Deliverable Form E – 5-Year Action Plans

MCAH SOW Goal 1: Access to Health Care	
Problem Category	**Access to health care, Partner/ family violence, SIDS/SUID, Perinatal mood/anxiety disorders, Child health**
Problem Statement(s)	**Low rate of early prenatal care entry in females delivering a live birth due to substance abuse and mental health issues.** **High rate of domestic violence calls in the county due to lack of education, early identification of problem behaviors, and resource identification.** **High rate of substance abuse hospitalizations in pregnant women due to mental health issues, social isolation, inadequate problem solving skills, poor self-esteem, and limited knowledge on the effects of substance use during pregnancy.** **High rate of mood disorder hospitalizations in pregnant women due to lack of early identification of mental health issues, provider screening, and resource identification.** **High Immunization Personal Belief Exemption rate in Kindergartens due to parental immunization safety concerns and lack of knowledge related to emerging Vaccine-Preventable Diseases.**
Five Year Local Goal(s)	**Decrease substance use in pregnant women and decrease domestic violence rates, improve maternal mental health, improve early childhood immunization levels, and maintain low SIDS/SUID incidence by implementing Community Hubs and mobile outreach to at-risk socially isolated families.**
Risk/Contributing Factors	**Exposure to violence and/or substance use in the home or community, cultural norms and beliefs that accept the use of violence in intimate relationships and model relationships based on power and control. Poor social emotional development/skills including low self –esteem, poor coping /problem solving skills, youth not connected to healthy adult/community, lack of knowledge and access to services, high rates of substance use and mental health issues, social isolation and low socioeconomic status, stress (external/internal), lack of system integration, lack of parental understanding of childhood brain development, impact of adverse childhood events on adult health and lack of parental understanding regarding vaccine importance and safety.**
Best Practice Strategies/ Interventions	**Collective impact approach, expanded stakeholder group to include broader representation including consumers, identify data sources to provide common measures across settings, identify best practice guidelines and provide leadership to help implement Community Hubs and mobile outreach to at-risk socially isolated families.**
Intervention Population(s)	**Medical providers, child welfare, treatment providers, hospitals, parents, adults, children, libraries, schools, Office of Education, child care providers.**

Short and/or Intermediate Objective(s)	Inputs, including Community Partner involvement	Intervention Activities to Meet Objectives	Performance Measures Short and/or Intermediate	
			Process Description and Measure(s) including data source	Outcome Measure(s) including data source
Fiscal Year 1 **Assess Community Needs** By June 30, 2016, develop a plan to provide primary prevention and early intervention services for pregnant women and families with young children through Community Hubs and mobile outreach.	Public Service Agencies, Community-based Agencies, Parents, First 5, County Office of Education & Schools, Early Care and Education Providers, Local Elected Officials, Civic Organizations, Hospitals and other Service Providers.	Define communities served by Hubs and mobile outreach. Convene potential partners in each community to: • Identify target populations • Discuss prevention and early intervention needs • Identify partners in providing collaborative services to address needs. Set regular meetings with identified partners to provide primary prevention and early intervention services: • Assess issues/barriers when serving target populations. • Share best practice/evidence based protocols for family support, education, and health screening and referral. • Identify the local library as a Hub and describe services. • Identify mobile outreach location(s) and describe services. • Identify screening methods and a community referral process. Develop a collaborative plan integrating services through a Hub and mobile outreach.	Briefly describe: Hub and mobile outreach targets and locations. Partners' roles, resources and responsibilities. How partners currently address primary prevention and early intervention strategies, issues in common, gaps and strategies to address them. Screening methods and referral processes.	At least 4 communities will be identified. At least 4 partners engage in primary prevention and early intervention services through Community Hubs and mobile outreach/potential partners. MOU developed. At least 3 community meetings will be held with Community Hub and mobile outreach partners. A plan is developed for each community.

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Fiscal Years 2-4 Community Hubs (If partner buy-in and funding obtained) By June 30, 2017, implement a plan to provide primary prevention and early intervention services for pregnant women and families with young children through Community Hubs.	Public Service Agencies, Community-based Agencies, Parents, First 5, County Office of Education & Schools, Early Care and Education Providers, Local Elected Officials, Civic Organizations, Hospitals and other Health Services Providers	Convene partners in each community on a regular basis to monitor implementation and service coordination: • Identify prevention and early intervention strategies (i.e. family engagement activities, parent education, link to medical care and social services). • Identify partners providing services to address needs. • Coordinate and promote services. Identify dates, times and locations for services. Develop a referral system: • Select screening tools for use with families (i.e. ACE, Edinburgh Postpartum Depression (PPD) Scale, etc.) • Develop a referral system to ensure a warm handoff. Establish a professional development plan for service providers: • Write policy and procedures to ensure integrity of model. • Train staff who are working in Community Hubs. Develop and implement a Continuous Quality Improvement/Quality Assurance (CQI/QA) process.	Briefly describe: Programmatic goals of partner agencies that link to delivery system issues associated with target population. Access to services. Referral system. Professional development plan. CQI/QA process developed. Evaluation plan.	At least 3 partners will engage in the Community Hub Model/potential partners. MOU executed. Number of clients served by Hubs. A referral system is developed. A professional development plan is developed. Describe the outcomes of the CQI/QA process. 50% of Program participants will report an increase in child development knowledge, parenting knowledge and reduced social isolation as measured by First 5 EDC Client Satisfaction Survey.

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			Process Description and Measure(s) including data source	Outcome Measure(s) including data source
		Monitor Community Hubs utilizing client satisfaction surveys.		
Fiscal Year 3 & 4 Mobile Outreach (If partner buy-in and funding obtained) By June 30, 2018, implement a plan to provide primary prevention and early intervention services for pregnant women and families with young children in socially isolated communities through mobile outreach.	Public Service Agencies, Community-based agencies, Parents, First 5, County Office of Education & Schools, Early Care and Education Providers, Local Elected Officials, Civic Organizations, Hospitals and other Health Services Providers	Convene partners in each community on a regular basis to monitor implementation and service coordination for mobile outreach: • Identify prevention and early intervention strategies (i.e. family engagement activities, parent education, link to medical care and social services). • Identify partners providing services to address needs. • Coordinate and promote services. Identify dates, times and locations for services. Establish a professional development plan for service providers: • Write policy and procedures to ensure integrity of model. • Train staff who are working in mobile outreach. Develop a referral system: • Select screening tools for use with families (i.e. ACE, Edinburgh PPD Scale, etc.) • Develop a referral system to ensure a warm handoff. Develop and implement a Continuous Quality	<u>Briefly describe:</u> List the programmatic goals of partner agencies that link to delivery system issues associated with target population. Target neighborhoods services. Professional development plan. Referral system. CQI/QA process developed.	Number of partners that agree to engage in mobile outreach. Number of clients served by mobile outreach. A professional development plan is developed. A referral system is developed. Describe the outcomes of the CQI/QA process. 50% of program participants will report an increase in child development knowledge, parenting knowledge and reduced social isolation as measured by First 5

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		Improvement/Quality Assurance (CQI/QA) process. Monitor Community Hubs utilizing client satisfaction surveys.	Evaluation plan.	EDC Client Satisfaction Survey.
Fiscal Year 5 Sustainability By June 30, 2020, produce a sustainability plan identifying additional resources and collaborations to sustain Community Hubs and mobile outreach to socially-isolated areas.	Public Service Agencies, Community-based Agencies, Parents, First 5, County Office of Education & Schools, Early Care and Education Providers, Local Elected Officials, Civic Organizations, Hospitals and other Health Services Providers	Meet with collaborative partners to discuss successes/challenges of program implementation. Identify funding sources and apply as appropriate. Identify other needed resources; human resources. Identify changes/modifications needed to existing program – reassessment. Continue to foster effective relationships with community. Identify goals, actions for next planning cycle.	<u>Briefly describe:</u> Meetings and their outcomes. Funding applied for and results. Resources identified. Changes to implemented activities. Actions and goals for sustainability of educational program.	Number of meetings. Funding awarded by at least one source to sustain implemented Hubs and mobile outreach. Conduct at least 3 meetings with community partners. Determine at least 3 changes to improve programs. Determine at least 3 goals for sustainability plan. Review of MOU completed.