Title V Needs Assessment Webinar Series: Session III, Steps 4-6

Transcript

Shirley Payne (she/her), HRSA/MCHB/DSCH

- I'm so glad to have you here in our session. 3 of our needs assessment
- Webinar series again. It's I hope you had an opportunity to go back and listen to the recording that we had, which was the 1st webinar 1st piece in the Webinar series here, and then you were able to join us for the second one. If not, you're able to be able to listen to that recording as well. So we are super excited. This is the final, the final from a webinar perspective. But, as we've said before.
- we'll have our partnership meeting that's coming up here in October. So remember it's October 20th through the 23d So if you have not yet registered, yeah, please make sure that you do so. I said, but we're looking forward to continuing this discussion, this conversation, and we. And even once it comes to the partnership meeting, and we have the session there. It is not the end. We want you to know that you can reach out and ask questions and ask about the resources just because we know you're going to continue
- to do this work well into the beginning of 2,025, especially when your needs assessments are going to be due. July 15.th so, without further ado again, still thinking just again. Thank you. Thank you. Thank you for engaging, and we really hope that you've seen, and what you felt that you got from this really was a reflection of the feedback that we did get at at Am Chip conference. I'm in the session, the skills building session.
- That the division of state and community health did. And you know John was able to join us, and we also had some, our state partners to do so, and we're super excited. To to have more of that for you today, and so we'll get as again for today we'll go through some additional different steps. And to think about you know what your goal is, and especially when it comes to setting your objectives and developing your action plan. But, John, I'm gonna stop there and I'm gonna turn it over
- to you, to get us started. One last piece to that. I will say everyone is that because we do have so much information, we will go into the QA portion. A bit. But please know that we're going to have plenty of time. For you all to be able to ask questions. All right, John.

John Richards

Shirley. Thank you so much

- There's great energy in this session. So I know we are going to just zoom through. We have our agenda here. Oops. I think we went through the agenda. We're already onto our message for today, and we'd like to start this way. Just so, you know
- we are there for you, and our message for today is, do not let perfection get in the way of completion.
- There are multiple tools to use. You can use these tools in combination. You can develop your own processes. There are multiple approaches. You can focus on priorities more broadly or more narrowly. There's no one door, there's no one right way. We like to say

there are different flavors of priorities, and you need to choose an approach that meets the needs of your populations and are responsive to the realities in which you live and work.

- So let's interact a little bit. We thought, we didn't want to be just sitting up here and talking at you for the next hour here. So we're kind of curious needs assessment, you know, comes along every 5 years in the chat. If you could open up the chat, and this will get you prepped for any questions and answers that you might have for our speakers today.
- But in the chat, if you could just let us know. Are you a needs assessment, Newbie? Have you never been through the needs assessment process. Yet, if so, let us know up. We already have someone couple of newbies, and as you're typing that in oh, my goodness, yep, a lot of newbies. Let us know one word of how you are feeling.
- And it can be it can be happy or sad or anxious anywhere along the continuum.
- We got some excited not new to neat. Oh, got a lot of excited and energized Christine. Thank you. We needed to hear that
- energized again. Yes, positive, excited, excited. We have some people not new to needs assessment, assessment, but are
- new to the title. 5 MCH. Process.
- This is this is good, grateful, ready. I think we are all we. Hopefully, we're all ready
- next question if you are a needs assessment. Pro. If you've been through the needs assessment process
- and we're not. We're not asking, not asking your age, but just how many needs assessment processes have you been through?
- It will be interesting. We have some people who have been up 2, 1, 3 needs assessments. This is great.
- A lot of first, st you know. This will be the second time. 2, 3, 3, 2, or 3, sometimes. We can't even remember all the years. Say, Oh, my goodness! We have a possible 6 timer. We might have a winner here. We can just we can just shut shut down because this person must know everything.
- And then, if you think about it. We're not gonna wait too long. But if you can just type in here, if you've been through this process, is there any one sentence of advice you could give to other people who might be newer along the the continuum. So we're just going to let that go through. That might take a little bit longer, but as you're typing there, we're going to move on to
- on to the next slide
- we were talking about. Let's start with the questions from the field just getting you prepped here?
- These were questions that we received just recently when we opened the registration up for this session and what we tried to do. We love to sort and classify along the steps of the the needs assessment continuum. So we have things from
- easy things like we heard from several people that they want copies of the presentation. We can do that really easily. But you can kind of see questions about, what do you do? If you have a small sample size, how do you select priorities? How do you make sure that

- the prioritization activities align with the needs of of your your populations looking here, and I know our friends from the bureau are going to talk about the blueprint, and we're going to talk about that a couple of ways, including the next slide. So take a look at these questions. They probably align with what you are asking yourself as well.
- and I see in our chat we're getting a lot of great comments, including diverse voice, diverse voices. Here's a great. It will all work out in the end. That makes me feel really good.
- We're gonna pause here just for a second and show you remind you about our MCH needs.net. Our title. 5 needs assessment toolkit. We are updating this constantly with new information. Right? Now, we have, some really great resources from our friends at AAP.
- who are focusing on the blueprint for change, and looking at the 4 pillars of change, and how to incorporate that into needs assessment. This is a great resource. We are thrilled that it got released in time for this webinar. So we have posted that actually up on
- up on the MCH needs.net, and already Karen is already saying the AAP resource is great, so big thumbs up. I put a link to it in in chat as well.
- So, moving on to the next slide, I told you this is going to be really fast and furious.
- We also asked in this last registration, where are you at this point? And interesting? Look at this, most of us here on the call. We're in the process of engaging our partners and assessing the needs. Very few of us are really far along the continuum. And that's okay. We are all mostly in the same place. What we are happy of here is, we are getting ahead of you and answering questions before you get to the setting performance objectives and developing that state action plan.
- So we're pretty happy about that.
- All right. Next slide, we're getting into
- what we're doing today. And today, we're gonna actually start with the goal here. We're going out of order a little bit and jumping ahead to step 6 and that elusive action plan. And we're really kind of excited because everything we've been talking about so far. And then everything we talk about the rest of today is in support of that action plan. And there are lots of ways to look at that action plan. So on the next slide, you can kind of see
- we're gonna go through this what the block Grant says. And you know this can be no offense to our MCHB. Partners, but this can be a little dry, but so there are some additional tips about drafting action plans coming up with timelines, criteria thinking of evidence based, and all the things that we know are important. On the next slide, though you can kind of see, this is where what we've heard from you.
- There's a lot of questions, how do we implement these universal Npms as part of the action plan, especially medical home? How do we approach similar strategies. And what are those specific strategies? And I am really happy on the next slide to welcome our 1st speaker today. Dr. Jeff. Brasco, who is the director of Audition at MCHB. Who's going to answer all of our questions, Jeff? I'm handing it over to you.

Jeff Brosco

Thanks, John. And as John said, can you go back? One slide, please, before you can get to this one? Just that this idea of talking a little bit about the action plan first.st the idea of this is that we it's much more.

- All the earlier steps make more sense if you start to think about what is it going to look like at the end of the day? What am I trying to get to and just by way of introduction, I think I know many of you. I've been in MCHB. For 2 years, but for the 20 years before that I was there at in Florida. I'm a pediatrician. I I take care of kids still on Monday afternoons, but I also had a series of roles in in Florida State government
- for almost 20 years was part of in one way or another, the title 5 program, including being the CYSHCN director for a while, and it's been so long, and I still live in Florida. So I often say we an hour when I'm talking about Florida but really the people who deserve the credit for this nowadays are Johnny Hollis and Linda Starnes and those guys.
- So let's talk about in particular, the medical home issue next slide, please. So I actually provide a medical home. And we've used medical home in Florida for one of the ways to think about our program over years. So I think this is a topic that we can really shed some light on today.
- Here is the big idea as you're thinking about. Well, what are we actually going to do? What's our action plan going to say? Keep in mind that you medical home is a universal measure.
- But it's not necessarily a universal goal.
- And I'm gonna come back this in a variety of ways, and go through a couple of examples and try to explain what I mean by that 1st thing to remember is on the sort of left side of this. What is a medical home? If you haven't already looked at the American Academy of Pediatrics. Definition, you go on the website there and are, as as John said, our colleagues at A. P. Blueprint consortium have put a lot of materials together. It is a really broad definition. If you're thinking of medical home as
- a kid has to go see their doctor. That is sort of the 19 fifties version. We are at the place now where we're thinking about it as a partnership among clinical specialists, families, community resources.
- And if you look at the way it's measured in the National Survey of child health, there's lots of parts of it.
- So yes, there's the question about. Do you have a personal doctor or nurse? And what's your usual source of care? But it's also a series of questions about family centered care. Are you are you being included? This is a caregiver self report. Are you parent caregiver, being included in decisions about your child. There's a question about referrals. But then there's another one about care coordination where you connected the services you need. And I bolded those 2 because I think those are going to be really key things for you to come back to, because, remember, you only need to do one component the medical home you don't have to do all 5.
- So that's sort of the left side of that. That slide on the right side are trying to separate out medical home as a goal from medical home, as a method to achieve other goals. So yes, a medical home has been shown to be effective, particularly among the children. You have special healthcare needs or the shin population, and I'm going to in the next couple of slides give you an example of work that we're doing now in conjunction with

some state title 5, on trying to Create a Medical Home for Children, medical Complexity, because it shows the kids and their families do better.

- The second part that might oh, not quite yet to the next slide back up one. The second point here that medical home is a method to achieve other goals. I'm gonna spend a little more time on it. And the idea is here that in your action plan you're gonna start with what your needs assessment showed. And then you're gonna think broadly about all the ways to reach that. And then you can imagine how medical home can be built into that. And I'm going to use as that example behavioral health, and show you the the really, the multitude of ways
- that you can use medical home as a universal measure or method to achieve goals that may seem distant@firstst All right, next slide, please.
- So just a quick reminder on the epidemiology of special healthcare needs. So there's all children in the United States, 80 million or so. Then there's the shin population. It's about 25% of kids. It's a lot 13,000 conditions. But really, it's a lot of kids with asthma and allergies. And then within that shin population, as you know, is the children medical complexity. These are the kids who have multiple doctor visits. They're in the hospital. They are 30%, 40% of costs.
- There are high range high number of deaths as well. They're really a very different population, and the research is pretty clear that providing a medical home with good care, coordination improves outcomes for these children.
- So next slide, please. Example number one is medical home as a goal.
- and our current MCHB effort is the idea that quote every Cmc. Every child medical complexity has access to a team based well coordinated health home
- and Academy health is our grantee helping us with this. There are about 5 States. We're part of an Affinity group. We're also creating tools for all states. So if you're interested in doing this, I will note that in the Evidence Review those sort of strategic, the evidence accelerators
- that's that John and his team have put together. You'll see that there, and I'll show you those in a few minutes. There's ways to try to improve medical home and all of its different components.
- So here I have. What are some potential roles? What could you put in an action plan. If this were your goal medical home for every Cmc well, you can convene stakeholders. That's something that we're particularly good at. You are the expert within State government. And I put a note there about the evidence acceleration. Even if you're not really an expert this second, it doesn't take long to become an expert by following up with those accelerators.
- What are the other things that Title 5 can do? State regulations, payment issues? We know that it's 1 thing to fund a pilot study, but unless you change the system of care in such a way that something can grow and flower and be sustained. It's not really going to make a difference. And I gave one example here of families have been shown to be wonderful navigators for other families.
- but sometimes you have to figure out how to get the state regulations worked out so they can be certified as navigators and paid to work as navigators. So that's 1 of the ways

that Title 5 can be in, not just training, not just setting it up in one place. But can it be sustainable using. Say, for example, insurance funding

- and then the last thing I put here was about funding pilots and initial infrastructure.
- for me when I'm thinking, putting on my title 5 hat from a million years ago, or even now, I don't want to fund any pilots unless I'm already thinking about sustainability.
- And so how can you do it? Well, part of it is, if you're working at that regulatory level and payment issues that can take 3 to 5 years, maybe to get in place by funding infrastructure and pilots upfront. It gives them a chance to build up their team, for example, bring in your social worker and nutritionist, and so on. Have the team. You need to provide that complex care until the sustainability is in place.
- and I noted here the equity opportunity. So, and I think, our Florida team. I think that Johnny has presented on this before you can do geomapping with your Ssdi colleagues. Figure out social vulnerability index, for example, and you can start your pilots in the places that need them the most
- next slide, please.
- I really want to spend a little more time. On example 2
- if you go to the next slide, please.
- And this is the medical home as method. Oh, back up one more.
- and let's just say, for example, that in your your needs, assessment, behavioral health comes up. It's almost certain to. And it is this, you agree through your priority setting. And you know that it is also a critical priority. And so through steps one and 4, you come out to behavioral health like, okay, now, what do we do?
- In the next slide? I'm going to show you a way that you can think about brainstorming, and as you're brainstorming to come up with all the possible ideas you want to remember. What are your strengths, what's your capacity as a state? What are the political winds saying? And then you can use one of those 5 components, the medical home as a way of implementing it. As I mentioned before, family centered care or care coordination are probably the ones that are most relevant, not so sure about the other components
- next slide.
- So this is something we put together a few years ago thinking about behavioral health, and this slide and the next one are very similar. But just to look at this for a minute, this is looking at the prevention pyramid right? So at the base of the pyramid, in a prevention pyramid you have
- promoting well being for every single child so universal primary prevention. And then the Second Level is at risk category for for folks that you think are at higher risk for behavioral concerns. And then at the highest part of the pyramid. There's there's the treatment of tertiary, and we just listed all the things we could think of that would make a difference. For universal. And you can see all of the details there.
- You can pick out almost any one of these, and imagine how you might implement it, either through a family centered care or care coordination idea. And I'll give you a couple of examples. So under universal programs.
- you can see, you know. Oh, I'm sorry my slides are moving around, you can see under universal programs.

- the universal pre-k, or somehow connecting well in the medical home context connecting with community resources is clearly part of what's there?
- Another one is a healthy steps program which are integrated into primary care, medical homes under built environment.
- the Eitc, the earned income support. We know that providing income support to families in poverty is one of the best ways to prevent behavioral concerns. So imagine that you are co-locating a Tax Advice group. And there are lots of volunteer groups that do this in a medical home or in other health clinics. That would be a great way of dealing with socioeconomic factors, doing equity and doing it in the context of a medical home.
- I'm not going to go through all these, but I'll provide one more example, the treatment is probably the easiest, and the one that we chose in Florida is the one in the top left with direct services, with treatment by primary care or mental health specialists in the primary Care medical home.
- And you can do more than one of these. So as you're thinking through your action plan. If you start with brainstorming, what are all the possibilities that we could do?
- And then you start saying, Well, what was likely to work in our state versus not work. And then how could we connect it, for example, through the immersive medical home measure?
- Next slide.
- some of you might find the public health pyramid easier. This is the exact same information, but it's in the slides in case you find this way of thinking about things easier. And then last slide, please.
- So just to sum up, the medical home definition allows a lot of different community based efforts. It's okay to brainstorm and capitalize on what your strengths are in capacity, and you can focus on just one component of the medical home. And I gave a couple of examples and rare medical home can be the goal, but it also can be the method.
- And the last thing you see there is a link. This is to the Florida fiscal year 24. Application again. Johnny Hollis and her team get all the credit for doing this, and if you look at those pages, 147. Through 53 you can see an example of a State plan that does both of these things that I just talked about.
- Thank you very much.

John Richards
Jeff. Thank you. That was a whirlwind of great information, and

- I invite everybody. If you didn't catch everything, please listen to the archive, too, because I was furiously taking notes, just learning all of this. So thanks to Jeff, we're going to jump right on to some specifics about medical. We talked about ideas, and this idea of different levels of approaching medical and looking at it as a means looking at as an outcome or a method and an outcome.
- So I will say what was so encouraging this time with the new block grant guidance is to see medical home broken out into its components. Because, as we can see here when we looked at our strategies, our evidence based strategies on medical home overall back in the day. In the last 5 years we didn't have. We had 10 strategies that were evidence based that we knew had a great potential to impact and to affect change.

- And you can kind of see I'm going to go through the new levels here or the new components very quickly. But I want you to take a look both at the ratings of the evidence. Everything, from mixed evidence to the scientifically rigorous evidence that we know has great impact. And then the levels, we have individual level, we have community focus, we have systems level. So when we started with medical, we didn't really have a lot of evidence on what works on a systems level point of view.
- On the next slide, though, you can kind of see.
- we're seeing some populations and systems focused approaches here. And you can see there are a lot of different options to use these strategies. And that's what's kind of wonderful, even though medical home is universal, and everybody has to report on it. There are so many ways for you to do these activities. You can also see at the bottom that there are a wide range of audiences, from professionals to families, to payers, to state legislators, to education providers. We're really kind of excited that there are many ways for Title 5
- to make this happen
- on the next slide we can see usual source of sick care. We're starting to see some trends, especially among the scientifically rigorous strategies. We know that FQHCs. That nurse practitioners, that patient navigators, that school based health centers. These are all very strong ways to incorporate the medical home model into your work.
- and you might already find that you're doing a lot of this work, not necessarily in the medical home. NPM, but you can always use that use the work you're doing as your medical home, universal model.
- Next side, family-centered care.
- You can see again some of the sometimes you might be missing strategies. You look you look here, and you're like family centered care. Well, I don't see care. Coordination in here, and that doesn't mean that it necessarily does not work. Or you could look at and say, Well, John, there's 0 population or systems based strategies here. What that literally just means is, there has not been good published resources research on this. So we try to find everything we can on very specific. So family centered care.
- We know it's effective. There hasn't been as much background research. So take a look if you do, it focused on family centered care. Look into care, coordination, look into some of those other components to make sure that what you're doing
- you might find a really good strategy just in a related what we call analogical piece of evidence.
- Finally, on our referrals. Page. Here you can see.
- we have a lot of
- strategies that are in the emerging evidence range. And again, that just means that the research is catching up with ongoing practice. What I always say the emerging evidence of today is going to be the scientifically rigorous evidence of tomorrow, and we're hoping that you, as title 5, help make that happen by looking at data that you collect over the course of the next 5 years.
- And then, finally, the last thing I will say is,
- There are some strategies we haven't seen much of. You might look at. You might have a strategy where you think? Okay, we think this is going to work.

- But it's not on this list, John, what do I do? I'll say, ask yourself, what makes it work. Is it the format? Is it the way it focuses on behavior change? We are writing the map for a lot of the strategies that we know in medical home. That will be part of your State action plans that will get translated into the work you do for the next 5 years.
- So a lot of information here. Don't forget these are all available in the slides and on those individual links that that I put in in the chat for you.
- With that. I'm going to send this over to Julie Prescott over at Uab, who Julie is the associate professor and director of the Applied evaluation and assessment collaborative, Julia, I'm so happy for you to wrap us up on this.

Julie Preskitt
Sure. Thank you, John. I'm glad to to be with you all this afternoon.

- Again. I'm Julie Prescott from the University of Alabama, Birmingham School of Public Health, and I've been honored to work together with this team, including John and and our bureau representatives, to help plan these sessions. For you all. So John and I were having some conversations, and we like to call these the Fireside Chats. If you were on session 2 last time. You know that, Carrie Ann.
- you, Asugi and I had some fireside chats, and so this is a fireside chat number 2 trying to bring some things together for you all thinking through step 6.
- And so you're seeing here some conversations last night that might or might not have been a happy hour time with the idea that if if you really want to roll, we've you've had a lot of information today. And so really thinking about just the bare bones, basics
- of action plans. So we all know that the old saying that if you've seen one title 5 program, you've seen one title 5 program, and the same is true for State action plans. While our friends at the Bureau have developed the format that the State action plan takes. There are many models, and many different models that you can use in your own state, that that fit where you are.
- what your political context is, and others. So you know some agencies use the State action plan with, you know, they give a lot of their funding to local health departments. So you might see that reflected in that way, while, as others may keep things more at a higher level, so just that organizational structure might change the way your State action plan looks. Also, some states tend to be very focused on specific topics or topical issues.
- and others tend to have much broader thematic approach, and both, and is fine. If you are very specific on, we're going to work on safe sleep and pediatric, medical home behavioral health. Those topical issues can be fine. Some are much broader. And as you, if you have an opportunity to go to the title, 5 information system website and and look at other State plans, you'll see that some States
- have a very high level with just the big major activities that they're going to do, whereas others have much more detail in their State action plan. And it really does look almost like a true work plan that you might see in a grant. So all this to say, there are many different models that you can use that really just fit the way your work style is, and the way you need to use the plan. And what we really wanted to say that as part of the bare bones basics.

- how important it is to continue to engage with people, with lived experience, so that you can inform not only the priorities that you have in this, it's needs assessment process that you've identified, but also the State action plans themselves, and not just the very 1st draft. But as you move along over the next 5 years, it's just important to continue to engage
- through this process. People have lots of ideas they like to share, and you know some of the things you might be able to do some of the things you might not be able to do now. Some might be identifying new partnerships and opportunities to work, not having to do it only on your own as a silo, but working with others. So really, in continuing to engage with people and capturing the wisdom of the crowds, especially people with lived experience is so important, and we felt like this was a bare bones. Basic.
- Then the second topic we talked about was, what if we dig a little deeper? And so, if any of you were to know me. I'm a real nerd about a logic model. If you don't know what a logic model is. Come, see me at the partnership meeting. I love to talk this. I really wish I had a T-shirt. That that was something about logic models. But logic models are those really high level. You know visions intended to be kind of a 1 pager
- that. Give this roadmap, if you will, about where what you're trying to change and how you're going to do that. So Google logic model if you haven't seen it. But we were talking about the action plan really can be seen as a logic model. And this might be one way that you conceive your action plan. So if you're more of a visual kind of person.
- they again, they can be simple but really thinking about that farthest right hand point of a logic model which is where you're trying to go. Those are those big, long term outcomes. What are we really trying to change in the world? And that's the idea of where we're trying to go with these action plans. You know. What is it that you're really trying to make, you know? Make changing happen, make the change happen.
- and then all the steps back as you move backwards are, how? How will we know that we are getting there?
- So notice the language choice there. John and I were talking about that. It's not just like, how do we know when we get there? Because we know that a lot of the issues that we work on really take lots of time. And, you know, continue really long. We used to call the sticky wicket issues, and we have measures and metrics in the national performance measures and the ESMs to give us these, you know, measurements along the way. But
- so, and when reaching certain things. But the action plan and the strategies really give us this idea of how you know. How will we know that we are getting there, getting there, not have gotten there? So be sure to think about those things, and how, if we really want to change something on the far right side, what are some steps and things that might, we could be brought brought to bear here
- and again you can keep your back to the point there of. If you think about some of the universal measures being more methods than they are goals.
- You can also think about your logic model in a way that is very simple working on topical areas. Or maybe you decide that you want your whole action plan to follow a specific model. So everything is aligned around health, equity. Everything goes through the social determinants of health. Or maybe you want to use the MCH pyramid of services

that Dr. Brasco showed you, and you want to try to align strategies at each of those different levels.

- So again, digging deeper in lots of ways to do this, harkening back to what we just said earlier, there are different models. You can find one that works for you, whether it be simple, whether it be more in depth, whether it be more focused or not.
- And then, finally, what are some tips and tricks. So we know that it is quite the labor of love to create these action plans. A lot of effort goes in. You. You start in one place, and then, as you do activities and learn more. And the environment changes around, you modify those action plans. So you know. But just stepping out on the very 1st draft when you've you've identified your priority needs. And now here you are trying to get your application ready for to submit next July.
- So if you, if you're if you're having problems, one of the 1st things to ask yourself, is is there anything that we're doing now? What are the things we're doing already? Because that's okay. I mean, do you have some things in the toolbox that you're already doing, that you could naturally align and report that's happening.
- and when we say we are doing it might be you in your own bureau, your own division, your own program, but it might be your neighbors in other places along the hallway or in other buildings around you. So really, who's doing this? And are there any things that are already happening that we can tag into. And when you identify those, are there opportunities to expand those activities going forward?
- You know, you might not necessarily have to create an entirely new program. And an entirely new thing. Is it just something we can expand a little bit or broaden, or, you know, add into. So those are important. And if you're really, really, really stuck.
- think about the 10 essential public health services, or even the 10 essential MCH services, and those are hyperlinks when you download the the slides for today, because those are really great ways that can be cheat sheets for you to use these established models to help you align some strategies with each of these levels of service. So again, a lot of information today, again, this was a a nice
- fireside chat that that John and I had. We're happy to talk more about it, and we hope that we'll have opportunities to interact with you more in depth and directly in the partnership meeting. So
- I'm going to pass it back now, John. Thank you.

John Richards

Truly. Thank you so much. Wow! We already I feel like this has been a if you've

- sat with us this long, you know how much information there's here. Now let's go back and fill in the how do we get to the State action plan? So on the next couple of slides. We'll take a look.
- steps 3 and 4, examining really our strengths and our capacity. And how does that capacity lead directly into selecting those priorities because it does no good if we select priorities, and we don't have the capacity to address them.
- So we have some tips here at the bottom. You know us, we love that. But here you see, our challenges be our barriers, and what you wanted to hear, and I will say.

- you can see there's a lot here, but we have some really good themes. When we looked at these themes, you know, we love to sort and classify
- what we found out that there are 2 states here that are really exciting and and sort of a wealth of information to share their experiences. So on the next slide.
- you can see we're going to be talking today with Arizona and Virginia, and I'm just going to jump right in, Martine. If you want to jump in. Martine is with the Bureau. He's the Bureau chief of the Bureau of Assessment and Evaluation in Arizona Department of Health services. So Martine's going to talk about capacity and using the cast. 5 tool.

Martin Celaya
Alright. Thank you. Buena. Status everyone. Good afternoon my! I'm Martin from Arizona, so we'll get right into it. Let me set up my timer, so I don't go over there, but

- you can probably recognize that this is our cycle right for the block round, and I just wanted to highlight where we are in the process. Currently, we started our needs assessment process back on April 7th of 2023. When we engage our needs. Assessment steering committee, and we've had some subsequent meetings, and we'll be going out in the field to collect some community perspectives. But now, we just recently finished our capacity assessment and happy to share on that example. So next slide, please.
- this is what our methodologies look like for the title 5 needs assessment. You can see a combination of early later methodologies and finally getting to our priority setting session and the different strategies that will do that will engage in that. But today I'm going to specifically speak on our capacity assessment, a tool which is called the cast 5. So just a little background. On this, this was developed a few years ago by
- John Hopkins and HRSA. MCHB. To help title 5 programs assess their capacity to sustain MCH. Programs measured against the 10 essential maternal and child health.
- Services focusing on 4 areas. It's a pretty practical tool. That is a combination of different methodologies that are in in essentially designed to tailor to the unique needs of the State.
- Next slide.
- These are the 10 essential MCH services that the Cas 5 is pretty much
- rooted on with, and so I won't go over those, but just kind of putting in a plug for those
- and 2020. We completed this cast 5 assessment, and this is where where we landed. BWCH, which is the Bureau of Women and Children's Health. Demonstrates strengths on. If those essential services listed there. We identified
- areas of for potential improvement where our capacity was partially to minimally adequate in fulfilling some of those essential services for 7, 8 and 9, and you can see that on the right. What went into our needs assessment were the recommendations for how to improve the capacity in the next 5 years of the site of the grant
- next slide.
- This is what the cast 5 process looks like. It can look pretty daunting. But I'll just let you know that you can plug in plug and play and adapt things as you see fit. The whole point of this is having a very intentional and engaged focused conversation on how your State's title 5 program is meeting the 10 essential services and identifying needs and

assets. So it's also identifies the strengths in your programs. And you can do this through of our

- various ways.
- but it all starts with the answering the core questions, which essentially is, is your title? 5 program. Does it have a mission values? What are the principles that it holds? A lot of us have this already because we have to write that in our block grant applications
- next slide
- these are the different capacity areas that the Cas 5 measures, structural resources data and information systems, organizational relationships, competencies and skills. And so we then assess each of these domains. In our assessment
- next slide.
- These are the different on the left, the components of it, and how we applied it in 2,019, and how we applied it in 2024. The main difference here is that for the rate process indicators. And what I mean by that is, you literally go through each essential service, and each essential service has, like sub
- processes that qualify essentially. If you are meeting that essential service or not. In the past pre covid times, we were able to meet all together, and we had
- small group discussions, and we were able to do kind of like a group writing of the process indicator. This time I'm seeing that our staff are primarily remote.
- We and decided to implement a survey approach to it so that we can still collect that data, but rather for being from like a group think activity. It went to an individual focused
- perspective exercise.
- The swot analysis was conducted in 2,019 with our leadership team, and here it was replaced with a different activity. That I'll present, and into a little bit. But the rest of the stuff pretty much stayed the same. So it just goes to show you that sometimes you have to adapt your methodology, depending on your current circumstance
- next slide. So this is what the capacity assessment looks like. It was a qualtric survey that was put together here with the help of our Mph. Student from Grand Canyon University, Stephanie Rodriguez.
- and so what we said here is regardless of your position. Is title 5 funded or not. If you work in the MCH. Space or ecosystem that is in your State. Within our agency
- at the Arizona partner. Health services you qualify for participating in this. That means like, sometimes you'll have folks that work in maternal mortality or newborn screening, for example, that don't get Title 5 funding. But we still wanted to include them because they form part of the agency's ecosystem for maternal and child health services.
- We did a confidential survey. Everybody got individualized links, and that help with monitoring response rates
- and the survey period was open for 15 days with weekly reminders amongst those that they're not responding.
- So how did we do next slide. We did pretty good, I would say 63 was the sample size and so for completed surveys was 57, with a 95% response rate, which I think it's fantastic for a survey. Thanks to the leadership and our various managers who really pushed the survey forward. Completion rate refers to if the survey was started, and the individual completed it

- next slide.
- These are the types of questions that went into the survey. The process indicators. You can see how the essential service one is listed on the top
- and then on the left are the different process indicators. And it's literally a likert scale.
- something that we added this year that was not in the tool was adding a not sure
- option, answer option. Because some of these questions depending on the level of engagement and work that the different types of staff engage, and they might not feel too comfortable in answering the question fully. So we wanted to make sure we had that. Not sure. The reason why we did that also is when you have the small group think, approach, you're able to have that dialogue and
- help increase understanding amongst the small group. But since this was an individual activity, we put the not sure
- the capacity needs was just simply, Do you have these items, yes or no, and drag them into the box.
- and then anything else that you'd like us to know to how to improve capacity. Next slide.
- Our analytical approach was primarily descriptive. We didn't do any sort of statistical inferencing or
- prediction modeling anything like that. It was strictly descriptive. We calculated mean scores to just see where the likert skill was
- approximating. We looked at standard deviation to see if there was a lot. If there was congruence or dispersion from the mean just to see how people were responding.
- we did thematic analysis with our qualitative data next slide.
- I'm not going to go through all of it. So I'm just going through the examples that we did. This is what the likert skill looks like. Books had to save minimally adequate to fully adequate. Of course, you assign a point value to each of those
- integers.
- and when you do the mean, you'll get like a
- you obviously can look at this in one number, and you're able to say, Okay, if
- the essential service was 2.6 5, then here, according to the legend, we can say that that process is substantially, adequately met
- next slide.
- This is each essential service. So after we did it for each process indicator. Then we did an average throughout all of the process indicators
- essential. Each essential service varies the number of process indicators within them. So here you can see where like, where, which essential services we did really good. And some, it's still pretty good. It's essentially adequate. Actually, that rating but could be areas to continue to improve in the next cycle in the red
- next life.
- So this is what it looks like at the individual essential service level. So you saw that 6 was one of those red bars. These are the individual processes and their mean along with the standard deviation. And just to provide a key there to understanding how to interpret standard deviation rates there, indicating. So, for example, and standard deviation of one or greater than this case in point 8 indicates that there wasn't
- a lot of agreement with a certain score, meaning that you have people.

- what's it called saying? Minimally adequate and substantially adequate on both ends. That's what that means. That's just another way for you to interpret the data. But the average score here was 2.5 9, which is substantially adequate next slide.
- This is what it looks like. So I mentioned there wasn't too much agreement. When you look at the individual spread of the responses there wasn't, like, everybody said was saying, fully adequate. You can actually see 2 peaks partially adequate and fully adequate.
- And then, you actually see a large, not sure percentage. And that's important also to know, because it could mean that Staff just didn't know how to interpret the question, or they truly do not know how to respond to that specific question. You can see how that can also affect your average score from taking it from substantially adequate to partially adequate.
- But just some data points there.
- Next slide I have like 10 seconds. I'll try to go through the rest.
- This is just a distribution of structure resources needs that. We're again
- from the tool itself. You just kind of opt them out to see what was the need. That was the highest next slide.
- and then we did some just thematic analysis on like, how else could we improve capacity in within our department? And those are just the main categories, the themes next slide.
- And then those are just some examples, of course, so that folks can kind of connect a little bit more of what the theme meant. And there's a statement that kind of amplifies the theme more appropriately
- next slide.
- So important here is that we did a comparison between the last capacity, assessment, and this current one, and you can see that we improved on almost all of the essential services, and I would honestly say that es one and es, 2 are partial decreases. Really, it's 2.8 8 to 3.0 4. The one is 3. Was it 2.9 9 2, 3.
- So really, the one that may be worth looking into is yes, to diagnose and investigate health problems and hazards affecting women, children and youth.
- Next slide.
- You can see here, that's just the percent difference. Sorry? Go back. Yeah. The percent difference overall. I think this provides a very good optimistic lens for the Arizona program, indicating that there were efforts there in that capacity was indeed improved in the last 5 years.
- Next slide
- we did a facilitated activity. And so I put there on the left. What did I use for my facilitated activity? Essentially, if we go to the next slide.
- we just did small groups. And we took those areas. And you can see there on the chart, on the screens that we took the areas that had the lowest mean scores, and we just had a conversation about what are some tangible items that we can do to improve that capacity within for us here for the next 5 years.

- And so we did 3 essential services. And if this, if you can leave it on that one, and then we wrote a tape them out. I'm sure everybody has seen that cartoon. But really a miracle happens during that conversation, and essentially you have the
- white sticky. What's it called the easel pad paper. And then folks identify main categories that after they have some internal discussion around what are some practical activities, they attach those activities to that index car. And then we start to categorize them as a entire group
- next slide.
- Those are just some examples of what the categories look like and what the sub items look like.
- Next slide.
- All in all
- through some magic, through the help of just interpreting the data and understanding what the conversation was about. These were our, for example, our recommendations for improving our capacity for essential service. 6. That will go into the block, grant for the next cycle.
- So really, it's, it's quantitative. And it's qualitative. And it's facilitated meeting. Just so that there is that component to it. The next step that we'll do is we'll review those recommendations with our leadership team just to make sure that they are
- that they are good to go into the Block Grant, and that QR. Code just has my contact information. Thank you. And sorry for going. Probably like 2, 3 min over.

John Richards
Martin, you we are happy that you did. I think the magic that happened was literally just a lot of hard work. You know it's easy to make something look simple, but we know behind all of that there's a lot of effort. I mean, you started with a good tool. You have needs assessments in the past that you've done. But you've built on them, and that's really sort of the the magic of Arizona. So

- want to just ask everyone grab a capture of that QR code. So you can, you can talk to Martine afterwards. And we're gonna take little breath here
- because there's a lot of information.
- But jumping in so, looking sort of passing the torch from assessment to priority, we have our friends over in Virginia. So Cindy and her team of Samara and Dane. I'm going to hand it right over to you with very little introduction, but a lot of enthusiasm.

Cynthia deSa
Oh, wow! Okay, so I will. I will introduce us. Hello, everyone. My name is Cindy deSa, and I am Virginia's MCH and title 5 director and I, the team of us that will be chatting with you today. Is

- myself, Samara, who is a our local health district, MCH. Coordinator, which is a brand new role. Samara has been in her position about 2 months, not new to the State, not new to MCH work. But this is a new role and new to her. And we're going to talk about how this role came about. In context of all of this.
- and then to to really pull us, pull, pull us into that space of the topic around priority selection. Will be Dr. Dane da Silva, who is

- our director of division of Population health data and oversees all of our Pop health epidemiologists
- next slide, please.
- So to be honest. We were invited to talk about where talk about something. That is a little ahead of where we actually are. So if we were to, you know. Be honest with you, and tell you where is Virginia and our needs? Assessment process? We are still
- officially, formally, in in Step one we are, we have. We're working on that engagement and gathering all of the information that the qualitative information that we need. Dane and his team are very busy. Doing all of the assessments of our stakeholder survey and our key informant interviews. We're about to go on a statewide road, show across
- September and October, sitting down with the community and having those conversations with the people, with lived experience, and learn from them. So
- if we're getting there right, we're getting to that step where we're pulling all that information in next slide.
- But if we were to think about where we are informally we've been doing steps 2 and 3 for quite some time. To be honest, we do steps 2 and 3 a lot in inside of this official formal process, but also just in our work as being as working in public health, working in MCH. Being a title 5 or Shann director. We are constantly moving in and out of a number of these things. Then we don't
- always operate in that very linear process.
- So if so what I'm gonna do now is kind of speak to all of the Newbies. I was just delighted to see all of the people who said that this is their 1st needs assessment, because that's me. And kind of kind of get into that Ted lasso space. I think just a little bit and really talk. Talk about
- the leadership experience and thought process experience to this process, which I think looking back
- at the barriers, or some of the struggles that that y'all have shared it. It's kind of where we where our anxiety kind of increases, because we're looking at a lot of tools that help us with the quantitative piece. The very technical piece of doing this this incredible work. But what bubbles up in into our anxiety zone are all of those things that that there might not necessarily be
- a a tool for measurement, right? That, and where we feel overwhelmed or a little bit inadequate. And we have all that negative self talk. So I'm I'm going to be very authentic and share what my experience has been like for the past 3 years that I've been in the title 5, director position. And what brings us into this space to be able to kind of operationalize this? This needs assessment.
- With more, with more vigor and excitement. Next slide next slide, please.
- So from my perspective, this needs assessment is just an opportunity to really to really get the clarity and purpose of what? What is the state title? 5 program. And through that we are collectively working on this new, this new State action plan as being really transformative for our state program.
- I think you would all agree with me that especially for all of those people who said that this is their 1st needs assessment. That

- that means that you have been in your role since the last one was done right. And so we all kind of stepped into a pre covid needs assessment and state action plan in the wake of all of these post covid implications. Even though we've tried actively to not
- talk about Covid anymore. We'll we're still very much in the aftermath of it, right? And what happened was
- was that Covid let us know the importance and the significance of all of those social determinants of health to everyone and every everything, to us internally and to everyone that we're working with our stakeholders and the people that we are working to serve right. And then there was workforce development issues. People were leaving, relationships were fractured and stepping
- and into a role as a new director. Not knowing how to even begin to explore, who is now new in a position because they left to right. So lots of disruption. And a lot of time. It's taken a lot of time as a new leader in a new space in a post covid world to really understand the interconnection and the interconnectedness of everything.
- And those are those are those soft, immeasurable
- leadership skills that that when you realize that I don't know everything, and I want to know everything. And why do I feel so anxious? And is there a tool to measure this that that is where some of the anxiety kind of creeps in.
- So the approach that I took was to really kind of offer myself. Strategic grace is what I'm going to call it, and kind of leaning back to that 10,000 h rule. That comes from something that I read. I think it was in a book by Malcolm Gladwell, and where he talks about it really takes 10,000 h
- to do something before you have mastery of it thinking about. You know you don't just sit down at a piano and your virtuoso. You don't. The Beatles had been
- playing together for 6 or 7 years before they ever released their 1st album or 1st record in the United States. And so we
- we're new in this right. And we're new in a new, in a new, in a new environment. So we have to give ourselves that strategic grace that we how do we take all of those transferable skills and find what the right hat is at the right table and being okay with just asking questions and being okay with just exploring and being okay to let
- what was put before us in that State action plan be the way that we're going to do it while we are actively watching and listening for what it is that we want to do when it becomes our own right. So kind of thinking about going back to this being our 1st needs. Assessment. There are 3 people on this call that I that that I think
- can have completed that 10 h rule absolutely. Ellen, who has done this 6 times. Does not. This doesn't apply Julie Prescott. This does not apply to, and John, by virtue of his being in this space. But for the rest of us, we and even those who have done this twice, or maybe 3 times.
- we probably haven't collected that 10,000 h yet. Right? Because you only do it every 5 years. 2 days ago somebody needed something to be put on a thumb drive. When was the last time I put something on a thumb drive? I had to sit there and go. I haven't done this in such a long time. I am not sure that I know how to operationalize a thumb drive right? So being kind to ourselves in this process, that

- if this is our 1st time. This is our 1st time doing this right. And if this is the second time for you to do this, you did this 5 years ago, and but then also leaning into what are the other
- other things that you do, that really, that you are also actively doing this, that you don't realize that you're doing some of those steps.
- So in in taking time over the past 3 years, have really spent spent a spent a good bit of that time re rediscovering and recentering title Five's purpose, and also thinking about what that transformation should look like. What are we doing good that we can do? Great. What? What could we be doing better? What should we be doing that we're not doing?
- And where are we best? Simply as champions of others. What is our role? In the seat that we're sitting? And we don't have to be all things to all things. And perhaps we're just champions. Perhaps we're just connectors. Or perhaps we're actually driving the car instead of enjoying the ride. So one of the things that that became very quickly
- apparent when I stepped into my role. Was that one of the things that we were doing that we really really needed to do better was to lift up our local health districts. Virginia has 35 local health districts, and we provide title 5, funding to all. 35. They are our biggest community champions and connectors.
- However, they were deeply impacted by Covid, so, recognizing that there was a lot of transformative work to be done in that one exact space. About 2 years ago I started the process of pulling someone into my team such that we can be ready now.
- To transform our relationship from central office out to the local health districts and really develop the work that is done through the local health districts. And that is how we got Samara. So I will turn it over to her and let her share a little bit about herself. Her new role and the transformation that she is that she is working on.

Samara Lott
Thank you. Hi, everyone.

- we could go to that next slide with showing a map of Virginia. So I'm Samira lot. I am with the local health district. Maternal child health coordinator. Cindy gave a glimpse of how my role is, but the next slide will give some more insight, but just real quick. This is what Virginia looks like, how the local health districts are broken out and structured.
- Throughout our different regions. And I'm sure as all can relate title 5 looks different from district to district. So
- in that next slide we can go.
- you know, my role is really trying to figure out what that looks like at the local level and balance that workforce. And so this newly created position. You know, I'm coming with over 6 years from one of the local health districts, and can
- be in this amazing position where I can advocate for the perspectives from other local health districts. And so really
- this, this new position is representing validation to the local health districts that they know their community. It's an investment to support and lift up those local health districts. It is showing innovation for us to challenge ourselves and restructure how we've been doing things.

- And so I think you know Cindy's done a really great job to set us up for success as we're navigating how to transform
- and really looking at it both as a capacity at the state level and local level. So state level, you know, how are we in alignment within other offices, divisions, programs in Central Office.
- Is there more room for alignment, as it relates to title 5 and MCH. Serving MCH. Populations, and then also what is available at the Central office
- to support the local health districts like the data dashboards that Dane and his team create, like the communication staff and marketing resources that we have. So all of that really to create that 2 way. That bidirectional support and relationship from central office to the State, to the local health district.
- And then again. Lastly, looking at that capacity at the local level, so
- looking for points of intersection between what may have been traditionally a clinical.
- you know, a clinical approach to Title 5, and taking that outside of the walls. And now looking at it through population health.
- so pulling in population, health, staff, community health workers, staff who are centered around health equity.
- Anything really? Again, to help lift up the local health districts to realize that they are local experts within their community who have the established trust, and we might be just the conveners, the champions to help support them along the way.
- So I'm excited to see where all of this goes. I know
- it could be a culture shift. It can take time to do it right. But to communicate and be transparent about the future direction about you know, continuously finding opportunities to increase that engagement with local health districts and and people that live in the communities
- will be and has been and will be important, so that we can really move at the pace of trust and see that transformation.
- I'm going to bounce it now to Dean.

Dane De Silva (VA)
Thanks. So really, what does this mean for our priority selection? And when we get to that phase, so of course, we're not there yet.

- And you know, we know that there are various methods to use for prioritization. So you know, these, this could be as simple as like ranking or a voting process using grids using criteria.
- There are a whole lot of tools out there that can help you with selecting the appropriate method for you. It could be a combination. I know that. One organization. Naccho also has, like some really cool tools, especially if you're if you're familiar with like community health assessments
- processes. And so they have kind of different methods that
- or explained.
- but of course, you know, the question always is like, how can we make this a little more objective? Or, you know, add that bit of objectivity to selecting the priorities.

- So I'll speak a little bit about kind of what Virginia did last time, and then kind of thinking through. And you know, based on what Cindy and Samara has presented. So far from Virginia's context, and the 3 of us being kind of new to and leading, this needs assessment for the 1st time here in Virginia. You know what this means, for when we, when we do get to that stage.
- So Virginia last time, did do a combination of a simple voting which was really a core. The core leads that were leading the needs assessment. That kind of did some voting to narrow down the list, and then, followed by what I considered to be quite a complex matrix
- for a criteria based that the kind of broader MCH team used with several sub components. So the broad categories that they used last time
- were, you know, related to the Virginia context. So how was Virginia doing compared to the nation?
- There were some a category on community and political will.
- A category on equity. So, looking at those disparities? And then impact severity. Which had again, multiple sub components about. You know, how does this look as it compares to? You know, when we
- look through the life course perspective, what are the gaps? Are there kind of evidence-based interventions?
- And what are those root causes so definitely. Multi component to this matrix. And you can see how you know. Complex that might be. And you know, assigning those scores.
- but next slide, please.
- You know, there were some lessons learned from this last cycle. So even though there was like this initial narrowing, and then kind of letting the team kind of work through this process. You know, it wasn't necessarily super transparent about, you know that multi-step process. And so some of the team thought that the initial ranking was what the priorities were going to be.
- And so, you know, there was a little bit of this lack of engagement overall in the process. And of course there was this whole complexity layer to this matrix. And
- and so, you know again with the confusion and not knowing the entire process completely. You know the matrix may not have been completed as a whole. And so people from similar teams would vote for like priorities in their lane or kind of ranked the or completed the matrix for that specific
- priority potential priority that came up.
- And then, of course, because all of this happened just before Covid hit Covid was a huge disruptor. So that kind of added to that, you know, lack of engagement and priorities shifting. And so some of that kind of occurred while, like in the peak of Covid, when the shutdown kind of happened.
- So you know, thinking through about like this whole theme of transformation. You know, we want to be a little more intentional about the process.
- But also keeping in mind. So you know, engaging the team beforehand, making sure that they're aware of the plan. And then, you know, considering what's been said, you know, in the chat and in in partnership meetings and things like that is you know, sometimes

simple is effective. So you know, there are ways to have more of a criteria base to include some of that objectivity to the process.

- So you know. Maybe it might be reviewing what was done last time. Kind of identifying some areas that may want to. You may want to consider for in in a, in a criteria based method, definitely kind of reducing maybe the matrix that was used last time. But also just exploring some other methods.
- so there are a lot of tools out there. And so our plan is to consider more of a a simpler based method, using our quantitative data and the comparisons that we've done and then incorporating that you know the local health district perspective as well. So how can that fit into this
- criteria? And because there will ultimately be also the boots on the ground. So that's how we we're gonna be approaching this prioritization method and kind of include kind of an aspect of being objective.

John Richards
And thank you so much.

- another great way of looking at something that appears magical on the outside, but is a lot of work. It looks like, even though for many of you. This is a new process you are building on years of work in Virginia.
- So
- we warned everybody that we were going to have a lot to talk about, and we did not disappoint with that. We're going to sort of slide into
- our Q. And a session, because so many of the questions we received talked about tools for performance objectives. How do we actually do this? You know, in this section. We are developing those evidence based action strategies to come up with our.
- You know, the heavy duty NPMs. The related ESMs that go with the NPMs and our SPMs are our State performance measures alongside with the standardized measures this year. So also aligned with this are those performance objectives. How do we start measuring this.
- and if we move to the next slide, we can kind of see.
- Yes, the number 3, or actually, we're leading in into down to Number one, number one at the bottom tools to help set priorities and objectives.
- And on the next slide you can see we're gonna leave you with Leslie de Rosette, who is talking to us from the Maternal Health Learning Innovation Center out at UNC. And Leslie has been my thought partner and work partner for many projects, and is gonna share one of our favorite tools that we use internally that can be used in in each of the agencies to help with this prioritization and setting priorities.
- Process. So I'm going to hand it over to you, Leslie, and take us away.

Leslie deRosset (she/her), The MHLIC
Okay. Great Hi, everyone. It's nice to see you. Just let me know if you can't hear me. So I do work with the Maternal Health Learning Innovation Center. You can see a little bit more about what we do here. Many of you actually work with us. We support 35 states with the MHI and

the Maternal Health Innovation Funding. I also work with John and the National Workforce Development Center. So I'm just kind of wearing a multiple of hat.

- The 1st thing we wanted to do was share our resource page with our website. If you'll go to the next slide, we have a plethora of resources which are available for download and viewing at your leisure. We also spent time this past year writing 17 different evidence briefs from the National White house blueprint to advance maternal health. There are also 5 policy briefs. So they have a lot of
- really current data. Most of the data comes from after 2,018. And so we encourage you to go there and utilize those resources for your needs, assessments for your data, for thinking about what questions to intervene with when you are in the community. And again, anything there is shareable and downloadable, and you'll also find some of our examples from some of the States that we work with.
- we have 4 seasons of podcasts that you can also view or listen to at your leisure. So one of the tools that we wanted to share with you today, just in the interest of time, is the hexagon tool, and I don't know if any of you are familiar with this. But this came out of the National Institute
- Research Network, which is NERN, and it has been adapted over the last few years to ensure that equity is centered in it. So we're going to dive into that tool and spend a little less time on the impact effort matrix. But both of these here are in the slides, and you can find more information by contacting John.
- So this is just a little bit about the hexagon tool. What is really nice about it is that it looks at both program indicators and implementing site indicators. And you'll see those in blue and green. It was developed by Metz and Lewis, and out of NERN, as I explained, and then, in 2,020, it was updated to include a series of equity questions. It is most advantageous to use it early in your
- work, but honestly, you can use it at any time to help kind of decide what you want to move forward and what you think you might want to implement within your ESMs
- on the next slide. We talk a little bit about some of the different tools. So this slide really does talk about how the 2,020 version sought to ensure that diversity, equity, and inclusion were included in the questions and in the work. And so we always want to disaggregate our data as down to the wire as we can. And we also want to make sure that we do that when we think about both outcome data, fidelity data and programmatic data
- next slide, please.
- What I personally like about this on the next slide, you'll see is that there are very systematic questions to ask so different than the impact effort matrix. This tool comes with a series of questions, and it asks you to rate them from one of like no evidence, or it doesn't meet the evidence to 5 being the highest. And that link in the screen in the screenshot, if you take it, is actually a worksheet. And
- so you can actually use that worksheet with your community partners, you could adapt it to do it online, if that's how you're meeting with your partners. But it allows for you to go through a series of questions in a conversational style, allowing people both individual time and then group time. So you individually rank it. And then, as a group, you kind of try to come to consensus on the next slide, please. You'll see

- just kind of what some of the questions are, and I know it's super duper, Tiny, but you'll see that this is how each of the pages are set up. So the blue are your implementing sites, and then your green are looking at the same green that are in your hexagon again. You do this both individually, and then you try to come to consensus. What I like about this is that it's got some questions for you to think about. They're very open.
- ended questions. They create opportunity for conversation, which we know is really the most important piece.
- And so, even though the impact effort. Matrix on the next slide is also a great tool and also a great thing that we've done with a lot of our States. This is not nearly as systematic, because the questions are questions that come from you. And so we can't say that it's necessarily a validated tool. But it definitely adds us allows for conversation for people to start trying to decide, you know, where do they want to
- put their different activities and priorities? Because we don't want to always have everything in a major project or a thankless task. We want to have a nice variety. If you go to the next slide, please. That just talks a little bit more about the impact effort matrix, so that you can kind of see the quadrants. This comes from a lot of different sources. And so if you Google it, you will find it the ones that I have a tendency to use come from 6 sigma.
- And then also some of the work from the Workforce development center on the next slide. We talk just about the process as you can go through this, and this is great and easy to do both in person and online. It's really easily adapted in mural or Google folder or Google file. Now that jamboard is going away in October next, please.
- The other 2. What we want to do is make sure that John's gonna put a link, or I think maybe he did, to all of these different tools that are on the website and exist in this kind of step 5, 6 area so that you can access them. And then I just wanted to encourage you to go to our resource page and connect with the Maternal health Learning and Innovation Center. You're welcome to email me. And I will connect
- to the right person. But hopefully, this will get you started, and most of these are pretty easy and self-explanatory. But if you need any kind of technical assistance or support, and just want to do a train. The trainer you can let John and I know, and we'll be happy to support you.
- Thanks.

John Richards
Leslie, thank you for bringing everything together and making it real. Sometimes we hear stories of what other people are doing, we think, oh, I can't possibly do that, or I don't know how to start. I will say we've used the hexagon tool of Leslie and I with multiple states over the years, and it is simple. You can go deeply, really, deeply. It can take you a couple of hours, or you can look at the questions much more on a surface level.

- So
- that being said,
- if anyone has used these tools, especially hexagon please let us know in the chat. Otherwise we're kind of back to where we started, and thank you for spending the extra time. I know that time is always of the essence, but

- Before we get into an open discussion, just sort of reminding us of what was on on the minds of everybody as you registered thinking of ways to engage our partners in the community thinking about what the issues with small sample size might be. And then I think we talked a lot about some of the ideas and examples of selecting priority priorities and coming up with those activities that might actually go into that process.
- Reminding, I think we've heard through many of our speakers today about
- keeping those partners engaged. You know it doesn't do any good if we engage our partners at the beginning
- and treat them as quote unquote stakeholders, and then drop them until the next 5 years assessment. So making sure that throughout these later steps in the needs assessment process that we are keeping our core partners listening to them, doing that co-creation with the people who we are serving. That's so critical as we think about selecting priorities and selecting performance objectives.
- and then the strategies. planning for evaluation long term. I'm opening all of these to see if any of them are resonating. If you were the person who put this question into the registration and still have a question, or want to hear from other people
- want to throw this out and see how you're all feeling.
- And I know we were really good at the beginning using chat. So if you also just want to type in chat
- of what is working for you or questions, or
- I see one message coming in.
- Oh, Nope, that's just Leslie's email. But Leslie's email is there.
- It'll give people a minute here to just sort of recover. This was a lot of information. This information will be up online. Both. MCHB will be sending out a link, and it will be on mchneeds.net.
- Right?
- Well, as we're thinking.
- I see some typing coming through.
- Or maybe people are just in the chat themselves.
- But what we'll make sure is in MCHneads net. We will have links to all of these tools. One of the questions that came early on
- was,
- in needs.net. You have a list of all the tools, but you have a list by
- that. Organize the tools by the step, and each step has its own tools. But we are going to work hopefully. By next week we'll have a new page up that lists all 9 steps, and the tools that are most useful for each one of those steps. So this is quality improvement at its best.
- Then let's see, we did. Have. We had a really good question earlier on that, I feel bears repeating.
- this question when we were looking back specifically at those strategies that were very scientifically, rigorously based, focused in this case on medical home. And you know the different components of medical home.

- But the question was, if we're doing a strategy, an activity, a program that focus, that's evidence based. And we're very happy with it. Can we use that same activity to address different needs, such as like school based health centers. And
- the answer is most definitely, yes. Sometimes what we have found from the evidence base is that
- there's been a lot of research in one area using, for example, school based health centers for immunizations.
- And we know that that works really well, but there might be a little less evidence in case like using SBHCs for adult mentoring, there might be. That might be a really good opportunity. And this is one of those cases where we look at what is the mechanism behind the strategy? How does that really work in real life?
- And that's, I think, what we're all kind of excited to see these tried and true. We know that the FQHCs. We know that the the school based health centers. We know that home visiting these are programs that have a lot of evidence behind them. Do we have evidence in every single new measure that they can possibly be used at Nope.
- But we're going to get there. So this is a great way to use one program, one strategy for multiple domains.
- And I do see there is 1 1 more
- comment here.
- wow! There's been a lot
- see. Oh, Leslie just wanted to let people know that.
- that MCHB and ACOG were heavily involved in the evidence reports that MHLIC has put together
- alright. And here is a question, Brittany. Thank you so much, or I'm sorry. Beneatha. Thank you.
- Any examples of tools that we can use to share the priorities identified from community surveys and focus groups with the core groups so they can choose final priorities.
- That is, actually, that's something that a lot of you are working up towards. Now.
- I will say.
- And this sounds really basic. But we have used in the past. We call them basically data placemats where we make a very simple kind of infographic about the priority that that has been identified. And
- that can be something that like infographic
- something that has a little bit of data that people can look at and compare little literally on a table
- and make those decisions.
- Leslie also says, this is definitely a case for impact effort, matrix.
- I will say if we go to, and I'm just going to pull this up on the fly here.
- That
- on MCH needs done it. We do have an example of these placemats and the priority matrix.
- So let me find that real quickly, and I will put that in the link. That's
- Where are data placements? Yes, here we go.
- these. This is from our friends at the Workforce development center.

- there is actually the tool themselves. And what's more, are examples for using those tools. So let me put this up here, too.
- and I want to open that door to everyone else. Any of our other speakers who have sort of experienced this, or have ideas.

Martin Celaya
So I can share Arizona's example. For oh.
- how we did that last time! So we had data presentations followed by facilitated small group discussions by the different population domains. Our stakeholders were able to kind of
- rotated into 3 different population domains.
- and then there were specific strategies that were proposed to be prioritized, and those were then categorized into affinity groups.
- And so, after we had the affinity groups.
- then an internal group just came up with the verbiage around to make it into a priority statement, and then we met again like a month later with our stakeholders, and offered some options for wording with some choices.
- and see like what would best resemble, you know, the priority, the
- the categories that were brought up through that facilitated discussion. So that's how we came up with those statements.

John Richards
Oh, that's great, Martin. I think you hit it on that. It's sort of similar in in concept, but just a different application. Here
- we also have
- Leslie reminded us that data Gallery walk is sort of way. If you're physically in person, some of us are not Martin. You guys are all remote now. So.
- looking at how to share, especially with partners, stakeholders that might be remote, we have to think of virtual ways to make this available.
- And finally, I just want to remind everybody. And Julie said this this perfectly, that these tools they are a great start, but they are not, you know, all tools are developed with one goal in mind, you can adapt these tools a lot of times. I'll take components of one like
- a data gallery, mix it with data placemats. So it actually works for what your needs are. The nice thing about these tools is, most of them are in the public domain and when you use them, you know, as long as you give citation. I know even
- the hexagon tool that Leslie showed shared with you has been through many versions, and each version gets a little better. So you know they're not perfect. But what you're using this time might be next time you're using it. In the next 5 year cycle, you might find that that it even matches your needs more.
- All right.
- we'll give people just a minute. I know there was so much to talk about, and Paz has been great. Thank you, Paz, for
- really manning the chat room here for us and

- I think we're doing pretty well. So at this moment I just want to thank everybody. I think we can wrap to our final slide here.
- just reminding people in this case that
- our session 4, our unofficial session, 4. Which will cover ongoing assessment, and really the final steps, not quite sure of the details yet, but we know we are doing something at the title. 5 Federal State Partnership meeting here in Washington, DC. In just a short time, October 20th and 23rd and as Shirley Payne mentioned at the beginning.
- please, if you, if you haven't registered register, find the information online, we'll put that information on. Actually, it is on mchneads.net now.
- and we just wanted to remind you that many of us will be
- physical in person, real people at the Annual City Match Conference, and that is coming up in oh, my gosh! Just a couple of weeks, September 9, th through the 11th in Seattle. So if any of you are there, we invite you. Several of us are doing presentations. Focused on some of these tools, and we would love to hear from you. With that I will hand it over if we have any final comments or closing from our bureau friends. But
- with this I'm sign out and wish everybody a great day. So maybe handing it over to Shirley.

Shirley Payne (she/her), HRSA/MCHB/DSCH
Thank you so much, John, again. Thank you. Everyone for your presentations today. And just lots of wealth of information. That we were able to receive. We really do hope that this was very beneficial. For you all, I mean, even for me. It's just like

- it's just like that reminder and the refresher of all the wonderful information. That is out there to help to assist, and we all of us your peers of everyone at the bureau. All of our ta centers, and all of our colleagues and partners. We really want you to feel like you are have succeeded. At doing what it is that you set out to do and I love how John said in the beginning just about, you know. Don't let perfect get in the way of your
- completion. Right? And so, and just. And as you know how we treat it is that you know. Yes, you are turning in your full needs assessment to us. But you're going to revisit that every year. And so versus looking at it as this final document. It's a working document. Of where you are. So again, please. We would love to hear any feedback you know. You all have about this session. And then again, as we are planning
- for the October and kind of this ongoing conversation, we're again really into 2025, when you need to submit this. What else is it, perhaps? That you may want to want to hear? But don't be afraid to lean on us, and don't be afraid to lean on one another. So thank you all so much again. Do not hesitate to reach out to any of us especially, you know, for you know, states and jurisdictions. Please feel free to reach out to your dish Po
- and your dish consultants. And also again our SSDI folks. Please don't be afraid to reach out to pause again. We are all here to help, so thank you everyone so much for joining us, and we'll talk to you soon. We'll see you soon.
- Have a great rest of the week.