Project Logic Model

Target Population and Needs	Inputs	Activities	Outputs	Outcomes
• Maryland children and youth with special health care needs with autism spectrum disorders and other developmental disabilities (CYSHCN-ASD/DD) and their families • Many CYSHCN-ASD/DD do not receive timely diagnostic and intervention services, especially low-income and minority children. • Inadequate access to medical homes • Lack of family-professional partnerships • Needed services are difficult for families to access	• PPMD and OGPSHCN Project Directors, Project Manager, Family Partnerships Coordinator, Parent Medical Homes Partners, Medical Homes Coordinator, Latino Resource Coordinator Administrative Coordinator, JHSPH Evaluators • Statewide and regional Advisory Panels, to include families and youth • Key Partners' expertise and staff time including MD AAP, PFA, JHU Medical Homes Project, CNMC • Primary care practices serving CYSHCN-ASD/DD • Various developmental and ASD screening tools and curricula; medical homes training curricula, PFA Providers Toolkit including Learn the Signs Act Early • MD AAP, PFA, PPMD, and OGPSHCN resource websites	• Regularly engage state and local stakeholders to increase coordination and collaboration • Conduct awareness and outreach activities for families and providers, including low-income and minority families and providers who serve them • Enhance and promote use of MDAAP website to include resource pages for medical home, ASD, and developmental screening • Enhance, expand and promote use of statewide resource repository and information websites • "Screening and Beyond" QI Learning Collaborative with primary care practices across the state • Parent medical home partners in primary care practices	• Number of meetings and participating stakeholders, including families • Number of families, providers and other stakeholders who receive information, services, resources and/or training • 3 new MDAAP website resource pages and number of members who use them for practice enhancement • Percent of CYSHCN-ASD/DD that are identified by 24 months of age, receive first evaluation by 36 months of age, and are enrolled in interventions services by 48 months of age • A minimum of 10 practices (at least 2 from each region of the state) show increased rates of developmental/ASD screenings, timely referrals, and entry into intervention services for CYSHCN-ASD/DD • A minimum of 5 practices (at least one from each region of the state) show growth in self- and family-scoring on cultural competency, family-centeredness, and care coordination domains of the Medical Home Index	• Improved organization and capacity of community-based service systems so that they are easy to use for families of Maryland CYSHCN-ASD/DD • Increased public and provider awareness of the signs and symptoms of ASD and other related DDs • Reduced barriers to screening, referral and diagnostic services for CYSHCN-ASD/DD • Increased access to culturally competent medical homes that coordinate care with pediatric subspecialties • Improved family-professional partnerships between families of CYSHCN-ASD/DD, primary care providers, and other stakeholders