

Cohort Project Summaries 2014-2017

**Alabama**

**Engagement:** Cohort 4 (2016)

**Summary:** Alabama conducted meetings with key stakeholders and surveyed partners to develop a 1 year action plan to realign the priority needs and performance measures of MCH programs and funding in the state with the MCH 3.0 Transformation. The team was able to garner stakeholder buy-in for this realignment and administration approval along with funding for an MCH coordinator to facilitate this new plan.

**Project Area:** Strengthen Title V Capacity

**Essential tools:** Implementation Plan, Action Plan, Cascading Logic Model

**Alaska**

**Engagement:** Cohort 2 (2015)

**Summary:** The state team strengthened their understanding of the Medicaid enrollment process and formalized partnerships between Title V and public assistance to work on decreasing the backlog of applications for Public Assistance in preparation for Medicaid expansion. The team worked with private and public sectors on process improvement and created a list of recommendations for DPA assistance. Alaska developed skills in systems mapping and new knowledge of experiences of rural tribal populations.

**Project Area:** Strengthen Title V Capacity

**Essential tools:** LEAN Value-Stream Mapping, Systems Mapping

**American Samoa**

**Engagement:** Cohort 4 (2016)

**Summary:** The state team worked to improve the systems of care for CYSHCN in the territory by facilitating cross-agency collaboration and developing a children’s health services work group. They conducted and analyzed a CYSHCN survey, conducted system support mapping, and developed work plans for improvement aims that gained buy-in from senior leaders.

**Project Area:** Care Coordination

**Essential tools:** Service Support Mapping, Flower Diagram, Fishbone Diagram, Process Flow Charts

**Arkansas**

**Engagement:** Cohort 2 (2015)

**Summary:** The state team created a breastfeeding and safe sleep toolkit to increase breastfeeding rates and safe sleeping practices in Arkansas hospitals. The team collaborated across organizations and engaged community partners to garner buy-in from the project and gain cross-sector support.

**Project Area:** Improve a specific health outcome

**Essential tools:** PDSA cycles, Measurement Table, Force Field Analysis, Project Charter

**Colorado**

**Engagement:** Cohort 1 (2014)

**Summary:** Colorado mapped care coordination activities across multiple systems, primarily the Title V Health Care Program for Children with Special Needs (HCP), Healthy Communities (EPSDT outreach) and the Medicaid Regional Care Collaborative Organizations (RCCOs), to maximize existing resources, identify duplications and gaps in care coordination services. The team began the process in one geographical region. More than 40 potential policy changes were identified and prioritized during the Cohort experience. These changes will result in a system of care coordination with clear roles and processes for state and local partners who play a role in implementing the identified programs.

**Project Area:** Care Coordination

**Essential tools:** Process Flow Diagram, Impact Matrix

**Florida**

**Engagement:** Cohort 2017

**Summary:** The state team developed a directory of statewide behavioral health resources, identified evidence-based behavioral health treatment guidelines, and created a Behavioral Health Toolkit for primary care providers to help integrate behavioral health services into primary care settings for children. They increased their partnerships across agencies and aligned common goals across their stakeholder group. The team also conducted readiness assessments for the implementation of pilot studies.

**Project Area:** Integrate primary care, specialty care, and public health

**Essential tools:** Logic Model, Impact Matrix, System Support Maps, Causal Loop Diagram, 5R’s, Measurement Table

**Georgia**

**Engagement:** Cohort 1 (2014)

**Summary:** Georgia worked to improve timely screening of referred children and reducing duplication of effort in obtaining family information for eligibility determinations. Georgia’s team included representatives of the Georgia Department of Public health (MCH Director, MCH Deputy Director, State Director of Intervention Services/CYSHCN Director, Parent Consultant, District Program Coordinator, and State Child Health Director of Epidemiology), Georgia Department of Community Health (Medicaid), and community partner representatives (Georgia Chapter of American Academy of Pediatrics and Georgia Academy of Family Physicians).

**Project Area:** Strengthening and streamlining screening services

**Essential tools:** Process Flow Diagram, PDSA Cycles

**Guam**

**Engagement:** Cohort 2 (2015)

**Summary:** This team expanded partnerships and created an Early Childhood Programs Workgroup to strive towards increasing the number of uninsured, Medicaid, and medically-indigent children (birth – age 8) who have access to timely and appropriate services. In this work, the team developed an action plan and concrete measures to simplify the process for Medicaid patients to make EPSDT appointments at CHCs and gained a deeper understanding of barriers to well-baby visits.

**Project Area:** Strengthen Title V Capacity

**Essential tools:** Systems Mapping, Flower Tool, 5 Rs, Impact Matrix, Process Mapping, Financial Mapping

**Hawaii**

**Engagement:** Cohort 1 (2014)

**Summary:** Hawaii strengthened the coordination of developmental screening and surveillance efforts and aimed to impact screening and referral rates of young children (birth through age 5). With the Center, Hawaii improved their stakeholder buy-in and support, increasing their partnering agencies from 6 to 22. They completed process maps for developmental screening and surveillance for 6 agencies, and developed action plans for further refining. The team also used frameworks to align their leadership priorities amongst MCH Workforce, HRSA/MIECHV, HRSA/ECCS, HRSA/Title V, and MCH 3.0.

**Project Area:** Strengthening and streamlining screening services

**Essential tools:** Process Mapping, Circle of Care

**Illinois**

**Engagement:** Cohort 1 (2014)

**Summary:** Illinois developed a systematic framework for developing, testing, and implementing a pilot project aimed at increasing knowledge about referral locations for newborns who do not pass hearing screenings and increasing knowledge regarding hearing screening and appropriate follow-up procedures across multi-faceted stakeholders.

**Project Area:** Strengthening and streamlining screening services

**Essential tools:** PDSA Cycle, Impact Matrix, 5 R’s, AIM Statement, Team Charter, System Mapping

**Iowa**

**Engagement:** Cohort 1 (2014)

**Summary:** Iowa worked to improve the MCH workforce capacity and knowledge for its role in health transformation. The state team first piloted the Title V State Access to Care Assessment tool, and then assessed their capacity to impact access to care with a large stakeholder group. Iowa built a shared Title V Value Proposition for eligibility and enrollment, continuity of care, provider network and network adequacy, coverage and insurance benefits, and partnerships between stakeholders (Title V, Medicaid, CHIP, and Marketplace). The team used their findings to develop an impact matrix, identify opportunities for improvement, and develop a shared action plan to support local and state action.

**Project Area:** Care Coordination

**Essential tools:** Getting to Your Value Proposition, Impact Matrix, Measurement Tables, Peer Consult, Title V State Access Assessment Tool

**Kansas**

**Engagement:** Cohort 2 (2015)

**Summary:** The state team created a toolkit for telehealth implementation to increase the system capacity for integrating telehealth to address the needs of CYSHCN families. For this work, the team established partnerships between Title V and hospital/prenatal care providers and developed a concurrent pilot project in a rural hospital.

**Project Area:** Improve a specific health outcome

**Essential tools:** Systems Mapping, Brainstorming/Modified Affinity Diagrams, Cost Benefit Analysis, Impact Matrix, PDSA Cycles

**Engagement:** Cohort 2017

**Summary:** The state team worked to increase access to adolescent well-visits by expanding school-based Health Centers. They compiled a School-Based Health Center “how-to-guide” and developed new and strengthened relationships with stakeholders including school-based health centers, schools, Medicaid, and School Nurses. The team also conducted a school nurse survey and analyzed the results to help determine opportunities at existing school-based health centers and identify potential pilot sites.

**Project Area:** Integrate primary care, specialty care, and public health

**Essential tools:** Plus Delta Evaluation, PDSA Cycle, Contingency Planning, 5 R’s, Comprehensive Literature Review, Action Plan

**Louisiana**

**Engagement:** Cohort 2017

**Summary:** The state team worked on developing a comprehensive developmental screening and early intervention service system for Louisiana by creating a resource library, a provider infographic, a developmental screening webpage, and a Developmental Screening Connections Newsletter. They also have achieved widespread dissemination of LDSG, and created a TA options form and Referral Tip Sheet. The team engaged stakeholders and strengthened existing partnerships to support this work.

**Project Area:** Strengthening and streamlining screening services

**Essential tools:** Systems Mapping, Shared Vision

**Maine**

**Engagement:** Cohort 2 (2015)

**Summary:** The state team worked to support transitioning youth with special healthcare needs (ages 14-26) to adult health care. In their work with the Center, the state team strengthened partnerships with stakeholders and created a shared understanding of the CYSHCN transitioning system by convening a workgroup of stakeholders and implementing methodologies to encourage systems thinking for the issue at hand. Maine was able to effectively identify needs and opportunities for collaboration with its stakeholders, and developed a better understanding of issues around transitioning.

**Project Area:** Improve youth transition to adulthood

**Essential tools:** System Support Maps

**Maryland**

**Engagement:** Cohort 2017

**Summary:** The state team created uniform standards for care coordination for CYSHCN and wrote an associated white paper after initiating a providers’ inventory survey, conducting statewide focus groups for parents/caregivers of CYSHCN, and identifying and engaging stakeholders after establishing a sense of urgency around this issue.

**Project Area:** Care Coordination

**Essential tools:** Appreciative Inquiry, System Support Maps, 8 Principles to Promote Effective Change, 5 R’s Framework, Measuring What Matters, Action Plan, Measurement Table

**Massachusetts**

**Engagement:** Cohort 2 (2015)

**Summary:** To promote a culture of social-emotional health for young children in Massachusetts, the state team used systems mapping to understand how to engage stakeholders, pursue funding options, and leverage opportunities for health transformation. The team worked with the Center to map the continuum of services that promote social and emotional wellness for young children in the state and convened a group of 25 experts to develop a position statement on standards of care and best practices for promoting social-emotional wellness in pediatric primary care.

**Project Area:** Integrate primary care, specialty care, and public health

**Essential tools:** System Support Maps, Whole Systems Mapping

**Michigan**

**Engagement:** Cohort 4 (2016)

**Summary:** The state team worked to improve health outcomes and quality of life for children and youth with epilepsy (CYE). The team analyzed Medicaid and CSHCS databases to identify key geographic information of CYE in Michigan to inform their Action Plan, and surveyed 3300 families of CYE to understand their experiences and needs to develop a process flow diagram. They provided training about epilepsy for care coordinators, providers, and local health departments at 6 different venues, and they recruited 5 epileptologists at four centers to establish telemedicine programs for CYE.

**Project Area:** Improve a specific health outcome

**Essential tools:** Project Charter, Action Plan, Process Flow Diagrams, Impact Matrix, Logic Model, System Support Map

**Minnesota**

**Engagement:** Cohort 1 (2014)

**Summary:** Minnesota convened stakeholders and grew relationships to improve cross-systems care coordination and increase the visibility of CYSCN populations in policy-making. The team identified related action steps to direct the allocation of their Systems Integration Grant.

**Project Area:** Care Coordination

**Essential tools:** Measurement Tables, Whole System Mapping, Network Mapping, Family Care Mapping, Circle of Care Modeling, Work Plan, Logic Model

**Mississippi**

**Engagement:** Cohort 1 (2014)

Mississippi worked on improving systems integration and care coordination for CYSHCN by developing an Advisory Committee for CMP. Mississippi engaged core stakeholders, including Medicaid, Department of Education, Social Security, MS Primary Healthcare Association, and the tertiary medical center UMMC, and completed a PDSA cycle with the interdisciplinary perspectives.

**Project Area:** Care Coordination

**Essential tools:** Fishbone Diagram, PDSA Cycle, Impact Matrix, Circle of Care, Systems Mapping

**Montana**

**Engagement:** Cohort 2017

**Summary:** The state team developed workforce capacity for convening and maintaining a diverse and engaged stakeholder group to enact action for strengthening the system of care for CYSHCN. They convened an actionable stakeholders group and convened a CSHS stakeholder group. The team worked with the Center to develop activities and presentations to engage stakeholders in the state CYSHCN program and created an Action Plan to address the issues of highest concern to Montana’s families.

**Project Area:** Strengthen Title V Capacity

**Essential tools:** Social Network Analysis, Prioritization Matrix, System Support Mapping, Asset Mapping

**Nebraska**

**Engagement:** Cohort 2 (2015)

**Summary:** The state team engaged young adults and partners to increase young adult utilization of health care services. They established two large work groups with these stakeholders to create a resource list of young adult essential benefits, health priorities, and data sources. In this work the Center supported the team in gaining a deeper understanding of young adult experiences in the care system, define the need for young adult engagement, develop a work contract model for young adult consumers, and align their project aims with a health transformation perspective. transformation.

**Project Area:** Improve youth transition to adulthood

**Essential tools:** Action Plan Template, PDSA Cycle, Impact Matrix, Process Flow Diagram, Progress Report Template

**New Jersey**

**Engagement:** Cohort 2017

**Summary:** The state team identified potential strategies and interventions to decrease low-risk cesarean deliveries among first-time mothers in New Jersey. The group convened physicians from hospitals and practices with both low and high C-section rates, and worked with partners to gain an understanding of clinical and community-based initiatives aimed at reducing low-risk C-sections.

**Project Area:** Improve a specific health outcome

**Essential tools:** Simulation Model

**North Carolina**

**Engagement:** Cohort 2017

**Summary:** The state team worked to improve the sustainability of North Carolina’s MCH systems of care initiatives in local communities by broadening their knowledge-base of sustainability and identifying a framework to support their work. The team also led 20 stakeholders in the completion of the Program Sustainability Assessment Tool and developed a sustainability action plan.

**Project Area:** Integrate primary care, specialty care, and public health

**Essential tools:** Program Sustainability Assessment Tool, Sustainability Planning Framework, Sustainability PDSA, Action Plan

**Rhode Island**

**Engagement:** Cohort 1 (2014)

**Summary:** Rhode Island worked to develop standardized curriculum for their peer support workers, and began by defining the role of a peer support worker in collaborative discussions with new partners. The state team developed a work-plan for sustainability of the peer support program, and progressed in developing core competencies and curriculum for training the workers.

**Project Area:** Strengthen Title V Capacity

**Essential tools:** Impact Matrix,Process Flow Diagram, PDSA Cycle Summary, System Mapping, Adaptive Inquiry, Stock and Flow Diagram

**South Carolina**

**Engagement:** Cohort 4 (2016)

The state team initiated South Carolina’s first ever state-wide Sickle Cell Disease (SCD) stakeholders meeting that brought together professionals from hospitals, universities, government agencies, insurance companies, and legislature to work on improving the system of care for those with SCD. The team worked to identify and engage clinical leaders in SCD care and developed a targeted state plan to enhance the coordination and quality of care for SCD across the lifespan.

**Project Area:** Improve a specific health outcome

**Essential tools:** Collective Impact, Return on Investment Toolkit

**Tennessee**

**Engagement:** Cohort 4 (2016)

**Summary:** The state team worked to promote the integration of behavioral health into primary care for children, youth, adolescents, and young adults (ages 0-21) by developing a toolkit with the Department of Education and increasing visibility of the issue through an expanded and strengthened partnership base. The team secured funding to continue this work from a SAMHSA SOC Expansion Grant, and shared their work to integrate stakeholder feedback at a TennCare Summit and at a Community Café with the state Commission on Children and Youth.

**Project Area:** Integrate primary care, specialty care, and public health

**Essential tools:** System Mapping, Fishbone Diagram, Brain Writing, Impact Matrix, Root Cause Analysis, the 5 R’s, Collective Impact, Implementation Science

**Texas**

**Engagement:** Cohort 2 (2015)

**Summary:** The state team worked with the Center to create the Corpus Christi Coalition to reduce adverse asthmatic experiences for children by coordinating the system of care in the Corpus Christi area. The state team convened a meeting of 40 stakeholders across schools, providers, and parents to identify childhood asthma challenges. They then developed a tiered asthma training agenda for school professionals, aligned Asthma Management Plans between schools and providers, established education service centers for eight schools, and created school asthma policy and procedure templates by building and strengthening state, community, and professional partnerships.

**Project Area:** Improve a specific health outcome

**Essential tools:** Process Flow Diagrams, Systems Mapping

**Virginia**

**Engagement:** Cohort 4 (2016)

**Summary:** The state team worked towards establishing a coordinated Medical Neighborhood model for CYSHCN. The team strengthened their partnership with AAP, held a regional interest meeting, worked with partners to diagram the end-state ideal model, and developed a formalized description of the medical neighborhood model.

**Project Area:** Care Coordination

**Essential tools:** System Support Maps, Project Charter, Process Flow Diagrams

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| **Project Areas** | **Center State Engagement**  | **Tools**  |
| Care Coordination  | Virginia – 4 American Samoa – 4Colorado – 1Iowa – 1 Maryland – 2017 Mississippi – 1Minnesota – 1  | Service Support Mapping, Flower Diagram, Fishbone Diagram, Process Flow Diagram, Impact Matrix, Getting to Your Value Proposition, Measurement Tables, Peer Consult, Title V State Access Assessment Tool, Appreciative Inquiry, System Support Maps, 8 Principles to Promote Effective Change, 5 R’s, Measurement Tables, Whole System Mapping, Network Mapping, Family Care Mapping, Work Plan, Logic Model, Fishbone Diagram, PDSA Cycle, Circle of Care |
| Improve a specific health outcome  | Michigan – 4Arkansas – 2 New Jersey – 2017 Texas – 2 South Carolina – 4Kansas – 2 | PDSA Cycles, Measurement Table, Force Field Analysis, Project Charter, Action Plan, Process Flow Diagrams, Impact Matrix, Logic Model, System Support Maps, Simulation Model, Collective Impact, Return on Investment Toolkit |
| Integrate primary care, specialty care, and public health | Tennessee – 4Florida – 2017Massachusetts – 2 Kansas – 2017North Carolina - 2017 | Program Sustainability Assessment Tool, Sustainability Planning Framework, PDSA, Action Plan, Logic Model, Impact Matrix, System Support Maps, Causal Loop Diagram, 5R’s, Measurement Table, Brainstorming/Modified Affinity Diagrams, Cost Benefit Analysis, Plus Delta Evaluation, Contingency Planning, Comprehensive Literature Review, System Support Maps, Whole Systems mapping, Fishbone Diagram, Brain Writing, Root Cause Analysis, Implementation Science |
| Strengthen Title V Capacity  | Alabama – 4Guam – 2 Rhode Island – 1Montana – 2017Alaska – 2  | Implementation Plan, Action Plan, Cascading Logic Model, LEAN Value-Stream Mapping, Systems Mapping, Flower Tool, 5 R’s, Impact Matrix, Process Mapping, Financial Mapping, Social Network Analysis, Prioritization Matrix, System Support Maps, Asset Mapping, Process Flow Diagram, PDSA Cycles, Stock and Flow Diagram |
| Strengthening and streamlining screening services  | Georgia – 1 Hawaii – 1 Illinois – 1 Louisiana – 2017  | Process Flow Diagram, PDSA Cycles, Process Mapping, Circle of Care, Impact Matrix, 5 R’s, AIM Statement, Team Charter, System Mapping, Shared Vision |
| Improve youth transition to adulthood | Maine – 2 Nebraska – 2  | System Support Maps, Action Plan Template, PDSA Cycle, Impact Matrix, Process Flow Diagram, Progress Report Template  |