Results: 2016-2020 Maternal and Child Health Needs Assessment

COLORADO
Department of Public Health & Environment

Overview

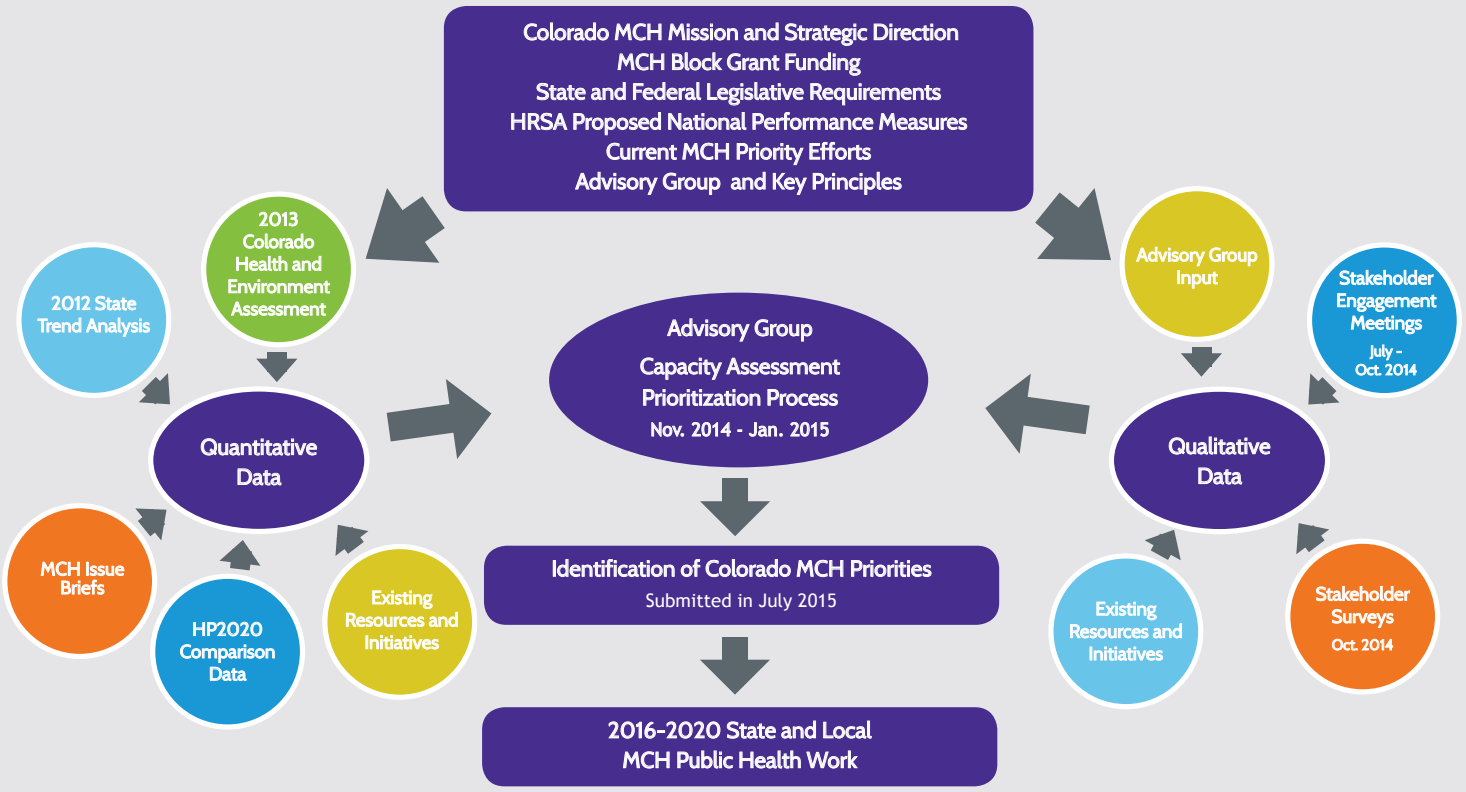
Every five years, the Colorado Maternal and Child Health (MCH) Program is required by Title V Block Grant funding to conduct a statewide needs assessment of the health and well-being of Colorado's women, children and youth including children and youth with special health care needs and their families. The goal of the needs assessment is to collect and examine data to inform the selection of seven to ten MCH priorities that will drive state and local public health work for the next five years with the overall aim of leading to a measurable improvement in the health of the MCH population.

Advisory Group

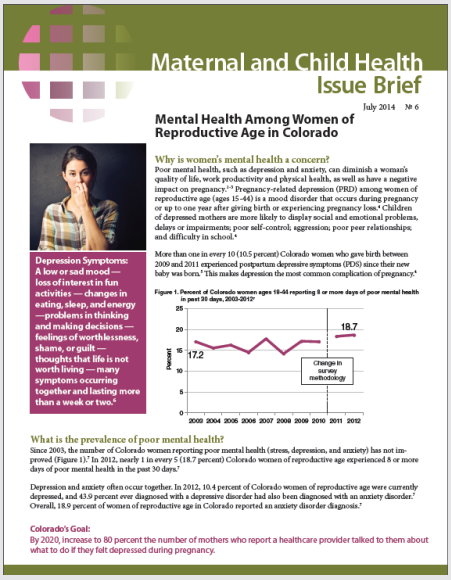
An eleven-member Advisory Group, in addition to a Project Manager, is responsible for guiding the development and implementation of the needs assessment process and to determine the final priorities. Nine of the members are MCH staff working at the Colorado Department of Public Health and Environment, and two members are from Tri-County and Summit County Departments of Public Health, respectively.

Using a best practice and mixed methods approach, the Advisory Group designed a needs assessment process that involved the collection of quantitative and qualitative data to assess maternal and child health status and state and local capacity. See the illustration below.

MCH Needs Assessment Process



Quantitative Data



Maternal and Child Health
Issue Brief

July 2014 № 6

Mental Health Among Women of Reproductive Age in Colorado

Why is women's mental health a concern?

Poor mental health, such as depression and anxiety, can diminish a woman's quality of life, work productivity and physical health, as well as have a negative impact on pregnancy.[1-3] Pregnancy-related depression (PRD) among women of reproductive age (ages 15-44) is a mood disorder that occurs during pregnancy or up to one year after giving birth or experiencing pregnancy loss.[4] Children of depressed mothers are more likely to display social and emotional problems, delays or impairments; poor self-control; aggression; poor peer relationships; and difficulty in school.[4]

More than one in every 10 (10.5 percent) Colorado women who gave birth between 2009 and 2011 experienced postpartum depressive symptoms (PDS) since their new baby was born.[4] This makes depression the most common complication of pregnancy.[4]

Depression Symptoms: A low or sad mood — loss of interest in fun activities — changes in eating, sleep, and energy — problems in thinking and making decisions — feelings of worthlessness, shame, or guilt — thoughts that life is not worth living — many symptoms occurring together and lasting more than a week or two.[4]

Figure 1. Percent of Colorado women ages 18-44 reporting 8 or more days of poor mental health in past 30 days, 2003-2012[5]

What is the prevalence of poor mental health?

Since 2003, the number of Colorado women reporting poor mental health (stress, depression, and anxiety) has not improved (Figure 1).[5] In 2012, nearly 1 in every 5 (18.7 percent) Colorado women of reproductive age experienced 8 or more days of poor mental health in the past 30 days.[5]

Depression and anxiety often occur together. In 2012, 10.4 percent of Colorado women of reproductive age were currently depressed, and 43.9 percent ever diagnosed with a depressive disorder had also been diagnosed with an anxiety disorder.[5] Overall, 18.9 percent of women of reproductive age in Colorado reported an anxiety disorder diagnosis.[5]

Colorado's Goal:
By 2020, increase to 80 percent the number of mothers who report a healthcare provider talked to them about what to do if they felt depressed during pregnancy.

The following key quantitative data was collected, synthesized and considered in prioritizing MCH issues:

- Comparisons of Colorado indicator data with Healthy People 2020 indicator data and targets,
- 2014-15 local public health agency priorities,
- 2014 Colorado Health and Environmental Assessment, and
- Issue briefs on the following topics:

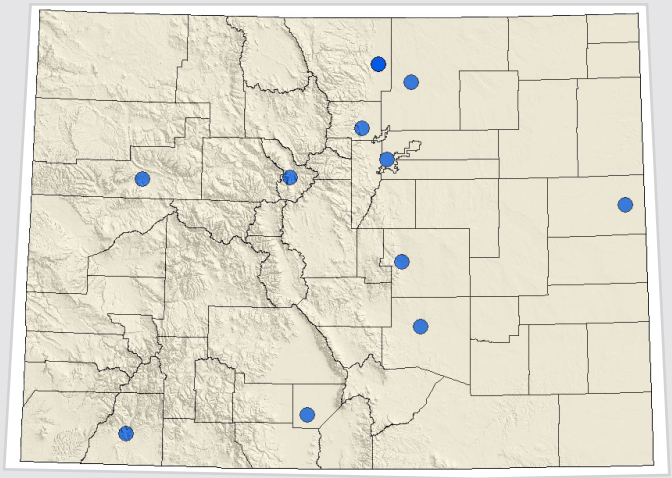
1. Unintended pregnancy
2. Mental health among women of reproductive age
3. Substance use among women of reproductive age
4. Infant mortality
5. Early childhood obesity
6. Immunization
7. Child/adolescent injury
8. Child and youth obesity
9. Mental health among children and adolescents
10. Substance use among adolescents
11. Oral health
12. Children and youth with special health care needs

Qualitative Data

Stakeholder input is critically important to the needs assessment process. The health status of the MCH population, the capacity of local communities to address priority MCH issues, and the availability of systems and supports for children and youth with special health care needs throughout Colorado were explored through 12 regional stakeholder meetings and 235 surveys.

The data collected from state and local partners was coded, synthesized and considered in the prioritization of MCH issues along with the quantitative data.

- Twelve regional meetings were facilitated statewide with 291 participants representing local public health, health care, education, community-based organizations, families and youth.
- Family leaders and youth completed 235 surveys at youth and family summits on what they thought were the most important issues facing the MCH population.



Regional Meeting Locations, Total Attendance: 291

Prioritization Process

The prioritization process was designed using best practice methods and commonly used criteria. Phase one was designed to assist Advisory Group members in narrowing from 48 to 19 potential priorities. In phase two, Advisory Group members determined the final seven priorities.

Key criteria used throughout the prioritization process included:

- Alighment with MCH mission and scope
- Federal requirements
- Incidence/prevalence
- Severity
- Health equity
- State and local capacity
- Availability of evidence-based/informed strategies
- Feasibility of population-based approaches
- Cost of potential strategies
- Ability to make a measurable impact in the short- and long-term

Results

The Advisory Group identified 19 potential priority health needs through the needs assessment process.

The input collected from the regional stakeholder meetings and surveys informed and aligned with the 19 priority health needs and, in most cases, with the final priorities.

Phase 1: Potential Priority by Federal Population Domain
Maternal/Women Health
Well-woman care (as part of mental health for women)
Mental health including pregnancy-related depression
Perinatal/Infant Health
Breastfeeding (as part of the early childhood obesity prevention priority)
Safe sleep
Reducing disparities in infant mortality among the African-American population
Children and Youth with Special Health Care Needs
Medical home
Transition
Respite

Phase 1: Potential Priority by Federal Population Domain
Child Health
Developmental screening and referral
Early childhood obesity prevention
Adolescent Health
Bullying
Mental health among youth including suicide prevention
Substance use among youth
Youth systems
Youth sexual health
Cross-cutting/Life Course
Oral health
Smoking/Substance Use

The Advisory Group organized the 2016-2020 priority efforts into seven state MCH priorities:

Phase 2: Final Priorties
Women's mental health including pregnancy-related depression
Reducing disparities in infant mortality among the African-American population
Early childhood obesity prevention
Developmental screening and referral systems building
Youth systems building with a focus on bullying, youth suicide and substance use prevention
Medical home for children and youth with special health care needs
Substance use/abuse prevention among the MCH population including marijuana, prescription drug abuse, alcohol and smoking (Specific focus to be determined)

Next steps

State MCH Implementation Teams, in partnership with key stakeholders, will begin action planning in June for work spanning the next three to five years. State MCH priority implementation will begin October 2015.

Local public health agency partners will begin action planning in March 2016 and priority implementation in October 2016.

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