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Practice Summary & Implementation Guidance

Incorporating the Social & Structural Determinants of Health in Colorado's Title V Program

The Colorado MCH Program used a structured, data-informed and inclusive needs assessment process to incorporate a focus on addressing the social and structural determinants of health into Title V new priority selection for 2021-2025.

Location	Topic Area	Setting
Colorado	Health Equity	Community

Population Focus	NPM	Date Added
Cross-Cutting/Systems Building	NPM 4: Breastfeeding, NPM 6: Developmental Screening, NPM 9: Bullying, NPM 11: Medical Home, NPM 14: Smoking	October 2020

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Section 1: Practice Summary

PRACTICE DESCRIPTION

The federal Title V Maternal and Child Health (MCH) block grant guidance provided states with the opportunity to incorporate a focus more intentionally on the social and structural determinants of health (SSDoH) across MCH populations in the selection of MCH statewide priorities for 2021-2025. The guidance included an option to capture cross-cutting and infrastructure building areas of focus, such as the social determinants of health. To address this, the Colorado MCH Program looked beyond the traditional population-specific strategies to identify upstream approaches to address the root causes that impact health outcomes across all MCH populations. The Colorado MCH Program used a structured, data-informed, and inclusive process to incorporate SSDoH into the needs assessment and priority selection, as well as the planning and implementation processes for the 2021-25 Title V grant cycle.

CORE COMPONENTS & PRACTICE ACTIVITES

Colorado's innovative approach to the MCH needs assessment and prioritization process resulted in the selection of four of Colorado's seven new MCH priorities focused on SSDoH: increasing prosocial connection, creating safe and connected built environments, increasing economic mobility, and reducing racial inequities. The remaining three priorities are: improving access to supports, increasing social-emotional wellbeing and promoting positive child and youth development. Following the selection of priorities, the program identified three strategic anchors to guide all aspects of the MCH program: racial equity, community inclusion and upstream; and three health impact areas: nutrition security, behavioral health, and access to care. The alignment of priorities with health impact areas resulted in the selection of the program's core measures, which includes five national performance measures, four state performance measures, and five state outcome measures. Teams with varied expertise and perspectives were established to develop action plans and logic models for each of the priorities, with support from the Foundations Workgroup and input from the MCH Community Advisory Board and the Title V Family Representative.

In early design stages of the 2021-2025 MCH needs assessment, the program adopted the Bay Area Regional Health Inequities (BARHII) Framework. This framework and the upstream approach the Colorado MCH Program took for the needs assessment, design, and implementation of the MCH priority work, positioned Colorado's MCH Program to address the interconnectedness of health outcomes with social and structural determinants for all MCH populations.

Core Components & Practice Activities

Core Component	Activities	Operational Details
Needs Assessment	Developed MCH SSDoH data report for Colorado; Assessed needs for MCH populations using quantitative and qualitative data	A data document highlighting the SSDoH data for Colorado was a primary data source for the needs assessment. In addition to population-specific workgroups, an SSDoH Workgroup met with a focus on identifying potential SSDoH cross-cutting priority areas. The six workgroups shared their findings and identified several similar themes. The groups were then re-chartered to focus on the emerging themes.
Priority Selection	Developed issue briefs; Conducted a structured prioritization process with the MCH Advisory Team	Each team developed issue briefs for the six priority areas identified, which included data on why the priority was important to the MCH population and strategy ideas to illuminate the potential public health role. The MCH Advisory Team convened for two days of a facilitated, structured prioritization process, reviewing the content for each potential priority, and ultimately selecting seven priorities aligned with the five MCH population domains and the sixth SSDoH cross-cutting domain.
Strategic Anchors and Health Impact Areas	Facilitated discussion with the MCH Advisory Team; Identified health impact areas and selected performance measures	The MCH Advisory Team identified strategic anchors to guide programmatic decision making. The group was clear that while reducing racial inequities was its own priority, activities to address racial equity also needed to be integrated across all priorities. The team also wanted to ensure the program demonstrates community inclusion and maintains a focus on upstream approaches. The needs assessment process also highlighted three areas of health outcomes that were critical to impact in Colorado: behavioral health, access to care and nutrition security. With these outcomes in mind the program selected five national performance measures, four state performance measures and five state outcome measures.
Infrastructure Development	Established a Foundations Workgroup; Identified	A workgroup was established to help guide the process for developing state logic models and action

	Priority Coordinators; Determined staffing needs and hired new positions	plans, as well as shifts in the programmatic infrastructure to support increased collaboration across implementation efforts. This included new reporting tools, changes in the make-up and purpose of internal collaborative teams and decision-making processes. Priority Coordinators were identified, job duties adjusted as needed and some new staff were hired to support implementation of the new work.
State Logic Models and Action Plans	Established priority-specific installation teams and created Year 1 action plans and logic models	Priority-specific installation teams met for a period of seven months to identify specific strategies, action steps and measures, which are reflected in the logic models and action plans the teams developed for each priority.
Community Inclusion	Engaged Community Advisory Board and Title V Family Representative	Installation teams presented drafts of the action plans and logic models to the Community Advisory Board to solicit input. Teams met with the Title V Family Representative to review plans and ensure community inclusion was embedded throughout the action steps. Each team created a Community Inclusion Roadmap for their priority.

HEALTH EQUITY

which SSDoH were most critical to the health of MCH populations and was influential in the ultimate selection and implementation of new MCH priorities and strategic anchors. The decisions that the Colorado MCH Program made throughout the needs assessment and planning stages for the new priority work reflected a commitment to health equity, with a particular focus on racial equity. In the early exploration of which determinants to select, the SSDoH workgroup identified racism and discrimination as the single most important contributing factor among all the social and structural determinants reviewed.

The group discussed whether to have racial equity as a standalone priority or embedded throughout all the priorities, and the group decided it should be both. As such, reducing racial inequities was selected as one of seven priorities for the upcoming MCH block grant cycle. Additionally, the program incorporated three strategic anchors: racial equity, community inclusion and upstream. The strategic anchors tether the individual priorities to overarching programmatic values, hold each priority implementation team accountable to these values and provide a lens through which every decision is viewed.

The strategic anchors were used by staff as guideposts as they developed action plans and logic models. The team responsible for developing strategies for the reducing racial inequities priority identified internal policy and systems changes to the MCH program, division, and department. For the other six priorities, teams were charged with including specific activities designed to impact racial equity. Examples include addressing access to care inequities, increasing access to breastfeeding supportive environments in communities facing the greatest racial/ethnic disparities, and built environment policies designed to increase safe and connected communities. Racial equity was incorporated into the performance measures and objectives that were selected, including a new state performance measure: "Number of new racial equity related policy, practices and systems changes implemented at program and department level" and a new state outcome measure using the Racial Equity Index.

While this is not the first time the Colorado MCH Program has included a focus on health equity, explicitly centering on racial equity is new. Because the predominant root cause of health inequities is racism, the MCH Advisory Team recommended centering more specifically on race versus the broader term of health equity. In addition, there has been a more intentional effort to identify clear racial equity-focused strategies, activities, and corresponding measures in priority action plans, which has and will continue to transform how the program approaches the work.

EVIDENCE OF EFFECTIVENESS

While this program has not been formally evaluated yet, the following were early successes identified during the assessment and planning stages. State and local MCH partners successfully integrated social and structural determinants (SSDoH) of health into the MCH needs assessment and resulting 5-year block grant priorities. Of seven new priorities, four focus on social and structural determinants of health. And a new infrastructure is now in place to support ongoing collaboration and steps are in place to conduct continuous assessment and make process improvements along the way.

Consideration of upstream determinants and health equity using Colorado-specific quantitative and qualitative data was a new and unique approach to the MCH needs assessment process. It resulted in MCH priorities that are not mutually exclusive but are instead intentionally interconnected. This approach allowed the program to explore cross-cutting strategies and upstream approaches that support multiple priorities and impact multiple MCH population groups. Priority coordinators considered level of evidence as one of the criteria when selecting strategies and activities to include in the state action plans for each of the priorities.

Importantly, the program is now poised to tackle the work around dismantling racism and white supremacy with concrete plans in place to move forward, including mechanisms to measure progress. The strategic anchor of racial equity was successfully woven throughout the effort in more actionable and measurable ways and a Racial Equity Specialist is leading the implementation efforts for the reducing racial inequities priority, as well as providing consultation to the other priority coordinators in addressing racial equity.

The program successfully incorporated community inclusion in the planning and implementation phases of the current block grant cycle. Additionally, the MCH program's commitment to resourcing a community inclusion specialist and ongoing backbone support of the Community Advisory Board further supports ongoing community inclusion in program development and implementation.

Section 2: Implementation Guidance

STAKEHOLDER EMPOWERMENT & COLLABORATION

Throughout the needs assessment, prioritization and planning process, the MCH program sought input and shared decision-making through a variety of qualitative methods including key informant interviews, dedicated work groups, stakeholder surveys, social media polls, and facilitated discussions with stakeholders. Stakeholders included local public health agency grantees, partner organizations, young people, community members, public health colleagues, and representatives from other state agencies.

Local public health agency staff were engaged in a variety of ways throughout the process. In 2017, this partnership began with conversations at the individual agency level and identified a clear need to incorporate upstream approaches. In summer 2018, a full-day summit followed the annual MCH block grant review focused on integrating upstream strategies and health equity into Colorado's future Title V block grant applications. From March - October 2019, eight MCH staff members from metro and rural local public health agencies participated in the SSDoH Workgroup meetings with five state staff to select SSDoH areas of focus for the needs assessment prioritization process. Additional convenings and opportunities to gather input included stakeholder surveys, MCH manager meetings, a Fall 2020 stakeholder planning meeting, and conversations with stakeholders via state MCH consultants and current priority leads.

In addition to engaging local public health agency staff, conversations were held with CDPHE's two advisory boards - the Youth Partnership for Health and the Community Advisory Board. The Youth Partnership for Health is a youth advisory council for state, local and community stakeholders, created to ensure that the needs of young people are included in the programs and policies that affect them. The Community Advisory Board is a formal infrastructure for community engagement with a membership reflective of the communities most impacted by MCH priority work. Continued partnership and engagement with these two councils is written into action plans for each priority in the coming year. Additionally, the MCH needs assessment included population-specific workgroups, some of which incorporated input from large stakeholder events.

Because the MCH program identified community inclusion as a strategic anchor, workgroups incorporated community inclusion strategies into state action plans. This included working with a contracted family leader and community engagement consultant to develop a community inclusion roadmap for each priority.

Local public health agencies grantees were essential collaborators. They provided invaluable input on all aspects of the practice, particularly for feasibility and local agency and community support. In some cases, they were already piloting strategies to impact SSDoH. They continue to be essential partners in building local action plans for the new priorities.

REPLICATION

This practice has not yet been replicated.

INTERNAL CAPACITY

State program staff from multiple programs including the Children, Youth and Families Branch; the Nutrition Services Branch; the Violence and Injury Prevention - Mental Health Promotion Branch; the Healthy Living and Chronic Disease Prevention Branch and the Center for Health and Environmental Data participated in the needs assessment, prioritization, planning and implementation phases of the project. The project relied upon an experienced needs assessment lead for the first phase of the project. Six workgroups also supported the needs assessment and prioritization processes, originally organized by the six MCHB domains and then by the six priority areas that emerged from the needs assessment. The MCH Advisory Team made priority recommendations and agreed on planning and implementation next steps. The MCH Core Team made decisions on process and final priorities. The Foundations Workgroup determined infrastructure changes needed to support the new priorities.

Dedicated staff time was essential to the success of this project. This included staff leads for the various phases of the process as well as staff input and participation from across the program. A minimum of 0.5 FTE to organize and oversee the project would be needed, along with staff time to participate in meetings, evaluate evidence, and inform and/or make decisions. Organization and administration of the process could be a short-term assignment. Staff expressed the process required significant time and effort. An alternate approach would be to hire a contractor to organize and lead the process, but the risk would be losing the staff development benefits and embedded knowledge of the process in future decisions.

Staff skills in implementation science, evaluation of evidence and facilitation proved helpful, as was the expertise of the MCH epidemiologist and program evaluator. A co-lead model to lead priority action planning was useful to share the workload and brainstorm next steps. Workgroup leads gathered regularly to share best practices and troubleshoot challenges. A shared e-folder of resources supported consistency and efficiency of effort.

PRACTICE TIMELINE

Phase: Planning/Pre-Implementation		
Activity Description	**Time Needed**	**Responsible Party**
Assessing/securing leadership and staff support for incorporating SSDoH into the state Title V program.	Variable 5-20 hrs. each; 5 leadership team members	Leadership Team

Phase: Implementation		
Activity Description	**Time Needed**	**Responsible Party**
Needs Assessment	18 months (July 2018 - December 2019) 16 hrs./week	Needs Assessment Lead
Prioritization and Selection	9 months (March 2019- November 2019) 2-4 hrs./week; 6 teams of approximately 6-8 people	SSDoH Workgroup, Population-Specific Workgroups, MCH Advisory Team
Infrastructure Development	12 months (December 2019 - December 2020) 2-4 hrs./week; 8 people	Foundations Workgroup
State Logic Models and Action Plans	7 months (January 2020 - July 2020)	7 Priority Coordinators + Installation Teams

	2-4 hrs./week; 2 Co-Coordinators/Priority Coordinators + 2-4 hrs./month for Installation Team members	

Phase: Sustainability		
Activity Description	**Time Needed**	**Responsible Party**
Program Evaluation, including quarterly progress reports and annual evaluation report	60 months	Priority Coordinators, Evaluator

PRACTICE COST

Budget			
Activity/Item	**Brief Description**	**Quantity**	**Total**
Staff time for coordination of the MCH Needs Assessment	4 FTE x 18 months dedicated to the overall leadership and coordination of the MCH Needs Assessment process that explicitly incorporated the social and structural determinants of health.	1	$50,000
Staff time for leading of workgroups and installation teams, and participation in MCH	MCH-funded staff participation in various planning and implementation activities. Exact hours were not tracked, and staff salary varied across positions.	*N/A.*	Staff salaries

Advisory Team meetings			
Community Inclusion	Community inclusion costs incurred over an 18-month period, such as meeting costs, stipends paid to community members who participated on the statewide needs assessment advisory board, the Youth Partnership for Health and the Community Advisory Board for the time spent engaging in the development of MCH priorities; the contract with Title V Family Leader; and external communication and printing costs.	*N/A.*	$80,000
		Total Amount:	**$130,000**

LESSONS LEARNED

- Initial alignment with Colorado's statewide public health needs assessment created opportunity and alignment with broader public health needs assessments in the state and leveraged resources to gather more community input.
- Having a shared understanding of the social and structural determinants of health (SSDoH) supported the early adoption of the BARHII Framework as a guide for how to review data, develop strategies and implement plans. Having a framework to reference was beneficial in explaining this new approach to others as well.
- Anchoring to the framework of Implementation Science provided operational tools and helped team members see the larger process and end goals.
- Developing data products with a focus on SSDoH helped staff identify and narrow potential cross-cutting priority areas.
- Stakeholders and community members were engaged regularly through a variety of qualitative methods including key informant interviews with local public health directors, MCH managers and key staff; population-specific work group conversations and stakeholder convenings; discussions with Colorado's youth advisory board and MCH community advisory board; and surveys. This provided a variety of different perspectives and mechanisms for soliciting input throughout the process.
- The engagement of eight public health agencies, in addition to state staff, on the SSDoH Workgroup provided critical perspectives on needs in different communities and supported buy-in on the final selection of priorities.
- Recognize when to pivot. Mid-way through the needs assessment, the population-specific teams and the SSDoH workgroup identified common issues across multiple populations. This

resulted in the teams reorganizing around the new common themes. It was an unexpected shift in the process that required staff to take a step back and rethink leadership and participation on teams for the different topic areas.

- Review existing data and evidence to inform decision making. Brief priority area documents were developed to outline the data related to each priority area. The documents included potential strategies, capacity, public health role and why addressing the issue was a good use of MCH resources. These documents served as key resources for the MCH Advisory Team in making final priority recommendations.
- Decision making in a large group is hard. Having a facilitator guide the dialogue through a structured prioritization process was essential in helping the 30-member MCH Advisory Team develop priority recommendations. Final wording of the priorities was completed by a smaller group.
- In early conversations program staff debated whether the racial equity work should be its own priority OR be embedded across all the plans and there were a variety of perspectives on why one approach was better than the other. Ultimately, the program embraced "both/and" thinking by standing up a priority dedicated to reducing racial inequities AND embedding racial equity as a strategic anchor across all the priorities.
- Because the predominant root cause of health inequities is racism, the MCH Advisory Team recommended centering more specifically on race v. the broader term of health equity. This is reflected in the reducing racial inequities priority and the racial equity strategic anchor.
- Key to the planning stage was coordination across priorities through regular meetings of the priority coordinators to ensure alignment of effort, identification of shared strategies, and development of logic models and action plans in tandem.
- Priorities were previously led by a single subject matter expert, typically with a focus on a specific population. The shift to priorities that cut across MCH populations required intentional focus at the strategy and activity level to ensure the MCH population groups continued to be represented in the work.
- As with many large program changes, this process brought up uncertainties for staff and a need to find a balance between different work styles and the amount of guidance or structure provided. The leadership team worked to maintain open communication and processes that could adapt to concerns as identified. This also prompted staff to examine team culture and structure to better reflect the program's desire for collaborative decision-making and power sharing.
- Designing action plans for priorities without having prior experience to know true resource and staffing needs to support implementation of new work presented challenges. One approach to designing through this uncertainty was to build in "sizing" options when scoping the action plans and developing budgets. Each budget included line items for year one work, along with optional line items that represent additional or expanded work that could be implemented if/when additional funds become available in year one (and/or could be included in the budget for year two).
- While program staff expressed that the needs assessment, prioritization and planning processes were a significant demand on their schedules, broad staff involvement supported buy-in for the new strategic direction of the program. It was important for staff to feel supported in stepping back from other work and activities to be able to commit the time needed.

- Although the processes were demanding and time-consuming, the MCH team of roughly 30 people found the outcome rewarding. Staff expanded their skills, forged new relationships, and co-created together. Through this process, Colorado's MCH program was able to embrace innovation in the Title V structure and move toward MCH 3.0.

NEXT STEPS

Colorado's MCH Program began implementing the new priorities in October 2020. Staff are implementing state action plans and launching the new infrastructure for collaboration, communication, and shared decision-making. There will be ongoing assessment of the new infrastructure to ensure that it is effectively supporting collaboration, communication, and overall program operations. Performance reporting and evaluation measures have been identified for each of the 2021-2025 priorities. A collaborative performance reporting tool will be completed quarterly by priority coordinators. The qualitative and quantitative data will be discussed quarterly to learn from each other's efforts and make adjustments to program implementation as needed. An annual evaluation summary will be completed beginning in the spring of 2021.

The coming year also involves supporting local public health agencies in the development of local logic models and action plans tailored to their specific community needs and agency capacity. Local public health agencies are expected to align their work with the state priorities, and the development process will follow many of the same steps taken to establish state logic models and action plans. By using a co-creation approach, the local public health agencies will have the opportunity to select activities that align with the relationships they have in place, the political and public will in their community and the needs they have identified through their local community health assessments and public health improvement plans.

RESOURCES PROVIDED

- Colorado 2021-2025 MCH Needs Assessment
- Colorado 2021-2025 MCH Priorities & MCH Framework
- 2019 MCH Snapshot on the Social Determinants of Health

APPENDIX

- The BARHII Framework