

2016-2020 Title V Needs Assessment Frequently Asked Questions (FAQs)

DATA QUESTIONS

1. **QUESTION:** What data sources were used for the DataBooks?

ANSWER: Here is the link to the file with the data sources for the Community Health Status Report (CHSR) Overview and DataBooks. More specific information on data sources for the DataBooks can be found in each DataBook.

http://familymedicine.medschool.ucsf.edu/fhop/docs/excel/mcah_t5/CHSR_Overview_Data%20Sources%202014.xls

2. **QUESTION:** What methods were used to analyze the data in the DataBooks?

ANSWER: Below is a link to a document that provides an overview of the DataBooks and methods used for creating the DataBooks. The Family Health Outcomes Project (FHOP) is more than happy to share the SAS codes we used to calculate each indicator in the DataBook. Please email FHOP@fcm.ucsf.edu for more information.

http://familymedicine.medschool.ucsf.edu/fhop/docs/pdf/pubs/TitleV_Indicators_2000-2011.pdf

3. **QUESTION:** Will there be additional information regarding obesity data in the updated DataBooks?

ANSWER: No.

4. **QUESTION:** Can you please clarify the definition for this indicator: “Substance use diagnoses per 1,000 hospitalizations of pregnant females age 15 to 44”? Does substance use mean drugs, alcohol or both? Is that hospitalizations at the time of delivery or is it hospitalization at any time during the pregnancy? Is the substance use diagnosis a secondary diagnosis or primary diagnosis with pregnancy as secondary?

ANSWER: This Databook is based on any hospital or emergency room record with an indication that the woman is pregnant. We search across all diagnoses to identify the pregnancy. Once we find a record with a pregnancy indication, we search for the specific issue, in this case substance use. This indicator focuses on substance **use**, including having used alcohol, drugs, or both, whether it was the primary or secondary diagnosis. For this indicator, diagnoses would indicate both that she was pregnant and had used alcohol, drugs, or both.

5. **QUESTION:** Can you verify that our DataBooks will NOT be updated with 2012 vital statistics data? Are the data sources cited anywhere in the DataBooks? If not, can you provide us with the sources, especially for data that is not from vital statistics?

ANSWER: The next cycle for updating the DataBooks using 2012 Vital Statistics data is scheduled after all Local Health Jurisdictions (LHJs) have submitted their Needs Assessment reports to MCAH. Thus, for purposes of the local needs assessment, the DataBooks will not have the 2012 vital statistics data; they will only go through 2011. The data sources are cited in the DataBooks, for both numerator and the denominator. They can be found on the rate tabs in the DataBooks.

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6. **QUESTION:** There were a few indicators that had NA (Not Applicable) under local vs. state that I didn't understand. Here's an example:

7-F	Children receiving free or reduced price meals at school per 100 students	2012	28.6	57.5	NA	Why NA?
7-G	High school dropout per 100 students in grades 9-12	2011	5.8	14.7	NA	Why NA?
8. Environmental Health Determinants						
8-A	Number of days with ozone above regulatory standards	2011	21	16	NA	Why NA?
8-B	Smoking in households with children < 5 per 100 enrolled in CHDP	2010	3.0	3.0	NA	

Can you explain why these are "NA?"

Where can we find the sources of the data?

ANSWER: The NA means "Not Applicable" as there was no statistical comparisons made between the local rates and the state rates. This is data that FHOP has reported to the LHJs, but we didn't analyze it as we have done for many of the other indicators. There is also a list of data sources posted on FHOP's website.

7. **QUESTION:** Is there a way to dig deeper into death data and find out what the causes of death are?

ANSWER: The death DataBook doesn't show causes of death, but it does let you see how different race/ethnic groups are doing on the indicator.

In terms of causes of death, here are a few other resources to explore.

The California Department of Public Health has death rates for cause of death by age and gender. Cause of death by county likely mirror these:

<http://www.cdph.ca.gov/data/statistics/Pages/DeathProfilesbyZIPCode.aspx>

<http://www.cdph.ca.gov/data/statistics/Pages/DeathStatisticalDataTables.aspx>

The Rand Corporation also has county level cause of death data. Here is a link to their website. Make sure you get deaths **by county of residence**, not county of occurrence.

<http://ca.rand.org/stats/popdemo/deathsres.html>

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8. **QUESTION:** For indicator 2B (cesarean births per 100 low risk females delivering a live birth), how is 'low risk females' defined?

ANSWER: "Low risk", as used in the indicator description is based on the definition of an **NTSV** mother. Specifically, this means that the female (mother) has not given birth to a viable or live infant previously (she is **N**ulliparous); the infant she delivered was at term, i.e., not premature (**T**erm) that she carried only one infant/ fetus during pregnancy (**S**ingleton); and, at childbirth, the infant/ fetus entered the pelvic area head first (in the **V**ertex position).

9. **QUESTION:** When the CHSR Overview indicates that there is not a statistically significant issue for an indicator, but the trend graph demonstrates there is, what should an LHJ do?

ANSWER: The CHSR Overview only has one comparison: comparing local rates at the end of the period (2009-2011) with state rates at the end of the period. The CHSR Details, which is derived from the DataBooks, provides more information about an indicator, including whether the local rate at the period end is significantly different than at the period start (2000-2002), whether the local has a significant trend, and whether the local has achieved the Healthy People 2020 objective. The DataBooks provide even more information, including graphs of trends, rates over time, and rates and trends by race/ethnic group. LHJs are not required to use the DataBooks, but FHOP recommends that you review them precisely because the indicator information presented in the CHSR Overview is limited.

Example: Smaller LHJ was significantly different than the state for indicator 5-J Substance Abuse Hospitalizations per 100,000 Population age 15 to 24, however, when looking at the Trend Graph over time, there was an obvious statistically significant trend of increasing hospitalizations over time.

10. **QUESTION:** What data are you using for the fetal death, infant death, gestational diabetes hospitalizations and substance use hospitalizations for pregnant women? Is it data that is available to us and can we do our own analyses?

ANSWER: Data on fetal and infant deaths come from the Death Statistical Master File (DSMF) compiled by the Office of Vital Statistics of the California Department of Public Health (CDPH). Data on gestational diabetes and substance use come from the Patient Discharge Data (PDD) compiled by the Office of Statewide Health Planning and Development (OSHPD). Due to privacy concerns, the California Committee for the Protection of Human Subjects' forbids any sharing of datasets. However, LHJs can request the DSMF from CDPH.

<http://www.cdph.ca.gov/data/dataresources/requests/Pages/VitalStatisticsBirthDeathFetalDeathMarriageData.aspx> or the PDD from OSHPD located at: <http://www.oshpd.ca.gov/>

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The DataBooks specify exactly how the indicators are defined and what the numerators and denominators are. FHOP is working on getting our data analysis programs online in the future so that other analysts can use them if you get the data. You may contact FHOP for further discussion.

The coding for gestational diabetes and substance use hospitalizations for pregnant women is complex. If you chose to analyze this data yourself, please consult FHOP so that we may share the coding.

11. **QUESTION:** Regarding the Data Book indicators....

- i. MHPD2011_34A – What specific discharge codes (preferably with code descriptions) are associated with:
 1. mental illness
 2. self-injury
 3. mood disorders
 4. substance abuse
- ii. The definition in the datasheet states that the indicator includes “a/an X diagnosis” (where X represents one of the bullets above). Should that be interpreted as “due to” or “history of” or both?
- iii. Concerning substance abuse, what exposures are included in the substance abuse discharge code? The rate tab footer indicates that CCS category 661 and 660 are included. This collection (especially CCS-MHSA 661) seems to indicate in the ICD-9 description, conditions outside substance-related disorders. Perhaps these are more specifically enumerated/documented somewhere?

ANSWER: FHOP has a spreadsheet that was used to make formats for classifying diagnoses (available upon request). It contains the full list of ICD-9 codes found in hospital data since 1983, and the CCS categories into which those diagnoses are classified. Note that in making the mental health DataBook, we are searching across all diagnoses (up to 28). For question 2, it should be interpreted as the indicator includes a “diagnosis of.” Please feel free to call Linda Remy at 415-435-5439 for further discussion.

Here is the link to the CCS categories where you can see what each category represents

http://www.hcup-us.ahrq.gov/toolssoftware/ccs/CCSCategoryNames_FullLabels.pdf

12. **QUESTION:** Race/Ethnicity – mixed/multi race people: how are they categorized?

ANSWER: Various data sources used for creating the Data Books collect and/or report mixed/multi-race in different ways that would have required various statistical techniques to account for them in the analysis of each indicator. In order to standardize analysis of race/ethnicity for all indicators in the DataBooks, mixed/ multi-race were excluded during analysis.

13. **QUESTION:** Is the Gestational Diabetes indicator just focused on only when women are hospitalized?

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ANSWER: Yes, the indicator is based on patient discharge data from the time of delivery and we look for any mention of gestational diabetes.

14. **QUESTION:** Why are there higher rates for the mental health emergency department data in my DataBooks? Could this be a data quality problem?

ANSWER: The data are of good quality, much better than the birth certificate data, and wouldn't be affected by the shift to electronic health records. Instead of attributing this increase to an artifact of data, most experts attribute this increase to a greater sensitivity by medical professionals in diagnosing a mental health disorder; a greater openness to a mental health disorder diagnosis; the greater availability of various psychotropic medications; and, the willingness to prescribe medication.

15. **QUESTION:** I cannot download the following DataBooks:
- 4A-E All Nutrition and Physical Activity Indicators
- When will they become available?

ANSWER: There are no DataBooks for indicators 4A-E as FHOP doesn't analyze this data but just reports data from other sources. Here is a link to the listing of data source posted on FHOP's website for all the indicators in the CHSR Overview:

http://fhop.ucsf.edu/fhop/htm/ca_mcah/counties/index.htm

16. **QUESTION:** Is there a way to get the Vital Records data from AVSS to STATA?

ANSWER: The AVSS to Excel to STATA transition is probably the way to go. However, we encourage you to check in with AVSS to see if they have a better suggestion. AVSS is a project of UC Santa Barbara and they can be reached at: 916-449-5174 or 805-893-3214.

17. **QUESTION:** Which counties are included for the Southeast Counties? How should this information be incorporated into the MCAH local needs assessment?

ANSWER: The Southeast California counties are San Bernardino, Riverside and Imperial. FHOP has a map showing which counties are in which regions located at:

http://fhop.ucsf.edu/fhop/htm/ca_mcah/counties/CA_regions_map.html

You are not required to incorporate information for the regional DataBooks in your needs assessment but you can if you want to. It is optional. The regional DataBooks were made to allow counties to compare rates in their DataBooks with rates for their region in the regional DataBooks if they so desire. You can compare your rate and confidence interval with the regional rate and confidence interval – if there is no overlap in the confidence intervals you can say that the rates are significantly different.

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18. **QUESTION:** Where do we look in the DataBooks to identify disparities between local race/ethnic groups?

ANSWER: You can identify disparities by looking at the rate tab and the graph tab; looking at the rate tab will allow you to identify disparities for particular years. This is done by comparing the rates of one local race/ethnic group to another local race/ethnic group and seeing if the confidence intervals overlap. For a more stable comparison, you can compare 3-year averages using the “Change of Rates within level and race/ethnic group,” table by looking at the rate for a time period for a particular group (i.e., 6.5 LBW rate for whites) and using the confidence interval (i.e., 0.3 for whites), and doing some simple math to get the upper and lower confidence interval range (for example, for a rate of 6.5 with a confidence interval of 0.3, we compute the range by adding and subtracting 0.3 to 6.5 for a range of 6.2 – 6.8). We can then compare this confidence interval range to the range we compute for African Americans (rate of 10.8 and confidence interval of 1.7 means the confidence interval range is 9.1 – 12.5) and if the ranges DO NOT OVERLAP, then we can say the one group is significantly worse than the other group.

19. **QUESTION:** Can we share our data with our partners?

ANSWER: LHJs may share their local data with whomever they choose.

20. **QUESTION:** Can we get data from neighboring LHJs?

ANSWER: FHOP has regional databooks on their website so you can compare your LHJ to the region you are in. FHOP also recommends asking the MCAH Directors from neighboring counties to share their data.

STAKEHOLDER QUESTIONS

21. **QUESTION:** How crucial is it that you get the same set of people for multiple stakeholder meetings?

ANSWER: You can only do your best to communicate and encourage people to attend. It may be to your advantage to have different people present, as they may have different points of view. There are situational barriers such as arriving at common meeting dates, times or locations that can be difficult to overcome. Some suggestions to mitigate these barriers are:

- Send out the dates for all your meetings at one time and early
- Use your meeting time efficiently; don't spend a lot of time keeping everyone in the loop
- Send materials to all participants prior to the meeting whether or not they will be present
- Consider obtaining input by email or some other method if a person can't attend a meeting.

22. **QUESTION:** What are some suggestions for the voting processes during stakeholder meetings?

ANSWER: Suggested options for stakeholder voting:

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- Provide criteria for voting (e.g., realistic expectations for funding), and have stakeholders prioritize problems using a criteria to score each problem. Consider using the Problem Prioritization Worksheet.
- Dot voting method http://www.albany.edu/cpr/gf/resources/Voting_with_dots.html
- Nominal Group Technique: <http://www.cdc.gov/healthyyouth/evaluation/pdf/brief7.pdf>
- Survey – take top 10 problem areas from the data and ask for a rating; ask the community at large (if LHJs are using surveys to get stakeholder input, please consider sharing so other LHJs can use/adapt the survey)
- Consensus can produce a high quality decision that has a strong commitment to implementation, but takes time and energy and a rich exchange of ideas and information.

23. **QUESTION:** If you attend existing stakeholder groups, how do you collate the information?

ANSWER: MCAH Directors don't have to just accept conclusions of stakeholder groups and can add, subtract, or adjust identified priorities to best reflect what is happening in your community, what is supported by data, and what can be realistically achieved. Even if you don't take their suggestions, consider what they say and count them as stakeholder input.

24. **QUESTION:** How do you involve non-traditional stakeholders?

ANSWER: It is important to involve as diverse a range of voices in your LHJ to arrive at the best decisions, maintain your program's legitimacy and provide the best public service possible. You may need to piggyback onto their agenda, build trust and find common areas of interest. Think about and communicate in their in their style and in their language how your programs can be leveraged to meet common goals and how improvements in the community's over-all health will benefit their programs or interests. Look at existing stakeholder groups and ask to attend their meetings. Keep presentations simple and easy to understand. Open as many opportunities as possible for full inclusion and participation.

25. **QUESTION:** When using criteria to prioritize problems, what if stakeholders don't understand concepts like the social determinants of health and health outcomes or the upstream/downstream concept?

ANSWER: This is a good opportunity to educate stakeholders about these important public health concepts. Criteria and wording of criteria in the problem prioritization tools can be changed to make it easier for stakeholders to understand and use.

26. **QUESTION:** How about doing stakeholder input via email or other ways (i.e. social media)?

ANSWER: Yes, we encourage you to do what is needed to make the process easy and efficient. Some suggestions are:

- Give people an option as to how to participate

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- Consider using the FHOP presentation template, populate with local data, and create a PDF to send via email
- Create a Facebook group for stakeholders and use it to solicit comments

DELIVERABLE FORMS QUESTIONS

Deliverable Form A: 'Stakeholder/Community Partner' Questions:

27. **QUESTION:** Deliverable Form A – Stakeholders/Community Partners asks for stakeholder's/community partner's initials. We are currently holding a series of four stakeholder events throughout the county to review and assess our data for priorities. We have sign-in sheets, but our plan was to fill in the Form A ourselves to keep it neat and tidy. Can we attach those sign in sheets as evidence that the folks we list actually participated in our needs assessment?

ANSWER: The intention is for the LHJs to fill in Form A themselves with the information from their sign-in sheets. Form A was created to help the state to more easily and meaningfully aggregate LHJ data. Form A allows you to add as many pages as you need. Sign-in sheets are to be kept at the LHJ.

FOLLOW-UP QUESTION: So does this mean we don't need their initials?

ANSWER: You do need their initials. In many cases there will be more than one person from the same agency. Having initials is a way to distinguish how many unique people came from an agency – it is a unique identifier of sorts. In the final needs assessment report that the state MCAH program will be sending to the federal Maternal Child Health Bureau, we will need to provide the number of California stakeholders that provided input into the statewide needs assessment, and further to provide which groups they belong to demonstrate the diversity of stakeholders. If someone doesn't want to put their initials, you need to use some other kind of unique identifier, like 00 etc.

28. **QUESTION:** We did a client survey but didn't request names or initials. How do we list them as stakeholders on Form A: Stakeholders/Community Partners?

ANSWER: Develop unique identifiers using numbers or numbers/letters, such as 0.1., 0.2., or 1.a, 1.b, etc. or some other naming convention. The goal is to know how many unique individuals participated and the participating organization.

Deliverable Form B: 'Problem Statements, Strategies, and Partners Questions

29. **QUESTION:** Why do we have to choose Sudden Infant Death Syndrome/Sudden Unexpected Infant Death Syndrome (SIDS/SUID) when completing Deliverable Form B- Problem Statements, Strategies, and Partners for Goal #3: Improve Infant Health, when SIDS/SUID numbers are so low?

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ANSWER: When you complete Goal #3 of Deliverable Form B: Problem Statements, Strategies, and Partners for the first time, you will be required to select SIDS/SUID as a problem under Step 1 Problem Category. Even though all LHJs receive a small amount of Title V funding for SIDS risk reduction education activities and grief/ bereavement support, SIDS/SUID numbers are low; therefore we encourage LHJs to address SIDS/SUID and infant health from a broader perspective. LHJs may choose to work on SIDS/SUID and/or other infant health problems as resources allow.

- Suggested problem areas that will improve infant health and decrease SIDS/SUID rates are to decrease perinatal substance use, prematurity/low birth weight, exposure to secondhand smoke, and increase breastfeeding rates, etc. It is not necessary to use the words SIDS/SUID in the problem statement in this situation.

30. **QUESTION:** Do we need to write a problem statement for SIDS?

ANSWER: Write a problem statement for SIDS if you are planning to address a SIDS specific problem. If you are going to work more broadly on infant health, the problem statement doesn't have to mention SIDS, and could focus on infant health.

31. **QUESTION:** What is the optimal number of problems that an LHJ should identify for the Needs Assessment?

ANSWER: Please identify and list all of the problems in your community, and then consider your priorities, staffing, and resources to choose the problems you will address. You must address at least one problem in each of Goals 1-3, and depending upon available resources you may then consider addressing additional problems. The idea is that effort should be made toward as many identified problems as possible that will have meaningful impact. If you are concerned about the ability to achieve a measurable impact, consider a different issue to address or choose a different strategy. It is better to address fewer problems effectively.

32. **QUESTION:** Do we have to develop problem statements for all our problems

ANSWER: Please list all your problems even if you don't plan to address them or don't know the cause(s) of the problem. Use the format "x (population) is (having y problem) due to z (cause).

- If you are not addressing a problem you may only know the problem and population having the problem, not the cause of the problem. If you don't know the cause of the problem, you can develop a problem statement by listing the problem and the population having the problem. For the cause of the problem you can say, due to unknown causes, multiple, complex causes, or leave it out.

33. **QUESTION:** During our work with stakeholders, we have discovered many problem areas that overlap; however there are some problems that are broad and indirectly affect MCAH. Can we include problem statements for these problems?

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ANSWER: Yes, you can include problem statements for issues that impact your LHJ and indirectly impact MCAH

34. **QUESTION:** Where is the best place to indicate that data from community stakeholders is in accord with the accreditation process and our efforts are linked?

ANSWER: You can add this type of information under 'Step 4: Describe how to best address this problem' in Deliverable Form B

- a. **Please be sure to use lists and bullets in Step 4 and Step 5 in Deliverable Form B**
- b. If possible, briefly list who will be working on the problem - MCAH staff, collaboration, coalition, or other organization

35. **QUESTION:** Will we be required to use the strategies or partners that we list in Step 4 and Step 5 in our 5-Year Action Plans?

ANSWER – The information you enter in Step 4 and Step 5 are your draft ideas; your outline on how to address your problems and who might help address your problems over the next 5 years. Problems, priorities, strategies, resources and partners may change over time.

36. **QUESTION:** How much information are you looking for in Form B: Problem Statements, Strategies, and Partners – should we be brief?

ANSWER: Yes, please be brief and use bullets in Form B, Step 4: Describe how to best address this problem and Step 5: Describe who will help address this problem. We don't expect you to have your five-year action plans fully developed; that is for the next fiscal year. You can use the Action Plans on the Needs Assessment website for ideas.

<http://www.cdph.ca.gov/programs/mcah/Pages/SampleProblemAnalysesandFive-YearActionPlans.aspx>

37. **QUESTION:** We have a high rate of uninsured children due to multiple causes, including immigration status, knowledge deficit, etc. Do I list all the causes of the problem in the problem statement on Deliverable Form B: Problem Statements, Strategies, and Partners?

ANSWER: You could separate them and have one problem statement focusing on the cause(s) you are going to address, and then write another problem statement that lists the other cause(s) that you don't plan address. It's also fine to list multiple causes in the problem statement as long as you plan to work on the causes.

38. **QUESTION:** Deliverable Form B – only has 3 problems. How do you add more problems?

ANSWER: Click the "Add Problem" button at top of page to add more problems.

39. **QUESTION:** I have several problem statements that relate to African Americans. Do I need to describe them if I have a robust BIH program?

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ANSWER: If BIH is addressing the problem, complete Deliverable Form B, checking that you are not addressing the problem. You will be prompted to answer a question about why you are not addressing the problem. You can respond saying that you are not addressing the problem because AFLP or BIH is addressing the problem.

40. **QUESTION:** Can you choose not to identify and address a problem in Goals 1-3?

ANSWER: No, all LHJs must list at least one problem in each of the MCAH SOW Goals 1, 2, and 3. If resources allow, LHJs may also identify and address additional problems that they may place under any of the MCAH SOW Goals 1 through 6.

Deliverable Form C: 'Capacity Needs' questions

41. **QUESTION:** Deliverable Form C- Capacity Needs – Do you want us to write capacity needs that the State MCAH could address or our partners could address?

ANSWER: List capacity needs that the State MCAH could help with (even if you don't think the State MCAH has the resources to provide the help).

42. **QUESTION:** Where do you record capacity needs for problems NOT being addressed?

ANSWER: You can describe your capacity needs for problems NOT being addressed in Form B: Problem Statement, Strategies, and Partners in the text box that appears when you check 'Other' or 'Other community groups are addressing the problem' and/or in Form C: Capacity Needs

- a. Try to determine and briefly describe what insufficient capacity means for this particular problem

Deliverable Form D: 'Summary' questions

43. **QUESTION:** How is deliverable Form D - Summary used?

ANSWER: Form D - Summary is intended to provide a one page snapshot of the health status of your community, key health indicators in your LHJ and your locally identified problems and strategies. You will need to enter your specific local data into your data table using your CHSR Overview. Please enter the number of State births as well.

44. **QUESTION:** I am confused about the relationship between Form B: Problem Statements, Strategies, and Partners and Form D: Summary. Are the problems we list in Form B the ones we should discuss in Form D?

ANSWER: Form D: Summary is intended to be an executive summary of your needs assessment. You will be submitting this form with your Agreement Funding Application each year. The Summary will replace the previously submitted Profile Narrative. The data will be updated yearly and you will

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be able to use the summary to share information with your administration, staff, and stakeholders. We suggest you discuss your problems more broadly, keep the language simple, and tell a story about the health and wellness of your jurisdiction.

45. **QUESTION:** Are we to use 2011 or 2012 data to fill in the numbers on Form D of the Deliverables?
ANSWER: Please use the data in your Community Health Status Report (CHSR). **A Crosswalk of CHSR data to use with Deliverable Form D** is available on the State and FHOP websites. The link on the state website is:
http://www.cdph.ca.gov/programs/mcah/Documents/MO-TitleV-DeliveryFormD_CHSRTable.docx
Please contact FHOP if you need assistance completing the table
http://fhop.ucsf.edu/fhop/htm/ca_mcah/title_v/2013_needs_assess.html or fhop@fcm.ucsf.edu and 415-476-5283.

MISCELLANEOUS QUESTIONS

46. **QUESTION:** How can interested parties, other than MCAH Directors, be included in the State's email distribution list regarding Technical Assistance (TA) calls, information updates, etc.?
ANSWER: Please send an email to Paula Curran at Paula.Curran@cdph.ca.gov and Gloria Calderon at Gloria.Calderon@cdph.ca.gov
47. **QUESTION:** Where can I find the template PowerPoint presentation developed by FHOP for LHJs to use when presenting their local data?
ANSWER: The data presentation is available and on the FHOP website at:
http://fhop.ucsf.edu/fhop/htm/ca_mcah/title_v/2013_needs_assess.html
48. **QUESTION:** When and where can the sample surveys and stakeholder recruitment documents used previously by other LHJs be found? They were discussed during TA calls and webinars.
ANSWER: FHOP is posting all sample materials on the MCAH Marketplace <https://sites.google.com/site/mcahmarket/>. You can also access the MCAH Marketplace by following the link on the homepage on FHOP's website. If you have needs assessment materials that your jurisdiction has developed and you are willing to share, please email them to FHOP at FHOP@fcm.ucsf.edu and Paula Curran at Paula.Curran@cdph.ca.gov.
49. **QUESTION:** When submitting our deliverable packet should we attach a cover letter, data, agendas or other supporting documents?
ANSWER: When submitting the Deliverable Forms packet, please submit ONLY the completed packet via email as instructed on the top of the first page of the form; no additions, attachments, resources, etc. are required to be submitted. Email the Deliverable Packet by June 16, 2014 to CATitleV@cdph.ca.gov

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50. **QUESTION:** Six priority areas were discussed at the MCAH Action meeting; are they to be followed exactly?

ANSWER: They are the major focus areas. All of your problems should fit under one of these areas. There is also an “other” problem category that you can use under each priority area to list other problems in areas that aren’t listed (for example, under ‘Improve Child Health’ you may list problems related to “Asthma” under the “other” problem area).

51. **QUESTION:** How do I save the Deliverable Packet while I am working on it?

ANSWER: To save information on the form, download the form and save it on your computer in your files. As you complete the document, be sure to save it before closing the form.

52. **QUESTION:** Is the father population an "allowed" population to be addressed in the MCAH Title V Needs Assessment? If yes, what suggestions do you have for data sources?

ANSWER: to "allowed" population

- MCAH wants to be inclusive of fathers, promote healthy relationships, life course, etc. as they relate to women, mothers, and families
- It is appropriate to include fathers in the Needs Assessment as long as priority problems and populations are addressed as they relate to the MCAH population
- Including the father population is relevant with regards to bullying, intimate partner violence, infant bonding, family well-being, child development, economic growth of the family, etc.
- Some LHJs include 'fathers', 'paternal', or 'family' in the titles of their MCAH programs (e.g., Alameda, San Diego)

ANSWER: Data Sources

- Healthcare.gov <https://www.healthcare.gov/>
- US Census, SAHIE - estimated uninsured males 18-64 years
<https://www.census.gov/did/www/sahie/data/interactive/#view=data&utilBtn=&yLB=0&stLB=0&aLB=0&sLB=0&iLB=0&rLB=0&countyCBSelected=false&insuredRBG=pu &multiYearSelected=false&multiYearAlertFlag=false>
- California Health Interview Survey <http://healthpolicy.ucla.edu/chis/Pages/default.aspx>
- American Community Survey - insurance or poverty status of males/fathers in CA
<http://www.census.gov/acs/www/>
- National Survey of Family Growth - data set on men and fathers
<http://www.cdc.gov/nchs/nsfg.htm>
- Birth certificates - when the father's name is left blank, it is determined that they are not claiming paternity; when paternity is not claimed, there are other adverse measures that increase (e.g., lack of insurance for mother, increased welfare, etc.)