

Act Early State Plan – Updated 2016

Goal 1: Family Engagement	Goal 2: System of Early Identification and Referrals	Goal 5: Statewide Coordination			
<p>Long-term vision: Families who have children with ASD/DD have access to clear and useful information, accessible community supports, and coordinated systems of care that are family-centered.</p> <p>Intermediate Goals</p> <ol style="list-style-type: none"> 1. All families are connected to support in the way they choose (e.g., telephone, chat, text, email). 2. A consistent set of information, both on-line and in print, is shared with families upon diagnosis, assessment or eligibility determination. 3. All families can access and advocate for services and supports. 	<p>Long-term vision: All children receive developmental screening and ongoing developmental monitoring, and are referred to services when a concern is identified, within a coordinated system of care including a Medical Home.</p>	Coordinated Communication Plan	Knowledgeable Referrals	Data Collection/Evaluation	Family Engagement
	<p>Intermediate Goals</p> <ol style="list-style-type: none"> 1. All families are informed and actively engaged partners in developmental screening and ongoing developmental monitoring. 2. All primary care, public health and early care and education providers consistently implement ongoing developmental monitoring and screening for child development and autism utilizing evidence-based, culturally normed validated screening tools. 3. All primary care, public health and early care and education providers are knowledgeable of available resources and utilize a system of coordinated referrals and follow-up services that align with best practices. 4. All primary care, public health and early care and education providers utilize a system of coordinated data collection that evaluates Wisconsin’s system of developmental screening, ongoing developmental monitoring, referral and follow-up. 				
	<p>Goal 3: Assessment, Evaluation and Diagnosis</p>				
	<p>Long-term vision: All children receive an evaluation within three months after a concern is identified through screening or developmental monitoring.</p>				
	<p>Intermediate Goals</p> <ol style="list-style-type: none"> 1. All providers, including primary care providers within a Medical Home, are knowledgeable of where to refer a child for assessment, evaluation and diagnostic services, and supportive services. 2. Increase the capacity to assess, evaluate and diagnose children who have a concerning result from early developmental screening. 3. Assessment, evaluation and diagnostic services are available, conveniently located and timely, for children who have a concerning result from developmental screening or as necessary. 				
	<p>Goal 4: Intervention and Coordinated Community Supports</p>				
	<p>Long-term vision: All children who have been identified and/or diagnosed with ASD/DD receive timely and effective individualized interventions within a system of coordinated community-based care.</p>				
	<p>Intermediate Goals</p> <ol style="list-style-type: none"> 1. Local communities have a coordinated system of evidence-based intervention, treatment and educational services. 2. Families, Medical Home providers, service providers, and educators coordinate to support families in building individualized service and support plans that are family-centered. 3. Children have their individual needs met after diagnosis in a timely manner by a network of providers in their local community. 				

“ASD/DD” refers to Autism Spectrum Disorder (ASD) and other Developmental Disabilities (DD)

Last Revised 4/11/2016