

**Colorado Maternal and Child Health Local Action Plan (updated 2/25/2016)**

<b>MCH Priority:</b> Developmental Screening & Referral		<b>Planning Period (MM/YY - MM/YY):</b>	10/1/16 - 9/30/18
<b>Local Agency Name:</b>		<b>Priority Lead</b>	<b>Priority Lead Email:</b>
<b>Overview:</b>	Developmental screening & referral is a 2016-2020 MCH priority in Colorado. The MCH priority profile on developmental screening & referral includes key information on the issue and priority effort. (See <a href="http:// TBD">http:// TBD</a> ). This action plan describes how the [LPHA name] will address developmental screening & referral at the local level.		

<b>Goal 1:</b>	Increase the number of children ages 0-5 identified with potential developmental delays who receive services in <geographical region/community> from X to X by September 2018.	<b>Data Source:</b>	Early Intervention data (0-3 yrs), ChildFind (3-5 yrs)	c	n	o	b
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<b>Strategy 1:</b>	Identify strategies and implement action steps to overcome prioritized barriers to increasing the number of children ages 0-5 that receive developmental screening, referral and services
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<b>Objective 1:</b>	Increase from X to X the # of public health, community and health care partners who implement at least 50% of the ABCD Quality Standards to improve developmental monitoring, screening and/or referral in <geographical region/community> by September 2018.	<b>Data Source:</b>	Community specific pre- and post-TA surveys	<b>Target</b>	12/30/15	3/30/16	6/30/16	9/30/16

<b>Key Activities</b>	<b>Start and End Date (MM/YY - MM/YY)</b>	<b>Responsible Persons or Group</b>	<b>Progress Status (c, o, b, n)</b>			
			12/30/15	3/30/16	6/30/16	9/30/16
Continue to convene a community stakeholder group and facilitate regular (insert frequency) meetings to work toward improvements to the system, or identify and support an entity willing to convene such a group.	1-24 months					

Describe and document the prioritized community-level barriers to screening, referral and services.	1-2 months					
Identify actionable community-based solutions to address barriers.	2-3 months					
Review and document roles for health care, public health-based early childhood service delivery programs (e.g. WIC, HCP, home visitation, etc.) and community partners involved in implementing ABCD Quality Standards.	2-3 months					
Develop and document protocols (if not previously completed) for participating health care, public health-based early childhood service delivery programs and community partners to support implementation of the ABCD Quality Standards.	2-3 months					
Coordinate planned outreach efforts between community-based providers and physician practices with ABCD Physician Outreach team. (Coordinating with ABCD on the LPHA role and ABCD's role)	3 months					
Create a community-specific technical assistance (TA) action plan to facilitate implementation of community-based solutions, including type of activities to be completed, selected entities receiving TA and specific timelines.	4-6 months					
Administer pre- and post-TA surveys (standard tool provided by ABCD), including qualitative and quantitative measures, to track extent to which TA recipients are implementing ABCD Quality Standards	4-6 months					

Implement TA as described in TA action plan	6-24 months					
Review survey data to determine if TA is increasing effectiveness of monitoring, screening and/or referral processes and make adjustments, as needed	semi-annually					
Identify barriers and make recommendations for potential solutions that need to be addressed at the state-level.	ongoing					
A minimum of two times per year describe in written form to state-level MCH staff the barriers and recommendations for state-level policy or systems change (can be included in standard MCH progress reporting or other stand alone document).	2x annually					
Refine and update community-specific resource and/or referral list based on improvements to the referral network.	annually or ongoing					

<b>Strategy 2:</b>	Engage families in the development and implementation of activities to increase screening rates
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<b>Objective A:</b>	Increase the number of families from X to X who participate in the community or coalition process by September 2018.	<b>Data Source:</b>	Agency tracking of family involvement	<b>Target</b>	<b>12/30/15</b>	<b>3/30/16</b>	<b>6/30/16</b>	<b>9/30/16</b>
<b>Key Activities</b>	<b>Start and End Date (MM/YY - MM/YY)</b>	<b>Responsible Persons or Group</b>	<b>Progress Status (c, o, b, n)</b>					
			<b>12/30/15</b>	<b>3/30/16</b>	<b>6/30/16</b>	<b>9/30/16</b>		

Identify opportunities in the community or coalition process where family engagement would provide valuable direction to the process	1-3 months					
Identify appropriate and meaningful mechanisms for family engagement (see Family Engagement Continuum)	2-4 months					
Identify recruitment processes to solicit family input according to the mechanism determined above (to include inviting potential family leaders through the list of graduates on the Family Leadership Training Institute Registry)	3-4 months					
Gather family input, according to mechanism defined above, to understand challenges with referral systems.	4-6 months or ongoing					
If family leaders are included in coalition meetings, identify initial onboarding process and ongoing engagement activities. Assign a coalition member to be responsible for this process.	ongoing					
Document how family members have influenced decisions, ideas, or direction of the community or coalition process.	annually					
Engage with CDPHE on technical assistance and/or shared learning focused on community engagement in support of MCH work.	ongoing					