

**Colorado Maternal and Child Health Local Action Plan (updated \_\_/\_\_/2016)**

<b>MCH Priority:</b> Women's Mental Health - Pregnancy-Related Depression	<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>	Women's mental health with a focus on pregnancy-related depression is a 2016-2020 MCH priority in Colorado. The MCH priority profile on women's mental health includes key information on the issue and priority effort. (See http:// TBD). This action plan describes how the [LPHA name] will address pregnancy-related depression at the local level.

<b>Goal 1:</b>	Increase the number of pregnant & postpartum women seeking help through campaign resources from 0 to XX by September 2018.	<b>Data Source:</b> Campaign evaluation data	c	n	o	b
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<b>Strategy 1:</b>	Implement cross-sector use of consistent public awareness messaging among community providers & organizations
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<b>Objective A:</b>	Increase the number of community targeted providers & organizations promoting PRD messaging in <geographical region/community> from 0 to XX by September 2018 as measured by number of placements of campaign materials.	<b>Data Source:</b> Campaign evaluation data	<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
Participate in peer learning opportunity to review results of state-level PRD formative research on public awareness and apply findings to community outreach approaches.	1 month					

Work with up to ___ # of existing community partnerships (e.g. WIC, early childhood councils, family planning, child care centers, health care providers, mental health agencies) to identify mediums for dissemination of public awareness messaging.	1-6 months					
Identify up to ___ # of existing community-based media outlets, including social media, who would be willing to partner on dissemination of messaging.	1-6 months					
Identify up to ___ # of non-traditional partnerships (e.g. birthing centers, prenatal yoga classes, food banks, breast pump rental locations, maternity and infant consignment stores) to assist with dissemination of public awareness messaging.	1-6 months					
Customize dissemination plan for local implementation of public awareness messaging.	4 months					
Customize the CDPHE provided toolkit to create a contextually appropriate monitoring and evaluation plan to track reach and impact of messaging efforts with targeted providers & organizations.	4 months					
Implement dissemination plan.	ongoing					
Actively monitor and evaluate messaging efforts and use findings to make adjustments in implementation activities and follow up with necessary stakeholders.	ongoing					
Engage with CDPHE on technical assistance and/or shared learning focused on community engagement in support of MCH work.	ongoing					

<b>Goal 2:</b>	Increase the number of women with PRD symptoms referred for treatment in <geographical region/community> from XX to XX by 2018 as measured by (TBD - mental health agency referrals?)	<b>Data Source:</b>	Provider survey
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<b>Strategy 2A:</b>	Collaborate with community partners to coordinate PRD screening, referral and treatment across local systems.
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<b>Objective 2A: New to the priority</b>	Increase the number of community partners who are willing to address PRD with women & their support systems in <geographical region/community> from XX to XX by September 2018 as measured by level of engagement agreed to by collaborative partners or other approved method.	<b>Data Source:</b>	Engagement tool and agreement document or other approved method	<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
Identify key community stakeholders.	1-5 months					
Identify key champions (e.g. physician, professional organization, mental health agency, new mother, etc.) who will assist in future communication regarding PRD to peers.	3-7 months					

Contact key stakeholders in community, like the local early childhood council, to determine if work is already underway to address developmental or social and emotional screening among new mothers and children and identify potential areas for collaboration.	1-4 months					
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					
Identify and agree on key priority areas needed for a coordinated system of screening and referral in _____ County, including follow-up for treatment.	4-6 months					
Develop action steps to address key priority areas.	6-8 months					
Engage with CDPHE to develop a method to measure this strategy in _____ County. This should be done as part of the development of action steps to address key priority areas.	1-2 months					
Implement action steps to address key priority areas.	8-24 months					
Engage with CDPHE on technical assistance and/or shared learning focused on community engagement in support of MCH work.	ongoing					

<b>Strategy 2B:</b>	Strengthen local referral networks for providers to address PRD
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Objective 2B: Continuing sites	Increase the number of providers who understand how to navigate referral networks in <geographical region/community> from XX to XX by September 2017 as measured by provider survey results or other approved method.	Data Source:	Provider survey or other approved method	Target	12/30/15	3/30/16	6/30/16	9/30/16
Key Activities	Start and End Date (MM/YY - MM/YY)	Responsible Persons or Group	Progress Status (c, o, b, n)					
			12/30/15	3/30/16	6/30/16	9/30/16		
Conduct community conversations with various providers and other points of contact for pregnant/postpartum women (e.g. OB/GYN, pediatric, mental health, home visitation, WIC, etc.) to determine current processes for referral, including gaps and barriers (process mapping).	1-5 months							
Gather parent/client-level feedback (e.g. focus groups, individual interviews, surveys) to understand challenges with referral systems.	1-4 months							
Create an initial resource and referral list specific to the community.	4-8 months							
Identify and document community-level barriers to referral.	4-6 months							
Engage with CDPHE to develop a method to measure this strategy in _____ County. This should be done as part of the development of action steps to address key priority areas.	1-2 months							
Prioritize barriers to address and identify actionable community-based solutions within _____ County.	6-8 months							
Implement activities to address identified solutions.	8-24 months							

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 action (can be included in standard MCH progress reporting or other stand alone document).	2x annually					
Refine and update community-specific resource and referral list based on improvements to the referral network.	annually or ongoing					
Coordinate with PSI state co-coordinators on identified resource and referral lists in the community.	ongoing					
Engage with CDPHE on technical assistance and/or shared learning focused on community engagement in support of MCH work.	ongoing					