Deliverable Form E – 5-Year Action Plans

MCAH SOW Goals 2 & 3: Perinatal Mood Anxiety Disorders/SIDS	
Problem Category	**Access to health care, Partner/family violence, SIDS/SUID, Perinatal mood/anxiety disorders**
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.**
Five Year Local Goal(s)	**Decrease substance use in youth and pregnant women and decrease domestic violence rates, improve maternal mental health and maintain low SIDS/SUID incidence by Increasing the proportion of primary care providers who screen pregnant and postpartum (up to one year) women for adverse childhood experiences.**
Risk/Contributing Factors	**Exposure to violence and/or substance abuse in the home or community and 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 the effect of trauma on early brain development, impact of adverse childhood events on adult health**
Best Practice Strategies/ Interventions	**Integration of screening for adverse childhood events into a range of clinical and community settings, such as Federally Qualified and Rural Health Centers, community clinics, health department, and other medical providers; increase client/population knowledge regarding adverse childhood events and the Adverse Childhood Events Study. Prevention efforts should ultimately reduce risk factors and promote resiliency and protective factors. Primary prevention will address all factors that influence domestic violence, substance use, and mental health: individual, relationships, community, and society (ecological model). Understanding the economic impact of domestic violence, substance use, mental health issues and efficiency/benefit of primary prevention. Understanding the impact of adverse childhood events on early childhood development.**

Intervention Population(s)	**Area medical providers; alcohol and drug programs; mental health, public health and social services programs, area hospital systems.**

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 1-2 By June 30, 2016, a plan will be developed to integrate ACE screening in coordination with community partners and county programs.	Primary Care Providers, Behavioral Health, Social Services, Alcohol and Drug programs, Community-based organizations, HHSA Leadership	Identify and engage community partners/collaboratives, County programs and HHSA leadership. Provide information on ACE, ACE Study and impacts on social and health outcomes. • Develop PowerPoint and other education materials. • Identify locations, dates and times of presentations. • Evaluation method for assessing intent to change practice and share information. Collaborate with providers, community organizations, and support groups to establish a referral resource network.	Briefly describe: Collaborative relationships that support screening for ACE. PowerPoint, and collaborative meetings. Agendas, minutes, meeting materials and list of participants on file. Resources and support groups for ACE. Brief description of referral resource network.	Number of partners with intent to change practice and share information /potential partners. Referral resource network developed.

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Fiscal Year 1 By June 30, 2016, determine the number of primary care providers who screen pregnant and postpartum (up to one year) women for adverse childhood events (ACE) and, of those who screened, the number referring women who screen positive for follow-up care.	Primary Care Providers, Behavioral Health, Social Services, Alcohol and Drug programs, Community-based organizations	Engage existing medical community partners/collaboratives. Provide information on ACE, ACE Study and impacts on social and health outcomes. Develop and implement a survey of primary care providers to determine whether they screen none, all, or some pregnant and postpartum women for adverse childhood experiences, and refer women who screen positive for follow-up care. Include questions about policies implemented, referral processes, barriers/ challenges, and willingness to screen all women. Identify the providers screening all or some pregnant and postpartum women for ACE and referring positive screens.	Briefly describe: Collaborative relationships that support screening all pregnant and postpartum women for ACE. Survey developed and implemented. Number of completed surveys/number of surveys sent out. Number of providers with policies implemented to screen all pregnant and postpartum women for ACE. Opportunities, barriers, and challenges to screening and referral for follow-up.	Number of providers who screen pregnant and postpartum women for ACE/Number of providers who treat pregnant and postpartum women. Number of providers who refer positive screens for follow-up/Number of providers who screen pregnant and postpartum women. Number of providers who screen other patients for ACE/Number of providers who treat other patients. Number of providers who refer positive screens for follow-up/Number of providers who screen other patients.

Short and/or Intermediate Objective(s)	Inputs, including Community Partner involvement	Intervention Activities to Meet Objectives	Performance Measures Short and/or Intermediate	
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Fiscal Year 2 -4 By June 30, 2019, nine providers will screen all pregnant/postpartum women and other patients for ACE and refer women who screen positive for follow-up.	Primary Care Providers, Behavioral Health, Social Services, Alcohol and Drug programs, Community-based organizations	Assist providers to identify and implement the use of ACE screening tool. Encourage and assist providers to develop a protocol to incorporate ACE screening tool in OB and other medical visits. Develop and implement a continuous quality improvement/Quality Assurance (CQI/QA) process to promote ACE screening through webinars, workshops, and presentations at conferences/professional meetings. Continue to engage existing medical community partners/collaboratives and share referral resource network.	Briefly describe: Process of developing provider protocol. Process to measure knowledge change and intent to implement policies to screen all pregnant/postpartum women or other patients. Policies implemented to screen all pregnant/postpartum women and other patients for ACE. CQI/QA process developed Collaborative relationships that support screening all pregnant/postpartum women and other patients for ACE.	Number of providers screening all pregnant/postpartum women and other patients for ACE/9. Number of providers demonstrating increased knowledge of ACE and their effects/Number of providers trained. Number of providers who have developed and implemented policies/procedures for ACE screening and referral / Number of providers who see pregnant and postpartum women. Brief description of outcomes of the CQI/QA process.

Short and/or Intermediate Objective(s)	Inputs, including Community Partner involvement	Intervention Activities to Meet Objectives	Performance Measures Short and/or Intermediate	
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Fiscal Year 5 By June 30, 2020, all pregnant and postpartum women in MCAH programs will be screened for ACE, and those who screen positive will be referred for appropriate follow-up care.	PHN Section Staff, Primary Care Providers, Behavioral Health, Social Services, Alcohol and Drug programs, Community-based organizations	Develop and implement a screening protocol to screen all pregnant and postpartum women in MCAH Programs for ACE. Develop and implement processes that link women who screen positive for ACE to appropriate resources. Develop evaluation process. Develop and implement a Continuous Quality Improvement/Quality Assurance (CQI/QA). Continue to engage existing medical community partners and collaboratives.	<u>Briefly describe:</u> Access to care issues. Rationale for interventions, recommendations, and protocols developed. Evaluation process developed and implemented. CQI/QA process developed. Collaborative relationships that support screening all pregnant and postpartum women for ACE.	Number of pregnant and postpartum women in MCAH programs who are screened for ACE/All pregnant and postpartum women in MCAH programs. Number of pregnant and postpartum women who screened positive for ACE and were referred for follow-up/All pregnant and postpartum women who screened positive for ACE. Number of pregnant and postpartum women who screened positive for ACE and were referred to and saw a provider/All pregnant and postpartum women who screened positive and were referred. Brief description of outcomes of the CQI/QA process.