

MCH Implementation Team State Action Plan
#6 Reducing Barriers to a Medical Home Approach
3-Year Planning Period: 2012, 2013 and 2014

Context

Essential components of a medical home approach include care that is accessible, patient/family-centered, continuous, comprehensive, coordinated, compassionate and culturally responsive. In Colorado, 59.3 percent of children and youth ages 0-17 meet the criteria for having a medical home (National Survey of Child Health, 2007). National survey data indicates that this percentage is consistently lower for children and youth with special health care needs (43.1%) versus the population of children and youth without special health care needs (62.6%). This is important to consider as 13.7 percent of Colorado's children and youth, ages 0-17, have a special health care need (National Survey of CSHCN, 2010). While the components of a medical home approach are implemented within the provider or practice setting, 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 and within the broader surrounding community.

In order to realize a population-based increase in the percentage of children and youth who experience a medical home approach, state and local public health must identify and reduce systemic barriers that diminish a health care provider's and/or community partner's ability to implement a medical home approach. In 2011, the Colorado Medical Home Initiative solicited input from community-based stakeholders to identify the following barriers to a medical home approach, which helped inform the focus of this action plan:

- Lack of adequate communication and collaboration amongst medical home efforts
- Policies that do not support a medical home approach and/or lack of policies that support a medical home approach
- Lack of consumer voice and influence on decision-making at the individual/family; community; and state levels.
- Lack of adequate support for providers to facilitate a medical home approach
- Lack of adequate support for community-based systems that facilitate a medical home approach

Goal(s)		Data Source(s)
G1	Increase the number of children and youth, including those with special health care needs, who receive comprehensive, coordinated care within a medical home in Colorado.	The Colorado Child Health Survey National Child Health Survey and National Survey of Children with Special Health Care Needs
G2	Adequate communication and collaboration exists amongst statewide medical home projects and initiatives	See Objective A
G3	Policies exist that support a medical home approach	See Objective B
G4	Consumer voice and influence on decision-making exists at the individual/family, community and state levels	See Objective C
G5	Adequate support for community-based systems exists to facilitate a medical home approach	See Objective D

Objective A: By September 30, 2015, an infrastructure to support statewide medical home partnerships has been strengthened and maintained.

Lead: Rachel Hutson

Target Population: Medical Home Coalition members, Medical Home Community Forum participants, Medical Home Implementation Team members

Criteria for Success:

- Key medical home stakeholders demonstrate an understanding of each other's role and the role of public health in reducing barriers to a medical home approach
- Statewide partnerships will be enhanced to ensure high levels of coordination to reduce barriers to a medical home approach in Colorado
- Effective communication mechanisms exist between CDPHE and external medical home stakeholders.
- Effective communication mechanisms exist amongst internal CDPHE stakeholders

As Measured by:

- Evaluation of effectiveness of the Medical Home Coalition and the Medical Home Community Forum in mobilizing partnerships to reduce barriers to a medical home approach

Strategy	Milestones / Key Activities	Target Completion Date	Responsible Persons/Group	Monitoring Plan
Mobilize partnerships to support the coordination of state and local medical home projects and initiatives.	A.1.1. Maintain internal Medical Home MCH implementation team (MIT) to lead implementation of the medical home action plan and monitor plan progress.	September 2014 Quarterly meetings (July-October-January-April) through September 2014	Rachel Hutson	Documentation of quarterly progress
	A.1.2. Finalize medical home state action plan	September 2012	Rachel Hutson Eileen Forlenza Audra Bishop Jane Gerberding Medical Home Policy Coordinator Health Systems Unit Manager	Medical Home State Action Plan approved by MH MIT and MCH Steering Team

	A.1.3. In collaboration with Health Care Policy and Financing, host bi-monthly Medical Home Community Forum meetings to promote statewide input and discussion of issues related to reducing barriers to a medical home approach	September 2014 Bi-monthly meetings (June-August-October-December-February-April) through September 2014	Medical Home Policy Coordinator Annie Guo	Documentation of topics addressed; summary of input; and meeting participation posted on MH web site
	A.1.4. In collaboration with Health Care Policy and Financing, host monthly meetings of the Medical Home Coalition to promote the strategic alignment of MH statewide projects and initiatives	September 2014 Monthly meetings Coalition evaluation methodology determined by January 2013	Medical Home Policy Coordinator	Documentation of topics addressed; meeting participation; and annual identification and implementation of tool to evaluate coalition effectiveness
	A.1.5. Create, launch and maintain a statewide medical home web site in coordination with HCPF and the Medical Home Coalition.	June 2012 and updated monthly	Annie Guo Medical Home Policy Coordinator	Web site launched; up to date content; analysis of web site analytics to inform ongoing website improvements; documentation of website improvements.

Objective B: By September 30, 2015, public health policies have been maintained or changed to reduce barriers to a medical home approach.

Lead: Barbara Martin

Target Population: Medical Home Coalition participants; Medical Home MIT participants; public health agency leads for the local medical home action plans

Criteria for Success:

- Effective policies that support a medical home approach and require state and/or local level action in order to be maintained have been identified.
- New or enhanced policies that support a medical home approach and require state and/or local level action have been identified.
- New and/or enhanced collaborative action steps for addressing policy maintenance or change have been developed and implemented.

As Measured by:

- CDPHE Medical Home Policy Agenda created
- Documentation of policies that have been maintained or changed to reduce barriers to a medical home approach.

Strategy	Milestones / Key Activities	Target Completion Date	Responsible Persons/Group	Monitoring Plan
Develop and implement a medical home policy agenda	B.1.1. Create an inventory of medical home policy for the state of Colorado. Policies that should be changed, improved or used as a good example. Start with state, move to Federal if appropriate.	January 2013 and updated annually	Medical Home Policy Coordinator	Medical Home Policy Inventory
	B.1.2. In collaboration with the Medical Home MIT, prioritize the inventory to identify policy agenda.	January 2013 and 2014	Medical Home Policy Coordinator	Prioritized list of areas of policy focus
	B.1.2. Communicate/collaborate with PSD policy workgroup and Executive Director's office to ensure the medical home agenda is being advocated for with legislators and policy makers statewide.	Ongoing through September 2015	Medical Home Policy Coordinator, Gabriel Kaplan, Health Systems Unit Manager	Log of policy issues presented/shared with PSD policy workgroup and ED's office and status of policy action
	B.1.3. Policy training and technical assistance will be provided to LPHAs that select medical home policy objective	September 2013, 2014, 2015	Medical Home Policy Coordinator	Log of policy training and TA provided; list of type of TA and participants
	B.1.4. LPHA input related to policy barriers that require state level action are solicited by the medical home implementation team to help inform state-level policy.	September 2013, 2014, 2015	Medical Home Policy Coordinator	List of policy barriers and log of actions taken to address the barrier

Objective C: By September 30, 2015, a sustainable infrastructure for a statewide network of individual/ youth engagement and/or family leadership training opportunities exists.

Lead: Eileen Forlenza

Target Population: Potential youth and family leaders, potential FLTI facilitators, potential community-based organizations interested in coordinating FLTI, potential state and local programs interested in integrating family and youth voice into their program planning and implementation.

Criteria for Success:

- A network of family leaders are trained and poised to represent the consumer voice in systems change activities related to system of care that serves children and youth.
- FLTI is offered in at least 5 diverse communities statewide and graduates and alumni are supported for involvement in systems change activities.

As Measured by:

Implementation of FLTI in 5 communities and graduates are matched with leadership opportunities within CDPHE and external partners.

Strategy	Milestones / Key Activities	Target Completion Date	Responsible Persons/Group	Monitoring Plan
Family Leadership				
Develop and implement a plan for a statewide network of consumer voice training opportunities	C.1.1. Maintain the four pilot sites currently offering FLTI and implement a robust evaluation plan to measure change in skills and knowledge of participants.	February 2013 DONE	Eileen Forlenza	Four pilot sites will begin cohort 5.
	C.1.2. Provide the FLTI curriculum in Spanish for mono-lingual Spanish speaking families to assure the development of strong family leaders from the Latino population.	February 2013 DONE	Eileen Forlenza	At least one FLTI site will be offered in mono-lingual Spanish.
	C.1.3 Expand FLTI to two additional communities outside the Denver metro area to assure statewide representation and cultural diversity.	February 2013 DONE	Eileen Forlenza	Mesa County will offer FLTI.
	C 1.4 A statewide training will be implemented to increase the number of credentialed FLTI Facilitators to support the capacity of additional communities able to implement FLTI.	December 2012 DONE	Eileen Forlenza	The National PLTI training team will conduct a training in Colorado.
	C 1.5 A statewide Family Summit will be conducted to raise awareness and build skills of family leaders so they may participate in leadership opportunities related to family-centered care.	September 2013 DONE	Eileen Forlenza	Summit is conducted and # of participants is documented.

	C.1.7. Develop and implement a mechanism to identify and track the leadership skills of FLTI alumni while matching them with programs, initiatives and/or projects that need family leaders, including Medical Home efforts.	June 2014 <i>Note: Informatics has not prioritized this project to date; exploring alternative options</i>	Eileen Forlenza	Data base of FLTI graduates and their area of interest/community projects established. Documentation of methodology for matching FLTI graduates with programs/initiatives/projects.
	C.1.8. Monitor and evaluate utility of mechanism implemented to match FLTI alumni with programs, initiatives, and/or projects.	October 2014	Eileen Forlenza	Evaluation summary
Youth Leadership/Youth Engagement				
	C.2.1. Explore options for a youth leadership training institute (YLTl) in Colorado.	September 2012 DONE	Eileen Forlenza/Audra Bishop	Documented action plan <i>Note: Not feasible to implement YLTl at this time, however, CSU received grant to implement Dare to be you curriculum in Larimer County; Eileen participating on grant steering team</i>
	C.2.2. Share standards for youth engagement with Medical Home partners via Medical Home Forum and/or Coalition.	June 2014	Audra Bishop/Eileen Forlenza	Track partners reached and usage of standards. <i>Note: youth engagement standards being developed through the youth systems action plan</i>

Objective D: By September 30, 2015, resources are available to support the development and implementation of local public health plans that relate to MCH priority #6.

Lead: Jane Gerberding

Target Population: local public health agencies

Criteria for Success:

- Implementation of local medical home action plans that have measurable community-based impact on reducing barriers to a medical home approach

As Measured by:

- All LPHAs have an approved medical home local action plan and corresponding budget to implement the plan
- Qualitative and quantitative data that demonstrates the impact on reducing barriers to a medical home approach in the community
- Assessment of training and technical assistance resources provided for LPHAs

Strategy	Milestones / Key Activities	Target Completion Date	Responsible Persons/Group	Monitoring Plan
Support local planning and implementation efforts to reduce barriers to a medical home approach	D.1.1. Develop local logic model and action plan for the MCH medical home priority.	March 2012 and updated annually	Rachel Hutson, Jane Gerberding	Completed local action plan template
	D.1.2. Provide consultation to LPHAs on their draft medical home action plans.	July 2012, 2013 and 2014	Jane Gerberding MCH Generalists	Approved local action plans for all LPHAs participating in the MCH planning process
	D.1.3. Identify, develop, support appropriate tools and TA to support medical home action plan development during the annual MCH planning process.	June 2012 and updated annually	Jane Gerberding	Completion of TA opportunities; documentation of participation from LPHAs

D.1.4. Develop document/spreadsheet that summarizes local medical home action plans to use as a communication tool to describe the efforts of LPHAs, as well as a planning tool for targeted technical assistance and training for LPHAs.	July 2012 and updated annually	Jane Gerberding	Completion of the summary document; list of how summary document is utilized to inform TA plan and communicate LPHA's efforts related to medical home
D.1.4. Identify, develop, support appropriate tools and TA to support medical home action plan implementation, specific to one or more of the four objectives in the local medical home local action plan.	September 2012 and updated annually	Jane Gerberding Eileen Forlenza Audra Bishop Medical Home Policy Coordinator Health Systems Unit Manager	Completion of TA opportunities; development of implementation tools
D.1.5. Identify/develop and implement methodology to assess quality and impact of the technical assistance provided to LPHAs (ie, resources, training, webinars, etc) to assure LPHA needs were met.	Developed by March 2013 Implemented by 2013	Jane Gerberding (with EPE and MCH Unit)	Completion of assessment of training and technical assistance provided
D.1.6. Develop and implement an evaluation plan to assess local impact on reducing barriers to a medical home approach.	Developed by March 2013 Implemented by October 2013	Jane Gerberding (with EPE)	Evaluation plan developed

Budget Information

Program Budget - Optional

(Describe the total dollars and FTE available, after subtracting indirect costs, to implement the programmatic activities in this action plan. Include the funding source(s) and amounts for the work.)

Data and Evaluation Budget – Optional

(Describe the total dollars available for data and evaluation activities, either through EPE or external contracts. Include the funding source(s). Programs are required to consult with EPE prior to entering into a contract for data or evaluation services.)

General Information

Primary Contact: (enter name of person responsible for this action plan)

Rachel Hutson

Phone Number: (enter phone number of lead)

303.692.2365

Integration Points: PSD Health Systems Unit, youth systems MCH priority, Interagency Systems Initiative, early childhood developmental screening MCH priority, early childhood oral health MCH priority

Link with Health Equity: The prevalence of patients experiencing a medical home varies by population resulting in inequities. For example, amongst children ages 1-14, variations in patient experience have been documented based on race/ethnicity; insurance type; presence of a special health care need; and region of residence (CDPHE Health Watch No. 87, November 2012).

Strategic Partner(s): Medical Home Implementation Team members

Key Stakeholders: Medical Home Community Forum participants, Medical Home Coalition members, HCPF, local public health agencies and other community based organizations