

MCH Implementation Team State Action Plan
Assuring Better Child Health and Development – Priority #3
3-Year Planning Period: January 1, 2012-December 31, 2015

Context

Research has shown that early screening leads to early identification and improved developmental outcomes for young children.

State and local public health have a role in increasing standardized screening within a medical home.

Increasing screening utilizing a medical home approach supports coordinated, high quality care.

Identified barriers to implementing standardized screening.

- Lack of provider support to fully implement standardized screening and referral
- Lack of parent knowledge on the importance of early identification and intervention
- Lack of coordinated systems within a community to develop timely and appropriate referral and interventions.
- Lack of early intervention providers
- Lack of funding to execute a comprehensive integrated data system to track and follow every child from screening through early intervention
- Lack of an integrated data system for surveillance activities
- Lack of policies mandating early and continuous screening for providers

Goal(s)

Data Source(s)

G1	Children in Colorado are screened early and continuously (at a minimum three by three) and receive timely and appropriate referrals and services..	ABCD data base Early Intervention Colorado CCMS Future registry
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Objective A: By September 30, 2013 an ABCD Implementation Team will provide leadership and guidance to ensure the needs of state and local partners are being represented **Lead: Eileen Bennett and Mary Martin**

Target Population: State and local partners

Criteria for Success:	As Measured by:
<ul style="list-style-type: none"> Team is formed and monthly meetings are held 	<ul style="list-style-type: none"> Documentation of meeting minutes

Strategy	Milestones / Key Activities	Target Completion Date	Responsible Persons/Group	Monitoring Plan
Maintain and enhance state partnerships to support standardized developmental and social emotional screening.	Identify state and local partners to serve on the ABCD Implementation Team	October 1, 2013	ABCD core team and Mary Martin	Implementation Team is formed
	Develop a team charter and roles/responsibilities	October 1, 2013	ABCD Implementation Team	Team Charter, roles/responsibilities adopted

Objective B: By September 30, 2015 pilot 3 communities to develop coordinated early childhood and maternal screening programs. **Lead: ABCD Core Team and CDPHE**

Target Population: Maternal Wellness, CYF, Early Childhood Program, ABCD State Coordinator

Criteria for Success:	As Measured by:
<ul style="list-style-type: none"> Identify three community pilots that have or may leverage funding for screening and referral, medical home, other efforts. <p>Adams, Arapahoe and Douglas counties (Tri-County) were identified. Other communities that have chosen developmental screening and PRD include Summit and Hinsdale</p>	<ul style="list-style-type: none"> ABCD Database Early Intervention Colorado CCMS

Strategy	Milestones / Key Activities	Target Completion Date	Responsible Persons/Group	Monitoring Plan
Coordinate across MCH priorities to	Key stakeholders from both screening programs meet regularly to coordinate efforts and leverage opportunities for integration at the	ongoing	Mandy Bakulski Krista Beckwith	Meeting minutes

integrate pregnancy related depression (PRD) into existing screening efforts	state and local levels. Contract execution delay has delayed progress with this activity. Initial conversations occurred and now regular meetings will be scheduled.		Mary Martin Eileen Bennett	
	State and ABCD staff participate in the PRD workgroup to strategize how communities and providers can offer all screens.	September 30, 2013	Mandy Bakulski Mary Martin Eileen Bennett	Meeting minutes, work plan
	Pilot communities include maternal and early childhood screening and referral in referral road maps Work is underway to develop referral road maps in Adams, Arapahoe and Douglas counties	September 30, 2014	Mandy Bakulski Mary Martin Eileen Bennett	Creation of local referral roadmaps
	At every juncture of the road map process, messaging to parents and providers is considered. Tri-County Health Dept staff is on the roadmap workgroup	Ongoing	ABCD	Referral Road Map

Objective C: By September 30 2015 increase the number of communities who have a coordinated system of care for screening, referral and follow up.

Lead: ABCD Core Team

Target Population: Local Early Childhood Councils and public health

Criteria for Success:

- Local communities identify a coordinated system of care for screening referral and follow up as a priority.
- Local communities have developed comprehensive systems of screening, referral, evaluation and early intervention services.

As Measured by:

- ABCD Database
- Early Intervention Colorado CCMS
- Future registry

Strategy	Milestones / Key Activities	Target Completion Date	Responsible Persons/Group	Monitoring Plan
Provide training and technical assistance to support local efforts to	Deliver Model Community training to local communities Otero and Crowley counties received training and are well on their way Tri-County has completed module 1 and is in module 2 Pueblo and Jefferson have completed training for module 1 El Paso is scheduled in June	Ongoing	ABCD core team	Communities have completed training on modules 1 -3

develop a referral road map.	<p>Denver is 5/16 Northeast is scheduled Summit is involved through the Rural Resort ECC and their HI grant San Juan Basin is scheduled for a TA visit through the ECC's Health Integration grant June 12-14 and the Council is reaching out to the SJBHD. Eileen will be calling Julie. Just heard the SJBHD Director resigned Hinsdale - ??</p> <p>Also, 2 regional learning circles on the referral road map have been delivered (well received) and the training has been revised based on feedback</p>			
	<p>Development of a local referral roadmap with agreed upon roles and responsibilities</p> <p>This has been completed</p>	12/31/2015	ABCD core team	Roles/Responsibilities worksheet and referral roadmap blueprint are completed
	<p>Identify opportunities and conduct yearly presentations to health care providers (NP, PA, MD) at state chapter meetings. Provide presentations to physician and nursing training programs at state colleges and universities.</p> <p>PA class at UC-Denver Medical Campus</p> <p>NP class at “</p> <p>Bill Campbell provided a CME at Northeast</p>	Ongoing	ABCD core team and Board	Presentations are documented and posted to the ABCD website.

Objective D: By September 30, 2015 increase the number of pediatric and family practices that refer children to Early Intervention Colorado from 30% to 50%

Lead: ABCD Board

Target Population: Pediatric practices, Family Practices that see children birth to age 3, Early Childhood Councils and Local Public Health Agencies

Criteria for Success:

- Children are being screening at a minimum 3 x 3 at well child visits

As Measured by:

- Referral Roadmaps
- ABCD Data Base
- Early Intervention data

Strategy	Milestones / Key Activities	Target Completion Date	Responsible Persons/Group	Monitoring Plan
Provide technical assistance to primary care providers to implement standardized screening and a process for referrals	Identify opportunities and conduct presentations to health care providers (MD, PA, NP) at local provider staff meetings CME approval was granted and 6 presentations have been provided	Ongoing	ABCD Core Team	Units of CME that have been distributed through ABCD
	Identify opportunities for quality improvement projects for maintenance of certification within pediatric primary care practices Mindy (at ABCD) has been certified to write and submit a QI project to the national AAP; the Colorado AAP has already endorsed it.	Ongoing	ABCD Core Team	QI data collection and analysis
	Identify local and state Family Practice champions El Paso obtained the list of providers and has been using it to reach out; Pueblo has begun, ABCD has connected Adams to 3 new FPs	Ongoing	ABCD Core Team	Consistent support from CAFPP

Objective E: By September 30, 2015 an integrated data system is collecting child level screening, referral and follow up results

Lead: ABCD Board and CDPHE

Target Population: Families, primary care providers, ABCD Board

Criteria for Success: Children birth to three are being screening at the minimum 3 x 3 and referred for evaluation

As Measured by:

- ABCD Data Base
- Early Intervention Data

Strategy	Milestones / Key Activities	Target Completion Date	Responsible Persons/Group	Monitoring Plan
<p>A plan is developed that includes an electronic screening platform that integrates into EMRs and shares results with primary care and other entities as designated by the child's family</p>	<p>HIE collects screening billing data from participating agencies</p> <p>This activity is being re-considered. There was initially discussion about piggy-backing on the newborn hearing screening registry that is being linked to the immunization registry and is among the PH-HIE projects being discussed and prioritized by the Steering Committee. Eileen and I plan to meet with Larry Wohl to have a more in-depth discussion about how the HIE's current data (from billing) meets/does not fit with what is needed. The first focus is on R/D around the electronic screening platform, which needs to have the functionality to push the results to EMRs.</p>	<p>December 2014</p>	<p>COHRIO, ABCD, Mary Martin</p>	<p>PH and HIE steering committee minutes reflect progress</p>
	<p>Identify funding opportunities to support the development/purchase of an electronic screening platform</p> <p>Once the next activity is completed the information and plan will be used to seek support from local foundations</p>	<p>December 2013</p>	<p>ABCD and Mary Martin</p>	<p>Grant funding is applied for and awarded</p>
	<p>Identify key stakeholders to form an ad hoc work group to gather information and develop a plan</p> <p>This is an "on-deck" activity, now that ABCD is catching up on the backlog of TA needs from the delayed contract execution</p>	<p>September 2013</p>	<p>ABCD Board and Mary Martin</p>	<p>Work group in place</p>

Objective F: By September 2015 develop a statewide policy for standardized developmental and social/emotional screening **Lead: ABCD Board and CDPHE**

Target Population: Blue Ribbon Policy Council, CANDO, Early Childhood Colorado Partnership, Early Childhood Council Leadership Alliance, Colorado Children’s Campaign, Colorado Chapter of AAP and CAFPE, others TBD

Criteria for Success:	As Measured by:
<ul style="list-style-type: none"> Target population agrees that a statewide policy is necessary 	<ul style="list-style-type: none"> A policy is developed

Strategy	Milestones / Key Activities	Target Completion Date	Responsible Persons/Group	Monitoring Plan
Develop a policy agenda for screening, referral and follow up	Identify, collect and analyze policies from other states	December 2014	ABCD Board and Implementation Team	Best practices are identified
	Analyze data to demonstrate the impact and outcomes of screening and early intervention for children birth to three	December 2014	ABCD Board and CDPHE	Data is compiled and reported
	<p>Local communities and providers implement a standard of practice for screening, referral, evaluation and services</p> <p>ABCD is having conversations with the CO Health Foundation re: funding to embed quality standards in the Model Community Framework to support QI at the practice level and then at the systems level. This fits under the Health Foundation’s Health Care priority to support quality standards at the practice and community level.</p> <p>Caring for Colorado is funding Adams and Pueblo to look at referral to evaluation benchmarks.</p> <p>There will be policy work related to developmental depression screening as a result of the new ECCS grant focused on mitigation of toxic stress and trauma for infants and toddlers.</p>	Ongoing	ABCD Core Team	Communities have referral roadmaps and agreed upon rules and responsibilities
	Identify legislators to champion the work	Ongoing	ABCD Board	A Legislative champion is on the ABCD Board

Budget Information**Program Budget****Data and Evaluation Budget****General Information**

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Integration Points. MCH Priority #2 - improve screening, referral and support for perinatal depression. MCH Priority #6 - Reduce barriers to a medical home

Link with Health Equity: Identifying all children who are at risk for developmental and social/emotional delay is essential for brain development, neural connections and lifelong positive effects. Once established social and emotional issues are highly resistant to change. The costs associated with antisocial and criminal behavior are high. Outcomes could be improved and societal costs saved if standardized screening, referral and early interventions were the standard of care. (NASHP)

Strategic Partner(s): ABCD Board, Early Childhood Councils, Early Childhood Colorado Partnership, Office of Information Technology, Local Public Health, Community based coalitions, ECCLA, funding community, COHRIO

Key Stakeholders: Children birth to three and their families