and MCH as a whole.

The group appreciated the expert panel process, which was conceived and implemented within an extremely short period of time. Results from a survey of panel participants indicated that the purpose of the panels was clear, with 86 percent of participants indicating that the desired outcomes were achieved. Steering Committee members found it helpful to have the issue areas identified by each expert panel and then compiled in such a way that staff could envision how they could work individually and collectively to address an issue across age groups.

The process led to a number of incidental outcomes in that the issue papers and other materials produced in the process have been used for related purposes along with stimulating opportunities for greater integration of state-level MCH efforts. Several group members noted that the process has allowed staff to better articulate program/unit goals and strategies, while fostering the development of new partnership as different expectations for MCH were generated. The needs assessment process served as the first step in broader strategic planning for MCH, and as a result, created energy for both the Prenatal Program and the Children with Special Health Care Needs Unit to reassess activities and structure.

In terms of improvements, the process could have benefitted from more planning initially, as one participant described it as "flying the airplane while building it." Future processes can benefit from establishing more definitive timelines and clarity of expectations. There was a recommendation that the conveners and facilitators determine the "how" and the steering committee address the "what and why." Being more intentional in defining the overall goals of the process, with attention

to integrating the federal requirements with the specific desired outcomes for the state, was stressed. The group agreed that the process took more time than was initially anticipated and, as a result, they recommended beginning the next needs assessment about 18 months prior to the deadline.

The group was also confounded by how few tools were available for use in the needs assessment process, with general agreement about the struggle that at times ensued to find tools that fit. This was particularly true in relation to the capacity assessment component, when the group was challenged to find a tool that could help quantify capacity. While the group ultimately decided to use a modified CAST V approach, most agreed that the assessment of capacity was superficial at best. In addition, there was general agreement to reassess the stakeholder survey in subsequent years in terms of timing, content and audience.

Given the exponential increase in the amount of data available for analysis in the last five years, the group agreed that developing the Colorado MCH Health Status Report in the same vein as 2005 was ultimately ill advised. As evidence of the increased depth and breadth of MCH-related data, the first draft of the 2010 Health Status Report was twice the length of the 2005 version. As a result, it became increasingly difficult to focus the scope of the project. Before such endeavors are undertaken in the future, the purpose for the data report and the intended audience(s) must be clearly determined. The group has entertained the notion of developing a series of shorter, more focused data summaries on key MCH topics.

Finally, staff agreed to reassess the membership of both the Steering and Advisory Committees in the future, in order to define the most effective structure for driving the process and communicating the results. Greater local public health participation will be solicited in the future.

2. Partnership Building and Collaboration Efforts

There are two centers within the Preventive Services Division of the Colorado Department of Public Health and Environment. They are the Center for Healthy Families and Communities and the Center for Healthy Living and Chronic Disease Prevention.

The Center for Healthy Families and Communities houses all MCH activities. The Center for Healthy Families and Communities includes the Nutrition Services Branch (Special Supplemental Nutrition Program for Women, Infants and Children (WIC), and the Child and Adult Care Food Program (CACFP)); the Women's Health Unit (WHU); the Child, Adolescent and School Health Unit; the Children with Special Health Care Needs Unit; the Injury, Suicide and Violence Prevention Unit; and the Center's Fiscal and Administrative Services Unit.

The Center for Healthy Living and Chronic Disease Prevention includes the Chronic Disease Prevention Branch (Diabetes; Cardiovascular Disease; Comprehensive Cancer Program; Breast & Cervical Cancer Program; and the Oral Health Unit); the Healthy Living Branch (Healthy Aging Unit, State Tobacco Education and Prevention Partnership, Colorado Obesity, Physical Activity and Nutrition Unit); and a Center-specific Fiscal and Administrative Services Unit.

Colorado's MCH Program has a long history of working collaboratively with other state, public and private agencies, and advisory and advocacy groups. The core MCH Units, found within the Center for Healthy Families and Communities, are the Women's Health, the Child, Adolescent and School

Health (CASH) and the Children with Special Health Care Needs (CSHCN) Units. Each unit manages on-going advisory groups and specific task forces that are made up of public and private partners that share concern and responsibility for addressing the needs of women, children and families. Additionally, staff participates in partnerships led by colleagues within other state, federal and community organizations.

Much of the statewide work accomplished by MCH staff is done in collaboration with other state agency staff, particularly those who work within the health department, and the Colorado Departments of Education; Health Care Policy and Financing; and Human Services. MCH personnel work with other state agency staff on a nearly daily basis through coalitions, task forces, advisory groups, committees, and through cooperative agreements.

The Colorado Department of Human Services, in particular the Division of Developmental Disabilities, is an essential partner of the Children with Special Health Care Needs Unit. Together the agencies offer services for children served by the Colorado Department of Human Services and the Health Care Program for Children with Special Needs. Programs include the Colorado Department of Human Services' Early Intervention Services for Child Development; Family Support Services Program for families with a member who has developmental disabilities; Children's Extensive Support Waiver for Children Birth to 18 who are at high risk for out-of-home placement; and the Children's Medical Waiver for Children Age Birth to 18 with Developmental Disabilities that allows access to Medicaid state plan benefits regardless of parental income. The Health Care Program for Children with Special Health Care Needs Program (HCP) in the Children with Special Health Care Needs Unit also works closely with Early Intervention Colorado to implement HCP care coordination standards. An HCP staff member represents the program and the department on the Interagency Coordinating Council and the state level Memorandum of Understanding committee.

The Colorado Department of Education is an essential partner in activities relevant to early childhood state systems building efforts; the coordinated school health model; work with school nurses; and school-based health center activities. The Child, Adolescent and School Health Unit leads efforts to ensure partnerships and collaborative efforts occur in this area. They also work with the Colorado Department of Human Services, Division of Behavioral Health, who leads underage drinking prevention efforts.

Other important partners who MCH collaborates with to address teen motor vehicle safety are the Colorado Departments of Transportation; Revenue, Motor Vehicle Division; and Public Safety, State Patrol. The Injury and Suicide, Violence Prevention Unit is housed in the same Center as the MCH Program and has strong ties to the federal, state and community agencies and programs that carry out injury reduction activities.

The department's Primary Care Office works with Colorado's community health center network to improve accessibility and expand primary care services for low-income and vulnerable populations. These efforts include information and data sharing; recruitment and retention of health professionals; policy development; and assisting communities with applying for health professional shortage area and medically underserved designations.

The Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT) is located at the Colorado Department of Health Care Policy and Financing. Typically, EPSDT coordinators work with other public health service programs such as WIC, prenatal, immunization services, and the

Health Care Program for Children with Special Needs, and other MCH supported child health initiatives.

The Nutrition Services Branch, that includes the WIC and CACFP Programs, is in the same Center as the MCH Program. The programs have worked collaboratively for many years. Current efforts are focused on increasing breastfeeding rates and decreasing childhood overweight and obesity.

Title X Family Planning is housed within the Women's Health Unit. The MCH Block grant and Title X family planning activities are well-integrated. Efforts to address unintended pregnancy, preconception health and teen fertility are targeted to both family planning and MCH contractors. MCH funds are not used for direct family planning services, but rather to support population-based activities around unintended pregnancy prevention. This unit has strong ties to the programs that work on STD/AIDS. Via the Prenatal Program, there are linkages to the Healthy Start Program in Aurora.

The CASH Unit also works with the state's Immunization Program via the Vaccine Advisory Committee for Colorado, as well as through interdepartmental activities, such as the H1N1 School and Child Care Workgroup.

Relationships with the Center for Healthy Living and Chronic Disease Prevention are strong and support work between MCH projects and programs such as Diabetes, Oral Health and other chronic disease prevention and health promotion. For example, the Colorado Nutrition and Physical Activity Program (COPAN) have long worked with MCH to promote breastfeeding and now to promote healthy weight among children.

The state health department's Health Statistics Section is an established partner of the MCH Program. This long-term relationship has led to the development of MCH-specific data and resources. The inception of the division's Epidemiology, Planning and Evaluation Branch, has further enhanced ties with the Health Statistics Section and has strengthened the MCH Program's ability to gather, interpret and use data at the state and community level.

Partnership building and collaboration specific to the needs assessment process has been described in detail in earlier sections of this document. To summarize, it would have been impossible to carry out a comprehensive needs assessment process without the assistance of the numerous partners throughout the state.

3. Strengths and Needs of the Maternal and Child Health Population Groups and Desired Outcomes

The Colorado MCH Health Status Report discusses the health status of each of the state's MCH populations, including morbidity, mortality, problems, gaps and disparities (Appendix C). The report was designed as a resource for the needs assessment process, as well as for use as a stand-alone document.

The Colorado MCH Health Status Report details strengths and needs for all MCH populations. Colorado's chosen priorities are cross cutting in that the strategies that will be employed to address each priority involve working across all MCH populations to address needs, as discussed in subsequent sections of this summary.

The status of the existing performance, outcome, health status, and health system capacity indicators is discussed in the FY11 MCH Block Grant application. Appendix B of the Colorado MCH Health Status Report also addresses these measures and the Healthy People 2010 and 2020 objectives were cross-walked in most chapters of the report. In addition, on the MCH website (www.mchcolorado.org), county-specific data and three-year trend analyses have been completed and posted.

Colorado collected both qualitative and quantitative data for all MCH populations. Expert panel input further informed quantitative data analysis by employing the "DIP" criteria (e.g. doable, important, and a clear public health role) to add practical context to the interpretation of the objective data. For example, each of the three expert panels discussed access to medical and mental health services, ultimately deciding that the MCH community had little chance of effectuating significant change in these areas. Systems building, however, appeared as a population-based strategy for improving services and supports, yet it is difficult to evaluate the effectiveness of these efforts. Issues that advanced from the expert panels were again reviewed by a large group of MCH stakeholders (n=172) in the Phase II survey, along with an assessment of capacity, providing another critical context for evaluating quantitative data results. These examples illustrate how quantitative data was further interpreted qualitatively to enhance the state's selection of priorities.

The needs assessment process in Colorado led to two general findings about quantitative data. First, creating the comprehensive report on the health status of the MCH population using quantitative data confirmed for staff and stakeholders that, since the last needs assessment five years ago, there has been an exponential increase in the amount of data available for interpretation. This phenomenon provides a challenge in defining the depth and breadth for an MCH five-year analysis. While there is a proliferation of quantitative data that describes population-based behaviors, risk factors and long-term outcomes, the state was also interested in identifying data to track intermediate measures of success, recognizing the need to demonstrate incremental progress that will ultimately lead to an overall population effect.

Efforts that are working well and should be continued along with new areas for investment are discussed in the section on the selection of the state priority needs. As noted subsequently, Colorado will maintain efforts to prevent teen motor vehicle deaths, as progress in the population-based measure has been demonstrated. Newly chosen state priorities have a more specific focus than in the past, with attention to intermediate or shorter term outcomes which may lead to later improvements in population-based measures.

4. MCH Program Capacity by Pyramid Levels.

a. Direct Health Care Services

Direct health care services are defined as basic health services. Such services are generally delivered "one on one" between a health professional and a patient in an office, clinic, or emergency room. Basic services include what most consider direct medical care, inpatient and outpatient medical services, specialty care, allied health services, laboratory testing, x-ray services, dental care and pharmaceutical products and services.

Block grant funding is no longer used to provide direct prenatal care services. Concerns regarding direct health care services focus primarily on financial barriers, lack of public or private insurance, and limited availability of providers serving low-income populations. It is anticipated that this will change with the implementation of health care reform.

Colorado is far from reaching the Healthy People 2010 goal of 100 percent of people with health insurance coverage, with only 80 percent of the population covered; low-income and minority populations have even lower rates of health insurance coverage. The cost of employer-based health insurance in Colorado has skyrocketed; the average annual cost to families increased from just over $1,500 in the year 2000 to over $4,100 in 2008. Approximately 81 percent of Coloradans under the age of 65 have health insurance of some kind; over 86 percent of those under 19 have health insurance. These percentages are low, however, compared to other states. Colorado is ranked 36th among all states and the District of Columbia based on the percent of persons younger than 65 years old who have health insurance coverage, 43rd for those under age 19, and 49th for those under age 19 and below 200 percent of the federal poverty guideline. In fact, Colorado lags behind most states in insurance coverage for all racial/ethnic and income groups.

The highest rate of coverage is found among White/Non-Hispanic individuals with over 87 percent reporting that they have health insurance. By contrast, less than half of the Hispanic population who are younger than age 65, with incomes below 200 percent of the federal poverty level (FPL) have health insurance. These data only show the percentage of Coloradans with any health insurance. It is unknown how many of those who are insured are also underinsured because deductibles and co-payments act as barriers to receiving care.

Several programs are available to reach low-income families and those without health insurance. Pregnant women and children living in households at or below the 200 percent of the federal poverty level are eligible for health insurance coverage either through the Child Health Plan Plus (CHP+) or Medicaid. Enrollments in these two programs have increased, and close to 400,000 Colorado children are now covered. A total of 6.1 percent of all Colorado children were enrolled in CHP+ at some time between July 2007 and June 2008, and 23.4 percent of all Colorado children were enrolled in Medicaid in the same period. Other health care services available to low-income and uninsured persons include 15 community health centers that operate 138 clinic sites in 35 counties. These are non-profit centers where 90 percent of patients served have incomes below 200 percent of the FPL and 40 percent are uninsured by either public or private programs.

Another factor that contributes to access to care is the availability of health care providers. Healthy People 2010 included an objective to increase the proportion of persons with a usual primary care provider to 85 percent. The Primary Care Office of the Colorado Department of Public Health and Environment estimates that over 1 million residents live in communities that have less than the optimal number of primary health care providers. Several local or county indicators of poor primary health care access include: the ratio of primary providers to the population, the distance required to access care, the concentration of low-income residents, and the birth outcomes of pregnant women in the service area. Based on these factors together, the communities with greatest need for additional providers in Colorado are Commerce City and Strasburg and the rural counties of Clear Creek, Conejos, Costilla, Dolores, Jackson, Moffat, Park, Saguache, Yuma, and the eastern part of El Paso County.

Expansions in Medicaid and CHP+ coverage as well as an increase in the number and capacity of community health centers have led to greater availability of providers, but access as described

above is still not equivalent to demand. There continues to be limited access for children and adolescents, including children and youth with special health care needs for primary care and specialty care due to insurance coverage, as well geographic barriers. Access to prenatal care has improved for women with Medicaid but eligibility enrollment processes can limit provider availability. Providers are hesitant to accept a woman without confirmation that she is Medicaid eligible, which limits early entry into care. The ability for undocumented uninsured individuals to receive care is limited and difficult to track.

Nationally and in Colorado more attention is being paid to the need for preconception health care. Clinical preconception heath care services for women are still limited to those with insurance coverage. The Women's Health Unit is engaged in efforts to increase awareness of the importance of preconception health primarily through population and infrastructure building activities.

Family planning services have expanded in the last two years due to the advent of funding from an anonymous donor and increased federal funding through Title X. Current data indicates that the Title X Family Planning Program distributed about $4.7 million to 29 local public health and non-profit agencies in 38 counties to provide family planning services to about 62,000 men and women in FY09.

Increasing awareness of and access to mental health services, especially for women with postpartum depression, has occurred over the last few years. The Women's Health Unit has engaged in activities that have developed infrastructure to address the issue and has worked with partners to increase access to care. However, demand continues to exceed need and increasing awareness of the issue among women and their providers is an ongoing challenge when referral sources are few.

Access to oral health care services for low-income pregnant women is also limited, but several efforts within the oral health and prenatal care arenas seek to address this issue. Issues include provider's awareness that care can safely be provided to pregnant women, as well as sufficient numbers of providers who will accept public insurance. Access to dental care for pregnant women is increasing due to training efforts among prenatal and oral health providers, but there continues to be much need.

As with prenatal care, local public health agencies have moved away from direct care provision for children with MCH block grant funds with the expansion of Medicaid and the State Children Health Insurance Plan, the Child Health Plan Plus (CHP+) Program. These resources have increased access to direct care for low-income populations. Challenges remain, especially for children who are undocumented and therefore ineligible for Medicaid or CHP+. Again, the community health centers are important sources of care for these children. However, community health centers are not present in some of the sparsely populated rural areas of the state as well as in most of the resort communities that have relatively large undocumented populations working in the service industries.

Colorado continues to actively promote the development of school-based health centers, as this is an effective means of providing both preventive and primary oral, medical and behavioral health services for children and adolescents. Maternal and Child Health funds have been used as incentive grants to expand the number of school-based health centers available throughout the state. Additionally, foundation funds have supported these efforts.

A number of projects have worked to increase access to oral health care for children and youth. The department has received several Centers for Disease Control (CDC) and MCH Bureau grants that have allowed infrastructure development, resulting in more awareness regarding access issues. The percentage of children receiving Medicaid receiving at least one dental service annually continues to increase, along with the number of children eligible for Medicaid and CHP+ reimbursed services. Community health centers have increased service capacity and in concert with the non-profit sector continue to provide free and low-cost care as well as serve children with private insurance.

The use of sealants continues to be a priority area for the prevention of caries. The Oral Health Unit and private foundations support community-based sealant programs. Again the need vastly exceeds the demand with only 28 percent of schools eligible for sealant program services offering them. The Oral Health Unit continues to support a school fluoride mouth rinse program for children in grades K-6 in areas where the drinking water is not fluoridated.

The CSHCN Unit houses the Health Care Program for Children with Special Health Care needs (HCP). The program has discontinued the direct delivery of and payment for direct care, except for some gap filling services described in subsequent sections. Services for low-income children are typically reimbursed by Medicaid and CHP+. Providing services to undocumented individuals remains an issue in this program, with care provided via community health centers and hospital emergency rooms.

The majority of pediatric health care providers and pediatric multi-disciplinary centers are located in the urban areas of the state. Pediatric medical subspecialty care is scarce in the rural areas where the HCP specialty, diagnostic and evaluation, and genetics clinics try to fill the gap. The absence of pediatric neurologists and mental health providers pose significant challenges, and newly trained subspecialists are not available in rural communities. There is an increased demand for pharmacological management of social /emotional disorders in all areas of the state. Medical schools do not offer adequate training to physicians on these and other issues regarding the care of CSHCN.

HCP also provides access to specialty services and coordination of primary and specialty care by providing clinics in outlying and rural communities. In 2009, there were 2,428 community encounters by public health contractors with other providers, agencies and organizations to organize services for ease of use by families. Access to specialty medical providers was addressed through 99 Specialty Clinics (Orthopedic 8, Neurology 64, Cardiology 5, Rehabilitation 18, and Pediatric 4). There were 1,116 total completed patient visits offered through 14 specialty clinic sites in 13 counties.

There continue to be large groups of other minority populations in Colorado. Services to overcome language and cultural barriers for families that speak languages other than English are limited, but are particularly important for families of children with special health care needs. The public health community continues to develop the capacity to work with immigrant families and to learn about the relationship of cultural beliefs to services for children with special needs.

b. Enabling Services

Enabling services are defined as services that allow or provide for access to the array of basic health care services and supports. Enabling services include transportation, translation, outreach, respite

care, health education, family support services, health insurance purchase, case management, and coordination of care. These kinds of services are especially necessary for low-income populations who are geographically or culturally isolated, and for those with special or complicated health needs.

The Family Healthline is an information and referral service managed on behalf of the MCH program by an information and referral specialty contractor, Maximus. It provides a critical enabling function by linking the MCH population to needed services. Bilingual (Spanish and English) information resource specialists assist individuals across the state to find a wide range of health and human services. The phone line received 10,969 calls from October 2008 to September 2009, approximately 500 more calls than the previous year. Fourteen percent of the calls were answered on the Spanish line. The majority of the referral requests are for WIC office information, with most calls for services benefitting individuals under age 25. Forty-three percent of callers indicate that they do not have health insurance.

Enabling Services for Prenatal Populations

The Women's Health Unit administers the MCH-funded services for the prenatal population, as well as for Title X Family Planning services. The unit will administer, until the end of this year, the Prenatal Plus Program for the Department of Health Care Policy and Financing. Prenatal Plus is a Medicaid-funded program that provides care coordination, nutrition and mental health counseling to eligible pregnant women who are at a higher risk for delivering low birthweight infants. The program's multidisciplinary approach uses professionals to effectively address risk reduction for women enrolled in the program. Care coordinators address client needs throughout pregnancy and up to 60 days postpartum. Concerns addressed include housing, nutrition, employment, domestic violence, substance abuse, high life stress, and depression and/or other mental health problems that may increase the risk of delivering a low weight infant. The Prenatal Plus Program serves approximately 1,900 women in 21 counties through 34 sites comprised of local health agencies, community health centers, private non-profit organizations, and hospital-based clinics.

Master settlement tobacco dollars fund the Nurse Home Visitor Program for implementing the Nurse-Family Partnership (NFP) model, which is an evidence-based, community health program that assists women pregnant with their first child. An eligible pregnant woman is partnered with a registered nurse early in her pregnancy and receives ongoing nurse home visits (64 planned visits) that continue through her child's second birthday. Through ongoing home visits, mothers receive the care and support they need to have a healthy pregnancy, provide responsible and competent care for their children, and become more economically self-sufficient. The program has disseminated nearly $13 million in master tobacco settlement funds to 19 local public health and non-profits agencies for nurse home visitation services covering 53 of the states' 64 counties serving 2,590 mothers annually.

Enabling Services for Child and Adolescent Populations including those with Special Health Care Needs

The majority of activities accomplished within the Child, Adolescent and School Health (CASH) Unit are at the population-based and infrastructure building levels which will be discussed later.

Local public health agencies throughout the state continue to provide EPSDT outreach and case management services under contracts with the Colorado Department of Health Care Policy and Financing (HCPF). EPSDT outreach workers and case managers are employed in local public health agencies around the state. The communication and cooperative working relationship between Title

V and the Medicaid program has continued, as specified in the annual interagency agreement between the department and Medicaid.

The HCP Program provides gap filling care coordination services, striving to avoid duplication while complementing other similar services in the state. The HCP Program contracts with 15 counties to serve as regional offices to provide administration and implementation of the program statewide. Program planning and reporting process are implemented with state staff support and consultation. HCP-sponsored clinic programs provide access to specialty medical care, genetic, and diagnostic and evaluation services. These clinics are important in assuring that families have access to specialized pediatric health services in rural and frontier areas of the state.

The Diagnostic and Evaluation (D&E) Program, also called the Diagnostic and Evaluation Clinics, provides access to comprehensive, multidisciplinary, developmental evaluation services for children who have or are suspected of having a developmental delay or disability. The program provides the needed medical diagnosis for many children who do not have access to a developmental pediatrician. It is community-based and coordinated with the Colorado Department of Education's Child Find and other local specialty providers. To ensure that D&E clinics are part of a child's medical home, training and consultation are provided to primary care physicians.

HCP has developed a care coordination definition describing three levels of coordination, service standards and an evaluation process. The care coordination definition and standards are used with Medicaid EPSDT Outreach, children receiving clinic services, the Colorado Responds to Children with Special Needs birth defects registry, and for infant hearing screening follow-up.

Public health nurses and HCP's regional office teams work to assure that there is coordination at the local level for all services needed by families and children. All local HCP agencies provide resource and referral information. Each HCP agency provides care coordination services to targeted populations depending on community need, capacity, and reimbursement. Additionally, local systems building services are provided in every county. Most local HCP staff members are also involved in other interagency work such as serving on child protection teams, working with school districts to support parents in special education staffing, and developing Individual Education Plans or Individual Family Service Plans.

c. Population-Based Services

The state MCH Program has shifted to population-based and infrastructure building activities. More information about these activities can be found in Section III of the block grant application.

Population-based activities are defined as those that are intended for and available to the entire population, rather than for a select group of individuals. Disease prevention, health promotion, and population outreach come under this heading. Population-based services are services generally available for all women and children in the state.

The Women's Health Unit has undertaken a number of initiatives to build the capacity of state and local MCH staff to provide population-based services. In 2000, the Women's Health Unit released a report that showed that one of the contributing factors to the high rate of low birthweight infants in Colorado was inadequate weight gain among 25 percent of pregnant women. The report led to the initiation of a statewide campaign, A Healthy Baby is Worth the Weight, to promote adequate weight gain during pregnancy. Over time the campaign has been renamed the Healthy Baby

Campaign and has expanded to include prenatal smoking cessation and preconception care information. The campaign uses social marketing techniques, targeted materials, training, and an informational website (www.healthy-baby.org) to reach out to prenatal care providers and consumers. An action guide was developed for use by local health agencies in implementing the campaign.

Since the provision of family-centered, community-based, coordinated care including care coordination is another responsibility of the HCP Program, the program is engaged in a public education campaign to assure that all families of children with special health care needs know about the services that are available to them. The campaign also targets health care providers and partner agencies.

Through the state health department's laboratory, the Newborn Screening Program provides screening at birth and again at eight to 14 days of age for a variety of metabolic and genetic diseases for all infants born in the state. The program provides data to ensure appropriate follow-up with contract sites. The Newborn Hearing Screening Program connects hospital birth certificate clerks and hospital audiologists with local HCP and early intervention personnel to ensure follow-up screening and referral for early intervention services. The metabolic screening program connects families with The Children's Hospital and community-based services. The program contracts with The Children's Hospital for follow-up services and makes connections to community supports to promote a medical home approach for children with metabolic conditions. This is a program that works at all level of the pyramid with the state role being primarily at the population and infrastructure levels.

The Colorado Infant Hearing Program tests the hearing of infants at birth to identify deaf and hearing impaired infants and makes appropriate referrals. The Newborn Hearing Screening program provides support to communities that have low follow-up rates, by developing local Early Hearing Detection and Intervention (EHDI) teams to develop systems for follow-up and referral into early intervention. The Colorado Infant Hearing and Newborn Screening Advisory Committee address standard practices, funding, and program development. The committee is comprised of parents, consumers, public health professionals, physicians, and other stakeholder state agencies. This is a program that works at all level of the pyramid with the state role being primarily at the population and infrastructure levels.

The Colorado State Genetics Program works to protect and improve the health of all Coloradans by promoting the availability of high quality, comprehensive genetic diagnostic, counseling, screening, treatment, and referral services. This is a program that works at all level of the pyramid with the state role being primarily at the population and infrastructure levels.

Fluoridation remains a top priority for preventing dental decay. Roughly 75 percent of Coloradans on public water systems receive optimal levels of fluoride in their drinking water. However, the issue continues to be a hotly debated public health strategy with multiple town councils and public referenda, requiring strong advocacy and education efforts on the part of the Oral Health Unit.

d. Infrastructure-Building Services

The Tobacco Cessation Workgroup for Pregnant Women and Medicaid Recipients was developed with the State Tobacco Education and Prevention Partnership (STEPP) to address the high rates of tobacco use among these populations. The group's goal is to increase the use of the Colorado

QuitLine tobacco cessation counseling service and Medicaid's tobacco cessation benefit. The staff also worked with the QuitLine to enhance the protocol to more effectively target pregnant women.

Prenatal smoking cessation clinical guidelines have been established. State and community personnel participate in an action learning lab addressing prenatal smoking cessation. Work with the health department's Diabetes Program, led to the development and dissemination of comprehensive guidelines for the diagnosis and treatment of gestational diabetes. Two action guides were developed for use by local public health agencies in addressing the low birthweight rate and teen pregnancy prevention. In 2009, preconception care clinical guidelines have also been developed with community partners.

WHU staff members also participate in a number of groups related to community-based health systems, including the Medical Policy Advisory Committee, Policy Advisory Committee and the Medicaid Waiver Advisory Committee established for the Title X Family Planning program.

WHU staff serves on a number of teams, with public and private partners. These groups include the Adolescent Sexual Health Team, the Advisory Council on Adolescent Health, Colorado Clinical Guidelines Collaborative, Colorado Nurse-Family Partnership Coordination Team, Colorado Perinatal Care Council, Folic Acid Task Force, HealthyWomen/HealthyBabies, Infertility Prevention Project Regional Advisory Committee, March of Dimes State Programs Committee, Tobacco Cessation Workgroup for Pregnant Women and Medicaid Recipients, Sexual Risk Prevention Group, Cessation Resource Alliance, Covering Kids and Families Workgroup, Maternal Mortality Review Committee, Prevention First NARAL Education Committee and the U.S. Department of Health and Human Services/ Office of Public Health and Science/ Women's Health/ Region VIII Partners.

Advisory groups convened by the CASH Unit include the following coalitions and boards. The Early Childhood Partners is a multi-disciplinary group of public and private early childhood stakeholders who advised in the creation, and now implementation, of the Early Childhood Colorado Framework in Action State Plan.

The Interagency School Health Team serves as the advisory group for the Coordinated School Health Program. The Advisory Council on Adolescent Health is an interdisciplinary group of adolescent health experts and community advocates, who advise the Colorado Department of Public Health and Environment, educate and inform the public, and advocate for policies and programs to improve the health and well-being of all Colorado adolescents.

The Colorado Youth Development Team is a public-private partnership of youth and professionals who raise awareness and promote the implementation of positive youth development efforts and strategies across the State of Colorado. The Youth Partnership for Health (YPH) is composed of 25 diverse youth, recruited from all parts of the state. YPH advises the state health department on policies and programs that affect adolescents. The Tony Grampsas Youth Services (TGYS) Board is an 11-member, board that provides guidance and oversight for the TGYS Program.

Collectively, these advisory groups include representatives from the Department of Human Services (Divisions of Behavioral Health Services, Child Care, Youth Services, Child Welfare, and the Office of Homeless Youth); the Department of Transportation; the Department of Education (Coordinated School Health Program, School Nursing Services, Special Education Services, and other early childhood initiatives); the Department of Public Safety; the Colorado State University Cooperative

Extension Program; higher education; Colorado-based foundations and other many other public and private partners.

The Child, Adolescent, and School Health (CASH) Unit administers Title V funding as well as other federal and state-funded grants directed at child and adolescent health and well-being. A variety of state and federally funded programs are administered by the unit to address the needs of children, youth and families The Early Childhood Team is currently focused on the following programs/initiatives: the Early Childhood Comprehensive Systems Grant, the Early Childhood Health Integration Initiative, the Assuring Child Health and Development Project, and the Early Childhood Obesity Prevention Needs Assessment Project.

The Early Childhood Systems (ECCS) Grant supports a statewide alliance of early childhood partnerships working together to create a comprehensive system for young children birth to age eight and their families. The Early Childhood Colorado Framework and the Framework in Action State Plan were developed to guide the state's systems-building efforts. Colorado's Lieutenant Governor has identified early childhood issues as a top priority and the ECCS Director, a CDPHE employee, is now physically located within the Office of the Lieutenant Governor.

The CASH Unit receives funding from a local foundation to provide technical assistance to Colorado's local early childhood councils who are Early Childhood Health Integration grantees. The technical assistance supports the integration of health into local early childhood systems-building efforts. A staff person was hired to assist the local councils in the development and implementation of local health integration plans.

Colorado is in the second year of a five-year funding cycle for the Coordinated School Health Program from the Centers for Disease Control and Prevention. The Coordinated School Health Initiative is a CDC-funded partnership to build state and local infrastructure to support the coordinated school health model, with an emphasis on nutrition, physical activity and smoking prevention. An adolescent and school health team, within the CASH Unit exists to maximize integration between the School-Based Health Center Program and the Coordinated School Health Program.

The CASH and HCP Units are working to implement the Assuring Better Child Health and Development (ABCD) Project that focuses on promoting the use of standardized developmental screening tools in primary health care settings to help increase early identification of developmental concerns.

The Colorado Medical Home Initiative promotes a team-based approach to providing health care. The Medical Home Initiative is another collaboration effort led by the CSHCN Unit that addresses the medical home national performance measure. The initiative consists of a state strategic planning group and the Medical Home Advisory Board. That includes staff from the state Family Voices advocacy group, the University of Colorado Health Sciences Center, the Colorado Department of Education, mental health providers, health care financing experts, and primary health care providers.

Colorado Responds to Children with Special Needs (CRCSN) is Colorado's birth defects monitoring and prevention program. CRCSN maintains a database with information about young children with birth defects, developmental disabilities, and risks for developmental delay. The program provides data to other programs, agencies, and researchers. CRCSN and HCP share data so that HCP can link

children and families, who have been identified with birth defects and related disabilities, with early intervention services through the HCP CRSCN notification program.

The Health Care Program for Children with Special Needs (HCP) is the lead program that manages the infant hearing screening and follow–up program, the Colorado Responds to Children with Special Needs notification follow-up, the newborn metabolic/genetic screening follow-up, and the Colorado Medical Home Initiative to provide a medical home for all children and youth with special health care needs. HCP coordinates with other agencies to provide public education about various diagnoses and disorders such as newborn prematurity, fetal alcohol syndrome prevention, child abuse prevention, traumatic brain injury, autism spectrum disorders, and genetics. The Colorado State Genetics Program works to protect and improve the health of all Coloradans by promoting the availability of high quality, comprehensive genetic diagnostic, counseling, screening, treatment, and referral services.

The Health Care Program for Children with Special Needs (HCP) carries out many infrastructure-building services to promote comprehensive systems of care and development of medical homes. The HCP Program is responsible for building family-driven, sustainable systems of health services and supports for children and youth with special needs. HCP's state and community level multi-disciplinary teams have moved from a clinical-oriented system to one focused on medical home, screening and the development of local systems of care.

HCP works with agencies at the state and local levels to develop statewide networks of durable medical equipment loaner banks for families. HCP has created the Communities in Faith Initiative through the HCP state Parent Consultant. The mission of this group is to link people with special needs to faith organizations that can address their needs. HCP also works to increase collaboration with Vocational Rehabilitation, Child Welfare, Juvenile Justice, Youth Corrections, Family Medicine, and the Community Health Network.

Other Specific Programs

The Colorado Department of Human Services, in particular the Division of Developmental Disabilities is an essential partner of the Children with Special Health Care Needs Unit within the MCH Program. Together the agencies offer services for children served by the Colorado Department of Human Services and the Health Care Program for Children with Special Needs. Programs include the Colorado Department of Human Services' Early Intervention Colorado; Family Support Services Program for families with a member who has developmental disabilities; Children's Extensive Support Waiver for Children Birth to 18 who are at high risk for out-of-home placement; and the Children's Medical Waiver for Children Age Birth to 18 with Developmental Disabilities that allows access to Medicaid state plan benefits regardless of parental income. The HCP program also works closely with Early Intervention Colorado to implement HCP care coordination standards, and to define respective roles in serving infants and toddlers with special health care needs at the community level. An HCP staff member represents the program and the department on the Interagency Coordinating Council and the state level Memorandum of Understanding committee.

Blind and disabled individuals under the age of 16 receive rehabilitation services under Title XVI (SSI). All SSI beneficiaries under 16 years of age are automatically eligible for Medicaid. Community-based EPSDT outreach workers call all newly enrolled SSI beneficiaries to assess whether each child's medical and support needs are being met. In the majority of cases, Medicaid is covering all of the medical needs. HCP staffs at the community level become involved when families have more complex medical or psychosocial needs needing care coordination.

As stated earlier and illustrated throughout this application, work accomplished by the MCH Program is done in collaboration with other stakeholders. The Women's Health Unit also works with the STD/HIV Section at CDPHE and with providers on the Colorado Clinical Guidelines Collaborative. Representatives from relevant medical associations representing nurses, pediatricians, family practice and other specialty physicians are participants in the work of the Child, Adolescent and School Health and Children with Special Needs Units. The WIC Program is a partner with MCH especially in the areas of breastfeeding promotion and reduction of obesity among children.

5. Selection of State Priority Needs

List of Potential Priorities:
As noted earlier, expert panels were commissioned, during Phase I of the process, to identify potential MCH priority issues. Upon completion of the process in December 2009, final recommendations from each panel were summarized. Members of the MCH Steering Committee reviewed the recommendations, aggregated themes and created a summary list of potential MCH priorities by target population, for use in Phase II (Appendix D).

The potential priorities considered for inclusion met criteria outlined early in the expert panel process. Potential issues were considered in terms of the MCH/public health role, the existence of strategies for intervention, and the ability to demonstrate outcomes/results within five years using established indicators to measure and demonstrate progress. These criteria were summarized as "DIP" (e.g., the potential priority needed to be "doable, important and a clear public health role). Quantitative data supporting the magnitude and severity of the issue were included in discussion of the issue's "importance." Priorities that met these criteria were recommended for consideration during Phase II of the needs assessment process.

State and local stakeholders prioritized their top three issues via online survey during Phase II. At the same time, a second survey asked local public health directors to assess agency capacity for each potential priority area. Aggregate results from both the MCH issue and capacity assessment stakeholder surveys were reviewed by members of the MCH Steering Committee during the Phase III final prioritization process. Top stakeholder priorities aligned fairly consistently with the final priorities chosen by the state.

Potential priority issues that were not chosen for inclusion in the final set of nine are discussed by population.

<u>Early childhood (birth-age 8), including children with special health care needs</u>

The following potential priorities were not chosen by the MCH Steering Committee.

- Increase system capacity to provide mental health services and supports for early childhood population;
- Increase comprehensive, coordinated care through a medical home approach (physical, mental, oral, and preventive health focus) for the early childhood population;
- Increase health and safety in early learning and school settings;
- Increase parent engagement and leadership at the program, community and policy levels.

Increasing system capacity to provide mental health services and supports for the early childhood population was viewed as being too broadly focused. In addition, MCH staff involvement in early childhood systems building efforts already includes mental health as a component of the early childhood framework. Given this existing investment, the decision was made to continue those efforts without resourcing a separate mental health systems effort.

Increase comprehensive, coordinated care through a medical home approach (physical, mental, oral, and preventive health focus) for the early childhood population is currently being addressed through National Outcome Measure 2. Additional specificity was added to the chosen priority, changing the focus to a reduction of systems barriers.

Increasing health and safety in early learning and school settings began with the federal investment in this area through MCHB CISS funding. Colorado's success in working with partners to address this issue led to other entities assuming a leadership role in this area.

Increasing parent engagement and leadership at the program, community and policy levels was ultimately viewed as a programmatic strategy versus a priority. Family involvement will serve as a key component of many strategies employed in implementing the new priorities.

<u>Children and adolescents (ages 9 - 21 years), including children and youth with special health care needs</u>

The following potential priorities were not chosen by the MCH Steering Committee.

- Improve access to behavioral health services for children and youth;
- Increase utilization of health services for children and youth;
- Prevent substance use/abuse among youth;
- Prevent/reduce overweight and obesity among children and youth;
- Increase implementation of positive youth development strategies.

Improving access to behavioral health services for children and youth and increasing utilization of health services for children and youth were viewed as being outside of the MCH sphere of influence, particularly as the state attempts to minimize investments in direct and enabling services in order to resource population-based efforts. The issue's broad focus also led to concerns about the state's ability to demonstrate tangible results/improvements within five years, one of Colorado's guiding principles for the needs assessment process. In addition, access should improve with the advent of health care reform.

Preventing substance use/abuse among youth did not fall within the MCH sphere of influence, with primary state responsibility for this issue residing within the Alcohol and Drug Abuse Division at the Colorado Department of Human Services. Preventing/reducing overweight and obesity among children and youth relates to National Performance Measure 14, therefore the decision was made to focus on early childhood obesity prevention in alignment with the state's emphasis on primary prevention and early programming. Positive youth development was not selected as a priority, as it was considered to be a key strategy related to two of the chosen priorities, youth sexual health and youth systems building.

Women of reproductive age (15 - 44 years)

The following potential priorities were not chosen by the MCH Steering Committee.

- Decrease tobacco use during pregnancy;
- Improve systems and infrastructure for addressing mental health for women of reproductive age;
- Decrease low birthweight among infants.

The Center for Healthy Living and Chronic Disease Prevention includes the State Tobacco Education and Prevention Partnership (STEPP) which resources smoking cessation activities. MCH will work in partnership on these efforts. Improving systems and infrastructure for addressing mental health for reproductive-age women was again viewed as a broadly focused issue beyond the scope of MCH.

Colorado's long-term efforts to address the state's low birthweight rate have not resulted in any significant reductions in the rate. The Steering Committee excluded this issue as a priority given the absence of evidence-based interventions to address this issue at the public health level coupled with the low probability of demonstrating measurable impact within five years. Given Colorado's high rate, this issue will be reconsidered once clear evidence is available to guide successful interventions.

Methodologies for Ranking/Selecting Priorities:
Once the results for the Phase II survey were aggregated and local capacity assessed, MCH staff prepared "Issue Papers" for each of the 21 potential priorities (Appendix D), to justify the inclusion of the issue in the final set of state priorities. The papers summarized the following:

- Data to support the need to address the issue, including health equity impact;
- Effective interventions/strategies to address the issue;
- The MCH public health role in implementing the interventions;
- The state and local capacity that currently exists to implement the interventions ;
- A description of how MCH can create an impact (e.g., is the issue within the MCH "sphere of influence");
- The population-based measures that could be used to demonstrate the MCH impact on the issue, e.g., the expected "result" and the indicator that could be used for measurement.

The issue paper template is included in Appendix G.

Members of the Steering Committee met for two days to determine the final 7-10 MCH priorities for 2011-2015. Steering committee members presented the issue papers to the group, with consideration given to the local capacity assessment score and the issue's average rank on the Phase II stakeholder survey. This discussion also included an assessment of state capacity to address the issue, using the scoring criteria developed for the local capacity assessment survey. (Please see section entitled "Methods for assessing state capacity.")

In addition, the group constructed a pie chart, entitled the "MCH Scope of Work (SOW)" representing the current responsibilities for each core MCH Unit to assure that new priorities could ultimately be addressed and realistically resourced. The chart identified the mandatory/formal commitments, including the 18 National MCH Performance Measures that would continue to be addressed regardless of the priority issues chosen along with discretionary efforts from which resources could potentially be re-directed to address new MCH priorities. As the issue papers were

reviewed, the group determined where the issue best "fit" within the MCH SOW in an attempt to assure that the new priorities would ultimately be resourced and implemented.

The group was then asked to rank the issue on a grid according to impact (vertical axis) and feasibility (horizontal axis). An example of a summary worksheet illustrating the final prioritization process is included in Appendix H: Priority Setting Grid. The eleven issues that ranked high on both impact and feasibility were again prioritized using the following criteria: congruence with the guiding principles; life course implications; state and local capacity, resource re-allocation requirements, and state/local responsibility. Nine issues remained after this second process, becoming the state's new priorities for FY2011-2015.

Next steps involved determining the State Performance Measure and/or National Performance or Outcome Measures that aligned with each priority. Staff ultimately responsible for crafting an implementation plan for each priority was charged with submitting potential state measures to the Steering Committee. These implementation teams included staff from multiple units within the division, thus meeting the state's original goal of working more horizontally across units on MCH issues. Priorities were further modified to fit with existing measurement and data sources were verified to assure appropriate reporting of data during the five- year period. Appendix I includes Colorado's final MCH priorities and state performance measures.

Priorities Compared with Prior Needs Assessment:

As noted in the "Goals and Vision" section of this summary, Colorado's planned outcomes from the needs assessment process differed significantly from those identified in FY 2005-2010. To foster integration of efforts horizontally among MCH units, staff felt that it was important to include children and youth with special health care needs with all children and youth, as opposed to considering their needs separately. The overall goal of the process focused on identifying a set of focused priorities that could be acted upon at some depth so that results, even preliminary ones, would be achievable and evident in five years. Strategies employed to achieve results were to be evidence-based/ promising practices or interventions grounded in sound public health theory or research and consistent with the mission and scope of Colorado's MCH Program. A clear MCH public health role needed to exist in order for an issue to be considered as a potential priority.

Many of the ten MCH priorities chosen by Colorado for FY2005-2010 did not align with the guiding principles for the process outlined above, lacking focus, specificity, evidence-based strategies for intervention and measurable outcomes. Given this rationale, only one of the previous priorities (teen motor vehicle injury and fatality) was retained for FY2011-2015.

Priority Needs and Capacity:

During the needs assessment process, Colorado reaffirmed an earlier commitment to prioritize efforts in the population-based and infrastructure building components of the MCH pyramid. Although the final implementation plans for each priority have not yet been finalized, it is unlikely that direct services will be employed as a strategy for addressing any of the priorities. Population-based and infrastructure building strategies will be prioritized to address Colorado's new MCH priorities, with the addition of enabling services as appropriate.

Once staff has completed the implementation planning process, resources will be shifted from discretionary components of the MCH scope of work to address the new priorities. Some of the priorities will be addressed with greater depth than others; however, implementation efforts will be put in place for all identified priorities. Core principles driving the process assured that the

priorities chosen would be addressed and measurable progress achieved in five years. The Steering Committee ultimately did not prioritize issues when capacity did not exist. Interestingly, average capacity scores did not vary greatly among the priorities chosen, averaging between some to adequate on both the state and local assessments.

MCH Population Groups:
As noted in Appendix I, priority numbers 1, 2, and 7 address women of reproductive age, while numbers 3-9 address children and youth, including those with special health care needs.

Priority Needs and State Performance Measures:

2011 - 2015 Colorado's Nine Priorities and Ten Accompanying State Performance Measures

Priority 1: Promote preconception health among women and men of reproductive age with a focus on intended pregnancy and healthy weight.

- SPM 1: Percentage of sexually active women and men ages 18-44 using an effective method of birth control to prevent pregnancy. (BRFSS)
- SPM 2: Percentage of live births to mothers who were overweight or obese based on BMI before pregnancy. (Birth certificate)

Priority 2: Improve screening, referral and support for perinatal depression.

- SPM 3: Percent of mothers reporting that a doctor, nurse, or other health care worker talked with them about what to do if they felt depressed during pregnancy or after delivery. (PRAMS)

Priority 3: Improve developmental and social emotional screening and referral rates for all children ages birth to 5.

- SPM 4: Percent of parents asked by a health care provider to fill out a questionnaire about development, communication, or social behavior of their child ages 1 through 5. (Child Health Survey - CH169)
- SPM 5: Percentage of Early Intervention Colorado referrals coming from targeted screening sources. (Early Intervention Colorado)

Priority 4: Prevent obesity among all children ages birth to 5.

- SPM 6: Percentage of live births where mothers gained an appropriate amount of weight during pregnancy according to pre-pregnancy BMI. (Birth certificate)

Priority 5: Prevent development of dental caries in all children ages birth to 5.

- SPM 7: Percent of parents reporting that their child (age 1 through 5) first went to the dentist by 12 months of age (Child Health Survey - CH63a)

Priority 6: Reduce barriers to a medical home approach by facilitating collaboration between systems and families.

- There is no state performance measures associated with this priority. However, this priority is measured by National Performance Measure 3 – The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (National CSHCN Survey) and National Outcome 2 – All Children will receive comprehensive, coordinated care within a medical home.

Priority 7: Improve sexual health among all youth ages 15 -19.

- SPM 8: Percentage of sexually active high school students using an effective method of birth control to prevent pregnancy (YRBS).

Priority 8: Improve motor vehicle safety among all youth ages 15 – 19.

- SPM 9: Motor vehicle death rate for teens ages 15-19 yrs old.

Priority 9: Build a system of coordinated and integrated services, opportunities and supports for all youth ages 9-24.

- SPM 10: The percentage of group members that invest the right amount of time in the collaborative effort to build a youth system of services & supports. (Wilder Collaborative Factor Inventory)

Appendix I lists the state priority needs, in table format ,along with the corresponding State and/or National Performance/Outcome Measures that will be used to evaluate progress. Each of the priorities is linked with at least one and sometimes multiple state and national measures. The state measures were chosen since, in all but one case, current population data sets (e.g., vital statistics, PRAMS, the Colorado Child Health Survey, BRFSS and/or YRBS) included data that aligned with the state performance measure. Wording used in a number of the state performance measures mirrors that used in the data source.

In developing the state measures, Colorado attempted to identify intermediate measures for specific aspects of the priority in order to demonstrate measurable progress within five years. Given the difficulty of impacting the national performance measures, the Steering Committee members felt that progress on intermediate measures might ultimately inform the next level of interventions needed to address more distal population-based measures.

A number of Colorado's new priorities cross MCH populations. For example, preventing obesity among all children ages birth through age 5 will include strategies addressing appropriate weight gain during pregnancy along with interventions related to infant feeding practices, infant weight gain, etc. for children with typical and special health care needs.

6. Outcome Measures - Federal and State

The following section offers a brief discussion of outcome measures. Colorado's FY2011 block grant application describes the relationship between state MCH Program activities and the National and State Performance Measures. As indicated in the guidance, a wide variety of factors influence outcome measures. The state has found it difficult to significantly address such a wide array of national and state performance and outcome measures given the limited resources available under the auspices of the MCH Block Grant. Progress on distal population-based measures requires targeted efforts and resources. The state has attempted to identify, through the FY2011-2015 needs assessment process, intermediate measures to establish a series of systematic steps that may ultimately lead to progress on more distal performance and outcome measures. To this end, Colorado's guiding principles for this needs assessment embraced the notion of focus, so that the state targeted fewer issues at more depth in an attempt to demonstrate results within five years.

As noted earlier, Colorado priorities focus on primary prevention and early intervention, which theoretically should ultimately impact health outcomes related to infant (neonatal and

postneonatal), perinatal and child mortality. Employing intermediate measures will assist the state in systematically implementing and evaluating strategies that may, over the course of time, impact these larger health outcomes. Given this emphasis on intermediate measures and the input gathered in the needs assessment process, Colorado chose not to add any state outcome measures.

The following offers an assessment of Colorado's progress in the areas measured by the six national outcome measures and the state outcome measuring addressing the measure looking at low birth weight rate for the period of 2003-2008:

- Colorado's Black/White infant mortality ratio declined from 3.7 in 2003 to 2.5 in 2008. The ratio is still above the 2010 target of 2.0 for Colorado.
- The perinatal mortality rate declined 6 percent from 6.7 in 2003 to 6.3 in 2008, although the current rate is higher than the Healthy People 2010 target rate of 4.5 per 1,000. The rate includes infant deaths from birth up to one week plus fetal deaths of gestational age 28 weeks or greater.
- The low birthweight rate decreased slightly over the five-year period from 9.1 percent in 2003 to 8.9 percent in 2008. Colorado's low birthweight rate is still far higher than the Healthy People 2010 target of 5.0 percent.
- The death rate for children ages 1 through 14 declined 12 percent from a rate of 20.2 per 100,000 in 2003 to a rate of 17.8 per 100,000 in 2008. The current rate is close to the Colorado 2010 target of 15.0 per 100,000.

However, some important measures of maternal and infant health had not improved or have worsened in that five-year period:

- The preterm birth rate in 2003 was 9.6 percent. It has fluctuated over time with a high of 10.2 percent in 2005, returning to 9.6 percent in 2008. The Healthy People 2010 target is 7.6 percent.
- The infant (under one year of age) mortality rate has increased slightly from a rate of 6.0 per 1,000 live births in 2003 to a rate of 6.2 per 1,000 live births in 2008. The current rate is higher than the Healthy People 2010 target of 4.5 deaths per 1,000 births.
- The neonatal (within the first 28 days of life) mortality rate, at 4.4 deaths per 1,000 live births, is considerably higher than the Healthy People 2010 target of 2.9 and has remained unchanged in the five-year period.
- The postneonatal (between 28 days and one year of life) mortality rate was 1.7 per 1,000 live births in 2003. The rate increased slightly to 1.8 per 1,000 live births in 2008. The current rate is above the Healthy People 2010 target of 1.2 deaths per 1,000 births.

Infant, Neonatal and Postneonatal Mortality

These three measures have all increased slightly or remained unchanged during 2003-2008. A previous state study of infant mortality using the Periodic Periods of Risk methodology indicated that the most important factors contributing to infant mortality in Colorado are those that impact women prior to and during pregnancy. The high level of unintended pregnancy in the state and the proportion of women without access to effective contraception, along with the low birth weight rate most likely impact the neonatal mortality rate. Technical assistance and support are offered to assist agencies in using the Perinatal Periods of Risk tool to analyze infant mortality on a community basis.

The MCH Program is placing more emphasis on preconception health as part of the new five-year work plan. The Women's Health Unit has instituted the Healthy Baby Campaign as a community-

based intervention to address two key factors associated with low weight births: adequate weight gain during pregnancy and smoking cessation.

The MCH Program continues to monitor trends and provide information to local health departments. Women's Health Section staff participate in committees projects such as the Colorado Perinatal Care Council and community-based efforts such as the Black Infant Mortality Project sponsored by the Tri-County Health Department.

Black/White Infant Mortality

Infant mortality rates are higher among Black infants than in White/Hispanic or White/non-Hispanic populations. Rates for other racial groups comprise fewer than two percent of all infant deaths. The Black infant mortality rate has consistently been double the White/Hispanic rate, and was more than triple the White/non-Hispanic rate at the end of the decade. Neonatal death rates have the greatest influence on the infant mortality rate, contributing at least two-thirds of all infant deaths in Colorado. Neonatal mortality rates are highest among Blacks and are markedly lower among White/Non-Hispanics and White/Hispanics.

Child Death Rate

The death rate for children ages 1 through 14 declined 12 percent from a rate of 20.2 per 100,000 in 2003 to a rate of 17.8 per 100,000 in 2008. The current rate is close to the Colorado 2010 target of 15.0 per 100,000.

Deaths to children in this age range occur for a variety of reasons including intentional (suicide, homicide) and unintentional (falls, motor vehicle crashes) injuries, infectious and chronic diseases, malignant neoplasms, and congenital anomalies. In 2008, a total of 172 deaths to children ages 1 through 14 occurred in Colorado. Of these, 29 percent (50 deaths) were caused by unintentional injuries. In 2003, there had been 181 deaths to children, of which 36 percent (66 deaths) were caused by unintentional injuries. The reduction in unintentional injury death over the period was the major reason that the overall child death rate dropped. And the decline in unintentional injury is due to a decline in motor vehicle deaths.

A number of programs or projects within the Children, Adolescent, and School Heath and the Injury, Suicide and Violence Prevention Units include active involvement in child safety measures such as car seats, graduated driver's licenses for teens, and statewide suicide prevention efforts.

ANNUAL NEEDS ASSESSMENT SUMMARY

1. Year that Needs Assessment is Due—Needs Assessment Summary

For the 2010 Colorado needs assessment and planning process, the state used a conceptual framework that integrated a strengths-based approach with the goal of optimizing health and well-being among the MCH population across the life course. The approach took into account that a complex interplay of biological, behavioral, psychological, and social factors (e.g., both risk and protective) contribute to health outcomes (e.g., the Life Course Health Development Model). In alignment with this model, the influence of early life events (early programming) and critical periods across the life course were considered with attention given to the cumulative impact of experiences over time, which resulted in an emphasis on primary prevention and early

intervention. The social determinants of health were also considered as factors that shape the health of individuals and communities.

For purposes of assessment and strategic planning, the MCH population was defined as women, children, adolescents, children with special health care needs, and families. The MCH population was further subdivided into women of reproductive age (ages 15-44), early childhood (ages birth-8), including children with special health care needs and child/adolescent (ages 9-21), including children and youth with special health care needs.

The MCH Needs Assessment Steering Committee with the leadership of the MCH Director established the overall strategic direction and methodology for the needs assessment while providing the ongoing project management and oversight for the process**.** The process focused on identifying a set of specific priorities that could be acted upon at some depth so that results, even preliminary ones, would be achievable and evident in five years. Strategies employed to achieve results were to be evidence-based/ promising practices or interventions grounded in sound public health theory or research and consistent with the mission and scope of Colorado's MCH program. A clear MCH public health role needed to exist for an issue to be considered as a potential priority. The process involved multiple state and community stakeholders/partners to enhance collaboration, and looked for opportunities to coordinate and integrate MCH efforts across the MCH continuum. The needs assessment served as a catalyst, fostering an integration of work activities across all MCH-related programs in CDPHE. Colorado employed a strategic planning process to examine how these new priority areas could be incorporated into the existing MCH scope of work.

The Steering Committee received support and counsel from the MCH Needs Assessment Advisory Committee, a group of external and internal stakeholders who served as advisors to the needs assessment process. This group convened twice during the during the 16-month project implementation period; initially providing critical feedback regarding the process methodology in August of 2009 and participating in a pilot and set of focus groups to finalize the Phase II stakeholder survey in February 2010. The Advisory Committee, along with other stakeholders, will be reconvened in September 2010 to review Colorado's new MCH priorities to identify future collaborative opportunities.

The Needs Assessment Steering Committee employed a three-phase methodology in planning and implementing Colorado's needs assessment. During Phase I, staff devised two strategies to solicit both qualitative and quantitative data to identify potential MCH priority areas. The first strategy involved convening a group of ten subject matter experts for each MCH population who served as expert panelists charged with identifying potential focus areas for future MCH. Panelists were presented with a series of background documents to inform the process and the panels were guided by a set of expectations regarding data-based decision making, prioritization criteria and desired outcomes. Prioritization criteria included considering potential issues in terms of the MCH/public health role, the existence of strategies for intervention, and the ability to demonstrate outcomes/results within five years using specific indicators that could measure and demonstrate progress.

The second Phase I strategy involved creating an updated version of the Colorado MCH Health Status Report, which served as a means for compiling and analyzing quantitative MCH population data. The revised report used a life course perspective. The report also complements the state and county MCH data sets developed under the auspices of the State Systems Development Initiative (SSDI) grant.

At the end of the expert panel process, results were summarized from all three groups and presented to the Steering Committee, along with the preliminary draft of the Colorado MCH Health Status Report. As expected, the focus areas identified by the three expert panels overlapped due to the impact that many of the issues identified exert throughout the life course. Phase I, then, concluded with the identification of 21 potential MCH priorities, generated by the expert panels, spanning the three populations.

During Phase II, the potential priorities identified by the expert panels were presented to key stakeholders, via a survey. The survey's goal was to gather additional input to further refine and prioritize the issues. The survey was pilot tested with internal state staff, revised and again reviewed by the MCH Advisory Committee before the final version was disseminated in February 2010. During Phase II, 265 stakeholders were invited to comment with 172 completing the survey for a completion rate of 62 percent. Survey participants chose their top three issues for each population and also identified any important issues not reflected in the original twenty-one topics. However the majority of issues identified by survey participants had been discussed by the Expert Panels or other stakeholders in earlier phases of the needs assessment process.

Local health agency directors were asked to assess the capacity of their agency to address the potential MCH priority areas. Of the 54 agency directors surveyed, 24 completed the survey. Since the responses were identified, analysis revealed that the largest public health agencies in Colorado were represented. The survey results were tabulated and a more refined list of key issues emerged for presentation to the Steering Committee in March 2010.

Phase III included the final prioritization process and state capacity assessment to determine the MCH priorities for FY2011-2015, including identification of the state performance measures. The Steering Committee focused on the goal of identifying fewer areas for MCH investment, so that a comprehensive set of interventions could be employed at more depth to impact five-year outcomes. The chosen priorities and the state performance measures were tied to the MCH sphere of influence to assure ultimate impact. The Steering Committee was charged with tying the potential priorities to an intermediate or population-based outcome measure. MCH staff prepared a two-page justification for each priority highlighting the following: public health/MCH role; data to support the need (severity or numbers affected); effective interventions/strategies that exist to address the issue; local capacity score for the issue and specific indicators that could be used to measure success within the five-year period. These issue papers, along with the assessment of state capacity, served as key resources for discussion in determining the final set of nine priorities. Following these discussions, each issue was ranked, using a grid specifying impact and feasibility along an x and y axis.

To assure that the MCH program could realistically resource the new priorities, Phase III also included the identification of all work being currently completed under the auspices of the MCH program. The MCH Scope of Work (SOW) that included all MCH-related statutory mandates and other required activities, including the MCH National Performance Measures, and other efforts related to MCH but funded by sources other than the block grant. These activities needed to continue regardless of the state's choice of new priorities. The SOW also encompassed discretionary MCH activities, e.g., current work that aligned with the existing set of MCH priorities that could be shifted in order to provide capacity (funding and staff time) to address the new priorities.

In the fall of 2010, specific work plans will be developed for each priority with goals, objectives, activities and evaluation measures that will drive state and local MCH-level activities from FY 2011-2015. Colorado will continue to systematically assess needs during the upcoming five-year time frame.

MCH Needs Assessment
Advisory Committee Members

Last Name	First Name	Organization	Division/ Unit/ Branch
Aakko	Eric	Colorado Department of Public Health and Environment (CDPHE)	Colorado Physical Activity and Nutrition (COPAN)
Anslemo	Theresa	CDPHE	Oral Health
Archer	Linda	CDPHE	Women's Health
Babler	Shirley	CDPHE	Health Care Program for Children with Special Needs (HCP)
Bakulski	Mandy	CDPHE	Women's Health
Bednarek	Jill	CDPHE	State Tobacco Education & Prevention Partnership (STEPP)
Bindel	Lynn	CDPHE	HCP
Braga	Anne-Marie	CDPHE	Child, Adolescent and School Health
Breitzman	Shannon	CDPHE	Injury, Suicide and Violence Prevention
Daniluk	Patricia	CDPHE	Nutrition Services (WIC)
Davis	Julie	CDPHE	Women's Health
Dellaport	Jennifer	CDPHE	Nutrition Services (WIC)
Dorjee	Tsering	CDPHE	Office of Planning and Partnerships
Febbraro	Gina	CDPHE	Maternal and Child Health
Gabella	Barbara	CDPHE	Epidemiology, Planning and Evaluation
Glantz	Namino	Boulder County Public Health	
Greenwell	Babette	University of Colorado Denver	
Huffman	Margaret	CDPHE	Disease Control and Environmental Epidemiology Division (DCEED)
Hunsaker-Ryan	Jill	Silver Street Consulting	
Hutson	Rachel	CDPHE	Child, Adolescent and School Health
Juhl	Ashley	CDPHE	Epidemiology, Planning and Evaluation
Leff	Marilyn	CDPHE	Epidemiology, Planning and Evaluation
Matthews	Kathleen	CDPHE	Office of Planning and Partnerships
McDermott	Kristin	CDPHE	Epidemiology, Planning and Evaluation
Myers	Lindsey	CDPHE	Injury, Suicide and Violence Prevention
Poniers	Andrea	CDPHE	Chronic Disease
Potter	Marti	Denver Health	
Ricketts	Sue	CDPHE	Epidemiology, Planning and Evaluation
Ruttenber	Margaret	CDPHE	DCEED
Shupe	Alyson	CDPHE	Center for Health and Environmental Information and Statistics
Thomson	Vickie	CDPHE	HCP
Trefren	Lynn	Tri-County Health Department	
Trierweiler	Karen	CDPHE	Maternal and Child Health
Wargo	Sara	CDPHE	Women's Health
Watters	Kathy	CDPHE	HCP
White	Cathy	CDPHE	Child, Adolescent and School Health
Ybarra	Esperanza	CDPHE	Women's Health

EXPERT PANEL PROCESS SUMMARY

Purpose

Phase One of the Colorado 2010 Needs Assessment process included the use of Expert Panels (EP) and the compilation and interpretation of the Health Status Report. The EP process was designed as a mechanism to solicit qualitative data from a variety of MCH stakeholders on potential MCH priority focus areas for Colorado, as required by the federal MCH program. Priorities were considered in terms of outcomes/results, indicators and strategies. The Health Status Report was used as a tool for compiling and examining quantitative data regarding issues affecting the MCH population in Colorado.

Population Groups

The expert panels were divided into three groups including the women of reproductive age group (ages 15-44), the prenatal through early childhood group, including children with special health care needs (CSHCN) (prenatal to age 8), and the child/adolescent/CSHCN group (ages 9-21). It was anticipated that the focus areas identified by the three expert panels would overlap due to the impact that many MCH issues have over an individual's life course. However, any duplication of ideas was addressed during the analysis phase of the data.

Process Design

Each expert panel was assigned two team co-leaders and a facilitator. The co-leads were state MCH staff who had expertise in the respective population group. They were responsible for determining who the expert panelists should be in their group, providing input to the facilitator on meeting agendas, welcoming the group, serving as the liaison between the expert panelists and the MCH steering committee, providing snacks, and participating in the expert panels as contributing members.

The facilitators, both on the MCH steering committee, were individuals who had facilitation training and experience and who were neutral on the topic at hand. Their role was not to participate as contributing members, rather, to facilitate the group process in order to achieve the meetings' intended outcomes and to create a safe and engaging space for the expert panelists to participate.

The meetings were structured as three, three-hour meetings that took place over the course of three months (October through December 2009).

Expert Panelists

Expert panelists included representation from state MCH programs (including needs assessment steering committee members), local MCH programs, family/youth service agencies, and other key MCH community partners such as healthcare organizations, community-based organizations, and academic institutions. Criteria used for selecting expert panelists included whether individuals had an understanding of public health, their workplace setting, their training and experience (credentials), geographic perspective, their expertise area, and their ability to see the big picture and not solely advocate for one issue.

Expert panelists were each sent an invitation letter explaining the level of commitment. If participants were unable to make it to one or more meetings, they were asked not to participate and another panelist was identified by the co-leads and then and invited.

EXPERT PANEL MEMBERS

Name	*Organization*	*Role*
Early Childhood, including Children with Special Health Care Needs (ages birth-8)		
Burns, Jennifer	Rocky Mountain Youth Pediatric Clinics	
Deloian, Barbara	Colorado Department of Public Health and Environment	
Dubiel, Heather	Colorado Department of Public Health and Environment	
Hardin, Jodi	Colorado Department of Public Health and Environment	
Hunsaker-Ryan, Jill	Colorado Department of Public Health and Environment	Facilitator
Hutson, Rachel	Colorado Department of Public Health and Environment	Team Leader
Plummer, Yvette	Denver Metro Community Parent Resource Center (CPRC)	
Scully, Sarah	Boulder County Public Health	
Talmi, Ayelet	University of Colorado Denver	
Watters, Kathy	Colorado Department of Public Health and Environment	Team Leader
Yahn, Sherri	Northeast Colorado Health Department	
Child and Adolescent, including Children with Special Health Care Needs (ages 9-21)		
Babler, Shirley	Colorado Department of Public Health and Environment	Team Leader
Braga, Anne-Marie	Colorado Department of Public Health and Environment	Team Leader
Bravo, Melanie	Boys & Girls Club/Girls Inc. of Pueblo County	
Febbraro, Gina	Colorado Department of Public Health and Environment	Facilitator
Hills, Kimberly	Boulder County Public Health	
Hunt, Cerise	Colorado Department of Public Health and Environment	
Kelly, Glenna	Kaiser Permanente	
Marks, Megan	Family Voices	
Myers, Lindsey	Colorado Department of Public Health and Environment	
Procell, Lynn	Pueblo City-County Health Department	
Sanford, Lauren	Youth Partnership for Health	
Schoenthaler, Celeste	Colorado Department of Public Health and Environment	
White, Cathy	Colorado Department of Public Health and Environment	
Women of Reproductive Age (ages 15-44)		
Bakulski, Mandy	Colorado Department of Public Health and Environment	Team Leader
Burford, Nina	Consultant, Formerly of Tri-County Health Department	
Ferguson, Janice	Rocky Mountain Health Plan	
Green, Kristina	Colorado Dept. of Public Health & Environment	Note Taker
Grosz, Candace	Colorado Dept. of Public Health & Environment	Team Leader
Hunsaker-Ryan, Jill	Colorado Department of Public Health and Environment	Facilitator
Kent, Helene	Healthy Women, Healthy Babies	
Leiferman, Jenn	Colorado School of Public Health	
Ruybalid, Sarah	Pueblo City-County Health Department	
Scott, Steve	Colorado Adolescent Maternity Program (CAMP)	
Shlay, Judy	Denver Health	
Trierweiler, Karen	Colorado Department of Public Health and Environment	
Underwood, Nettie	Larimer County Health Department	
Wallace, Lindy	Colorado Department of Health Care Policy and Financing	

APPENDIX C

THE COLORADO MCH HEALTH STATUS REPORT

www.cdphe.state.co.us/ps/mch/HealthStatus.html

Colorado Department of Public Health and Environment

POTENTIAL MCH PRIORITIES

The following issues have been identified as potential priorities by Colorado-based experts in Maternal and Child Health (MCH) for the following target populations: early childhood (0-8 years), including children with special health care needs; children and adolescents (9-21 years), including children with special health care needs; and women of reproductive age (15-44 years).

Early childhood (0 – 8 years), including children with special health care needs	
Potential MCH Priority	**Example Indicators of Success**
Prevent obesity among the early childhood population	Decreased rate of overweight and obesity among infants and children; increased rate of fruit and vegetable consumption; increased rate of physical activity levels; increased rate of appropriate pregnancy weight gain.
Improve oral health among the early childhood population	Reduced rate of dental caries; reduced rate of untreated tooth decay; increased sealant rates; increased dental utilization rates.
Increase system capacity to provide mental health services and supports for the early childhood population	Increased numbers of children screened for social-emotional concerns; Increased utilization rates of mental services; number of early childhood mental health specialists.
Improve screening, referral and follow-up rates related to developmental, physical and oral health for the early childhood population	Increased rates of developmental screening, screening/referral for Part C Early Intervention, and newborn metabolic/hearing screening; increased utilization of billing codes for developmental screening.
Increase comprehensive, coordinated care through a medical home approach (physical, mental, oral, and preventive health focus) for the early childhood population	Increased percent of children with a primary care provider; increased Medicaid utilization related to medical homes; increased health care utilization rates.
Increase health and safety in early learning and school settings	Increased number of early learning environments with child care health consultants; improved child care provider health measures.
Increase parent engagement and leadership at the program, community and policy levels.	Increased numbers of family members who participate in leadership training opportunities; increased rate of parents who feel like a partner in their child's care
Children and adolescents (9 - 21 years), including children and youth with special health care needs	
Potential MCH Priority	**Example Indicators of Success**
Improve sexual health among youth	Reduced teen fertility rates; reduced rates of STD/HIV; increased use of contraception; reduced incidence of partner/dating violence; increased exposure to comprehensive sexuality education.

Improve access to behavioral health services for children and youth	Decreased rates of depression; decreased rates of suicide; increased numbers of children and youth screened and receiving mental health services; increased percentage of school-based health centers that provide behavioral health services.
Build a coordinated, integrated system of services and initiatives for youth	Improved inter/intra agency collaboration.
Increase utilization of health services for children and youth	Increased rates of Medicaid utilization for oral, behavioral and physical health.
Prevent substance use/abuse among youth	Decreased tobacco initiation rates; reduced substance use rates for alcohol, tobacco, and other drugs.
Prevent/reduce overweight and obesity among children and youth	Increased rates of body mass index in the healthy weight category; increased fruit and vegetable consumption; increased physical activity levels.
Improve teen motor vehicle safety	Decreased rates of teen motor vehicle fatality; decreased hospitalization; increased seat belt usage; increased adherence to graduated driver's license laws.
Increase implementation of positive youth development strategies	Increased connections of youth with caring adults; increased number of peer mentors; increased numbers of opportunities for youth community engagement
Women of reproductive age (15 - 44 years)	
Potential MCH Priority	**Example Indicators of Success**
Promote healthy behaviors during the preconception period among all women of reproductive age	Decreased tobacco use prior to pregnancy; increased multivitamin and/or folic acid intake, increased number of women receiving preventive health check-ups.
Decrease unintended pregnancy among women of reproductive age	Reduced rates of unintended pregnancy.
Decrease tobacco use during pregnancy	Reduced rate of smoking during pregnancy; increased utilization of the QuitLine program by pregnant women and women of reproductive age.
Improve systems and infrastructure for addressing mental health for women of reproductive age	Decreased rates of depression (including postpartum); lower rates of suicide; increased numbers of women screened and receiving mental health services.
Decrease low birth weight among infants	Reduced low birth weight rates.
Promote healthy weight among women of reproductive age	Increased rates of body mass index in the healthy weight category among women of reproductive age.

RESULTS FROM THE MATERNAL AND CHILD HEALTH STAKEHOLDER SURVEY: PRIORITIES

Response Rate: 65% (172 / 265 invited respondents)

Table 1:

Respondent Characteristics	Proportion (Frequency)
Type of Agency	
Local public health agency	58.1% (97)
Colorado Department of Public Health and Environment	21.0% (35)
Other State department	3.6% (6)
Private, non-profit organization	7.2% (12)
Other	10.2% (17)
Role in Organization	
Local public health agency director	19.8% (33)
Local agency MCH/CSHCN program director or program staff	27.5% (46)
State department program director or program staff	24.0% (40)
Private, non-profit agency director or staff	6.6% (11)
Other	22.2% (37)
Participated in MCH Expert Panel / Advisory Group	
Yes	21.8% (36)
No	78.2% (129)
Working with MCH Populations*	
Early childhood (0-8 yrs)	73.2% (120)
Children and adolescents (9 -21 yrs)	75.6% (124)
Children with special health care needs (CSHCN)	57.3% (94)
Women of reproductive age (15-44 yrs)	73.2% (120)
Number of Years Working in Field of MCH	Mean = 15.3 years

*Proportions > 100% because respondents were able to select more than one answer

MCH Stakeholders, State and Local, Invited to Complete Priorities Survey

Name	Organization
Aakko, Eric	Colorado Department of Public Health and Environment
Adamson, Kelli	Cheyenne County Public Health Agency
Aduddell, Michael	Mesa County Health Department
Albanese, Bernadette	El Paso County Department of Health and Environment
Anderson, Stephanie	Northwest Colorado Visiting Nurse Association
Anselmo, Theresa	Colorado Department of Public Health and Environment
Antuna, Amy	Weld County Dept of Public Health and Environment
Archer, Linda	Colorado Department of Public Health and Environment
Auer Bennett, Eileen	Assuring Better Child Health & Development
Aukema, Abigail	Denver Health and Hospital Authority
Babler, Shirley	Colorado Department of Public Health and Environment
Bailey, Anne Marie	Gilpin County Public Health and Environment
Baker, Nancy	Crowley County Public Health Agency
Bakulski, Mandy	Colorado Department of Public Health and Environment
Barr, Emily	The Children's Hospital
Barta, Jean	Clear Creek County Public Health and Environment
Bates, Patricia	Prowers County Public Health
Beam, Rita	Tri-County Health Department
Beaman, Charity	Jackson County Public Health Agency
Beard, Kelly	Delta County Health Department
Belew-LaDue, Brene	Grand County Public Health
Benkert, Molly	Denver Health and Hospital Authority
Betts, Ingrid	Elbert County Health and Environment
Bindel, Lynn	Colorado Department of Public Health and Environment
Bongiovanni, Bob	Colorado Department of Public Health and Environment
Borden, Marti	Pueblo City-County Health Department
Bradrick, Cynthia	Larimer County Health Department
Braga, Anne-Marie	Colorado Department of Public Health and Environment
Bravo, Melanie	Boys & Girls Club/Girls Inc. of Pueblo County & Lower Arkansas
Breitzman, Shannon	Colorado Department of Public Health and Environment
Briokering, Terri	San Juan County Public Health Service
Brown, Jacqueline	Prowers County Public Health
Brown, Renee	Gunnison County Department of Health and Human Services
Brunk, Tammy	Eagle County Public Health Agency
Brunson, Diane	University of Colorado Denver
Buckland, Kandace	El Paso County Department of Health and Environment
Burford, Nina	Consultant, Formerly of Tri-County Health Department
Burns, Jennifer	Rocky Mountain Youth Pediatric Clinics

Name	Organization
Burton, Ginger	Colorado Department of Health Care Policy and Financing
Chavez, Natalie	Conejos County Public Health Nursing Service
Clement-Johnson, Andrea	Larimer County Health Department
Clinkenbeard, Crystal	Oral Health Awareness Colorado!
Connor, Karen	Montrose County Department of health and Environment
Cooper, Lori	Montezuma County Public Health Agency
Costin, Debbie	Colorado Association for School-Based Health Care
Crain, Renay	Kiowa County Public Health Agency
Crook, Deborah	Summit County Public Health Department
Crosthwait, John	Northeast Colorado Health Department
Crotser, Judy	Colorado Department of Public Health and Environment
Dacey, Jane	Boulder County Public Health
Daniluk, Patricia	Colorado Department of Public Health and Environment
Davies, Jill	University of Colorado Denver
Davis, Julie	Colorado Department of Public Health and Environment
DeLeeuw, Karen	Colorado Department of Public Health and Environment
Dodge, Kristin	Weld County Dept of Public Health and Environment
Donkle, Karen	Bent County Public Health Agency
Dubiel, Heather	Colorado Department of Public Health and Environment
Edgar, Connie	Conejos County Public Health Nursing Service
Eggleston, Faith	Broomfield City-County Public Health and Environment
Ellis, Susan	Chaffee County Public Health Department
Emerson, Kristy	Mesa County Health Department
English, Jo	Colorado Department of Public Health and Environment
Esquibel, Jose	Colorado Department of Public Health and Environment
Febbraro, Gina	Colorado Department of Public Health and Environment
Federico, Steve	Denver Health and Hospital Authority
Ferguson, Janice	Rocky Mountain Health Plan
Figaro, Sarah	Pueblo City-County Health Department
Finn, Jean	Colorado Department of Public Health and Environment
Ford, Patsy	San Juan Basin Health Department
Forsyth, Jessica	The Children's Hospital
Foster, Nina	San Juan County Public Health Service
Foster, Sue	South Central HCP Regional Office
Fox, Dianna	Mesa County Health Department
French, Don	Delta County Health Department
Gabella, Barbara	Colorado Department of Public Health and Environment
Gallegos, Glenda	Delta County Health Department
Gallegos, Jon	Colorado Department of Public Health and Environment
Gallegos, Vivian	Costilla County Public Health Agency
Garcia, Mary	Las Animas-Huerfano Counties District Health Department

Name	Organization
Gawlik, Diana "Di"	El Paso County Department of Health and Environment
Geiser, Julie	Alamosa County Public Health Department
Gibbs, Jane	Healthy Women, Healthy Babies
Givray, Deborah	University of Northern Colorado
Glantz, Namino	Boulder County Public Health
Golden, Tammy	Boulder County Public Health
Gonzales, Melinda	Colorado Association for School-Based Health Care
Guccione, Amy	Jefferson County Public Health
Hadleydike, Karen	Grand County Public Health
Hansen, Michelle	Colorado Department of Public Health and Environment
Hardin, Jodi	Colorado Department of Public Health and Environment
Hardy, Tara	Hinsdale County Public Health Agency
Harris, Michelle	Broomfield City-County Public Health and Environment
Harrison, Jennifer	San Juan Basin Health Department
Harsh, Kevin	Otero County Health Department
Henry, Linda	Weld County Dept of Public Health and Environment
Hill, Anne	Pueblo City-County Health Department
Hills, Kimberly	Boulder County Public Health
Hillyard, Ginger	Larimer County Health Department
Holloway, Steve	Colorado Department of Public Health and Environment
Horton, Don	Boulder County Public Health
Hubbard, Martha	Teller County Public Health Department
Hudson, Lisa	Mesa County Health Department
Huffman, Margaret	Colorado Department of Public Health and Environment
Hulse, Jonni	El Paso County Department of Health and Environment
Hunsaker-Ryan, Jill	Colorado Department of Public Health and Environment
Hunt, Cerise	Colorado Department of Public Health and Environment
Hutson, Rachel	Colorado Department of Public Health and Environment
Imus, Kelly	Weld County Dept of Public Health and Environment
Ireland, Lynn	Colorado Department of Public Health and Environment
James, Dawn	Kit Carson County Health and Human Services
Johnson, Mark	Gilpin County Public Health & Environmental Services
Johnson, Mark	Jefferson County Public Health
Jones, Kristy	Rocky Mountain Center for Health Promotion and Education
Jordan, Rebecca	Colorado Department of Public Health and Environment
Kelly, Anna	Healthy Women, Healthy Babies
Kelly, Glenna	Kaiser Permanente
Kent, Helene	Healthy Women, Healthy Babies
Kinsella, Emily	Colorado Department of Public Health and Environment
Kinzie, Kay	The Children's Hospital
Kissler, Aaron	Clear Creek County Public and Environmental Health

Name	Organization
Kleckner, Susie	San Juan Basin Health Department
Klein, Chandra	Larimer County Health Department
Klingler, Greta	Colorado Department of Public Health and Environment
Koehler, Bonnie	Delta County Health and Human Services Department
Kurth, Pam	Tri-County Health Department
Kwerneland, Carolyn	Jefferson County Public Health
Landa, Tiffany	Las Animas-Huerfano Counties District Health Department
Langan, Sarah	San Juan Basin Health Department
Lasseter, Alyssa	Colorado Department of Public Health and Environment
LeBailly, Adrienne	Larimer County Health Department
Lee, Annie	Colorado Department of Health Care Policy and Financing
Lehman, Betty	Autism Society of Colorado
Leiferman, Jenn	Colorado School of Public Health
Leifert, Alison	Mesa County Health Department
Leslie, Jill	U.S. Department of Health & Human Services
Liss, Mary Sue	Elbert County Health and Environment
Little, Laurel	Garfield County Public Health
Lloyd-Cumley, Mary	Weld County Dept of Public Health and Environment
Long, Kim	Rio Blanco County Department of Public Health and Environment
Lujan, Yvette	South Central HCP Regional Office
Mandl, Christine	Colorado Department of Public Health and Environment
Marks, Megan	Family Voices
Marshall, Julie	Rocky Mountain Prevention Research Center
Martin, Mary	Colorado Department of Public Health and Environment
Martindale, Dan	El Paso County Department of Health and Environment
Martinez, Flora	Colorado Department of Public Health and Environment
Martinez, Maryanne	Costilla County Public Health Agency
Matthews, Kathleen	Colorado Department of Public Health and Environment
Matthews, Scott	March of Dimes Colorado
Mattson, Mel	Colorado Department of Public Health and Environment
McClain, Patricia "Trish"	Northeast Colorado Health Department
McDonnall, Donna	Custer County Public Health Agency
McNeely, Heidi	Tri-County Health Department
Meisner, Mary	Garfield County Public Health Service
Melinkovich, Paul	Denver Health and Hospital Authority
Mewes, Peggy	Montrose County Department of Health and Human Services
Miller, Diane	Moffat County Public Health Agency (Northwest Colorado Visiting Nurse Association, Inc.)
Miller, Diane	Routt County Public Health Agency (Northwest Colorado Visiting Nurse Association, Inc.)
Mohan, Margaret	Colorado Department of Health Care Policy and Financing

Name	Organization
Montera, Cathy	Las Animas-Huerfano Counties District Health Department
Morrison, Gaye	Weld County Dept of Public Health and Environment
Mulch, Kindra	Kit Carson County Health and Human Services
Murphy, Carol	Hinsdale County Public Health Agency
Myers, Lindsey	Colorado Department of Public Health and Environment
Neil, Misti	Larimer County Health Department
Nelson, Lorene	Otero County Health Department
Nepsky, June	San Miguel County Department of Health and Environment
Nevin-Woods, Christine	Pueblo City-County Health Department
North, Jeanne	Tri-County Health Department
O'Connell, Joan	University of Colorado Denver
O'Fallon, Molly	Colorado Community Health Network
Orr, Kathy	El Paso County Department of Health and Environment
Oswald, Rebecca	Otero County Health Department
Oys, Rachel	Eagle County Public Health Agency
Pappas, Jennifer	The Children's Hospital
Park, Lorri	Autism Society of Colorado
Patrick, Kathy	Colorado Department of Education
Patterson, Shana	Colorado Department of Public Health and Environment
Pemberton, Michelle	Northeast Colorado Health Department
Perry, Patricia	Rio Grande County Public Health Agency
Peterson, Karen	Denver Health
Phillips, Robin	Park County Public Health Department
Plummer, Yvette	Denver Metro Community Parent Resource Center (CPRC)
Podratz, Alana	El Paso County Department of Health and Environment
Poniers, Andrea	Colorado Department of Public Health and Environment
Potter, Marti	Denver Health and Hospital Authority
Procell, Lynn	Pueblo City-County Health Department
Randolph, Mary	Dolores County Public Health Agency
Reynolds, Joni	Colorado Department of Public Health and Environment
Ritter, Richard	Otero County Health Department
Roahrig, Colleen	Mesa County Health Department
Roberts, Cheryl	Ouray County Public Health Agency
Robinson, Anne	Eagle County Public Health Agency
Robinson, Gina	Colorado Department of Health Care Policy and Financing
Robinson, Kelli	South Central HCP Regional Office
Rodriguez, Sara	Colorado Department of Public Health and Environment
Roth, Linda	Cheyenne County Public Health Agency
Rubin, Christina	Teller County Public Health Department
Ruttenber, Margaret	Colorado Department of Public Health and Environment
Ruybalid, Sarah	Pueblo City-County Health Department

Name	Organization
Sanchez, Jessica	Colorado Community Health Network
Sanford, Lauren	Youth Partnership for Health
Satkowiak, Linda	Qualistar Early Learning
Savoie, Karen	University of Colorado Denver
Scanlon, Jody	Boulder County Public Health
Schoenthaler, Celeste	Colorado Department of Public Health and Environment
Scott, Hilda	Mineral County Public Health Agency
Scott, Steve	Colorado Adolescent Maternity Program (CAMP)
Scully, Sarah	Boulder County Public Health
Shlay, Judy	Denver Public Health
Shupe, Alyson	Colorado Department of Public Health and Environment
Smartt, Sherry	Denver Health and Hospital Authority
Smith, Cassidy	Colorado Department of Health Care Policy and Financing
Sobeck, Linda	Boulder County Public Health
Stack, Lynda	Montrose County Department of health and Environment
Stager, Ann	El Paso County Department of Health and Environment
Stark, Liz	Pitkin County Public Health Agency (Community Health Services, Inc.)
Stenmark, Sandra	Kaiser Permanente
Stewart, Maren	Live Well Colorado
Stoll, Jeff	Broomfield Health and Human Services Department
Strand, Averil (Avie)	Larimer County Health Department
Sullivan, Pat	Delta County Health Department
Talkington, Kathie	Mesa County Health Department
Talmi, Ayelet	University of Colorado Denver
Thornton, Michelle	Colorado Department of Public Health and Environment
Tolliver, Rickey	Colorado Department of Public Health and Environment
Torpy, Lynne	Colorado Department of Public Health and Environment
Trefren, Lynn	Tri-County Health Department
Tregillus, Liza	San Juan Basin Health Department
Trierweiler, Karen	Colorado Department of Public Health and Environment
Troyer, Mary	Bent County Public Health Agency
Trujillo, Robin	Baca County Public Health Agency
Trujillo, Tara	Colorado Children's Campaign
Tubman, Norma	Jefferson County Public Health
Tuttle, Brenda	Larimer County Health Department
Tyson, Judy	Lake County Public Health Department
Underwood, Nettie	Larimer County Health Department
Urbina, Chris	Denver Health and Hospital Authority
Vahling, Jason	Colorado Department of Public Health and Environment
Van Iwarden, Kenneth	Alamosa County Public Health Department

Name	Organization
Van Zet, Angela	Tri-County Health Department
VanWyk, Bethany	Eagle County Public Health Agency
Vellinga, Gloria	Colorado Department of Public Health and Environment
Vettese, Rebecca	Fremont County Public Health Agency
Vieira, Della	Saguache County Public Health Agency
Vogt, Richard	Tri-County Health Department
Wadhwa, Sandeep	Colorado Department of Health Care Policy and Financing
Wallace, Lindy	Colorado Department of Health Care Policy and Financing
Wallace, Mark	Weld County Dept of Public Health & Environment
Watson, Beth	Northwest HCP Regional Office
Watters, Kathy	Colorado Department of Public Health and Environment
Westberg, Lynn	San Juan Basin Health Department
White, Cathy	Colorado Department of Public Health and Environment
Wilford, Kori	Larimer County Health Department
Williams, Judi	San Juan Basin Health Department
Wilmoth, Ralph	Colorado Department of Public Health and Environment
Wilson Ball, Michelle	Summit County Public Health Department
Wooten, Marti	Lincoln County Department of Public Health
Worrall, Carol	Gunnison County Department of Health and Environment
Yahn, Sherri	Northeast Colorado Health Department
Yale, Andrew	Denver Public Health
Ybarra, Esperanza	Colorado Department of Public Health and Environment
Zaborek, Robin	Autism Society of Colorado
Zayach, Jeff	Boulder County Public Health
Zeiset, Zack	Chaffee County Public Health Department

FY2011-2015 MCH Needs Assessment Process
De-Brief Questions

Objective Questions:

1. In thinking about the MCH Needs Assessment (NA) process for 2011-2015 and your role as a steering committee member, what do you remember?

2. What caught your attention most about the process?

Reflective Questions:

3. What about the process was really clear and what was most confusing? What was the most: exciting? boring? anxiety-producing?

4. What was easy? What was difficult?

5. What seems the most critical? What are you the most doubtful about?

Interpretative Questions:

6. What is the importance of this process? What difference will it make?

7. What (if any) insights are beginning to emerge?

8. Was this process beneficial to you personally in your job? Why or why not?

9. What other things do we need to consider and/or what questions did this raise for you?

10. What kinds of changes will we need to make? What kind of decisions do we need to make? What values are we holding here?

Decisional Questions:

11. When we do this again, what parts of the process would we retain? What would we change? Consider the following:

    - ***Structure*** – Conceptual Framework & Guiding Principles; Steering and Advisory Committees, Expert Panels.
    - ***Logistics*** – Meeting schedules, timelines, length of entire process.
    - ***Data collection processes:*** Health Status Report, Stakeholder survey, Capacity assessment process.
    - ***Final Prioritization Process***
    - ***Communication/Collaboration***

12. What have you learned? What do you see as the next steps?

ISSUE PAPER TEMPLATE

Colorado 2010 MCH Needs Assessment
Prioritization Template
(Please limit your response to 2-3 pages)

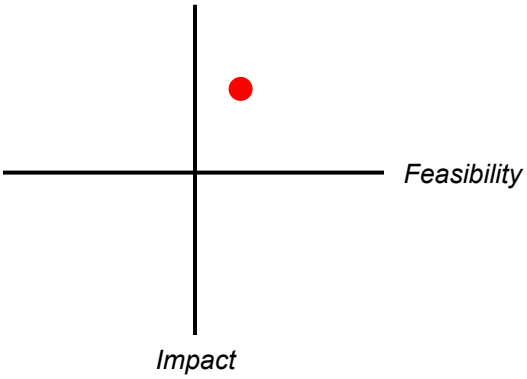
Issue under consideration
Provide data to support the need to address the issue (severity or numbers of the MCH population affected). Include health equity data, if available.
Describe effective interventions / strategies to address the issue.
Describe the MCH public health role in implementing these interventions/strategies.
Describe the state and local capacity within MCH that exists to implement these interventions / strategies (capacity is broadly defined to include financial, human, and material resources; policies and protocols; technological resources enabling information management and data analysis; knowledge, skills, and abilities of Title V staff and/or other individuals/agencies accessible to the Title V program; partnerships, communication channels, and other types of collaborations with public and private entities)
Describe how MCH can impact this issue (Is it within the MCH sphere of influence?)
What population-based measures could be used to demonstrate the MCH impact on the issue?
When facing competing priorities, why do you consider addressing this issue to be a good use of MCH resources?
Additional comments

PRIORITY SETTING GRID

Potential Priority #1: Prevent obesity among the early childhood population

DECISION: Keep as a potential priority.
STATE CAPACITY SCORE: **2.8** (Some to Adequate) *Structural Resources* = *2.0*
Data Information Systems = 2.5
Competencies/Skills = 3.2
Organizational Relationships = 3.0

GRID:



Priorities Survey

	Proportion (Frequency)			Rank (Frequency)
Obesity	***Priority 1 (n=163)***	***Priority 2 (n=162)***	***Priority 3 (n=160)***	**All Priorities**
All respondents	35.0% (57)	17.9% (29)	13.1% (21)	One (107)
Local agencies	34.8% (32)	19.8% (18)	10.1% (9)	One (59)

Capacity Survey

Potential Priority & Capacity Factors	**Current Capacity Proportion (Frequency)**				
	None (1)	**Some (2)**	**Adequate (3)**	**Well Established (4)**	**Most Frequent Response**
Obesity					
Structural Resources	29.2% (7)	**37.5% (9)**	25.0% (6)	8.3% (2)	Some
Data/Information Systems	8.3% (2)	**45.8% (11)**	**45.8% (11)**	0.0% (0)	Some/Adequate
Competencies/Skills	8.3% (2)	33.3% (8)	**45.8% (11)**	12.5% (3)	Adequate
Organizational Relationships	0.0% (0)	25.0% (6)	**50.0% (12)**	25.0% (6)	Adequate

DISCUSSION NOTES:
Increasing prevalence of obesity is obvious. There are best practices on obesity practices in child care. This is an issue that is "upstream." For this issue, Breastfeeding is a potential outcome. Strategies for this issue can also apply to other issues. There is a role for both programs and policy.

2011-2015 Colorado MCH Priorities with State and National Performance Measures

The following nine (9) issues have been identified as priorities for the Maternal and Child Health Block grant for the following target populations: early childhood (birth-8 years), including children with special health care needs; children and youth (9-21 years), including children and youth with special health care needs; and women of reproductive age (15-44 years).

Colorado MCH Priorities	State Performance Measures	National Performance Measures
1. Promote preconception health among women and men of reproductive age with a focus on intended pregnancy and healthy weight.	**SPM 1:** Percentage of sexually active women and men ages 18-44 using an effective method of birth control to prevent pregnancy. (BRFSS) **SPM 2:** Percentage of live births to mothers who were overweight or obese based on BMI before pregnancy. (Birth certificate)	▪
2. Improve screening, referral and support for perinatal depression.	**SPM 3:** Percent of mothers reporting that a doctor, nurse, or other health care worker talked with them about what to do if they felt depressed during pregnancy or after delivery. (PRAMS)	▪
3. Improve developmental and social emotional screening and referral rates for all children ages birth to 5.	**SPM 4:** Percent of parents asked by a health care provider to fill out a questionnaire about development, communication, or social behavior of their child ages 1 through 5. (Child Health Survey - CH169) **SPM 5:** Percentage of Early Intervention Colorado referrals coming from targeted screening sources. (Early Intervention Colorado)	▪ **NPM 12** – Percent of newborns who have been screened for hearing before hospital discharge.
4. Prevent obesity among all children ages birth to 5.	**SPM 6:** Percentage of live births where mothers gained an appropriate amount of weight during pregnancy according to pre-pregnancy BMI. (Birth certificate)	▪ **NPM 11** – The percent of mothers who breastfeed their infants at 6 months of age. ▪ **NPM 14** – Percent of children, ages 2 to 5 years, receiving WIC services that have a BMI at or above the 85th percentile.
5. Prevent development of dental caries in all children ages birth to 5.	**SPM 7:** Percent of parents reporting that their child (age 1 through 5) first went to the dentist by 12 months of age (Child Health Survey - CH63a)	▪

The following nine (9) issues have been identified as priorities for the Maternal and Child Health Block grant for the following target populations: early childhood (birth-8 years), including children with special health care needs; children and youth (9-21 years), including children and youth with special health care needs; and women of reproductive age (15-44 years).		
Colorado MCH Priorities	**State Performance Measures**	**National Performance Measures**
6. Reduce barriers to a medical home approach by facilitating collaboration between systems and families.		▪ **NPM 3** – The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (National CSHCN Survey) ▪ **National Outcome #2** – All Children will receive comprehensive, coordinated care within a medical home.
7. Improve sexual health among all youth ages 15 -19.	**SPM 8:** Percentage of sexually active high school students using an effective method of birth control to prevent pregnancy (YRBS).	▪ **NPM 8** – The rate of birth (per 1,000) for teenagers aged 15 through 17 years.
8. Improve motor vehicle safety among all youth ages 15 – 19.	**SPM 9:** Motor vehicle death rate for teens ages 15-19 yrs old.	▪
9. Build a system of coordinated and integrated services, opportunities and supports for all youth ages 9-24.	**SPM 10:** The percentage of group members that invest the right amount of time in the collaborative effort to build a youth system of services & supports. (Wilder Collaborative Factor Inventory)	▪ **NPM 6** – The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence. (National CSHCN Survey) ▪ **NPM 8** – The rate of birth (per 1,000) for teenagers aged 15-17 years. ▪ **NPM 16** – The rate (per 100,000) of suicide deaths among youths 15-19.