

Reducing Barriers to a Medical Home Approach: MCH Priority #6

Local Action Planning Resource Document

Medical Home Approach

Definition: Essential components of a medical home approach include care that is accessible, patient/family-centered, continuous, comprehensive, coordinated, compassionate and culturally responsive. While the health care provider or practice setting is one place that the components of a medical home approach are implemented, it is critical to recognize that a provider/practice is operating within the context of a larger medical home system. A medical home system is the state and local infrastructure (personnel, processes, policies, procedures, materials, organizational structures, etc.) that support the implementation of a medical home approach within practices, as well as within the broader surrounding community.

Objective	Technical Assistance Tips or Resources
<p>Objective A: Mobilize partnerships</p>	<p>Objective A provides the platform for stakeholder engagement and education, which serves as Step 1 of the policy/systems change process outlined in Appendix A. This is most effective when the group has a clear understanding about the issue(s) or problem(s) they are trying to impact. Examples of priority areas that impact a community-based medical home system include, but are not limited to: lack of communication and/or collaboration across care coordination programs; limited access to specialty care; poorly coordinated transitions from the hospital/NICU to community based services; and/or inefficient referrals across systems of care. Developing a problem identification statement(s) will help further define the issue and support the development of policy/systems change strategies in objective B.</p>
<p>A.1: Identifying key stakeholder group</p>	<p>Guiding questions to help identify the appropriate key stakeholder group:</p> <p><i>For those communities that have an existing stakeholder group or coalition to address barriers to a medical home approach:</i></p> <ul style="list-style-type: none"> • Who are the medical home groups or coalitions that already exist within the community with whom you could partner?

	<ul style="list-style-type: none"> ● What is the primary purpose of the group? ● What is your local public health agency (LPHA)'s role in this group? ● What are the strengths and challenges of this group? ● What are the strengths and challenges of your LPHA's role in this group? ● Does the group already have a shared understanding of the components of a medical home approach (patient/family-centered, comprehensive, coordinated, culturally responsive, continuous, compassionate and accessible)? If not, how can you help support a shared understanding? ● Are there specific areas of focus that the group has identified that would support a medical home approach in your community? If not, what could be your role in helping the group identify a specific area of focus? ● What data or information might be needed to help the group identify a specific area of focus? ● Would the specific area of focus best be addressed by the coalition or by a sub-group of the coalition? ● Are the right partners participating in the coalition who can help shape policy/systems change related to the identified priority area of focus in your community? ● Has the group developed a problem identification statement to further describe the area of focus? If not, what could be your role in helping the group develop one? <p><i>For those communities that do not have an existing stakeholder group or coalition to address barriers to a medical home approach:</i></p> <ul style="list-style-type: none"> ● Have you already identified a specific priority area of focus, for your medical home local action plan based on qualitative and/or quantitative data? ● Is there momentum within your community to address the priority area of focus collectively? ● If so, who are the key stakeholders in your community who would be important to engage? ● If not, who are the key stakeholders in your community who could provide input and data to help identify and prioritize the areas of focus in your community? ● Do these stakeholders already have a shared understanding of the components of a medical home approach (patient/family-centered, comprehensive, coordinated, culturally responsive, continuous, compassionate and accessible)? If not, how can you help support a shared understanding? ● Are there any stakeholders who you might partner with to co-lead this stakeholder group with your LPHA?
<p>A.2: Creating a team charter</p>	<p>Team Charter Template</p> <p>Background: What are the reason(s) for chartering the team? State the perceived problem/project and any information that would be useful to those involved in the group.</p> <p>Goal or Deliverable(s): What does the convener and/or the participants of the group want to achieve? Clarify group expectations and what changes are expected to result from this</p>

	<p>teamwork.</p> <p>Membership: Are all the appropriate key stakeholders represented? Who is missing and how could they be engaged to join the group? Are family leaders and families represented?</p> <p>Duration: How long is the group going to exist?</p> <p>Checkpoints: What might be the critical milestones or timeframes when the group might revisit its purpose and progress towards the identified goals?</p> <p>Feedback Mechanism: What should the feedback mechanism be between the participants and the convener(s) of the group? How the team communicates with the sponsor, the people they are representing and other members on the team.</p> <p>Boundaries: Are any issues “out of bounds” and not for the team to consider?</p> <p>Decisions: Who makes the final decisions? Most collaborative groups aim for consensus, with a fallback to the team leader or majority vote.</p> <p>Resources: What resources (money, training, specialists, support, equipment, and/or supplies) will be needed to support the group? What resources will be needed to accomplish the team’s goals?</p> <p>Guidelines: Any specific areas to address, processes to be used, people to involve or whatever else needs to be considered in order to accomplish the team’s goal.</p> <p>Logistics: When, where, how often, and for how long will the group meet?</p>
<p>A.3: Identifying barriers and prioritizing area(s) of focus</p>	<p>Guiding questions to consider when assessing systemic barriers and prioritizing an area(s) of focus to support a medical home approach in the community:</p> <ul style="list-style-type: none"> ● What qualitative and/or quantitative data would be important to collect and analyze to identify and prioritize systemic barriers to a medical home approach in your community? ● Does your local CYSHCN care coordination data and/or experience working with children with special health care needs illuminate existing barriers? ● What existing community assessment data would be helpful to utilize? ● Have any key informant interviews been conducted with the stakeholders and/or a cohort of patients/families to identify barriers? If not, could this be a strategy for collecting qualitative data from the stakeholders? ● What may be preventing individuals/families from receiving care that is accessible, patient/family-centered, continuous, comprehensive, coordinated, compassionate and culturally responsive? ● Would it be useful to conduct a Strengths, Weakness, Opportunities, Threats (SWOT) analysis to assess your community’s medical home system to help determine the priority/focus of the group? Another useful tool to help identify opportunities for

	<p>improvement is a process flow diagram (insert process flow diagram from internet)</p> <ul style="list-style-type: none"> • What other tools have you utilized before that could help identify barriers and prioritize an area of focus for the group?
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<p>A.4: Identifying and framing the problem</p>	<p>Problem Identification (Step 2 of the policy/systems change process): The first step once the overarching barrier to a medical home approach (or priority area of focus) has been identified, is to clearly describe the problem or issue the group is trying to address.</p> <p>A problem statement helps clarify and frame the problem or issue. In order to develop a problem statement:</p> <ul style="list-style-type: none"> • Collect, summarize, and interpret information relevant to a problem or issue (e.g., nature of the problem, causes of the problem) • Define the characteristics (e.g., frequency, severity, scope, economic and budgetary impacts) of the problem or issue • Identify gaps in the data • Consider potential policy/systems change solution(s) <p>Gathering the data described above will most often require input from your partners and may reveal gaps in existing data. This may occur as a facilitated group discussion or through key informant interviews or a combination of both. A review of the available information and literature may also help delineate a specific problem statement.</p> <p>In short, a problem statement should reveal:</p> <ul style="list-style-type: none"> • What’s wrong? • Why does it matter? • What should be done about it? <p>Example from “Sabin County”:</p> <p>Staff from Sabin County Health Department identified a lack of coordinated care for children and youth with special needs as the priority area for their medical home action plan. They engaged local partners through their Medical Home Coalition to identify and compile existing data to help describe the issue:</p> <ul style="list-style-type: none"> • Less than half (43.7 percent) of CYSHCN in Colorado receive coordinated, on-going, comprehensive care within a medical home, according to the National Survey of Children’s Health. • Two thirds of the HCP care coordination caseload is enrolled in Medicaid. • It is unknown how many HCP care coordination clients, if any, are also receiving care coordination support through the RCCO. • The Regional Care Collaboration Organization (RCCO) does not know how many children and youth with special health care needs are currently attributed to their organization. • The RCCO provides care coordination services for anyone enrolled in Medicaid who
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	<p>is attributed to their RCCO, either through delegation agreements to practices or directly through their organization.</p> <ul style="list-style-type: none"> • The hospital is unsure when it is appropriate to refer children and youth for community-based care coordination services through the RCCO and when it is appropriate to refer children and youth to HCP. • The hospital is unsure of the role of the community-based care coordination programs compared to the in-patient care coordinator. <p>Based on this data discussion, they develop a problem statement:</p> <p>Children and youth with special needs experience greater challenges accessing coordinated care than the general population of children and youth. While care coordination resources exist in the community, the programs providing care coordination lack systematic processes and mechanisms for communicating and collaborating with each other to assure the needs of the CYSHCN population are being met and existing care coordination resources are being maximized.</p>
A.5: Identifying roles	<p>It is important to define the role of public health and the other stakeholders/partners specific to the problem statement.</p> <ul style="list-style-type: none"> • What might you and/or your agency contribute to the partnership (content knowledge, staff time, space, connections to other community partners, etc) in order to successfully respond to the problem statement? • What might others contribute? • Where are there gaps and which partners might need to be engaged to address these gaps?
A.6: Assessing progress to date	<p>Process Evaluation</p> <p>A strong process evaluation includes <i>consistent attention</i> to results, <i>shared understanding</i> of goals, <i>honest reflection</i> on successes and failures, <i>clear rationale</i> for decisions, and <i>responsiveness</i> to evaluation data and the external environment. It is the process of tracking progress toward goals and allowing for adaptation based on information gathered from group reflection and discussion in order to better meet these goals.</p> <p>Strategic learning questions may be used in a process evaluation to help facilitate the group discussion and illuminate the successes, challenges, and lessons learned, as well as what adjustments may need to occur as the group continues to work collaboratively to address goals.</p> <p>Sample strategic learning group discussion questions to discuss with the stakeholder group:</p> <ol style="list-style-type: none"> 1. <u>Describe the group’s progress</u> toward meeting the Objective A “criteria for success” measures during the last 3 months (quarter). 2. How has existing and/or new data <u>informed your progress</u> toward meeting the

	<p>criteria for success for Objective A?</p> <ol style="list-style-type: none"> 3. Is there <u>additional information/data needed</u> to help inform your progress? 4. What's <u>working well</u> in helping you to progress toward the criteria for success? <ol style="list-style-type: none"> a. How might this be sustained? 5. What are the <u>current challenges</u> to meeting the criteria for success? Please describe. <ol style="list-style-type: none"> a. What actions are being taken to address these challenges? b. Are there additional partners who could be engaged to help address these challenges? c. Is there a role for technical assistance in helping to address these challenges? 6. Based on current progress, what's working well, and current challenges, what are the <u>next steps</u> that the LPHA and/or stakeholders will conduct in the next 3 months to work toward meeting the criteria for success for Objective A? <p>In addition to, or instead of, the strategic learning questions mentioned above, Coalitions Work has developed tools that also promote “real time learning” that can help maximize the effectiveness of a coalition. http://coalitionswork.com</p> <ul style="list-style-type: none"> ● Coalition Meeting Check-up ● Meeting Effectiveness Inventory (MEI)
<p>A.7: Assessing collaboration</p>	<p>There are existing tools to measure collaboration of stakeholder groups, partnerships or coalitions. Here are examples that are no-cost and available on the internet:</p> <p>The Wilder Collaboration Factors Inventory http://wilderresearch.org/tools/cfi/</p> <p>https://www.wilder.org/Wilder-Research/Research-Services/Documents/Wilder%20Collaboration%20Factors%20Inventory.pdf</p> <p>The Coalitions Work website has free tools available to assist in evaluating partnerships and coalitions in the Tools and Resources section http://coalitionswork.com</p>
<p>A.8 Analyze the results from assessment of collaboration</p>	<p>Guiding questions:</p> <ul style="list-style-type: none"> ● What does the data (i.e. results of the baseline survey) tell you about the strengths and challenges of the partnership? ● Does the feedback lead to actionable change to enhance the collaboration?
<p>A.9 Evaluate progress of stakeholder group and measure</p>	<p>Guiding questions:</p> <ul style="list-style-type: none"> ● Review results of the follow up survey in relation to baseline. What changed? What stayed the same? ● What course corrections, if any, does the group need to consider (i.e meeting

collaboration	<p>structure, engaging new partners, changing meeting times, locations, facilitator, etc.)</p> <ul style="list-style-type: none"> • When should the next follow up survey be conducted? Annually? Bi-annually?
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A.10: TA opportunities and resources	Members of the Medical Home MCH Implementation Team will provide technical assistance through individual meetings with local public health agencies and/or webinars.
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<p>Objective B: Policy</p>	<p>What do we mean by medical home policy?</p> <p>Medical home policy, for the purpose of this action plan, is any principle or rule that guides decisions and supports systems change. This goes beyond legislation and includes organizational practices and procedures, program eligibility criteria, interagency standards of communication and or referral, etc.</p> <p>What do we mean by a policy/systems change process?</p> <p>The Medical Home MCH Implementation Team has adapted the CDC Policy Process Framework to support implementation of objective B in the medical home state and local action plans. Stakeholder engagement (objective A), which is reflected in the center of the diagram as Step 1, continues throughout the process. Likewise, evaluation must be considered at every stage. The three outer domains (problem identification; policy/systems change analysis; strategy development and implementation) are core components of a policy/systems change process. They are represented as sequential steps, but in practice will not always follow a linear pattern.</p> 
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B.2: Policy/systems change analysis	<p>Policy/systems change analysis (Step 3): identify potential policy/systems change solutions that could address the issue described in the problem statement (Step 1). Identifying and researching policy/systems change options may be done through key informant interviews with individual stakeholders or through facilitated group discussions or a combination of</p>
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both.

Example:

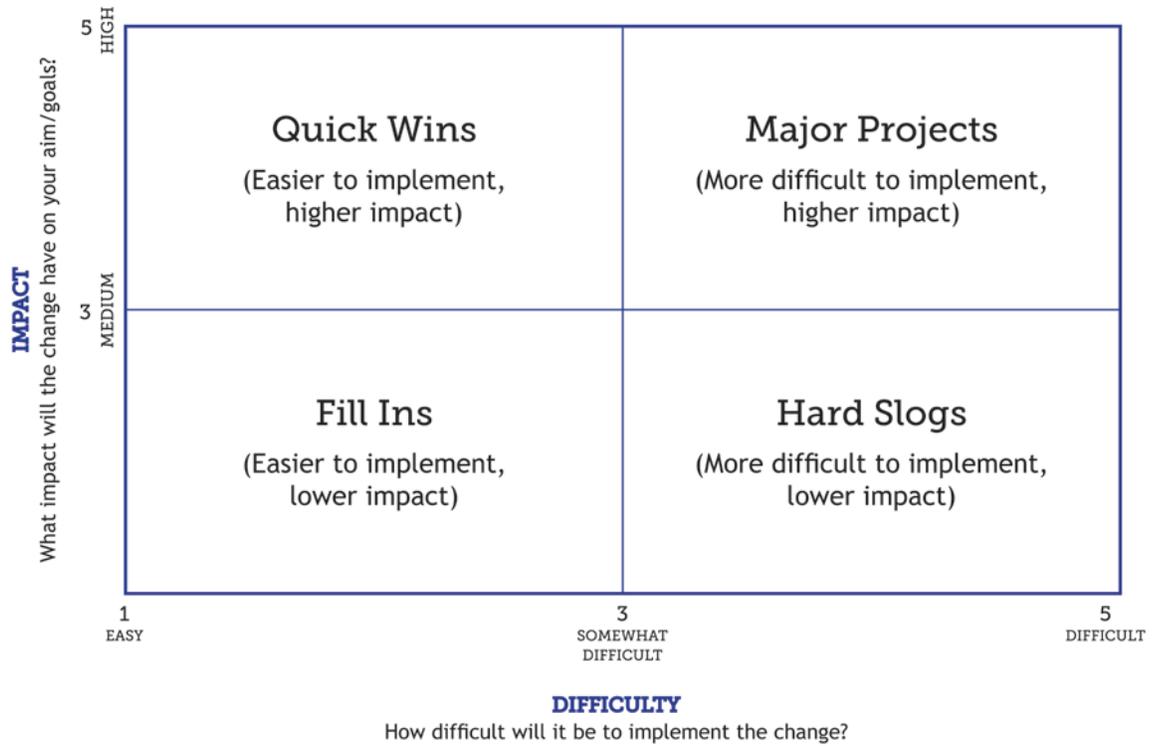
Potential policy/systems change solutions to address the problem statement example in A.4:

- Develop method to identify when/if more than one organization (local public health agency, RCCO, etc) is providing care coordination for a child/youth.
- Create a policy to guide appropriate referrals for community-based care coordination that is shared across referring organizations (i.e., hospitals, HCP, RCCO, etc).
- Establish MOUs between organizations that provide care coordination services that clarify target population and eligibility criteria in order to promote appropriate referrals.
- Host a forum for interagency case conferences to promote complementary care coordination support and reduce duplication of effort.

Assess and prioritize policy/systems change solutions (Step 3): Discuss with stakeholders: a) how the policy will impact health and well-being of the target population (health impact), b) the costs to implement the policy and how the costs compare with the benefits (economic and budgetary impacts) and c) the political and operational factors associated with adoption and implementation (feasibility). Use one of the tools included below, or other tool preferred by your agency and/or stakeholder group, to assess and prioritize policy/systems change solution(s).

An “impact matrix” is a tool that can be used to facilitate a group prioritization of potential policy/systems change options.

IMPACT MATRIX



Adapted by the Center for Public Health Quality from Action Matrix on Mind Map Tools

B.1-2: Assess and prioritize policy/systems change options

The CDC’s “policy analysis table” is another tool that can be used to help guide a policy/systems change assessment and prioritization process.

POLICY ANALYSIS TABLE

CRITERIA	PUBLIC HEALTH IMPACT	FEASIBILITY	ECONOMIC AND BUDGETARY IMPACT	
Scoring Definitions	Low: Small reach, effect size, and impact on disparate populations Medium: Small reach with large effect size or large reach with small effect size High: Large reach, effect size, and impact on disparate populations	Low: No/small likelihood of being enacted Medium: Moderate costs to implement High: Low costs to implement	Less favorable: High costs to implement Favorable: Moderate costs to implement More favorable: Low costs to implement	Less favorable: Costs are high relative to benefits Favorable: Costs are moderate relative to benefits (benefits justify costs) More favorable: Costs
			BUDGET	ECONOMIC
Policy 1	<input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High Concerns about the amount or quality of data? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High Concerns about the amount or quality of data? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Less favorable <input type="checkbox"/> Favorable <input type="checkbox"/> More favorable Concerns about the amount or quality of data? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Less favorable <input type="checkbox"/> Favorable <input type="checkbox"/> More favorable Concerns about the amount or quality of data? <input type="checkbox"/> Yes <input type="checkbox"/> No
Policy 2	<input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High Concerns about the amount or quality of data? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High Concerns about the amount or quality of data? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Less favorable <input type="checkbox"/> Favorable <input type="checkbox"/> More favorable Concerns about the amount or quality of data? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Less favorable <input type="checkbox"/> Favorable <input type="checkbox"/> More favorable Concerns about the amount or quality of data? <input type="checkbox"/> Yes <input type="checkbox"/> No
Policy 3	<input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High Concerns about the amount or quality of data? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High Concerns about the amount or quality of data? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Less favorable <input type="checkbox"/> Favorable <input type="checkbox"/> More favorable Concerns about the amount or quality of data? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Less favorable <input type="checkbox"/> Favorable <input type="checkbox"/> More favorable Concerns about the amount or quality of data? <input type="checkbox"/> Yes <input type="checkbox"/> No

NOTE: Scoring is subjective and this table is intended to be used as an organizational guide.

Regardless of the tool used, the prioritization process is necessary in order to appropriately focus time and effort to achieve an impact on the problem.

B.3-4: Strategy development and implementation

Strategy development (Step 4): identify the strategies and associated next steps for adopting the prioritized policy/systems change(s). Consider strategies and next steps that will:

- Translate the policy/systems change into operational practice and define implementation standards.
- Lead to implementation of new regulations, guidelines, recommendations, directives and/or organizational practices.
- Coordinate resources and build capacity of personnel to implement policy/systems change.
- Identify indicators and metrics to evaluate implementation and impact of the policy/systems change.

For each strategy and next step determine a timeline, lead/point person(s) and progress to

date.

- Strategies/next steps: what needs to happen next in order to support the proposed policy/systems change?
- Timeframe: what is the target date for completing the strategy? Include a timeframe for the strategy, as well as the associated immediate or next steps.
- Lead/point person: who is responsible for completing the action step?
- Notes/Progress to date: what is the status of progress on the action step(s)? Are there considerations, challenges and/or key information to capture and communicate?

Strategy document: Document this information in a format (table or spreadsheet) that can be readily shared with partners and used as a guide at coalition meetings and/or sub-group meetings. Update this strategy document regularly to track progress, ensure compliance with policy/systems change, as well as support on-going sustainability of the policy/systems change.

Prioritized policy/systems change example from B.1: Develop mechanism to identify when/if more than one organization (local public health agency, RCCO, etc) is providing care coordination for a child/youth.

Example components to include in the strategy document:

Strategy: Develop data sharing agreements between community-based organizations in order to share caseload rosters in order to assess gaps and/or duplication in care coordination services.

Timeframe: Target date for completion is three months.

Action step: Suzy, from the local public health agency, and Gabe, from the RCCO, will contact their organization's leadership to research their agency requirements for developing a data sharing agreement and obtain samples of existing data sharing agreements that could be used as a template.

Timeframe: By next coalition meeting.

Lead/point person(s): Suzy and Gabe

Notes/progress to date: Suzy thinks there is an existing MOU in place between the local public health agency and the RCCO that could be updated to include this data sharing agreement.

<p>B.4-5: Evaluation of the policy/systems change</p>	<p>Evaluation (Step 5): assess the steps of the policy/systems change cycle, including the impact and outcomes of the prioritized policy/systems change(s).</p> <p>Conduct evaluation by answering the following questions with key stakeholders/coalition:</p> <ul style="list-style-type: none"> • How far have you progressed in the policy/systems change process (from Step 1 through Step 5)? • Was the problem defined in a way that led to action to address the problem? • How were stakeholders engaged? Was this effective in supporting the implementation of the policy/systems change? • Is the prioritized policy/systems change(s) being implemented as intended? • What has been the impact of the policy/systems change? If it is still too soon to measure impact of the policy/systems change, what is the <i>anticipated</i> impact of the policy/systems change?
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Medical Home Web Links

Colorado Medical Home Initiative

- coloradomedicalhome.org

American Academy of Pediatrics, National Center of Medical Home Initiatives for Children with Special Needs

- www.medicalhomeinfo.org

Center for Medical Home Improvement

- www.medicalhomeimprovement.org

National Initiative for Children’s Health Quality

- www.NICHQ.org

Overview of CDC’s Policy Process

- www.cdc.gov/policy/process/docs/CDCPolicyProcess.pdf

CDC’s Policy Analytical Framework

- www.cdc.gov/policy/process/docs/CDCPolicyAnalyticalFramework.pdf

Standards for Systems of Care for Children and Youth with Special Health Care Needs

- www.mchlibrary.info/KnowledgePaths/kp_CSHCN.html

Data Sources

- Medical Home among Colorado Children Ages 1-14 Health Watch
- <http://www.chd.dphe.state.co.us/Resources/briefs/MedicalHome2.pdf>

National Survey of Children’s Health

- <http://www.nschdata.org/Content/Default.aspx>
- <http://www.nschdata.org/browse/medicalhome>

Colorado Child Health Survey

- Note: Click on link below, then scroll down to Child Health Survey tab
- <http://www.chd.dphe.state.co.us/topics.aspx?q=Maternal Child Health Data>

Questions?

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Medical Home Policy/Systems Change Process Technical Assistance and Monitoring Tool

This worksheet will help local public health agencies identify the step of the policy/systems change process in which they are currently engaged, as well as monitor and document progress through future steps. By the end of the FY16, each agency is expected to complete steps 1-4 of the policy/systems change process as outlined in the medical home local action plan template. Please refer to the Medical Home Resource document for specific tips and guidance specific to each step of the policy process.



Step 1: Stakeholder Engagement and Education



Date started (month/year):
Date completed (month/year):

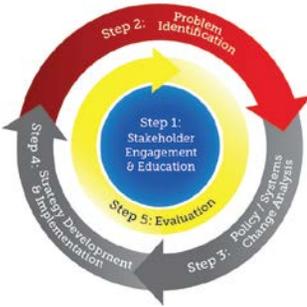
What is the name of the stakeholder group you are partnering with to implement your medical home local action plan? Refer to A.1 of the local action planning resource document.

Text Box: [Type your answer here.]

What is the purpose for convening the group, as reflected in the team charter? Refer to A.2.

Text Box: [Type your answer here.]

Step 2: Problem Identification



Date started (month/year):
Date completed (month/year):

What is the “problem statement” related to the issue that illuminates possible policy/systems change solutions? Refer to A.1.4.

Text Box: [Type your answer here.]

Step 3: Policy / Systems Change Analysis



Date started (month/year):
Date completed (month/year):

What are the 1-2 prioritized policy/systems change solutions that the coalition/workgroup will address in FY16? Refer to B.2.

[Type your answer here.]

Step 4: Strategy Development and Implementation



Date started (month/year):

Date completed (month/year):

What are the main strategies and/or action steps needed to implement the policy/systems change? Refer to B.3-4.

[Type your answer here.]

Have you developed a strategy document to capture and track progress on the strategies/action steps? If yes, please share the current draft with your MCH Generalist and/or Medical Home Technical Assistance Coordinator.

- Yes
- No, but in development
- No, not yet

Step 5: Evaluation



What, if anything, has changed in your community as a result of your policy/systems change efforts to support a medical home approach? Refer to B.5.

Text Box: [Type your answer here.]