

Colorado Maternal and Child Health Program FY 17-21

Medical Home Logic Model

Overarching Goal: Increase the number of children and youth, including those with special health care needs, who receive comprehensive, coordinated care within a medical home

INPUTS	STRATEGIES	OUTPUTS	SHORT-TERM OUTCOMES	MEDIUM-TERM OUTCOMES	LONG-TERM OUTCOMES
			Accomplished in 6 months - 1 yr	Accomplished in 1-3 yrs.	Accomplished in 3-5 yrs.
CDPHE infrastructure and staff  Local public health agency infrastructure and staff  Community-based coalitions/partnerships  State-level coalitions/partnerships  MCH Block Grant Funding  State General Fund  Got Transition?	Identify and implement policy/systems changes that support communication and collaboration between programs that provide care coordination for children and youth.	Implementation of the HCP Policy and Guidelines.	Implementation of a policy that defines a systematic process for shared plans of care and interagency case conferencing.	Increase the number of CYSHCN who receive HCP care coordination services that have an inter agency plan of care with the RCCO or a delegated practice.	Increase the percent of children with special health care needs who experience a medical home approach.
		The creation/revision of planning documents, such as team charter, impact matrix, process flow diagrams and strategy document (see Appendix A of Medical Home Resource Document).			
		Participation in CDPHE training and technical assistance opportunities on medical home care coordination policy and systems.		Implementation of identified policy or process that supports increased access to pediatric specialty care.	
	<i>Option for specialty clinic host sites:</i> Identify and implement policy/systems changes that enhance local access to pediatric specialty care.	Scan of local pediatric speciality care completed.	Identification of a policy and/or systematic process that increases coordination of pediatric specialty care partners (such as local pediatric providers, hospital systems and RCCOs) to address gaps and barriers.		
	<i>Option for FY18:</i> Identify and implement policy/systems change that strengthens youth to adult transition for CYSHCN and their families.	Implementation of the HCP Policy and Guidelines specific to youth to adult transitions.	Identification and implementation of a policy and/or systematic process that strengthens transition preparation and planning for CYSHCN from youth to adult systems.	CYSHCN who receive HCP care coordination services and their families report successful transition from youth to adult systems.	
	Scan of local transition resources completed.				
Participation in CDPHE training and technical assistance opportunities on transition efforts.					



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