Pennsylvania Project LAUNCH

Year One Evaluation Report

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This evaluation report was developed and prepared by the University of Pittsburgh Office of Child Development under contract with Pennsylvania Project LAUNCH and in partnership with the Pennsylvania Project LAUNCH Implementation Team and the State and Local Young Child Wellness Councils which serve as the governing bodies for Pennsylvania Project LAUNCH.

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Executive Summary

Introduction and Background

The purpose of LAUNCH is to help all children reach social, emotional, behavioral, physical, and cognitive milestones and to thrive in school and in life. It focuses on children birth to 8 years of age and their families and pregnant women at risk for mental health concerns and living at or under 200% of the federal poverty level. Prevention and promotion strategies focus on 1) screening and assessment in a range of child-serving settings, 2) integration of behavioral health into primary care, 3) mental health consultation in early care and education, 4) home visiting focusing on social and emotional well-being, and 5) family strengthening and parent skills training. Cross-cutting issues include racial/ethnic disparities in access to services, cultural and linguistically appropriate services, workforce development, and public awareness.

In October 2014, the Pennsylvania Office of Mental Health and Substance Abuse Services (OMHSAS) was awarded a Project LAUNCH grant – Linking Actions for Unmet Needs in Children's Health. OMHSAS selected Allegheny County to be the local project site, and state and county leaders created a PA Project LAUNCH Implementation Team comprised of representatives from relevant state and county departments and the University of Pittsburgh Office of Child Development (OCD). OCD was selected as the subcontractor responsible for conducting, writing, and updating the project's Environmental Scan, Strategic Plan and Evaluation Plan, which were among several major accomplishments of Year One.

PA Project LAUNCH is an alliance among partners that have a shared vision for the wellness of young children and a history of working together on their behalf. Pennsylvania's Department of Public Welfare Office of Mental Health and Substance Abuse Service (DPW/OMHSAS the applicant State agency and has selected Allegheny because of its 1) commitment to early childhood and evidence–based practices, 2) unique but representative population, and 3) access to networks of providers dedicated to improving the lives of young children and their families. Allegheny County's Department of Human Services is leading a partnership that includes the Allegheny County Health Department, the University of Pittsburgh Office of Child Development, a network of parents, and numerous providers of services that have a

commitment to promoting the social, emotional, behavioral, and physical health, and cognitive development of young children from birth to eight years of age.

The Environmental Scan. The Environmental Scan consisted of a review of previous scans, reports, and research pertaining to Project LAUNCH priorities; qualitative perspectives and opinion obtained through personal and telephone interviews with key informants; and an on-line survey that produced usable responses from 463 professionals and parents. Generally, the Scan identified a variety of existing exemplary services and programs in each Project LAUNCH core strategies as major strengths in Pennsylvania and Allegheny County, but the primary challenge was to coordinate and expand such model programs to better meet the needs of low-income families with young children.

The Strategic Plan. The PA Project LAUNCH Implementation Team took the major results of the Environmental Scan and structured an agenda for five State and five Local Work Groups representing the major PA Project LAUNCH goal areas of Screening and Assessment, Integration of Behavioral and Physical Health, Early Childhood Mental Health Consultation, Home Visiting, and Family Strengthening and Parent Skill Building. Each Work Group met twice to review the Scan results and recommendations, discuss and modify draft goals and objectives suggested by the Implementation Team, and create a draft of first-year activities and timeframes. This draft was reviewed by both the State and Local Young Child Wellness Councils (YCWCs), and the Implementation and Evaluation Teams integrated their suggestions, aligned the Strategic Plan with the Scan, added measurement suggestions (i.e., Indicators), and helped revise the logic model. The resulting Strategic Plan consisted of seven total goals – the five listed above, plus two goals related to infrastructure (Local Systems Change and State Systems Change) – each with several specific objectives and activities.

Evaluation Purpose, Questions, and Methods

The Evaluation Plan follows the framework of the Strategic Plan and includes objectives, activities, indicators/measurements, and short- and long-term process and outcome questions to be addressed. Its general purpose is to describe the process of implementation and the outcomes of such activities as they pertain to four cross-cutting goals and seven more specific goal areas that are enumerated below. The major purpose and methods of the first-year evaluation are aimed at describing planning and outreach, because considerable implementation efforts were devoted to coordinating, planning, and prioritizing activities and audiences. The evaluation methods described below were planned during the first year of LAUNCH and tentatively apply to the entire five years of LAUNCH; most will be enacted in subsequent years once relevant LAUNCH activities have been implemented. In contrast, LAUNCH accomplishments reported here represent progress as of September 30, 2015.

The four cross-cutting domains are described below followed by the seven specific goals.

Workforce Development (WD). The Evaluation Team developed general *post-* and *follow-up* training surveys to permit comparisons across goal areas with regard to the extent to which trainees feel they gained new and relevant knowledge (*post-training survey*) and the extent to which the new knowledge influenced their work with clients following trainings (*follow-up survey*).

Cultural Competence (CC). Cultural competence will be assessed on a sample of agencies that serve relatively large numbers of clients who belong to diverse and targeted populations. After LAUNCH affiliated providers are selected, the directors of these agencies will be asked once per year to respond to a modified version of the self-assessment checklists developed by the National Center for Cultural Competence (NCCC) at Georgetown University. NCCC designed the checklists to align with the Culturally and Linguistically Appropriate Services (CLAS) Standards.

Behavioral Health Disparities (BHD). The Evaluation Team developed a demographic data form to supplement the manner in which providers (e.g., primary care, home visiting, early childhood mental health) ask participating families to indicate their racial/ethnic/gender/sexual identity and membership in special populations (e.g., military, homeless).

Evaluation Questions for Cross-Cutting Themes

WD: *To what extent do trainings provide new and useful information to practitioners as a function of type of training and background of trainee?*

CC: *To what extent does cultural competence improve over the years of LAUNCH as a function of LAUNCH cultural competency activities?*

BHD: *To what extent do disparities exist and change over the project period for different types of services?*

PAW: *To what extent are public awareness activities conducted?*

Public Awareness (PAW). Several goal areas include objectives to make professionals and the public more aware of certain information (e.g., validated screening assessment tools, the importance of early social-emotional health, the value of incorporating behavioral health into primary care, disseminating family-strengthening information, etc.). The Evaluation Team will summarize these efforts based on the minutes of YCWCs and Work Groups, the monthly Outreach Activity Logs, and interviews with key informants.

Other methods and questions are tied more closely to specific goal areas. This information is described below.

PA Project LAUNCH Goal Areas

Goal 1 – Screening and Assessment. *Ensure young children at-risk for poor developmental outcomes (especially social-emotional) are screened and provided appropriate resources, including referrals.* The process is assessed from a review of YCWC and Work Group minutes and interviews to determine what resources are provided to support agencies' promotion of high-quality screening and assessment. Once trainings and other activities are initiated, outcome assessments will be developed to match the specific agency and purpose.

Goal 2 – Behavioral and Physical Health Integration. *Enhance integration of physical health and behavioral health practices to improve access to care for children birth to 8 years, pregnant women, and their families.* An interview tool (Pediatric Provider Integration Assessment – PPIA) has been developed to gather information from pediatric practices on their level of integration, types of integration models, screening tools and referral procedures, collaborative strategies, billing and data management processes, integration-related support needs, services to special populations, and other relevant information. LAUNCH will use this information to create individualized support plans and measure progress across years on integration, screening, and referral. Records and interviews are being used to document systems change activities that occur at the local and state levels.

Goal 3: Early Childhood Mental Health. Strengthen existing ECMH consultation and extend services to children birth to 8 years and pregnant women in multiple early childhood settings (including, but not limited to, Early Care and Education (ECE), family support, elementary schools, EI, afterschool programs, pediatricians' offices, etc.). Early activities are focused on training in ECMH best practices and creating a learning community. Cross-cutting procedures for evaluating the process and outcomes of training and system changes will be employed to assess progress toward improving quality and cultural competence.

Goal 4: Home Visiting. *Promote integrated, evidence-based, high quality home visiting services and ensure access to those who need them.* This year, a major focus of activities has been supporting the planned implementation of "The Link," a telephone hotline that will provide families with home visiting and counseling/referral options as a means of getting more families into home visiting services. The Link will record the number of calls, referrals to specific services, and demographics of callers.

A comprehensive process was used to consider several possible programs to determine the best fit for capturing individual level direct service data. As a result of this process, a collaboration was forged with a prevention demonstration project, Smart Beginnings. Smart Beginnings will start in May 2016 and provide videotaped feedback on parent-child interactions through the (Video Interaction Project (VIP) at routine doctor visits for high-risk families of infants, birth to 6 months, and the Family Check Up (FCU) with the families at highest risk from 6 to 27 months of age. The program will use multiple child and parent/family assessments that include observations, surveys, developmental assessments, and program records, as well as intervention fidelity measures.

Goal 5: Family Strengthening and Parent Skill Building. Ensure families with young children are connected to needed information and services. This goal will be pursued with training and public information activities that will be evaluated with the appropriate cross-cutting methods described above.

Goal 6: Local Systems Change. Create a sustainable infrastructure, including data systems, to promote social- emotional and physical wellness for children birth to 8 years, pregnant women, and their families. In Year One, LAUNCH built critical networks within the YCWC and beyond through outreach activities. YCWC composition and attendance, Wilder Collaborative Factors

Inventory, and cross-cutting methods were used to determine the quality and extent of collaboration and networking.

Goal 7: State Systems Change. Create a sustainable infrastructure and governance structure to promote social-emotional and physical wellness and communicate its importance. Parallel to the methods utilized to assess Local Systems Change (Goal 6), methods used to assess State Systems Change included YCWC composition and attendance, Wilder Collaborative Factors Inventory, as well as the previously described cross-cutting methods.

Findings

Some findings, mostly planning, awareness activities, and collaborations to this point, were specific to each goal area. The following is a condensed summary of the Year One findings at Local and State levels for the five goal areas of 1) Screening and Assessment, 2) Behavioral and Physical Health Integration, 3) Early Childhood Mental Health, 4) Home Visiting, and 5) Family Strengthening and Parent Skill Building followed by local and state systems changes.

Screening and Assessment. At the Local level, gaps in screening were identified, fact sheets on the ASQ and Early Intervention were distributed, and efforts to improve community awareness of the importance of screening were undertaken. At the State level, a strategy to increase the number of children screened was explored, and updates on the new ASQ: SE-2 were provided to the statewide training program.

Behavioral and Physical Health Integration. At the Local level, four major pediatric practices were engaged and are scheduled to complete the Pediatric Provider Integration Assessment in Year Two. Awareness and collaboration efforts were made at the State and Local levels.

Early Childhood Mental Health. At the Local level, activities focused on planning to promote ECMH best practices, specifically the January 2016 training on ECMH best practices and kick-off event to create a learning collaborative on the subject. Public awareness and outreach to other organizations occurred at the State level.

Home Visiting. Locally, preparations were made to roll out The Link, a coordinated home visiting options counseling and referral hotline in early 2016. The intent of the hotline is to increase families' referrals to and participation in home visiting services.

PA Project LAUNCH also established a partnership with Smart Beginnings, a demonstration prevention service that will provide parent-child intervention services in pediatric (VIP intervention) and home (FCU) settings. PA Project LAUNCH will fund a nurse recruiter for one year; recruitment will begin in May 2016.

Family Strengthening and Parent Skill Building. Locally, collaborations were established with Kidsburgh (a collaborative group seeking to improve the lives of children in Pittsburgh) to redesign the Health and Wellness section of their website, and with the Early Learning GPS (a digital resource for parents) to get links to this resource established on other groups' websites.

Notices of available information were distributed via email, meetings, and resource fairs, and planning occurred to increase parental involvement in social networks through Parent Cafe models that focus on the Strengthening Families Protective Factors. At the State level, collaboration began with Illinois Strengthening Families on their parent café model, which focuses on the Strengthening Families Protective Factors.

The major systems events were the creation and operation of the Young Child Wellness Councils and the conduct of outreach activities.

Systems Changes – Local. At the end of Year One, the Local YCWC had 43 members; 33% or 14 of whom were family representatives. The Council met five times with an average of 50% attendance; an average of 29% of family members attended (of the total number of member attendees). Wilder Collaboration Inventory factors for the Local YCWC ranged from moderate to strong at the end of Year One. The highest rated factors were *Members see collaboration as in their self-interest* (4.32), *Favorable political and social climate* (4.22), and *Unique purpose* (4.22). This seems to reflect a positive attitude and commitment to LAUNCH. The lowest rated factors were *Collaborative group seen as a legitimate leader in the community* (3.46); *Sufficient funds, staff, materials, and time* (3.46); and *Multiple layers of participation* (3.40). These represent reasonable and expected challenges for a new group. It is notable that no factor was rated to be "a concern."

Outreach for the purpose of coalition building, public information dissemination, advocacy, and funding sustainability was a major activity and produced a number of promising collaborations. The YCW Coordinator and other team members reached more than 1,200 people across 60 different outreach activities. Outreach was specific to each local goal domain and primarily involved planning and awareness activities and collaborations.

Systems Changes – State. The State YCWC consisted of 28 members, 5 (18%) of whom were family representatives. The Council met four times with an average attendance of 82%; an average of 20.5% of family members were present (of the total number of member attendees). Wilder Collaboration Inventory factors for the YCWC ranged from moderate to strong at the end of Year One. The highest rated factors were *Members see collaboration as in their self-interest* (4.44), *Skilled leadership* (4.44), and *Favorable political and social climate* (4.32). The lowest rated factors were *History of collaboration or cooperation in the community* (3.63), *Multiple layers of participation* (3.62), and *Sufficient funds, staff, materials, and time* (3.56). These also represent early commitment to the group and expected challenges. No factors were rated to be "a concern."

At the State level, outreach, especially for the purpose of coalition building, was the major activity. The YCW Expert and other team members participated in 19 such events with over 600 people in attendance.

Lessons Learned and Recommendations

Year One work has yielded a strong foundation on which to pursue PA Project LAUNCH goals. The project has been highly collaborative, involving 87 Local Council and Work Group members,

28 State Council and Work Group members, and 18 members of the Implementation Team. The lessons learned from the first year of PA Project LAUNCH largely center around the importance of planning (for both implementation and evaluation), awareness, collaborations/partnerships, and evaluation. This should provide a crucial collaborative foundation for conducting the work ahead.

While planning in Year One has played a significant role in this year's accomplishments, more detailed, short-term planning under each of the goal areas is recommended for Year Two. Priorities should be assigned across goal areas to stress the area(s) of most need and feasibility; focusing on the three pilot communities may play a role in prioritizing. Setting priorities is necessary, because PA Project LAUNCH is exceptionally broad in geographical and services scope and all of its aspirations are unlikely to be achieved. Furthermore, an emphasis should be placed on strategies to address and evaluate the needs of children and families at risk for behavioral health disparities and strategies to build and support culturally competent staff, programs, resources, and policies. These are likely to be among the more challenging goals to address.

Committed agencies will play crucial roles in implementing strategies to move toward five-year goals by engaging additional agency and community partners in LAUNCH efforts and by providing critical evaluation data. Identifying and finalizing formal partnerships with LAUNCH affiliated providers should be a major focus of the early work in Year Two. This is a necessary part of focusing LAUNCH efforts and setting priorities. In addition, PA Project LAUNCH leadership should also continue to ensure diverse representation on Councils and Work Groups. Last, but not least, strong lines of communication between all LAUNCH governance and service agencies involved in this work will continue to be crucial to the strength and sustainability of accomplishments, including data sharing. Communication in a project this broad and complex with so many Council and Work Group members is both crucial and complex and it should be as strategic and coordinated as possible in Year Two, both within the state and local Councils and between them.

PA Project LAUNCH Logic Model

The logic model, which is provided in Table 1, summarizes the linkages between PA Project LAUNCH's goals, objectives, activities, indicators, and anticipated outcomes.

Table 1. Pennsylvania Project LAUNCH Logic Model

Goal	Inputs	Outputs	Intermediate Outcomes	Long-term Outcomes
Ensure young children at risk are screened and provided appropriate resources Enhance integration of physical health and behavioral health practices Strengthen existing ECMH consultation and extend services for children birth to 8 years, their families, and pregnant women Promote high quality home visiting services Ensure families with young children are connected to needed information and services Create a sustainable infrastructure, including data systems, to promote social emotional and physical wellness for PA children birth to 8 years, their families, and pregnant women	PA Project LAUNCH Implementation Team PA Young Child Wellness Council Allegheny County Young Child Wellness Council PA & AC Workgroups Pilot Community School Districts (Woodland Hills, Baldwin Whitehall, Pittsburgh Public) PA Project LAUNCH affiliated providers Other federal, state & privately funded projects PA & AC funding SAMHSA GPO & TA AC-DHS DARE Data warehouse and county/school data sharing agreements Evidence-Based Practices (e.g., PW-PBIS, FCU, Parent Cafes)	Number of child screens & assessments by setting type Number of referrals & follow-ups Providers trained in culturally competent, high quality support processes & best practices Physical and behavioral health providers will be trained in topics related to integration of services across systems Identified payment models, policies, and other strategies to support integration of BH & PH Consultants and providers trained in ECMH best practices and supports Home visiting staff trained in home visiting best practices and supports Number of children and families participating in EBP's Key communication messages and materials to parents, community & key stakeholders Community members trained in mental health issues Parent leadership networks PA Project LAUNCH governance structure Data sharing systems	Providers will use the most appropriate instruments for screenings and assessments in all early childhood settings for children ages birth to 8 years, their families, and pregnant women. Stakeholders across systems and the community will have increased awareness about the importance of and availability of screening and assessments, ECMH consultation and support, home visiting, social emotional wellness and their relation to physical health and school success. ECMH consultants have consistent, uniform knowledge about best practices in ECMH consultation Home visiting staff will have knowledge about best practices in home visiting within evidence based or evidence informed programs EBP's will be more readily available and easily accessed for children and families who need them Parents will have increased access to information and resources to support healthy child development and social-emotional wellness. PA Project LAUNCH governance and partners are cross-disciplinary, including parents, and work in close collaboration	Providers, including primary care offices, will implement high-quality screening and assessment processes (e.g., implementation fidelity, cultural competence, relationship building, and communication). Relevant data will be collected and available for use by systems serving children birth to 8 years, their families, and pregnant women Pediatric practices will integrate behavioral health resources to meet the needs of young children and their families. Physical and behavioral health providers will have knowledge of topics related to integration of services across systems ECMH consultants implement consistent, uniform best practices in early childhood settings ECMH consultation services expands to new settings, and new age groups Home visiting programs will provide behavioral and physical health resources to meet the needs of families and support home visiting staff Children and families receiving direct services will have improved outcomes Community members will have knowledge of mental health issues. Parents will be engaged in social networks that promote their leadership skills. AC & PA policies will be developed and implemented when needed to support PA Project LAUNCH efforts A coordinated system of promotion and prevention for social emotional wellness of children birth to 8 years, their families, and pregnant women will be demonstrated on a county level and replicable statewide

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PA Project LAUNCH Year One Evaluation Report Narrative

Approach and Methods

The purpose of LAUNCH is to help all children reach social, emotional, behavioral, physical, and cognitive milestones and to thrive in school and in life. It focuses on children birth to 8 years of age and their families and pregnant women at risk for mental health concerns and living at or under 200% of the federal poverty level. Prevention and promotion strategies focus on 1) screening and assessment in a range of child-serving settings, 2) integration of behavioral health into primary care, 3) mental health consultation in early care and education, 4) home visiting focusing on social and emotional well-being, and 5) family strengthening and parent skills training. Cross-cutting issues include racial/ethnic disparities in access to services, cultural and linguistically appropriate services, workforce development, and public awareness.

In October 2014, the Pennsylvania Office of Mental Health and Substance Abuse Services (OMHSAS) was awarded a Project LAUNCH grant – Linking Actions for Unmet Needs in Children's Health. OMHSAS selected Allegheny County to be the local project site, and state and county leaders created a PA Project LAUNCH Implementation Team comprised of representatives from relevant state and county departments and the University of Pittsburgh Office of Child Development (OCD). See Appendix A for a list of Implementation Team members. OCD was selected as the subcontractor responsible for conducting, writing, and updating the project's Environmental Scan and Strategic and Evaluation Plans, which were among several major accomplishments of Year One.

The Environmental Scan. The Environmental Scan consisted of a review of previous scans, reports, and research pertaining to Project LAUNCH priorities; qualitative perspectives and opinion obtained through personal and telephone interviews with key informants; and an on-line survey that produced usable responses from 463 professionals and parents. Generally, the Scan identified a variety of existing exemplary services and programs in each Project LAUNCH domain as major strengths in Pennsylvania and Allegheny County, but the primary challenge was to coordinate and expand such model programs to better meet the needs of low-income families with young children.

The Strategic Plan. The PA Project LAUNCH Implementation Team took the major results of the Environmental Scan and structured an agenda for five State and five Local Work Groups representing the major PA Project LAUNCH goal areas of Screening and Assessment, Integration of Behavioral and Physical Health, Early Childhood Mental Health Consultation, Home Visiting, and Family Strengthening and Parent Skill Building. Each Work Group met twice to review the Scan results and recommendations, discuss and modify draft goals and objectives suggested by the Implementation Team, and create a draft of first-year activities and timeframes. This draft was reviewed by both the State and Local YCWC's, and the Implementation and Evaluation Teams integrated their suggestions, aligned the Strategic Plan with the Scan, added measurement suggestions (i.e., Indicators), and helped revised the logic model. The resulting Strategic Plan consisted of seven total goals – the five listed above, plus two goals related to

infrastructure (Local Systems Change and State Systems Change) – each with several specific objectives and activities, plus four cross-cutting emphases.

The Evaluation Plan. Using the Strategic Plan as a guide, the Evaluation Team developed a five-year Evaluation Plan, and revised and strengthened the plan with input and support from the Implementation Team, Government Program Officer (GPO), and Technical Assistance (TA) support. The primary intent of PA Project LAUNCH is to promote and provide infrastructure to services, practices, and policies that promote social-emotional wellness for children birth to 8 years, their families, and pregnant women, particularly in three target regions in Allegheny County. As such, the evaluation focuses on documenting the process of providing that infrastructure support and the outcomes of the support activities. The appropriate outcomes are primarily the supports themselves, that is the:

- trainings provided,
- screenings conducted,
- referrals made,
- nature and extent of the integration of behavioral health into primary care practices,
- infusion of behavioral and physical health resources into home visiting,
- expansion and improvement of mental health consulting,
- reductions in disparities of services for minority groups,
- improvement in the cultural sensitivity of services,
- new collaborations arranged,
- regulations and policies created, and
- changes in child, family, and providers as a result of the outcomes noted above.

The Evaluation Plan developed in Year One serves as the foundation for the information collected and summarized in this Year One Evaluation Report. What follows here and in other sections of the report represents plans established in Year One, most of which will be implemented in Year Two and beyond. A complete list of acronyms used in this report can be found in Appendix B. The term "goal areas" used in this report includes the five LAUNCH core strategies (Screening and Assessment; Behavioral Health and Physical Health Integration; Early Childhood Mental Health; Home Visiting; Family Strengthening and Parent Skill Building) and state and local systems change, or infrastructure.

The "Approach and Methods" section is organized in terms of themes that cut across individual goal areas, the five goal domains, and Local and State systems changes.

Methodologies for Themes that Cut Across Goal Areas

Workforce Development

The Evaluation Team developed *post*- and *follow-up* training surveys for use across goal areas, since training is likely to occur in each of the five goal areas. The broad nature of these assessments provides PA Project LAUNCH with feedback on the extent to which the trainings offered relevant and useful information across topics and goal areas as well as the opportunity to chart changes over time. The *post-training survey* (See Appendix C: Post-Training Survey)

captures the extent to which trainees feel they gained new knowledge and the extent to which they feel the information is potentially usable in their practice (ratings); specifics on how the information will be incorporated in their practice (open-ended); and trainee contact, affiliation, and background information.

The *follow-up training survey* (See Appendix D: Follow-Up Training Survey) assesses the extent to which the training increased their knowledge, confidence, and access to resources (a rating); the extent to which the information was implemented in their practice (a rating); and the nature of that usage (open ended). This survey will be sent electronically to participants three months following their respective training sessions.

Cultural Competence

Improvements in cultural competence will be assessed for a sample of agencies that serve relatively large numbers of clients who belong to diverse and targeted populations and are representative of the major goal areas. Once PA Project LAUNCH affiliated providers are selected, the directors of these agencies will be asked once per year to respond to a modified version of a self-assessment questionnaire from the National Center for Cultural Competence.

The Evaluation Team created the modified assessment (See Appendix E: Culturally & Linguistically Appropriate Services [CLAS] Tool) that will measure outcomes that are comparable across different contexts. Based on multiple CLAS self-assessment checklists (Goode, 1989/2009), the team identified items that were common across the checklists as well as unique to the following contexts: (a) behavioral and primary care health services, (b) early childhood and early intervention settings, and (c) services and supports for children with disabilities and special health care needs and their families. Common items, deemed most central to the construct of cultural competence, were retained, as were key unique items for each context.

The self-assessment tool contains 23 items that are common across contexts and six items unique to specific contexts. The greatest concentration of items are in the areas of values, attitudes, and communication. These align most closely with CLAS Standard #1 of "[to] provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs" (U.S. Department of Health and Human Services, 2013, p.1). In addition, the response option "no opportunity/need for use" was added based on the recommendations of colleagues from the behavioral health and early childhood communities.

Behavioral Health Disparities

The Evaluation Team developed a demographic data form to supplement the manner in which providers (e.g., primary care, home visiting, and early childhood mental health) ask participating families to indicate their racial/ethnic identity and membership in special populations (e.g., military, homeless, gender/sexual orientation). Racial/ethnic identity will encompass the categories required by SAMHSA and the ethnic groups that are prevalent in our target neighborhoods. Due to the nature of select questions (e.g., refugee status, homeless status, gender/sexual identity), service staff will collect this information by having clients

complete the form and place it in a sealable envelope so staff are not privy to clients' responses (See Appendix F: Demographics). Forms will be coded by particular provider and service and may be modified to ensure that clients are not asked to provide agencies or practices with duplicate information on multiple forms. In Year One, no formal agreements have been made with LAUNCH affiliated providers involving data collection, and therefore no behavioral health disparity data has been collected (See Appendix G: Year One Disparities Impact Table).

Public Awareness

Several goal areas include objectives to make professionals and the public more aware of certain information (e.g., validated screening assessment tools, the importance of early social-emotional health, the value of incorporating behavioral health into primary care, disseminating family strengthening information, etc.). The Team utilizes the meeting minutes of YCWCs and Work Groups and the monthly Outreach Activity Logs (See Appendix H: Outreach Activity Log) of the YCW Expert, Coordinator, and Partner. In addition, the YCW Expert, Coordinator, and Partner provide additional key details about the nature and extent of such activities and their intended audience via an online end-of-year survey and follow-up interview.

Methodologies for Specific Goal Areas

In this section we describe the evaluation methodologies for each of the five core PA Project LAUNCH goal areas – Screening & Assessment; Behavioral Health & Physical Health Integration; Early Childhood Mental Health; Home Visiting; Family Strengthening & Parent Skill Building. Additionally, this section covers the methodology for assessing an additional goal identified in the PA Project LAUNCH Strategic Plan – infrastructure – as represented by Local Systems Change and State Systems Change. Specifically, for each goal, we identify the key activities completed during Year One by the respective Workgroups and Councils, and describe the resulting process evaluation activities, implementation questions, outcome evaluation activities, and outcome questions. Process evaluation activities across goal areas include record review, end of year survey and follow-up interviews, and Outreach Activity Logs. Goals areas may include additional process evaluation activities as described. Populations benefiting from the outcomes discussed are indicated in parenthesis following the pertinent evaluation questions and major limitations and constraints are summarized. In addition, an at-a-glance summary of evaluation questions, data sources/instruments, and respondents across goal areas is provided in Appendix I.

Screening and Assessment

PA Goal 1: Ensure young children at risk for poor developmental outcomes (especially social-emotional) are screened and provided appropriate resources, including referrals.

Year One Activities

A key activity during Year One within Screening and Assessment was the identification and creation of resources. The Implementation Team conducted outreach activities to facilitate collaborative relationships in this area, and the Local Work Group organized information about various screening tools and the locations that used these tools.

Process Evaluation Activities

The Evaluation Team uses a mixed methods case study approach to measure implementation of key activities in this area. This approach includes review and monitoring of YCWC and Work Groups' minutes and project records, completion of an online end-of-year (EOY) survey (See Appendix J: End Of Year Survey), and follow-up interviews with the YCW Coordinator, YCW Expert, and other key PA Project LAUNCH staff. In addition, the YCW Coordinator and YCW Expert maintain monthly Outreach Activity Logs that list focal activities and accomplishments. As PA Project LAUNCH affiliated providers join the project, they will be asked annually to complete the modified version of the self-assessment checklists developed by the National Center for Cultural Competence (NCCC) (CLAS Tool) and provide demographic data. Collectively, the Evaluation Team uses the above strategies to examine the following implementation questions:

Implementation Questions

1. What resources are promoted to support agencies' usage of high quality screening and assessment? (Systems)
2. How well do major Project LAUNCH agencies conform to the CLAS principles? (Provider)

Outcome Evaluation Activities

Outcome evaluation activities will start once trainings are developed and LAUNCH-affiliated providers[1] and partners[2] are engaged with the project. At that time, the Team will work with provider agencies to facilitate data collection through the most appropriate method for each agency and will coordinate the collection of post-training data through the YCW Coordinator and YCW Expert. Electronic follow-up surveys, targeted at examining practice change, will be administered by the Evaluation Team three months following each training.

Outcome Questions

1. How many children and adults do agencies screen or assess with a recommended vs. non-recommended tool by setting and by racial, ethnic, and /or special population? (Systems: *Children & Families*)
2. Does usage of recommended tools increase over the years? (Systems: *Children & Families)*
3. Of those children and adults screened with a recommended tool, how many are designated at-risk and what percentage are referred for diagnosis and/or services by racial, ethnic, and/ or special population? (Systems: *Children & Families*)
    a. Does Referral Rate increase over years? (Systems: *Children & Families)*
4. How many agencies and staff are trained on high quality screening and assessment processes by setting and professional background? (Systems: *Providers*)

[1] LAUNCH affiliated provider: parties that engage in LAUNCH activities, make a commitment to practice change, and collect/share data on their services and clients.

[2] LAUNCH partner: parties that participate in targeted activities at the provider level (e.g., workforce development).

5. Do trained staff report increased knowledge, relevance, and changed practices on screening and assessment processes? (Provider)
6. To what extent are agencies and staff trained in cultural competency? (Systems: *Providers*)
7. Do trained staff report increased knowledge, relevance, and changed practices in delivering culturally competent care? (Provider)

Major Limitations and Constraints

Although the Team will make every effort to collect the data described above, it is limited by the willingness of trainees to complete the post- and follow-up surveys and agencies to complete the modified CLAS Tool questionnaire. In addition to our standard evaluation procedures (e.g., relationship building [agency completion of CLAS], targeted, concise survey content; gathering secondary contact information; scheduled follow-up reminders), we will develop evaluation scripts/tips to help ensure that trainees and agencies receive consistent information about the importance of their responses and contributions to the project. In addition, it would be beneficial to know how many children and families screened and referred actually carry out the referral, but the Team has been informed that such data are not always kept or available. This potential issue may result in missing data. We will report the prevalence of missing data and employ the most appropriate statistical techniques to handle the situation, if they arise.

Behavioral Health and Physical Health Integration

PA Goal 2: Enhance integration of physical health and behavioral health practices to improve access to care for children birth to 8 years, pregnant women, and their families.

Year One Activities

The group working to integrate behavioral health practices into primary care settings identified baseline data collection as a primary objective to move this work forward. To that end, the key activities of Year One for this goal area were to develop a measure of pediatric provider integration and to establish relationships with major pediatric providers in the region.

Process Evaluation Activities

The Evaluation Team uses the mixed methods case study approach described for the Screening and Assessment Study. This approach includes review and monitoring of YCWC and Work Groups' meeting minutes and project records, completion of an online end-of-year (EOY) survey and follow-up interviews, and review of monthly Outreach Activity Logs maintained by the YCW Coordinator, Expert, and Partner. In addition, members of the BH/PH Work Group and the Evaluation Team developed the Pediatric Provider Integration Assessment (PPIA) for use with primary care providers. The PPIA (See Appendix K: Pediatric Provider Integration Assessment) is comprised of three parts: (1) the Integrated Practice Assessment Tool (IPAT), developed by Waxmonsky and colleagues (Waxmonsky, Auxier, Romero, & Heath, 2014); (2) a modified version of the Mental Health Practice Readiness Inventory (MHPRI) (American Academy of Pediatrics, 2010); and (3) supplemental open-ended questions. This tool was designed to gather information across a number of areas that include level of integration, types of integration models, screening tools and referral procedures, collaborative strategies, billing and

data management processes, integration-related support needs, and other relevant information. A complete description of the measure is available in the Revised PA Project LAUNCH Evaluation Plan.

In 2016, the BH/PH Work Group and Evaluation Team will create quantitative summaries and will aggregate all data (See Appendix L: PPIA Baseline Assessment Summary Template) to identify themes that guide the major activities of subsequent BH/PH Work Group meetings and collaborations (e.g., resource development, trainings, learning community). Additionally, as with the other PA Project LAUNCH goal areas, the training surveys, the CLAS Tool, and demographic measures will be used with LAUNCH affiliated providers. Collectively, the Evaluation Team will use all the strategies described in this section (i.e., Process Evaluation Activities) to examine the following implementation questions.

Implementation Questions

1. What resources and strategies are promoted to support pediatric practices' usage of high quality screening and assessment? (Systems)
2. What strategies and models are identified and communicated to support the integration of behavioral health and physical health? (Systems: *Providers*)
3. How well do major Project LAUNCH practices conform to the CLAS principles? (Provider)

Outcome Evaluation Activities

As in the previous Service Strategy area, outcome evaluation activities will start once the project develops trainings and officially engages LAUNCH affiliated providers and partners. The Evaluation Team will work with the practices to facilitate data collection (i.e., screenings, referrals, demographics) through the most appropriate method and will coordinate the collection of post-training data through the YCW Coordinator and YCW Expert. Electronic follow-up surveys, targeted at examining practice change, will be administered three months following each training. In addition, the PPIA will be administered by the leader of the BH/PH Work Group (with an Evaluation Team and a BH/PH Work Group member serving as note takers during the assessment). Baseline assessments will be completed with the four main pediatric health clinics in the region by the end of the 2015 calendar year and will be repeated yearly to assess change.

Outcome Questions

1. How many children and adults do practices screen or assess by tool, setting, and racial/ethnic/special population? (Systems: *Children & Families*)
2. Of those children and adults screened to be at-risk, what percent are referred for diagnosis and/or services by tool and racial/ethnic/special population? What is the racial/ethnic/special population distributions in targeted primary care practices? (Systems: *Children & Families*)
3. To what extent are behavioral health and physical health practices and staff trained in providing integrated care? (Systems: *Providers*)
4. Do trained staff report increased knowledge, relevance, and changed practices in providing integrated care (e.g., warm transfers, resources, billing)? (Provider)

Major Limitations and Constraints

This Work Group and the four pediatric practices have been very energetic and committed to integration. At the same time, they are sensitive to the potential burden of evaluation and additional assessments. Consequently, data provided by practices for the evaluation are likely to be restricted to those that each includes in their Electronic Medical Records system, which are not necessarily identical across practices.

Early Childhood Mental Health

PA Goal 3: Strengthen existing ECMH consultation and extend services to children birth to 8 years and pregnant women in multiple early childhood settings (including, but not limited to, ECE, family support, elementary schools, EI, afterschool programs, pediatricians' offices, etc.).

Year One Activities

The key activities in Year One within the Early Childhood Mental Health theme focused on identifying and promoting best practices in ECMH consultation services and raising awareness of the importance of Early Childhood Mental Health with ECMH consultants.

Process Evaluation Activities

As in previous goal areas, the Team uses a mixed methods approach to measure the implementation of key activities in this area. This approach includes review and monitoring of minutes, project records, and Outreach Activity Logs and an end of year survey and follow-up interview with the YCW Coordinator. Baseline CLAS data collection will occur once LAUNCH affiliated providers are engaged with the project. The implementation questions for the ECMH Study are:

Implementation Questions

1. What are best practices in ECMH across systems? (Systems)
2. How many trainings are conducted on ECMH topics and topics related to various supports to stakeholders across systems? (Systems: *Providers*)
3. How well do major Project LAUNCH agencies conform to the CLAS principles? (Provider)

Outcome Evaluation Activities

Outcome evaluation activities will commence once trainings begin (in January 2016) and once providers associated with this goal area are engaged in formal project activities (e.g., trainings, learning community). At that time, the YCW Coordinator and YCW Expert will coordinate the collection of post-training data (at the end of the training session) and the Evaluation Team will administer electronic follow-up surveys, targeted at examining practice change related to trainings. The January training will provide a broad overview of ECMH consultation (e.g., ECMH models, ECMH settings, ECMH vs. MH consultation). Future training topics are under discussion.

Outcome Questions

1. Do trainees report increased knowledge of ECMH best practices and change in practices? (Provider)

2. To what extent are agencies and staff trained in cultural competency? (Systems: *Providers*)
3. Is the quality of ECMH consulting services improving? (Systems)
4. How many new children of different ages and in different settings are served by expanded ECMH consultation over the course of the project? (Systems: *Providers and Children*)
5. Do trained staff report increased knowledge, relevance, and changed practices in delivering culturally competent care? (Provider)

Major Limitations and Constraints

The Team is again limited by the willingness of trainees to complete the post- and especially the follow-up questionnaires and agencies to complete the CLAS Tool questionnaires. The Evaluation and Implementation Teams will utilize the same strategies noted in previous goal areas to address response rate, missing data, and analytic issues.

Home Visiting

PA Goal 4: Promote integrated, evidence-based, high quality home visiting services and ensure access to those who need it.

Year One Activities

During Year One the key activities for the Home Visiting goal area centered on preparing for the launch of a new coordinated referral telephone line for home visiting services[3] (i.e., "The Link") and identifying potential LAUNCH affiliated providers from whom to collect individual-level outcome data.

Also, the Implementation Team utilized a comprehensive selection process to determine the best fit for PA Project LAUNCH priorities (See Appendix M: Decision Tree and Program Information Template) and selected the prevention demonstration project, Smart Beginnings.

Smart Beginnings is a prevention demonstration program, and its evaluation includes individual level assessments on children, parents, and families in addition to fidelity of implementation measures. The project is scheduled to begin in May 2016 and is federally funded through NICHD. A complete list of measures is located in Appendix N and further details on Smart Beginnings' interventions, measurement strategies, and copies of assessment measures are available in the PA Project LAUNCH Evaluation Plan revised November 2015. Multiple assessments are offered in English and Spanish and are culturally appropriate for the focal population.

Process Evaluation Activities

As in other goal areas (i.e., Goals 1 and 3), the Team uses a mixed methods approach to measure implementation of key activities in this area. In addition, Smart Beginnings will utilize curricular and facilitator checklists and the COACH Fidelity Protocol to assess intervention fidelity. The acronym COACH stands for "**C**onceptual accuracy and adherence, **O**bservant and

[3] The County Department of Human Services started planning and development efforts for The Link prior to PA Project LAUNCH. However, in Year One LAUNCH was actively involved in planning and support of this initiative.

responsive to client needs, **A**ctively structures sessions, **C**areful and appropriate teaching, **H**ope and motivation are generated." Collectively, these strategies will be used to examine the following implementation questions:

Implementation Questions

1. Is the coordinated referral line established for families to access home visiting programs working satisfactorily? (Systems)
2. To what extent are the Video Interaction Project (VIP) and Family Check Up (FCU) [Smart Beginnings] interventions implemented with fidelity? (Provider)

Outcome Evaluation Activities

Outcome evaluation activities will start for The Link and Smart Beginnings once the programs are launched in 2016. The County is using The Link to counsel families on home visiting program options. They will provide PA Project LAUNCH with The Link referral data. Smart Beginnings, an evidenced-based home visiting service for families with very young children, intends to recruit 200 low-income and potentially at-risk newborns and their families. Upon enrollment, the program will randomly assign half of these families to the control condition and the other half to the VIP intervention. At six months, "VIP condition families" who score at-risk on program assessments have the option to participate in the FCU intervention. For further details, please see the PA Project LAUNCH Evaluation Plan – Revised.

The YCW Coordinator and Evaluation Team will work with these and other LAUNCH affiliated providers in the collection of client level data.

Outcome Questions

1. How many referrals does The Link make to local home visiting programs? (Systems: *Families*)
    a. To what extent are referrals filling existing program vacancies? (Systems: *Provider*)
2. What is the racial/ethnic/special population distribution of clients served by LAUNCH affiliated providers? (Systems: *Children & Families*)
3. To what extent does the VIP intervention impact infants' social emotional and developmental skills in comparison to children in the no treatment condition? (Child)
4. To what extent does the VIP intervention impact family processes that may mediate intervention impacts, including increased positive parenting and reductions in psychosocial stressors in comparison to families in the no treatment condition? (Family)
5. To what extent does the VIP + FCU intervention contribute to better children's development? (Child)
6. To what extent does the VIT + FCU intervention address challenges associated with parenting and parenting stressors in at-risk families? (Family)

Major Limitations and Constraints
Data will only be available for home visiting programs participating in The Link. The evaluation will be limited by the type and quality of the data collected by The Link, which include number of calls, programs referrals, and client information collected during calls.

Family Strengthening and Parent Skill Building

PA Goal 5: Ensure families with young children are connected to needed information and services.

Year One Activities
Key activities surrounding Family Strengthening and Parent Skill-Building during Year One focused on identifying and compiling digital resources for families and collecting feedback from families to shape the design and presentation of the material on local and state websites. This group also planned the launch of peer-to-peer support strategies.

Process Evaluation Activities
Similar to other goal areas, the Team uses a mixed methods approach to measure implementation of key activities in this area. The Evaluation Team will collect data once the endorsed materials are identified as planned, once dissemination has begun, and once trainings are underway. Specific dates are to be determined. This approach is used to examine the following implementation questions and entails the same evaluation strategies described for Goals 1, 3, and 4:

Implementation Questions

1. What materials and types of dissemination efforts are promoted to support parents' usage of endorsed materials on children's healthy development and social emotional wellness? (Systems)
2. Do agencies report increased dissemination of culturally relevant materials? (Systems)
3. How many trainings are conducted on Mental Health (MH) First Aid for community leaders? (Systems: *Providers*)

Outcome Evaluation Activities
Outcome evaluation activities will start once trainings are developed and LAUNCH affiliated providers and partners are engaged with the project. At that time, the Team will work with provider agencies to facilitate data collection through the most appropriate method for each agency (e.g., revising data collection forms, extracting data from organizational databases, or creating data collection tools) and will coordinate the collection of post-training data through the YCW Coordinator and YCW Expert. In addition, electronic follow-up surveys, targeted at examining practice changes, will be sent to participants by the Evaluation Team three months following each training.

Outcome Questions

1. Are an increasing number of parents involved in social networks that promote their leadership skills? (Systems: *Families*)
2. Do trainees report increased knowledge and potential use in practice of MH First Aid? (Provider)
3. To what extent are agencies and staff trained in cultural competency (i.e., increased number of trainings, increased number of participating agencies and staff)? (Systems: *Providers*)
4. Do trained staff report increased knowledge, relevance, and changed practices in delivering culturally competent care? (Provider)

Major Limitations and Constraints

The limitations are the same as for other training activities noted for other goal areas.

Local (Allegheny County) Systems Change

PA Goal 6: *Create a sustainable infrastructure, including data systems, to promote social-emotional and physical wellness for children birth to 8 years, pregnant women, and their families.*

Year One Activities

Efforts to promote local systems change during Year One included the convening of Local Young Child Wellness Council meetings, Local Work Group meetings, and dozens of outreach activities aimed at promoting the goals of PA Project LAUNCH.

Process Evaluation Activities

The Evaluation Team uses a mixed methods case study approach to measure system change at the local level. This approach includes review and monitoring of YCWC and Work Groups' minutes and project records, completion of an online end-of-year survey, and follow-up interview with the YCW Coordinator (See Appendix O for Meeting Minutes Template). In addition, the YCW Coordinator maintains an Outreach Activity Log that lists focal activities and accomplishments, which is reviewed for key themes and accomplishments. Collectively, the above strategies are used to examine the following implementation questions:

***I**mplementation Questions*

1. What efforts are made to promote coordination and collaboration and improve policies and regulations? (Systems)
2. Does the local YCWC achieve the desired diversity of membership and attendance, particularly family/parent representatives, from year to year? (Systems)
3. To what extent [time/hours] do local YCWC and Work Group members engage in PA Project LAUNCH activities? (Systems)

Outcome Evaluation Activities

In addition to the process evaluation activities described above, the Wilder Collaborative Factors Inventory (See Appendix P: Wilder Collaborative Factors Inventory) was used to assess the quality of collaboration of parents and professionals on the local YCWC (Mattessich,

Murray-Close, & Monsey, 2001). The Inventory includes 40 Likert type items with responses of *Strongly Disagree, Disagree, Neutral/No Opinion, Agree,* and *Strongly Agree* for items such as "People involved in our collaboration always trust one another," and "People in this collaborative group have a clear sense of their roles and responsibilities." The complete list of the 20 factors associated with effective collaboration is located in Table 6.

Baseline Wilder data was collected via an online link emailed to each Local YCWC member after the first three YCWC meetings had occurred (March/April 2015). Two surveys were sent via postal mail for individuals who did not utilize email. After sending the online survey link, the Evaluation Team sent reminder emails four times across a two week period and follow-up reminder calls were made to the two Council members without email access. The Inventory response rate for the Local Council was 71% (25 of 35 members).
The team used record review, end of year surveys, interviews, outreach summaries, and Wilder Inventories to examine each of the following outcome questions:

Outcome Questions

1. What efforts are made to improve data collection, data sharing, and data reporting across organizations and systems? (Systems)
2. To what extent do efforts related to data collection, sharing, and reporting, improve collaboration and coordination across organizations and systems? (Systems)
3. To what extent do sustainability efforts support local Project LAUNCH priorities? (Systems)
4. Is the YCWC functioning in a collaborative and effective manner from year to year, especially for family/parent representatives? (Systems)
5. To what extent [time/hours] do state YCWC and Work Group members engage in PA Project LAUNCH activities? (Systems)

Major Limitations and Constraints

The members of the YCWC are very busy professionals and parents, and even after several reminders Wilder data were obtained from 71% of members. As such, the response rate may limit generalizability of the findings across council members. Sustainability is of critical importance for all PA Project LAUNCH efforts. The Evaluation Team will capture sustainability efforts and accomplishments through the Multi-Site Evaluation (MSE), end of year surveys, and key informant interviews in Year Two and beyond when planning and implementation have progressed further.

State Systems Change

PA Goals 7a-7c:

- *Disseminate by target audience messages about the importance and benefit of social-emotional wellness and services.*
- *Create a sustainable infrastructure, including data systems, to promote social-emotional and physical wellness for PA children birth to 8 years, pregnant women, and their families.*
- *Create and maintain a governance structure to promote social-emotional and physical wellness for PA children birth to 8 years, pregnant women, and their families.*

Year One Activities

Efforts to promote state systems change in Year One included convening of State Young Child Wellness Council meetings, State Work Group meetings, outreach activities aimed at promoting PA Project LAUNCH goals, and invitations for PA Project LAUNCH representation on state level initiatives and privately funded initiatives that align with the goal areas of Project LAUNCH.

Process Evaluation Activities

Parallel to the methods utilized to assess Local Systems Change (Goal 6), methods used to assess State Systems Change included YCWC composition and attendance, Wilder Collaborative Factors Inventory, record review, interviews, surveys, and outreach summaries. These strategies were used to examine the implementation questions listed below.

***I**mplementation Questions*

1. What efforts are made to promote public awareness around Project LAUNCH priorities? (Systems)
2. How many and how often are messages disseminated? (Systems)
3. Who are the target audiences and how far is the potential reach of the messages disseminated? (Systems)
4. Does the State YCWC achieve the desired diversity of membership, particularly family/parent representatives, from year to year? (Systems)

Outcome Evaluation Activities

The Wilder Collaborative Factors Inventory was used to assess the quality of collaboration of parents and professionals on the State YCWC (Mattessich, Murray-Close, & Monsey, 2001). The inventory and factors were described in more detail under the "Local System Changes."

Baseline Wilder data were collected via an online link emailed to each State YCWC member after the first three YCWC meetings had occurred (May/June 2015). After sending the online survey link, the Evaluation Team sent email reminders four times across a two week period. The response rate for the State Council was 89% (25 of 28 members).

Outcome Questions

1. What type of strategies are implemented for sustainability? (Systems)
2. What policies are changed or added to support long-term strategy implementation? (Systems)
3. Is the YCWC functioning in a collaborative and effective manner from year to year? (Systems)

Major Limitations and Constraints

Despite being very busy professionals and family members, the State YCWC response rate to the Wilder questionnaire was 89%. The response rate does not represent a limitation to survey data.

Data Analysis

Analysis of Planning Information [from Project Records]

A major source of data for many of our questions involves record keeping of contacts made, meetings attended, meeting attendance, family member representation, organizational affiliations, and public awareness activities. We report the number and purpose of such activities, the number of people involved, and the percentage of various groups represented on Councils and Work Groups in Year One. In the future, the Evaluation Team will continue to report such information as well as plot changes over time associated with these infrastructure activities and for trainings, screenings, and efforts around disseminating endorsed resources. These counts will be broken down by various factors (e.g., setting, racial/ethnic characteristics, etc.) when appropriate.

Key Informant Interviews, Surveys, and Outreach Activity Logs

Much of the qualitative information in Year One is from the Outreach Activity Logs, end of year (EOY) surveys, and key informant interviews. Log and EOY survey data reflect simple events, collaborations, attendance, etc., and information provided in key informant interviews was a means of clarifying and supplementing EOY surveys; as such, thematic analyses were not needed at this point in time. Moving forward, we will develop note tables and/or explore the usage of a qualitative software package for conducting thematic analyses, when needed. Other measurements provide quantitative scores (e.g., Wilder Inventories) that can be averaged over participants. In the future, we will conduct statistical analyses (e.g., analyses of variance) of longitudinal or cross-sectional change across time when appropriate; but sometimes there will be too few such units (e.g., four primary care providers) for statistical analyses other than plotting the average scores or providing frequencies.

Analysis of Individual Level Child, Parent, Family, and Program Outcomes

Analysis of individual level child, parent, and family outcomes will focus on relative improvements over time (i.e., 6, 18, and 21 months) for families participating in the three conditions, namely, no treatment, VIP Only, and VIP+FCU. The comparison of VIP Only and Control families will provide evidence for the effectiveness of the VIP intervention for various aspects of child and parent characteristics and parent-child interactions (See Appendix N: Smart Beginnings Measures). The VIP + FCU vs. VIP Only intent-to-treat comparison will assess the additional benefit of the FCU intervention applied at this young age. The collection of data on risk factors in families involved in the project permits subgroup analyses of different racial-ethnic and risk groups, and mediational analyses can be utilized to describe the extent to which child outcomes are associated with improved parent-child interaction. In addition, the extent to which the intervention is implemented with fidelity will be measured and examined in relation to participant outcomes by using curricular checklists, observational feedback, and the COACH fidelity protocol.

We will report on the prevalence of missing data and make statistical adjustments when feasible and appropriate.

Gaps and Limitations

The analyses of process and outcome data for Year One are limited by the nature and extent of these data, which are simply counts of individuals and events. When more metric data are available (e.g., The Wilder Inventory), simple averages will be reported; some statistical analyses will likely be possible when we have such data over years.

Much of the evaluation data expected in subsequent years will continue to be frequencies and percentages. The exception is the VIP/FCU project, which will have individual measures of children, parents, families, and program fidelity available. One challenge is to investigate covariates and moderators (e.g., extent of initial risk, demographics, racial/ethnic/special population, etc.) for which there may not always be sufficient numbers of cases. A second challenge is comparing the VIP + FCU group to an appropriate comparison group. The FCU intervention is only given to a subsample of VIP families who are at highest risk at 6 months; those VIP families not given the FCU intervention would be at lower initial risk. Thus, initial risk status is confounded with treatment condition. However, plotting outcome results for these two groups over time should describe the effects of FCU vs. no FCU even though the two groups likely will not start at the same level. Depending on the extent of initial differences, covariance analyses may help.

Findings to Date

PA Project LAUNCH has operated as a highly collaborative process involving 87 Local Council and Work Group members, 28 State Council and Work Group members, and 18 members of the Implementation Team. Further, PA Project LAUNCH involves a large potential number of service agencies and participants and covers a large geographical area. Considerable time and attention have been necessary not only to coordinate project priorities and next steps with this number of professionals and agencies, but also to identify and engage potential LAUNCH partners and affiliated providers. For these reasons, most of Year One has been devoted to planning, setting priorities, and choosing project directions. We believe forging such collaborations has been major accomplishment in Year One and ultimately will produce a more successful and sustainable project. Outcome findings for activities that have not been implemented to date were omitted from this report (e.g., number of screenings conducted, number of policy changes). Anticipated data collection and analysis dates cannot be determined until formalized activities have occurred (e.g., MOU's, trainings).

Specific goal area process evaluation findings are located in Table 2.

Table 2. Goal Area Specific Process Evaluation Findings

Goal Area	Local Level	State Level
Screening and Assessment	Gaps in screening were identified, fact sheets on ASQ and Early Intervention were distributed, and efforts to improve community awareness of the importance of screening were undertaken.	A strategy to increase the number of children screened was explored, and updates on the new ASQ:SE 2 were provided to the statewide training program.
Behavioral and Physical Health Integration	Four major pediatric practices were engaged and are scheduled to complete the Pediatric Provider Integration Assessment in Year Two. Awareness and collaboration efforts were made with other groups interested in this topic at the county level.	Awareness and collaboration efforts were made with other state level groups.
Early Childhood Mental Health	Activities focused on promoting ECMH best practices, most specifically the January 2016 training on ECMH best practices and kick-off event to create a learning collaborative on the subject.	Public awareness and outreach to other organizations occurred at the state level.
Home Visiting	Preparations were made to roll out The Link, a coordinated home visiting options counseling and referral hotline in early 2016. The intent of the coordinated hotline is to increase families' referrals to and engagement in home visiting services. PA Project LAUNCH established a partnership with Smart Beginnings, a demonstration prevention service that will provide parent-child intervention services in pediatric (VIP intervention) and home (FCU) settings. Project LAUNCH will fund a nurse recruiter for one year; recruitment will begin in May 2016.	
Family Strengthening and Parent Skill Building	Collaborations were established with Kidsburgh[4] to redesign the Health and Wellness section of their website and with the Early Learning GPS[5] to get links to this resource established on other groups' websites. Notices of available information were distributed via email, meetings, and resource fairs, and planning occurred to increase parental involvement in social networks through Parent Cafe models that focus on the Strengthening Families' Protective Factors.	Collaboration with Illinois Strengthening Families on their parent café model which focuses on the Strengthening Families Protective Factors.

Screening and Assessment Findings

PA Goal 1: Ensure young children at risk for poor developmental outcomes (especially social-emotional) are screened and provided appropriate resources, including referrals.

Process Evaluation Progress

The Local Screening and Assessment Work Group has produced a chart organizing the locations that are currently completing developmental screenings with the intent to identify gaps in screening and assessments for particular risk factors as well as gaps in geographic areas where

[4] Kidsburgh: The central focus is to improve the lives of children in Pittsburgh.
[5] Early Learning GPS[5]: is a digital resource for parents.

screenings may be needed. Additionally, a list of screenings and assessments currently in use is being compiled and will be reviewed by the Integrated Behavioral Health/Physical Health Work Group.

Partnering with the Office of Children, Youth, and Families (OCYF) and the Alliance for Infants and Toddlers (the screening agency), PA Project LAUNCH staff have: 1) assisted in the creation of fact sheets about the ASQ and Early Intervention, 2) developed a more efficient process for the requests for screenings, and 3) provided resources to support these staff members. These efforts are in support of OCYF to increase the number of screenings completed for children who are accepted for in-home service as part of the Child Welfare Demonstration Project.

Also, locally, resources have been shared with child welfare, pediatric practices, family support providers, family advocacy organizations, educational liaisons, and the City of Pittsburgh with the intent to promote the importance of screening and assessment. The BH/PH Work Group has also developed an interview tool to gather information about screening tools used (among other pieces of information) within pediatric practices.

At the State level, the Young Child Wellness Expert (YCWE) and State Council members have begun collaborating with Pennsylvania Partnerships for Children (PPC) to develop strategies to increase the number of children in Pennsylvania who receive a developmental screening in the first five years of life (the Screening, Assessment, Referral and Follow-up Initiative, privately funded through the David and Lucille Packard Foundation). Recommendations from this initiative will help inform the work that PA Project LAUNCH does within the Screening and Assessment core strategy. In addition, the YCW Expert attended a training of trainers on the new ASQ:SE-2 screening instrument. Information from this training will be used to update the current statewide training module on the ASQ-3 and ASQ:SE-2 screening instruments.

Behavioral Health & Physical Health Integration Findings

PA Goal 2: Enhance integration of physical health and behavioral health practices to improve access to care for children birth to 8 years, pregnant women, and their families.

Process Evaluation Progress

The BH/PH Integration Work Group identified four local major pediatric practices that are implementing integrated models of behavioral and physical health services. In collaboration with the Evaluation Team, this Work Group developed an interview tool, the Pediatric Provider Integration Assessment (see the Approach and Methods section under Behavioral Health & Physical Health Integration for more details) and interview summary form, which were finalized during the closing weeks of the reporting period. As of Sept. 30, 2015, the four major pediatric practices in Allegheny County had agreed to complete the assessment by the end of 2015. This assessment is ideally administered with the input of multiple staff members from these given settings (e.g. physicians, psychiatrists, senior administrators, registered nurses, mental health nurse practitioners, licensed clinical social workers, etc.).

In addition, PA Project LAUNCH has begun building collaborations at the local and state levels. Locally, LAUNCH is working with the Conference of Allegheny Providers (CAP) to share and gather information that can be used to further the integration of behavioral health and physical health services. At the state level, the State YCWC co-chair participates in the Pennsylvania Physical Health/Behavioral Health Learning Community (PA PH/BH LC) and is working to connect the Local YCWC and its PH/BH Work Group to this learning community.

Early Childhood Mental Health Findings

PA Goal 3: Strengthen existing ECMH consultation and extend services to children, birth to 8 years, and pregnant women in multiple early childhood settings (including, but not limited to, ECE, family support, elementary schools, EI, afterschool programs, pediatricians' offices, etc.).

Process Evaluation Progress

Locally, this year's focus has been to develop strategies to promote ECMHC best practices. An informational training event is being developed and is scheduled for January 14, 2016. It is designed to help trainees gain a deeper understanding of ECMH and will include identified professionals that provide services in the three target communities. The content will include ECMHC models, settings, and implementation; differentiation of ECMHC from other mental health interventions; and the role of mental health consultants. Aligned with the upcoming training, the local ECMH Work Group is creating a learning collaborative through which best practices, including engagement and implementation, are identified and promoted. Additional goals of the collaborative are to expand the availability of ECMH consultation by connecting providers and ensuring warm transitions for children and families between providers. The January 2016 training event will serve as a setting for recruiting members into the learning collaborative.

At the state level, the YCW Expert presented at state and national conferences on early childhood brain development, social-emotional development, and Pennsylvania's work in the areas of Positive Behavior Intervention and Support (PBIS), including Program-Wide PBIS which is used in early care and education settings. National resources were promoted by the YCW Expert in support of working with families at these venues that included the Center for Social Emotional Foundations in Early Learning, Technical Assistance Center for Social Emotional Intervention, and the Center for Early Childhood Mental Health Consultation. The YCW Expert also participated in Head Start Collaboration Office Roundtables to increase awareness of Project LAUNCH, meet Head Start grantees, and inquire about their use of mental health consultation services in terms of program model and practices.

The State YCWC and members of the Local YCWC agreed to pursue bringing an Infant Mental Health Competency and Endorsement System to Pennsylvania, organized by Project LAUNCH in collaboration with the PA Association for Infant Mental Health (PA-AIMH). The State YCWC Workforce Development Work Group will explore funding options and develop a proposal for review and support by leadership in various state departments whose services support young children and their families. Due to the nature of IMH Competency and Endorsement systems, this work would be sustained through PA-AIMH following implementation.

Home Visiting Findings

PA Goal 4: Promote integrated, evidence-based, high quality home visiting services and ensure access to those who need it.

Process Evaluation Progress

Multiple objectives exist for this goal, including increasing referrals to local home visiting programs, engaging families of infants identified at-risk for mental and behavioral health issues in an evidenced-based home visiting intervention, and increasing public and professional awareness of home visiting best practices. A major focus is the creation and rollout of "The Link". The Link is a coordinated referral telephone line that will provide home visiting options and counseling/referrals to families. The goal of The Link is to fill existing home visiting program vacancies across the County, allow families easier access to home visiting programs, and better align families' needs with the most appropriate home visiting programs, which, in turn, should increase program retention rates. The logistics and details of The Link have been carefully developed in Year One. It is scheduled to begin service in January 2016 and will enable DHS and PA Project LAUNCH to chart system-level data on the number of referrals, existing vacancies, and client demographics across a comprehensive sample of area home visiting programs over time.

The Home Visiting Work Group has developed brochure card materials to promote home visiting and the coordinated referral line (The Link) with input from a racially diverse focus group of ten family members with young children. The group helped ensure that the materials included diverse representation in the photos and discussed the translation needs of some providers. These materials will initially be distributed through the United Way's PA 2-1-1 Southwest call center and local hospitals, with future plans to be broadly distributed.

The Implementation Team devoted a considerable amount of time in the fourth quarter of Year One identifying potential LAUNCH affiliated providers that were best positioned to implement direct service interventions and collect individual level outcome data. A partnership was forged with Smart Beginnings for this purpose. Smart Beginnings, led by Dr. Daniel Shaw at the University of Pittsburgh, is a home visiting service demonstration project designed to promote healthy development and address behavioral/mental health concerns in very young children and their families. Smart Beginnings will pilot the Family Check Up (FCU) and Videotaped Interactions Project (VIP) interventions with children 0-27 months of age. Both interventions were found to be effective in previous studies of families with older children, and the Family Check Up is a SAMSHA Evidence Based Program.

The demonstration program will randomly assign approximately 200 families to the control or intervention condition (VIP) at the time of recruitment (i.e., birth). At 6 months, all families will receive an assessment battery. Those families who had been randomly assigned to the VIP intervention and who score above cut points on risk for child, family stress, and/or caregiving domains (i.e., at least above threshold in one of the three domains) will be offered the option of participating in the VIP + FCU intervention. Children, parents, and families in all three conditions (i.e., no-treatment Control, VIP Only, VIP + FCU) will be assessed when their child is

18 and 21 months of age, and fidelity to the service programs will also be assessed. Recruitment and enrollment will begin in May 2016.

Family Strengthening and Parent Skill Building Findings

PA Goal 5: Ensure families with young children are connected to needed information and services.

Process Evaluation Progress

To support parents' use of endorsed materials that promote children's healthy development and social-emotional wellness, local efforts have been made to collaborate with Kidsburgh, a collaborative group that includes parents, educators, and others (working with kids or on kids' issues) who are dedicated to improving the lives of children in the Pittsburgh area. Kidsburgh contacted PA Project LAUNCH representatives with aims to redesign the Health and Wellness section of the kidsburgh.org website. To support this redesign, leaders of Project LAUNCH brought families and professionals together to obtain feedback on the content and organization of the website. In addition, eight members of the Local Young Child Wellness Council and Work Groups have continued to participate in a Kidsburgh advisory group as the organization moves forward in the website redesign.

Also at the local level, Early Learning GPS, a digital resource for parents with a broad array of information on child development, was reviewed and discussed within the Local Family Strengthening Work Group. Members decided to include an Early Learning GPS link on each represented organization's website, and to promote registration on the website for families. Promotion of the Early Learning GPS is a collaboration between PA Project LAUNCH and PA Race to the Top – Early Learning Challenge (RTT-ELC). In addition to the Early Learning GPS, other resources have been disseminated via email, meetings, and/or resource fairs. The materials disseminated and the original authoring agencies include:

- Military Families Materials, Zero to Three
- Strengthening Families, Protective Factors Information
- Explore your Emotions Coloring Book, Allegheny County System of Care
- Trauma fact sheets, National Childhood Traumatic Stress Network
- When Families Grieve, PBS
- Brain development, toxic stress, and other key child development information, The Center on the Developing Child, Harvard University
- National Alliance on Mental Illness (NAMI) and NAMI Walk materials, raising awareness about mental illness

To increase parent involvement in social networks that promote parent leadership skills, local efforts included planning a kick-off event to introduce interested members of communities to Strengthening Families Protective Factors. Another approach is the Be Strong Families model, a collaborative project also in development. Be Strong Families is a Parent Café model that supports programs and communities in engaging parents, building protective factors, and promoting deep individual self-reflection and peer-to-peer learning. The event will provide a foundational understanding of the Strengthening Families Protective Factors, which includes 1)

Parental Resilience, 2) Social Connections, 3) Concrete Supports, 4) Knowledge of Parenting and Child Development, and 5) Social and Emotional Competence of Children. The Strengthening Families State Leadership Team is working with PA Project LAUNCH to explore a potential collaboration with Illinois Be Strong Families around using their Strengthening Families Protective Factors Parent Café model. Additional activities and programs supporting parent leadership skills locally include:

- Peer support sessions and classes for mothers offered through Kids Plus Pediatrics,
- Trainings provided through the Local Interagency Coordinating Council (LICC), and
- Scholarships provided through PA Project LAUNCH to the 7th Annual PA Infant Mental Health Conference in Monroeville, PA (October 15-16, 2015)

State (as well as Local) YCW Councils reviewed and discussed the Early Learning GPS promotional kits through the Race to the Top – Early Learning Challenge (ELC) grant to support parents' use of endorsed materials that promote children's healthy development and social-emotional wellness. The Early Learning GPS is an online, interactive tool that helps families learn the most important things they need to know and can do to help their young child grow. Additionally, families can search for local resources in their county, a list that is consistently updated.

To promote parent leadership opportunities, the Local YCWC currently has 33% family representation and the State YCWC has 18% family representation. In Year Two, the Local YCWC will offer child-care and stipends to facilitate increased participation by families in the local community. The YCW Expert and YCW Partner continue to work to identify additional family representation at the State level.

Local (Allegheny County) Systems Change Findings

PA Goal 6: *Create a sustainable infrastructure, including data systems, to promote social-emotional and physical wellness for children birth to 8 years, pregnant women, and their families.*

Process Evaluation Progress

The Local YCWC is one of two governing bodies established by PA Project LAUNCH. This body is largely responsible for initiating and overseeing strategy implementation, initiating and supporting local practice and policy changes and local collaborations, and addressing barriers that may arise with respect to implementation, collaboration, and sustainability.

In Year One, the Local Work Groups focused primarily on building critical networks through outreach and networking activities. Key relationships were forged with Dr. Todd Wolynn (CEO of Kids Plus Pediatrics), Dr. Daniel Shaw (Researcher for the Smart Beginnings project at the University of Pittsburgh), the Carnegie Library of Pittsburgh, Promised Beginnings through the City of Pittsburgh's Department of Public Safety, and Mercy Behavioral Health.

Local outreach activities promoted community buy-in around coordination of services for targeted populations (e.g., members of targeted communities, school-age children and parents, and veterans). Specific local efforts included beginning discussions to align the Immigrants and

International Committee's strategies with PA Project LAUNCH, grant representation on the Children's subcommittee and the Strategic Planning subcommittee of the Immigrants and International Committee, and staff participation in the County's effort to formally review and develop strategies that address racial disparities in the Child Welfare System.

Local YCWC Composition. After the initial Local YCWC was formed, ten Local YCWC members were added, including two family member representatives. During this report period, one Council member was replaced by an individual within their respective organization, and two Council members resigned with no identified replacements. Thus, at the end of Year One, the Local Young Child Wellness Council had 43 members; 25% were African American, 2% were Latino, and 33% were family member representatives, which is substantially above SAMSHA's requirement of 10%.

The Local YCWC is made up of 22 different organizational partner types plus family member and State YCWC representatives. The following organizational partner types are represented on the Local YCWC:

- Adult and Family Services
- Child and Family Serving Agencies
- Child Care
- Child Welfare
- Community Health Center
- Early Childhood Education
- Faith Based Community
- Family Support Groups
- Head Start and Early Head Start
- Health (including private sector)
- Higher Education
- Home Visiting Program
- IDEA Part B
- Immigrant and Refugee Serving Agency
- Local Education Agencies
- Managed Care Organizations
- Mental Health/Behavioral Health
- Municipal Officials or Aides
- Pediatrician, Family Physician, Nurse Practitioner, OB/GYN, or Midwife
- Social Work
- Substance Abuse Prevention
- WIC

Local Work Groups. Local Work Groups were devoted to 1) Screening and Assessment, 2) Integration of Behavioral Health and Physical Health, 3) Early Childhood Mental Health (ECMH) 4) Home Visiting, and 5) Family Strengthening. These Work Groups are made up of Local YCWC members and other stakeholders within Allegheny County (who are not Council members), chosen for their relevant experience and expertise. At the end of the Year One reporting period, Work Groups included 44 non-Council member stakeholders, one of which was a family member representative. After the initial Local Work Groups were formed, ten Work Group member stakeholders (non-Council members) were added, including one family member representative. Two individuals (a Local Council member and a non-Council member stakeholder) resigned from their respective Work Groups in this reporting period. The number of family members and total number of members in each Work Group are as follows:

Table 3. Local Council and Work Group Family Member Representatives

Goal Area	Percentage of Family Member Representatives	Number of Family Members	Total Number of Members
Local YCWC	33%	14	43
Family Strengthening	46%	6	13
Early Childhood Mental Health	18%	2	11
Home Visiting	4%	1	23
Screening and Assessment	0%	0	11
Behavioral Health and Physical Health Integration	12.5%	2	16

Attendance and Volunteer Hours. Attendance was obtained for Local YCWC and Work Group meetings via sign-in sheets and/or records kept by Implementation Team members or Work Group chairs. Sign-in sheets and/or digital Word document attendance (included in minutes) were submitted to the Evaluation Team after each meeting.

The Local YCWC convened five meetings, with volunteer hours totaling 180 for member attendance. Total attendance across the five YCWC meetings averaged 50%, with an average of 29% family members in attendance (of the total number of members in attendance). Volunteer hours at Work Group meetings totaled 198 (meetings are approximately two hours in length). The number of Local Work Group meetings, the average percentage of total attendance, and the average percentage of family member representation in attendance are as follows:

Table 4. Local Council and Work Group Attendance

Goal Area	Number of Meetings	Mean % of Total Attendance (Of Total Number of Members)	Mean % of Family Members in Attendance
Local YCWC	5	50%	29%
Family Strengthening	3	49%	44%
Early Childhood Mental Health	5	60%	11%
Home Visiting	4	30% (for the 3 meetings reporting attendance)	0% (for the 3 meetings reporting attendance)
Screening and Assessment	3	57%	0%
Behavioral Health and Physical Health Integration	2	28%	0%

Behavioral Health Disparities. How to effectively address behavioral and physical health disparities in the region is part of ongoing discussions within the Local and State YCWC's and Work Groups. The focus of these discussions include criteria for reviewing existing resources and screening tools (i.e., empirical evidence for use with identified special populations) and professional development opportunities for personnel serving targeted sub-populations. The professional development opportunities included the awarding of 19 scholarships, of which four were awarded to African American professionals, three to African American family members, and one to staff serving the Latino Family Center. Externally, LAUNCH project members are engaged in local collaborations targeting disparity issues. These collaborations include membership and involvement in strategic planning on the Immigrants and Internationals Committee and participation with DHS in formally reviewing and discussing strategies to address racial disparities in the County's Child Welfare system.

Local Outreach Activities. To capture the work being done to promote Project LAUNCH goals at the local level, the YCW Coordinator completed the Outreach Log created by the Evaluation Team based on information provided by SAMHSA. Each outreach activity was coded to represent one of the categories listed below.

(a) *Coalition-Building (CB):* 1) Setting policies and guidelines related to health insurance, health providers, education, home visiting, or parenting and changing other policies, rules, or guidelines; 2) increasing collaboration; 3) developing or improving referral or data systems; 4) integrating funds across organizations; 5) submitting funding applications; and 6) other coalition building outcomes.

(b) *Public Information Campaigns (PIC):* 1) Providing education on childhood MH; 2) promoting policies and guidelines that integrate BH screening in pediatric primary care; 3) promoting evidence-based practices for childhood wellness; 4) promoting policies and guidelines related to health insurance, education, home visiting, or parenting and changing other policies, rules, and guidelines; 5) promoting integrated services for childhood MH at the local or state level; 6) providing education about integrated funding sources for childhood MH and/or the need for sustainable funding sources; and 7) other public information campaign outcomes.

(c) *Advocacy (A):* 1) Setting policies and guidelines related to health insurance, health providers, education, home visiting, and parenting; 2) changing rules at private or non-profit institutions or other policies and guidelines; 3) increasing or reallocating state or institutional funding; 4) getting state or municipalities to apply for funds; and 5) other advocacy outcomes.

(d) *Funding Sustainability (FS):* 1) Writing grants or other funding applications, 2) increasing Medicaid or private insurance reimbursements for services, 3) using integrated funding sources, 4) using or submitting applications to receive sustainable funding sources, and 5) other funding sustainability outcomes.

In the time period covered by the report (October 1st, 2014 – September 30th, 2015), a total of 60 outreach activities occurred at the local level which are described in Table 5. Outreach activities in this first year were primarily focused on coalition building and public information

campaigns, and one outreach activity did fall under the umbrella of advocacy. Subgroups that were targeted spanned a wide range, including government officials, higher education representatives, community-based organizations, cultural groups, corrections facilities, early care and education (ECE) providers, elementary education providers, health-care providers, early intervention providers, child welfare staff, mental health care service providers, funders, and media. Target communities and special populations were strategically targeted through events such as the Homewood Health Matters, the Allegheny Family Network Resource Fair, and the Seamless Care Symposium (attended by professionals serving veterans), in an effort to address behavioral health disparities.

Table 5. Local Outreach Activities from Oct. 1, 2014 to Sept. 30, 2015

Month	Total # of Outreach Activities	Types of Organizations Reached	Number of Participants	*Activity Types	Disparities Addressed
Nov 2014	5	Early Care & Education; Government; Cultural Group; Elementary Education; Corrections	85+	All 5: CB & PIC	n/a
Dec 2014	5	Government; Early Care & Education; Child Welfare; Mental Health Providers; Public Health; Funders	120+	All 5: CB & PIC	n/a
Jan 2015	1	Public Health	~18	CB	n/a
Feb 2015	2	Early Care & Education; Health Care Providers	~36	1: CB 1: CB & PIC	n/a
Mar 2015	3	Funders; Government; Early Care & Education; Elementary Education	63+	All 3: CB & PIC	n/a
Apr 2015	6	Medicaid (Behavioral Health carve-out); Mental Health Services; Advisory Board; Child Welfare; Health Care Providers; Early Care & Education	130+	4: CB & PIC 2: CB	Provided trauma resources
May 2015	7	Mental Health Providers; Child Welfare; Early Care & Education; Elementary Ed.; Cultural Group; Veterans Affairs	~100	6: CB & PIC 1: CB	n/a
Jun 2015	7	Advocacy; Early Intervention; Child Welfare, Government	90+	4: CB 2: PIC 1: A	Addressed Infant mortality & school success of African Americans; Sought foster care rep for Council
Jul 2015	5	Government; Homeless Advocacy Group	71+	5: PIC	Identified homeless children as an at-risk category in Early Intervention
Aug 2015	9	Early Care & Education; Government; Higher Education; Community Organizations; Mental Health Providers; Elementary Education	293+	6: PIC 3: CB	Addressed LGBTQ awareness / culturally appropriate practices & vocabulary
Sep 2015	10	Elementary Education; Funders; Media; Child Welfare; Higher Education; Public Health; Funders; Mental Health Providers	187+	7: PIC 3: CB	Strategized ways to reduce number of children & families of color in child welfare and promote equitable reporting; Strategized process to expand ECMHC services to children experiencing homelessness
Total	**60**		**1193+**	44: PIC 39: CB 1: A	

* Coalition Building (CB), Public Information Campaigns (PIC), Advocacy (A); definitions are available on pp. 36 & 37

Outcome Evaluation

Wilder Collaboration Factors Inventory. The Local YCWC's Wilder scores and interpretations are grouped by domain and listed below. Although the inventory does not provide normative scores, the authors provide general guidelines for score interpretation as follows:

- *4.0 or higher* show *a strength* and probably do not need special attention.
- *3.0 to 3.9* are *borderline* and should be discussed by the group to see if they deserve attention.
- *2.9 or lower* reveal *a concern* and should be addressed (Mattessich, et al., 2010)

Local YCWC's Wilder response rate was 71% of members. Non-responders included family representation (50% of the total nonresponses), and individuals representing organizations in Early Childhood Education, Local Education Agencies, Substance Abuse Prevention, Health (including private sector), and Family Support Groups partner types.

With regard to Local YCWC scores, the highest rated factors at baseline were *Members see collaboration as in their self-interest* (4.32), *Favorable political and social climate* (4.22), and *Unique purpose* (4.22). This showed a positive attitude toward the group. The lowest rated factors at baseline were *Collaborative group seen as a legitimate leader in the community* (3.46); *Sufficient funds, staff, materials, and time* (3.46); and *Multiple layers of participation* (3.40). These represented some of the challenges the group will face. It is notable that no factor was rated to be "a concern."

Table 6. Local YCWC Wilder Factors Collaboration Baseline Inventory Results (n=25)

Domain	Factor	Mean Score	Score Interpretation
Environment	History of collaboration or cooperation in the community	3.78	Borderline
	Collaborative group seen as a legitimate leader in the community	3.46	Borderline
	Favorable political and social climate	4.22	Strength
Membership Characteristics	Mutual respect, understanding, and trust	3.78	Borderline
	Appropriate cross section of members	3.68	Borderline
	Members see collaboration as in their self-interest	4.32	Strength
	Ability to compromise	3.68	Borderline
Process and Structure	Members share a stake in both process and outcome	4.11	Strength
	Multiple layers of participation	3.40	Borderline
	Flexibility	4.04	Strength
	Development of clear roles and policy guidelines	3.50	Borderline
	Adaptability	3.74	Borderline
	Appropriate pace of development	3.64	Borderline
Communication	Open and frequent communication	4.08	Strength
	Established informal relationships and communication links	3.90	Borderline
Purpose	Concrete, attainable goals and objectives	3.97	Strength-Borderline
	Shared vision	4.02	Strength
	Unique purpose	4.22	Strength
Resources	Sufficient funds, staff, materials, and time	3.46	Borderline
	Skilled leadership	4.12	Strength

State Systems Change Findings

PA Goals 7a-7c:

- *Disseminate by target audience, messages about the importance and benefit of social emotional wellness and services.*
- *Create a sustainable infrastructure, including data systems, to promote social-emotional and physical wellness for PA children birth to 8 years, pregnant women, and their families.*
- *Create and maintain a governance structure to promote social-emotional and physical wellness for PA children birth to 8 years, pregnant women, and their families.*

Process Evaluation Progress

The State YCWC is one of two governing bodies established by PA Project LAUNCH. This body is largely responsible for initiating and/or supporting policy and practice change, developing and communicating key messages, and addressing barriers that may arise with respect to implementation, collaboration, and sustainability. In Year One, this body's main focus was to facilitate collaboration and ownership among Council and Work Group members around PA Project LAUNCH goals, promote awareness of Project LAUNCH, and build relationships with external organizations through outreach activities.

Organizations engaged by the State Project LAUNCH Team include Race to the Top – Early Learning Challenge Safe Schools Healthy Students (SSHS), PA Partnerships for Children (PPC), PA Positive Behavior Support Network (PA PBS), Head Start Collaboration Office, Maternal Infant Early Childhood Home Visitation (MIECHV) Grant Leadership, and Strengthening Families State Leadership Team.

PA Project LAUNCH has also focused on sustainability at the state level largely through collaborations and infrastructure building. The YCW Expert said "I am hopeful that LAUNCH will bring Infant Mental Health Competency and Endorsement to PA to ensure a competent cross-sector workforce in infant and early childhood mental health in a sustainable manner (B. Fox personal communication, November 25, 2015). Project LAUNCH has representation and established collaboration with numerous organizations, reviewed other initiatives to identify alignment in approaches and foci, as well as determined opportunities for leveraging resources and reducing duplication in efforts."

State YCWC Composition. At the end of this reporting period, the State Young Child Wellness Council had 28 members. After the initial State YCWC was formed, five State YCWC members were added, including two family member representatives, and two Council members were replaced by two individuals within their respective organizations. Five of these 28 members are family representatives (18%).

The State YCWC is made up of representatives of 16 different organizational partner types, as well as family members and Local YCWC representatives. The following organizational partner types are represented on the State YCWC:

- Child Welfare
- Early Childhood Education
- Early Childhood Initiatives
- Elementary Education
- Family Health Care Provider
- Health (including private sector)
- Higher Education
- Medicaid
- Mental Health/Behavioral Health
- Military Liaison
- Office of the Governor
- Professional Associations
- Service Providers
- State Infant-Early Childhood Mental Health Association
- Substance Abuse Prevention
- Other Grant Representation (e.g., State Government)

State Work Groups. State Work Groups originally included 1) Family Strengthening, 2) Early Childhood Mental Health (ECMH), 3) Home Visiting, 4) Screening and Assessment, and 5) Integration of Behavioral Health and Physical Health, with an ad-hoc Work Group on IMH Competencies/Endorsement. The State Work Groups are made up of State YCWC members, based on their relevant experience and expertise. The number of members in each group and number of family members are as follows:

Table 7. State Council and Work Group Family Member Representatives

Goal Area	Percentage of Family Member Representatives	Number of Family Members	Total Number of Members
State YCWC	18%	5	28
Family Strengthening	60%	3	5
Early Childhood Mental Health	0%	0	7
Home Visiting	40%	2	5
Screening and Assessment	0%	0	8
Integration of Behavioral Health and Physical Health	17%	1	6
IMH Competencies/Endorsement	12.5%	1	8

Attendance and Volunteer Hours. Attendance and volunteer hours for the State Council were obtained in the same manner as for the Local Council. In Year One, the State Young Child Wellness Council held four meetings, with volunteer hours totaling 396. Members had the ability to attend meetings in person or remotely as needed. Total attendance across the four YCWC meetings averaged 82%, with an average of 20.5% family members in attendance (of the total number of members in attendance).

Near the end of this reporting period (August 2015), State YCW Council leaders decided to revise the Work Group structure to better meet PA Project LAUNCH goals. The new organization includes groups on 1) Workforce Development, 2) Promotion and Prevention, and 3) Communication. These new groups have not yet met as of the end of Year One. Volunteer

hours totaled 31 hours for Work Group member attendance at these meetings (approximately one hour in length). The number of State Work Group meetings, the average percentage of total attendance, and the average percentage of family member representatives in attendance are as follows:

Table 8. State Council and Work Group Attendance

Goal Area	Number of Meetings	Mean % of Total Attendance (Of Total Number of Members)	Mean % of Family Members in Attendance
State YCWC	4	82%	20.5%
Family Strengthening	1	60%	67%
Early Childhood Mental Health	2	63%	0%
Home Visiting	1	40%	50%
Screening and Assessment	1	50%	0%
Behavioral Health and Physical Health Integration	1	67%	25%
IMH Competencies/ Endorsement	1	62.5%	20%

State Outreach Activities. The same processes described in the *Local Outreach Activities* section to capture the work being done to promote Project LAUNCH goals at the local level was implemented at the state level through records kept by and interviews with the YCW Expert and YCW Partner. From October 1, 2014 to September 30, 2015, a total of 19 state level outreach activities occurred. The nature of all outreach activities at the state level was categorized as Collaboration Building (CB) according to the scheme described above for local activities. The types of organizations reached included physical and mental health providers, elementary and higher education, advocacy, business, families, early care and education, child welfare, public health, early intervention, government, Head Start programs, community organizations, state-wide organizations, and the Community Systems Development & Outreach Team. The number of participants attending these outreach activities ranged from 11 to 145+, with an estimated total of 636+ individuals participating. These activities are summarized in Table 9.

Table 9. State Outreach Activities from Oct. 1, 2014 to Sept. 30, 2015

Month	Total # of Outreach Activities	Types of Organizations Reached	Number of Participants	Activity Types	Disparities Addressed?
November 2014	1	Health Care Providers, Mental Health Providers, Higher Education, Advocacy, Business, Families, Elementary Education, Early Care & Education	60+	CB	n/a
February 2015	1	Mental Health Providers, Child Welfare, Public Health, Health Care Providers, Early Intervention	60+	CB	n/a
March 2015	1	Health Care Providers - Leadership	25+	CB	n/a
April 2015	4	Government officials; Head Start Programs	145+	4: CB	n/a
May 2015	5	Head Start Programs	117	5: CB	n/a
June 2015	3	Head Start Programs	115+	3: CB	n/a
July 2015	2	Government; Community Organizations; Community Systems Development & Outreach (CSDO) team	73+	2: CB	n/a
August	1	Government officials; State-wide Organizations	30+	CB	n/a
September	1	CSDO team	11	CB	n/a
Total	**19**		**636+**	**19: CB**	**n/a**

* Coalition Building (CB), Public Information Campaigns (PIC), Advocacy (A); definitions are available on pp. 36 & 37

Outcome Evaluation Progress

Wilder Collaboration Factors Inventory. The State YCWC's Wilder scores and interpretations are listed in Table 10 by domain. The guidelines for score interpretation are the same as described above for the Local YCWC.

State YCWC's Wilder response rate was 89% of members. Non-responders included individuals representing organizations in the Child Welfare, Family Healthcare Provider, and Health (including private sector) partner types.

The highest rated factors at baseline were *Members see collaboration as in their self-interest* (4.44), *Skilled leadership* (4.44), and *Favorable political and social climate* (4.32). These seem to

reflect a positive attitude toward the group and its purpose. The lowest rated factors at baseline were *History of collaboration or cooperation in the community* (3.63), *Multiple layers of participation* (3.62), and *Sufficient funds, staff, materials, and time* (3.56). These items reflect the newness of the group and some of the challenges it will face. No factor was rated to be "of concern."

Table 10. State YCWC Wilder Collaboration Factors Inventory Results (n=25)

Domain	Factor	Mean Score	Score Interpretation
Environment	History of collaboration or cooperation in the community	3.63	Borderline
	Collaborative group seen as a legitimate leader in the community	3.81	Borderline
	Favorable political and social climate	4.32	Strength
Membership Characteristics	Mutual respect, understanding, and trust	4.10	Strength
	Appropriate cross section of members	3.96	Strength-Borderline
	Members see collaboration as in their self-interest	4.44	Strength
	Ability to compromise	3.96	Strength-Borderline
Process and Structure	Members share a stake in both process and outcome	4.20	Strength
	Multiple layers of participation	3.62	Borderline
	Flexibility	4.20	Strength
	Development of clear roles and policy guidelines	3.70	Borderline
	Adaptability	3.96	Strength-Borderline
	Appropriate pace of development	3.84	Borderline
Communication	Open and frequent communication	4.17	Strength
	Established informal relationships and communication links	4.04	Strength
Purpose	Concrete, attainable goals and objectives	4.28	Strength
	Shared vision	4.26	Strength
	Unique purpose	4.18	Strength
Resources	Sufficient funds, staff, materials, and time	3.56	Borderline
	Skilled leadership	4.44	Strength

Conclusions

Year One work has yielded a strong foundation on which to build PA Project LAUNCH goals. The project has been highly collaborative, involving 87 Local Council and Work Group members, 28 State Council and Work Group members, and 18 members of the Implementation Team. The lessons learned from the first year evaluation of PA Project LAUNCH largely center around the importance of planning (for both implementation and evaluation), awareness, collaborations/ partnerships, and evaluation.

In addition, there have been several lessons learned from the various evaluation methods used in Year One that can improve implementation of the strategic plan. One such lesson comes from qualitative methods and includes the importance of rigorous but collaborative planning. This was evident in the successful inclusion of a large number of constituent agencies and people on the implementation team, councils, and workgroups. Over 1800 individuals participated in a variety of LAUNCH activities with positive feedback. This finding from the interviews and survey tells LAUNCH staff to continue to be inclusive in its outreach efforts.

Next, although Year One was used primarily to build ownership by participants and to plan long term goals, Year One evaluation findings have pointed to the need to focus on more detailed selection of priorities across goal areas. Surveys and interviews of key stakeholders also inform PA LAUNCH staff to focus Year Two activities on the three pilot communities when possible. Many of Year One's activities were spread over the entire county rather than these three communities. Additionally, findings from focus groups and interviews presented the need to target activities that build culturally competent staff and programs, also implying the need for advocating for policies that promote work that strengthens activities that narrow the behavioral health disparities found in this region.

Planning

PA Project LAUNCH Governance (Implementation Team, Councils, and Work Groups) accomplished a great deal of background work and planning that has built a strong foundation for the future of PA Project LAUNCH, especially considering the large number of constituent agencies and people involved at both the local and state levels. Major milestones include the creation of an extensive Environmental Scan, Strategic Plan, and Evaluation Plan and the formation and operation of State and Local Young Child Wellness Councils and Work Groups.

Awareness

PA Project LAUNCH made considerable efforts to communicate the nature of the project and its major priorities to many different groups, agencies, and individuals to lay the groundwork for collaborations and support. Local and state outreach efforts were extended collectively to slightly over 1,800 individuals.

Collaborations

PA Project LAUNCH governance devoted a large part of the planning process to coalition building and forging informal and formal collaborations with a host of relevant agencies and interest groups at both the state and local levels. The YCW Expert and the YCW Coordinator engaged over 1,800 individuals with potential for future collaborations with PA Project LAUNCH. In addition, representatives of numerous different constituency groups and parents

participate on the State and Local Young Child Wellness Councils. This representation is important for diverse perspectives, buy-in of PA Project LAUNCH goals by various service types, and integration of services across systems.

Evaluation

The Evaluation Team and Implementation Team created a comprehensive Evaluation Plan that identified, modified, and created assessments and record keeping forms in preparation for four years of data collection. The Evaluation Team thoroughly informed Councils, Work Groups, and providers of the evaluation requirements. The Implementation Team, including the Evaluation Team, conducted a very comprehensive vetting process to select an intervention project that balanced meaningful impact for PA Project LAUNCH target populations, would fulfill the team's and SAMHSA's guidelines (See Appendix M: Decision Tree and Program Information Template), and was in a position to be operational in Year Two.

The Evaluation Team recognizes the importance of providing continuous evaluation feedback to Project LAUNCH participating groups. Thus far, the Evaluation Team sent the Evaluation Plan and made several presentations to the State and Local YCWC's. The Evaluation Team provided the Wilder Inventory results on collaboration to the Councils, and reported on Council composition percentages and meeting attendance to the YCW Expert and Coordinator. The Evaluation Team also worked closely with the Behavior Health and Physical Health Workgroup to develop a PPIA feedback template so that results can be shared with the primary care practices once assessments have been completed. In addition, plans are underway to provide additional information gathered in Year Two, for example, profiles of the Council and Workgroup members and Membership Directories.

Recommendations

While planning in Year One has played a significant role in this year's accomplishments as a result of interviews and the evaluation survey, more detailed, short term planning under each of the core strategies is recommended for Year Two. Priorities should be assigned across goal areas to stress the area(s) of most need and feasibility; focusing on the three pilot communities may play a role in prioritizing. Furthermore, an emphasis should be placed on strategies to address and evaluate the needs of children and families at risk for behavioral health disparities and strategies to build and support culturally competent staff, programs, resources, and policies.

Based on the evaluation findings of Year One, primarily through the qualitative methods used, Year Two recommendations fall into two broad categories – those that are high priority next steps in PA Project LAUNCH implementation and those that aim to address longer-term project strategies.

Next Steps

Providers. Identify Project LAUNCH affiliated providers, which are those organizations that will implement Project LAUNCH activities and contribute to evaluation data collection.

Activities. Specify more detailed activities for Work Groups and Councils to accomplish during Year Two, including how the activities will be executed, person(s) responsible, and a timeline for each task as needed to reach the intended outcomes within each goal area.

Priorities. Prioritize potential Project LAUNCH activities. Initially, pursue a selected few that are the best blend of high need, feasibility, and sustainability, and integrate into all activities strategies to assess and/or address (whichever is most appropriate at this point in time) behavioral health disparity issues.

Evaluation. Implement the evaluation assessments and gain the cooperation of affiliated agencies in conducting data collection.

Representation. Maintain attendance and diversity of representatives at Council and Work Group meetings, and provide incentives to keep family representatives engaged.

Long-Term Strategies

Communication. Develop communication strategies between Local and State Councils, across major systems (e.g., two-way communication and follow-up between agencies providing screenings and agencies providing treatment) and within priority Service Strategies to achieve a smoother, more coordinated early childhood mental health environment. Strong lines of communication between all PA Project LAUNCH governance and service agencies involved in this work will continue to be crucial to the strength and sustainability of accomplishments, including data sharing. Communication should be as strategic and coordinated as possible in Year Two.

Disparities. Formulate strategies for how to assess, describe,, and address disparities, including collaborating with agencies specifically focused on special populations, determining baselines, and engaging Project LAUNCH affiliated providers who are also part of strategic planning efforts in this regard. Also, integrate cultural competence into workforce development and public awareness efforts across Project LAUNCH strategies.

Data Use and Sharing. Develop procedures to facilitate use of evaluation information to improve Project LAUNCH affiliated services.

Policy. Increase emphasis on strategic policy initiatives within each Council.

Pilot Communities. Explore strategies for focusing Project LAUNCH activities on the three geographic areas targeted in the Strategic Plan, given that many potential Project LAUNCH affiliated services are countywide and not targeted to specific neighborhoods.

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Appendix A: Current Implementation Team Members

Name	Affiliation
Sheila Bell	Allegheny County Department of Human Services
Michelle Connors	Pennsylvania Department of Health Bureau of Family Health
Ellen DiDomenico	Pennsylvania Office of Mental Health & Substance Abuse Services
Brandy Fox	Pennsylvania Project LAUNCH Partnership
Chris Groark	University of Pittsburgh Office of Child Development
Karen Hacker	Allegheny County Health Department
Bradford Hartman	Pennsylvania Department of Health Bureau of Family Health
Robert McCall	University of Pittsburgh Office of Child Development
Stephanie McCarthy	University of Pittsburgh Office of Child Development
Laurie Mulvey	University of Pittsburgh Office of Child Development
Samantha Murphy	Allegheny County Department of Human Services
Terri Reighard	Allegheny County Department of Human Services
Debra Reuvenny	Pennsylvania Office of Child Development and Early Learning
Winnie Richards	Pennsylvania Office of Child Development and Early Learning
Janell Smith-Jones	University of Pittsburgh Office of Child Development
Amy Sula	Allegheny County Health Department
Patricia Valentine	Allegheny County Department of Human Services
Makeda Vanderpuije	Allegheny County Health Department

Appendix B: List of Acronyms

List of Acronyms

A	Advocacy
AC	Allegheny County
AC-DHS DARE	Allegheny County Department of Human Services Data Analysis and Research Evaluation
ASQ	Ages and Stages Questionnaire
ASQ-3	Ages & Stages Questionnaires, Third Edition
ASQ-SE	Ages and Stages Questionnaire - Social-Emotional
ASQ:SE-2	Ages & Stages Questionnaires - Social-Emotional, Second Edition
BH	Behavioral Health
BHD	Behavioral Health Disparities
BH/PH	Behavioral Health/Physical Health
CAP	Conference of Allegheny Providers
CB	Coalition-Building
CC	Cultural Competence
CBCL/1 ½ -5	Child Behavior Checklist (Preschool Version)
CDI	(MacArthur) Communicative Development Inventory
CEO	Chief executive officer
CES-D	Center for Epidemiologic Studies Depression Scale Revised
CLAS	Culturally and Linguistically Appropriate Services
COACH	**C**onceptual accuracy and adherence, **O**bservant and responsive to client needs, **A**ctively structures sessions, **C**areful and appropriate teaching, **H**ope and motivation are generated
DA	Direct Assessment (of the child)
EBP	Evidence-Based Practice
ECE	Early Care and Education
ECMH	Early Childhood Mental Health Consultation
EF	Executive Function
EI	Early Intervention
ELC	Early Learning Challenge
EOY	End-of-Year
FCU	Family Check Up
FFY	Federal Fiscal Year
FS	Funding Sustainability

GPO	Government Project Officer
GPS	(Early Learning) Global Positioning System
IDEA	Individuals with Disabilities Education Act
IMH	Infant Mental Health
IPAT	Integrated Practice Assessment Tool
ITSEA	Infant-Toddler Social Emotional Assessment
LAUNCH	Linking Actions for Unmet Needs in Children's Health
LGBTQ	Lesbian, Gay, Bisexual, Transgender, and Queer
LICC	Local Interagency Coordinating Council
MH	Mental Health
MHPRI	Mental Health Practice Readiness Inventory
MIECHV	Maternal Infant Early Childhood Home Visitation
MMNQ	Me and My Neighborhood Questionnaire
MR	Medical Risk
MSE	Multi-Site Evaluation
NAMI	National Alliance on Mental Illness
NCCC	National Center for Cultural Competence
NIH	National Institutes of Health
NY	New York
OB/GYN	Obstetrician/Gynecologist
OCD	(University of Pittsburgh) Office of Child Development
OCDEL	Office of Child Development and Early Learning
OCYF	Office of Children, Youth, and Families
OMHSAS	Office of Mental Health and Substance Abuse Services
PA	Pennsylvania
PAW	Public Awareness
PA PBS	Pennsylvania Positive Behavior Support Network
PA PH/BH LC	Pennsylvania Physical Health/Behavioral Health Learning Community
PBIS	Positive Behavior Instructional Support
PBS	Public Broadcasting Service
P-Ch	Parent-Child
PH	Physical Health
PIC	Public Information Campaigns
PPC	Pennsylvania Partnerships for Children

PPIA	Pediatric Provider Integration Assessment
PSI	Parenting Stress Index
PSRA	Preschool Self-Regulation Assessment
PW-PBIS	Program-Wide Positive Behavior Instructional Support
RTT	Race to the Top
RTT-ELC	Race to the Top – Early Learning Challenge
SAMHSA	Substance Abuse and Mental Health Services Administration
SSHS	Safe Schools Healthy Students
TA	Technical Assistance
VIP	Video Interaction Project
WD	Workforce Development
WIC	Women, Infants, and Children
YCW	Young Child Wellness (Expert, Coordinator, Partner)
YCWC	Young Child Wellness Council
YCWE	Young Child Wellness Expert
YCWP	Young Child Wellness Partner

Post Training Survey Template
PA Project LAUNCH

[Insert Name & Date of Training] Today's Date: _____

Trainee Name: _____ Trainee email address: _____

Alternate email address: _____

Please respond to the following items, marking your choice with an "X".

1. My knowledge in this area increased because of this training.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
☐	☐	☐	☐	☐

2. The information provided in the training was valuable to my work.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
☐	☐	☐	☐	☐

3. How much of the information in today's training was NEW to you?

Not At All	A Little	Some	A Lot
☐	☐	☐	☐

4. To what extent will you be able to use the information from today's training in your work?

Not At All	A Little	Some	A Lot
☐	☐	☐	☐

5. What information from the training will you use in your work?

_____

_____

_____

_____

6. What type of agency do you work at?

☐ Mental Health Consultation ☐ Home Visiting Program ☐ Medical

☐ Other ☐ Education/Afterschool ☐ Social Services

Please specify:

_____

7. What is your position at your agency?

☐ Direct Service Staff*
(*teacher, home visitor, aide, case worker) ☐ Administrator

☐ Other ☐ Supervisor/Manager

Please specify:

_____

8. What is the name of your agency? _____

9. In what settings do you provide services to children?

☐ ECE Program ☐ Primary Care Agency ☐ Elementary School

☐ Other ☐ Home

Please specify:

_____

10. What is your **highest** level of education?

☐ High School Graduate / GED ☐ 2-year College Graduate ☐ 4-year College

☐ Certification Program

Please specify:

_____

☐ Other

Please specify:

_____

Thank you!

Office Use Only

Topic: (e.g., MH Resources in Home Visiting) **Goal Domain:** (e.g. Home Visiting)

Follow-Up Training Survey
PA Project LAUNCH

[Insert Name & Date of Training] Today's Date: _____

Please think about the training you attended and respond to the following items, marking an "X" where appropriate.

Because of the training I attended …	*Strongly Disagree*	*Disagree*	*Neutral*	*Agree*	*Strongly Agree*
1. I increased my personal knowledge or understanding about the topic.					
2. I increased my confidence in my professional practice.					
3. I improved my access to up-to-date information or resources about this topic.					

4. I implemented changes in my practice/work because of this training.

☐ Not at all ☐ A little ☐ Some ☐ A lot

5. What changes have you implemented? (If you marked "not at all" – please briefly explain why.)

_____

_____

_____

_____

Thank you!

Office Use Only

Topic: (e.g., MH Resources in Home Visiting) **Goal Domain:** (e.g. Home Visiting)

CLAS Self-Assessment Checklist
PA Project LAUNCH

Respondent Name: Organization Name:

Date:

The purpose of this questionnaire is to provide a snapshot of the practices that support children and families from diverse backgrounds. It should take about 10 minutes to complete.

- Please mark the box to the right of each item (✖ or ✓) that best represents your organization's behavior or characteristics.
- Please do not respond to these items considering only your *personal* behavior or characteristics.
- If an item does not apply to your organization or there is no opportunity or need, please indicate this within the last response box to the right.

#	Item	Things we do **frequently**, or statement applies to us **to a great degree**	Things we do **occasionally**, or statement applies to us **to a moderate degree**	Things we do **rarely or never**, or statement applies to us **to minimal degree or not at all**	No opportunity /need or Does not apply
	PHYSICAL ENVIRONMENT, MATERIALS & RESOURCES				
1	We display pictures, posters and other materials that reflect the cultures and ethnic backgrounds of children and families served in our program or agency.				
2	We ensure that the book/literacy area has pictures and storybooks that reflect the different cultures of children and families served in my early childhood program or setting.				
3	We select videos, films, or other media resources reflective of diverse culture to share with children and families served in my early childhood program or setting.				
	COMMUNICATION STYLES				
4	For children/individuals who speak languages or dialects other than English, we attempt to learn and use key words in their language so that we are better able to communicate with them.				
5	We use visual aids, gestures, and physical prompts in our interactions with children and youth who have limited English proficiency.				
6	When interacting with parents/individuals and other family members who have limited English proficiency we always keep in mind that: (a) limitation in English proficiency is in no way a reflection of their level of intellectual functioning; (b) their limited ability to speak the language of the dominant culture has no bearing on their ability to communicate effectively in their language of origin; and				

#	Item	Things we do **frequently**, or statement applies to us **to a great degree**	Things we do **occasionally**, or statement applies to us **to a moderate degree**	Things we do **rarely or never**, or statement applies to us **to minimal degree or not at all**	No opportunity /need or Does not apply
	(c) they may neither be literate in their language of origin nor English.				
7	We use bilingual or multilingual staff and/or trained/certified foreign language interpreters for meetings, conferences, or other events for parents and family members who may require this level of assistance.				
8	We ensure that all notices and communications to parents are written in their language of origin.				
9	We understand that it may be necessary to use alternatives to written communications for some families, as word of mouth may be a preferred method of receiving information.				
10	We use alternative formats and varied approaches to communicate with children and/or their family members who experience disability.				
	VALUES AND ATTITUDES				
11	We avoid imposing values that may conflict or be inconsistent with those of cultures or ethnic groups other than our own.				
12	We intervene in an appropriate manner when we observe other staff or parents within our program or agency engaging in behaviors that show cultural insensitivity, bias or prejudice.				
13	We recognize and accept that individuals from culturally diverse backgrounds may desire varying degrees of acculturation into the dominant culture.				
14	We understand and accept that family is defined differently by different cultures (e.g. extended family members, fictive kin, godparents).				
15	We accept and respect that male-female roles in families may vary significantly among different cultures (e.g. who makes major decisions for the family, play and social interactions expected of male and female children).				
16	Even though our professional or moral viewpoints may differ, we accept the family/parents as the ultimate decision makers for services and supports for their children.				
17	We recognize that the meaning or value of early childhood education or early intervention/treatment/ medical intervention may vary greatly among cultures.				
18	We accept that religion, spirituality, and other beliefs may influence how families respond to illness, disease, and death.				
19	We recognize and accept that familial folklore, religious, or spiritual beliefs may influence a family's reaction and approach to a child born with a disability or later diagnosed with a disability or special health care needs.				

#	Item	Things we do **frequently**, or statement applies to us **to a great degree**	Things we do **occasionally**, or statement applies to us **to a moderate degree**	Things we do **rarely or never**, or statement applies to us **to minimal degree or not at all**	No opportunity /need or Does not apply
20	We understand that beliefs about mental illness and emotional disability are culturally-based. We accept that responses to these conditions and related treatment/interventions are heavily influenced by culture.				
21	We seek information from family members or other key community informants that will assist us to respond effectively to the needs and preferences of culturally and linguistically diverse children and families served in our early childhood program or setting.				
22	We advocate for the review of our program's or agency's mission statement, goals, policies, and procedures to ensure that they incorporate principles and practices that promote cultural diversity, cultural competence and linguistic competence.				
****These items may or may not apply to your organization. If the item does not apply, please select the response *No opportunity or need / Does not apply***					
23	We ensure that magazines, brochures, and other printed materials in reception areas are of interest to and reflect the different cultures and languages of individuals and families served by our program or agency.				
24	We ensure that toys and other play accessories in reception areas, and those which are used during assessment, are representative of the various cultural and ethnic groups within the local community and the society in general.				
25	We understand that families from different cultures will have different expectations of their children for acquiring self-help, social, emotional, cognitive, and communication skills.				
26	We understand that traditional approaches to disciplining children are influenced by culture.				
27	We understand the impact of stigma associated with mental illness and behavioral health services within culturally diverse communities.				
28	We accept that many evidence-based prevention and intervention approaches will require adaptation to be effective with children, youth and their families from culturally and linguistically diverse groups.				
29	We discourage children from using racial and ethnic slurs by helping them understand that certain words can hurt others.				
30	We either contribute to and/or examine current research related to ethnic and racial disparities in mental health and health care and quality improvement.				

Office use only:
Date entered _____ Domain _____ Version: 10.6.2015

Demographics

1. Do you consider yourself... (Please select one or more.)

- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Black or African American
- ☐ White
- ☐ Other (please specify): _____
- ☐ I prefer not to answer

2. Do you consider yourself Hispanic or Latino?

- ☐ Yes
- ☐ No
- ☐ Unknown / Not sure
- ☐ I prefer not to answer

3. What is your gender?

- ☐ Female
- ☐ Male
- ☐ I prefer not to answer

4. What is your Country of Origin?

- ☐ Please specify:_____
- ☐ I prefer not to answer

5. Does your family hold a refugee status?

- ☐ Yes
- ☐ No
- ☐ I prefer not to answer

6. Does your family hold an immigrant status?

- ☐ Yes
- ☐ No
- ☐ I prefer not to answer

7. When you are at home with your family, what language or languages do you usually speak? (Please select all that apply.)

- ☐ English
- ☐ Spanish
- ☐ Other (please specify:_____)
- ☐ Multiple languages
- ☐ I prefer not to answer

8. Would you characterize your family as a military family?

- ☐ Yes
- ☐ No
- ☐ I prefer not to answer

9. Do you currently reside in a shelter or housing program due to a loss of housing? (For example, for financial or domestic violence reasons)

- ☐ Yes
- ☐ No
- ☐ I prefer not to answer

10. Are you currently residing with someone else due to a lack of other housing options and/or due to financial reasons?

- ☐ Yes
- ☐ No
- ☐ I prefer not to answer

Appendix G: Year One Disparities Impact Table

	Year One Target	*Baseline	*Numbers Served to Date
Direct Services: Number to be served	250 children and families	N/A	N/A
By Race/Ethnicity (Including Sub-Populations)	195 Caucasian 37 African American 18 Hispanic/Asian/European	N/A	N/A
By Gender	146 Male 104 Female	N/A	N/A

*Direct services have not begun in Year One

Appendix H: Outreach Activity Log

PA LAUNCH Outreach Activity Record – SEPTEMBER 2015 (Example)

Please mark Local or State with an ☐ **Local YCWC** ☐ **State YCWC** *"X"*

Date	Participant Name	Organization Name (e.g., AIU, DHS, HV Stakeholder mtg, PAEYC dinner)	Number of Participants	Organization Type (e.g., CW, Educ., Gov't., Fund, Advocacy)	Content	*Activity Type(s)	Meeting Outcome / Next Steps	Collaboration Status (e.g., pre; ongoing; etc.)
			____ 0-10 ____11-25 ____ 25+					
			____ 0-10 ____11-25 ____ 25+					
			____ 0-10 ____11-25 ____ 25+					
			____ 0-10 ____11-25 ____ 25+					
			____ 0-10 ____11-25 ____ 25+					
			____ 0-10 ____11-25 ____ 25+					
			____ 0-10 ____11-25 ____ 25+					
			____ 0-10 ____11-25 ____ 25+					
			____ 0-10 ____11-25 ____ 25+					

***ACTIVITY TYPE KEY:**

Activities that work toward…

(CB) Coalition building: 1) setting policies and guidelines related to health insurance, health providers, education, home visiting, or parenting, or changing other policies, rules, or guidelines, 2) increasing collaboration, 3) developing or improving referral or data systems, 4) integrating funds across organizations, 5) submitting funding applications, or 6) other coalition building outcomes.

(PIC) Public Information Campaigns: 1) providing education childhood MH, 2) promoting policies and guidelines that integrate BH screening in pediatric primary care, 3) promoting evidence-based practices for childhood wellness, 4) promoting policies and guidelines related to health insurance, education, home visiting, or parenting, or making a change in other policies, rules, and guidelines, 5) promoting integrated services for childhood MH at the local or state level, 6) providing education about integrated funding sources for childhood MH and/or the need for sustainable funding sources, or 7) other public information campaign outcomes.

(A) Advocacy: 1) setting policies and guidelines related to health insurance, health providers, education, home visiting, and parenting, 2) **changing** rules at private or non-profit institutions or other policies, and guidelines, 3) increasing or reallocating state or institutional funding, 4) getting state or municipalities to apply for funds, or 5) other advocacy outcomes.

(FS) Funding sustainability (building funds):
1) writing grants or other funding applications, 2) increasing Medicaid or private insurance reimbursements for services, 3) using integrated funding sources, 4) using or submitting applications to receive sustainable funding sources, or 5) other funding sustainability outcomes.

Appendix I. Evaluation Questions and Data Sources/Instruments by Goal Area

Goal 1: Screening and Assessment Evaluation Question	Indicator Type	Data source/ Instrument	
1.1 What resources are promoted to support agencies' usage of high quality screening and assessment?	Implementation	Local YCWC, YCW Work Groups, YCW Coordinator	Minutes review, Interviews
1.2 How many children and adults do agencies screen or assess with a recommended vs. non-recommended tool by setting and by racial, ethnic, and /or special population?	Outcome	Agencies	Review of agency records
1.3 Does usage of recommended tools increase over the years?	Implementation	Agencies	Questionnaire
1.4 How well do major Project LAUNCH agencies conform to the CLAS principles?	Outcome	Agencies/ Modified CLAS Questionnaire	Review of agency records
1.5 Of those children and adults screened with a recommended tool, how many are designated at-risk and what percentage are referred for diagnosis and/or services by racial, ethnic, and/ or special population? Does referral rate increase over years?	Outcome	Agencies	Review of coordinator's and trainers' records
1.6 How many agencies and staff are trained on high quality screening and assessment processes by setting and professional background?	Outcome	YCW Coordinator, Trainers	Questionnaire
1.7 Do trained staff report increased knowledge, relevance, and changed practices on screening and assessment processes?	Outcome	Trainees	Document review
1.8 To what extent are agencies and staff trained in cultural competency?	Outcome	Records	Questionnaire
Goal 2: Behavioral Health & Physical Health Integration Evaluation Question	**Indicator Type**	**Data source/ Instrument**	
2.1 What resources and strategies are promoted to support practices' usage of high quality screening and assessment?	Implementation	Pediatric practices	Interviews
2.2 How many children and adults do practices screen or assess by tool, setting, and racial, ethnic, and /or special designation?	Outcome	Pediatric practices	Review of agency records
2.3 Of those children and adults screened to be at-risk, what percent are referred for diagnosis and/or services by tool and racial, ethnic, and /or special designation?	Outcome	Pediatric practices	Review of agency records
2.4 How well do major Project LAUNCH practices conform to the CLAS principles?	Implementation	Pediatric practices/ Modified CLAS Questionnaire	Questionnaire
2.5 What is the racial and special population distributions in targeted primary care practices?	Outcome	Pediatric practices	Review of agency records
2.6 To what extent are behavioral health and physical health practices and staff trained in providing integrated care?	Outcome	Records	Document review
2.7 Do trained staff report increased knowledge, relevance, and changed practices in providing integrated care (e.g., warm transfers, resources, billing)?	Outcome	Trainees	Questionnaire
2.8 What strategies and models are identified and communicated to support the integration of behavioral health and physical health?	Implementation/ Outcome	YCWC, Workgroups, YCW Expert, YCW Coordinator, Selected pediatric practices/Modified AAP MH Practice Readiness Inventory/IPAT	Minutes review, Interviews Review of agency records
Goal 3: ECMH Consultation Evaluation Question	**Indicator Type**	**Data source/ Instrument**	
3.1 What are best practices in ECMH across systems?	Implementation	YCW Work Groups, YCW Coordinator	Minutes review, Interviews
3.2 How many trainings are conducted on ECMH and support to stakeholders across systems?	Implementation	Coordinator, Agencies	Review of agency records
3.3 Do trainees report increased knowledge of ECMH best practices and change in practices?	Outcome	Trainees	Questionnaire
3.4 To what extent are agencies and staff trained in cultural competency?	Outcome	Records	Document review
3.5 Is the quality of ECMH consulting services expanding and improving?	Outcome	Agency Directors, ECMH Supervisors	Interviews
3.6 How many new children of different ages and in different settings are served by expanded ECMH consultation over the course of the grant?	Outcome	Agencies, Consultants	Review of agency records
3.7 Do trained staff report increased knowledge, relevance, and changed practices in delivering culturally competent care?	Outcome	Trainees	Questionnaire

3.8 How well do major Project LAUNCH agencies conform to the CLAS principles?	Implementation	Agencies/ Modified CLAS Questionnaire	Questionnaire
Goal 4: Home Visiting Evaluation Question	**Indicator Type**	**Data source/ Instrument**	
4.1 How many staff participate in presentations on providing physical and behavioral health resources through home visiting?	Outcome	YCW Work Groups, YCW Coordinator	Review of agency records
4.2 How many home visiting programs provide behavioral and/or physical health resources to their families?	Outcome	YCW Coordinator	Review of agency records, Interviews
4.3 What is the racial and special population distributions across HV services?	Outcome	Agencies	Review of agency records
4.4 To what extent does the VIP intervention impact children's social emotional and developmental skills in comparison to children in the no treatment condition?	Outcome	Smart Beginnings	Questionnaire Observation Interview
4.5 To what extent does the VIP intervention impact family processes that may mediate intervention impacts, including increased positive parenting and reductions in psychosocial stressors in comparison to families in the no treatment condition?	Outcome	Smart Beginnings	Observation Questionnaire
4.6 To what extent does the added value of the FCU intervention to the VIP intervention address challenges associated with the skill development of children in at-risk families?	Outcome	Smart Beginnings	Questionnaire Observation Interview
4.7 To what extent does the added value of the FCU intervention to the VIP intervention address challenges associated with parenting and parenting stressors in at-risk families?	Outcome	Smart Beginnings	Observation Questionnaire
4.8 To what extent are the VIP and FCU interventions implemented with fidelity?	Implementation	Smart Beginnings	Fidelity protocol Fidelity checklists
4.9 How well do major Project LAUNCH agencies conform to the CLAS principles?	Implementation	Agencies/ Modified CLAS Questionnaire	Questionnaire
Goal 5: Family Strengthening and Parent Skill Building Evaluation Questions	**Indicator Type**	**Data source/ Instrument**	
5.1 What materials and types of dissemination efforts are promoted to support parents' usage of endorsed materials on children's healthy development and social emotional wellness?	Implementation	Local YCWC, YCW Work Groups YCW Coordinator	Minutes review, Interview
5.2 Do agencies report increased dissemination of culturally relevant materials?	Implementation	Agencies, Local YCWC. YCW Work Groups, YCW Coordinator	Review of minutes and agency records, Interviews
5.3 What activities are supported by LAUNCH to increase parent involvement in social networks that promote their leadership skills?	Implementation	Local YCWC, YCW Work Groups, YCW Coordinator	Minutes review, Interview
5.4 Are more parents involved in social networks that promote their leadership skills?	Outcome	YCW Coordinator	Review of agency records
5.5 How many trainings are conducted on MH First Aid for community leaders?	Implementation	YCW Coordinator	Review of agency records
5.6 Do trainees report increased knowledge and potential use in practice of MH First Aid?	Outcome	Trainees	Questionnaire
5.7 To what extent are agencies and staff trained in cultural competency?	Outcome	Records	Document review
5.8 Do trained staff report increased knowledge, relevance, and changed practices in delivering culturally competent care?	Outcome	Trainees	Questionnaire
Goal 6: Local Infrastructure Evaluation Question	**Indicator Type**	**Data source/ Instrument**	
6.1 Does the local YCWC achieve the desired diversity of membership, and attendance, particularly family/parent representatives, from year to year?	Implementation	Local YCWC	Review of agency records
6.2 Is the YCWC functioning in a collaborative and effective manner from year to year, especially family/parent representatives?	Outcome	Local YCWC/ Wilder Collaboration Factors Inventory (mean total and factor scores) by affiliation type	Questionnaire
6.3 What efforts are made to promote coordination and collaboration and improve policies and regulations?	Implementation	Local YCWC, YCW Coordinator	Review of minutes and agency records, Interviews
6.4 To what extent do sustainability efforts support local Project LAUNCH priorities?	Outcome	Local YCWC, YCW Coordinator	Review of minutes and Interviews

6.5 What efforts are made to improve data collection, data sharing, and data reporting across organizations and systems?	Outcome	Local YCWC, YCW Work Groups, YCW Coordinator	Review of minutes and agency records, Interviews
6.6 To what extent do efforts related to data collection, sharing, and reporting, improve collaboration and coordination across organizations and systems?	Outcome	YCW Coordinator, YCW Work Groups	Review of minutes and agency records, Interviews
State Evaluation Plan Evaluation Question	**Indicator Type**	**Data source/ Instrument**	
7.1 Does the State YCWC achieve the desired diversity of membership, particularly family/parent representatives, from year to year?	Implementation	State YCWC	Review of agency records
7.2 Is the YCWC functioning in a collaborative and effective manner from year to year?	Outcome	State YCWC/ Wilder Collaboration Factors Inventory	Questionnaire
7.3 What type of strategies are implemented for sustainability?	Outcome	State YCWC, YCW Work Groups YCW Expert	Minutes and review of agency records, Interviews
7.4 What policies are changed or added to support long-term strategy implementation?	Outcome	State YCWC, YCW Work Groups YCW Expert	Minutes and review of agency records, Interviews
7.5 What efforts are made to promote public awareness around Project LAUNCH priorities?	Implementation	State YCWC, YCW Expert, and YCW Coordinator	Minutes and review of agency records, Interviews
7.6 How many and how often are messages disseminated?	Implementation	YCWC workgroups, YCW Expert, and YCW Coordinator	Minutes and review of agency records, Interviews
7.7 Who are the targeted audiences and how far is the potential reach of the messages disseminated?	Implementation	YCW Work Groups, YCW Expert, YCW Coordinator	Minutes and review of agency records, Interviews

Appendix J: End-Of-Year Survey

PA Project LAUNCH Annual Report – Survey Questions

1. What resources and strategies are being promoted to support the use of high quality screening and assessment?

2. What work has been done to support the integration of behavioral health and physical health into primary care and agency settings? Please specify any settings outside of primary care practices.

- Strategies, Assessments, Models/Resources

3. How is LAUNCH promoting the identification of best practices in ECMH across systems?

3.1 Where is LAUNCH at in this process?

4. How are LAUNCH activities moving toward service expansion and improvement in ECMH?

5. How many home visiting programs are (or **to what extent** are home visiting programs) providing behavioral and/or physical health resources to their families? (by type)

6. To what extent are families (of different racial, ethnic, and special population groups) engaged in home visiting services?

7. What materials and types of dissemination efforts are being promoted to support parents' usage of endorsed materials on children's healthy development and social-emotional wellness?

8. Have agencies reported any increase in dissemination of culturally relevant materials?
If yes, what is the increase and what are the indicators of this increase?

9. What activities are being supported by LAUNCH to increase parent involvement in social networks that promote their leadership skills?

10. What efforts coordinated, collaborations, and/or relationships created **because of LAUNCH** stand out to you?

11. What efforts are being made to improve data collection, data sharing, and data reporting across organizations and systems?

12. What types of strategies have been implemented [or are being discussed] for sustainability?

13. What policies have been changed or added [or are being discussed] to support long-term strategy implementation?

14. Looking back on the outreach activities completed during the past year, what efforts do you feel were the most important, effective, and/or had the widest potential reach in terms of promoting public awareness of the goals of Project LAUNCH?

14.1 Were these efforts targeted to reach any particular audience(s)?

15. For **systems change activities**, please include any information that addresses SAMHSA's disparities requirements.

16. For **service activities**, please include any information that addresses SAMHSA's disparities requirements.

17. From your point of view, how do you see evaluation's role in helping to improve program design and quality?

18. From your point of view, how do you see evaluation's role in helping to inform partners, stakeholders, the public, funders, and policymakers?

19. Is there anything we missed that you believe should be noted or addressed?

Pennsylvania Project LAUNCH

Pediatric Provider Integration Assessment

Baseline

HARD COPY ADMINISTRATION GUIDE

Date: _____ Time:_____ Location: _____

LAUNCH Team Member(s) Administering Assessment:

_____

LAUNCH Team Member(s) Supporting the Assessor:

_____

_____

Practice Name & Practice Team Members Completing Assessment (specify roles and credentials):

_____

_____

_____

Part 1: Integrated Practice Assessment Tool (IPAT)

Directions: Responses to the questions can vary depending upon the level of knowledge of both on-the-ground operation and conceptual understanding of integration. The questions are framed as yes/no but will raise the question; "Is this 'partially', 'mostly' or 'completely' a yes or a no response?" A "yes" response is recorded only if it is completely a yes response. Anything less must be considered a "no" response – even understanding that there is good progress toward a "yes."

The IPAT is designed to be simple to use. There are a total of 8 questions (the 8th being a compound question) in the full decision tree but responses to no more than 4 questions will determine the level of integration. The IPAT is best completed collaboratively by 2 or more persons (whether or not a formal care team) who are intimately knowledgeable about the operation of the practice.

Integrated Practice Assessment Tool	
1. Do you have behavioral health and medical providers physically or virtually located at your facility? ❒"No", then pre-coordinated or coordinated – Go to question 4 ❒ "Yes", then co-located or integrated – Go to question 2	"Virtual" refers to the provision of telehealth services; and the "virtual" provider must provide direct care services to the patient, not just a consult, meaning that the provider visually sees the patient via televideo and vice versa.
2. Are medical and behavioral health providers equally involved in the approach to individual patient care and practice design? ❒"No", then co-located – Go to question 7 ❒"Yes", then co-located or integrated – Go to question 3	EXAMPLE: Is there a team approach for patient care that involves both behavioral health and medical health providers?
3. Are behavioral health and medical providers involved in care in a standard way across ALL providers and ALL patients? ❒"No", then co-located - Go to question 7 ❒"Yes", then integrated – Go to question 8	EXAMPLE: All patients are considered for appropriate behavioral health consultation or intervention, regardless of insurance provider, primary language or ability to pay
4. Do you routinely exchange patient information with other provider types (primary care, behavioral health, other)? ❒"No", then pre-coordinated - STOP ❒"Yes", then pre-coordinated or coordinated – Go to question 5	EXAMPLE: Behavioral health provider and medical provider engage in a "two way" email exchange or a phone call conversation to coordinate care.
5. Do providers engage in discussions with other treatment providers about individual patient information? ❒"No", then pre-coordinated - STOP ❒"Yes", then coordinated – Go to question 6	In other words, is the exchange interactive? Is there follow up between provider types to discuss course of treatment and any progress or results?
6. Do providers personally communicate on a regular basis to address to specific patient treatment issues? ❒"No", then Level 1 coordinated - STOP ❒"Yes", then Level 2 coordinated – STOP	EXAMPLE: Some form of ongoing communication via weekly/monthly calls or conferences to review treatment issues regarding shared patients: use of a registry tool to communicate which patients are not responding to treatment so that the behavioral health provider can adjust treatment accordingly based on evidenced based guidelines.

7. Do provider relationships go beyond increasing successful referrals with an intent to achieve shared patient care?	EXAMPLES can include: coordinated service planning, shared training, team meetings, use of shared patient registries to monitor treatment progress.
❒"No", then Level 3 co-located - STOP	
❒"Yes", then Level 4 co-location – STOP	
8. Has integration been sufficiently adopted at the provider and practice level as a principal/fundamental model of care so that the following are in place?	
a. Are resources balanced, truly shared, and allocated across the whole practice?	NOTE: In other words, all providers (behavioral health AND medical) get the tools and resources they need in order to practice.
b. Is all patient information equally accessible and used by all providers to inform care?	EXAMPLE: All providers can access the behavioral health record and medical record.
c. Have all providers changed their practice to a new model of care?	EXAMPLES: Primary Care Providers (PCPs) are prescribing antidepressants and following evidenced based depression care guidelines; PCPs are trained in motivational interviewing; behavioral health providers are included in the PCP visit.
d. Has leadership adopted and committed to integration as the model of care for the whole system?	EXAMPLES: Leadership ensures that system changes are made to document all _____scores in the electronic health record (EHR); leadership decides to hire a behavioral health provider for a primary care clinic after grant funding ends.
e. Is there only 1 treatment plan for all patients and everyone has access to the treatment plan?	NOTE: Treatment plan includes behavioral AND medical health information. EXAMPLE: Even though there may be a medical record and a behavioral health record (separate EHRs) the treatment plan is pushed to both and accessible in real time by all providers.
f. Are all patients treated by a team?	Team in this context requires membership from all disciplines.
g. Is population-based screening standard practice and used to develop interventions for both the populations and individuals?	EXAMPLE: All patients are screened for body mass index (BMI) and then offered weight loss interventions by their primary care provider or a referral to a health coach or wellness program.
h. Does the practice systematically track and analyze outcomes related for accountability and quality improvement?	Population based measures and outcomes are used in improving population health.
❒"No" to any, then Level 5 integration - STOP	
❒"Yes" to all, then Level 6 integration – STOP	

Assessment Summary/Notes:

Circle the Current Level of Integration (per IPAT):

PRE-COORDINATED LEVEL1 LEVEL2 LEVEL3 LEVEL4 LEVEL5 LEVEL6

Part 2: Mental Health Practice Readiness Inventory [Modified]

Directions: The purpose of this tool is to help primary care clinicians assess the extent to which their office systems promote and support mental health practice. It is recommended that the entire practice team complete this tool together, select priority areas (building on strengths) and stage practice improvements incrementally. Use the following rating system to evaluate your practice:

1 = We do this well (substantial improvement is NOT needed)
2 = We do this to some extent (improvement is needed)
3 = We do not do this well (significant practice change is needed)

1	Collaborative Relationships	1	2	3	Primary care practice team has collaborative relationships with school- and community-based providers of key services.
2	Mental Health Promotion	1	2	3	Primary care practice team promotes the importance of mental health through posters, practice web sites, newsletters, handouts, or brochures and by incorporating conversations about mental health into each office visit.
3	Engagement	1	2	3	Primary care practice team actively elicits mental health and substance abuse concerns; assesses patients' and families' readiness to address them; and engages children, adolescents, and families in planning their own mental health care at their own pace.
4	Referral Assistance	1	2	3	Primary care practice is prepared to support families through referral assistance and advocacy in the mental health referral process.
5	Care Coordination	1	2	3	Primary care practice routinely seeks to identify children and adolescents in the practice who are involved in the mental health specialty system, ensuring that they receive the full range of preventive medical services and monitoring their mental health or substance abuse condition.
6	Special Populations	1	2	3	Primary care practice team is prepared to address mental health needs of special populations within the practice (e.g., minority and immigrant populations, those in foster care, those whose families have experienced disasters, those with parents deployed in military service).
7	Quality Improvement	1	2	3	Primary care practice periodically assesses the quality of care provided to children and adolescents with mental health problems and takes action to improve care, in accordance with findings.
8	Registry	1	2	3	Primary care practice has a registry in place identifying children and adolescents with mental health or substance abuse problems (including those not yet ready to address problems).
9	Recall and Reminder Systems	1	2	3	Recall and reminder systems are in place to identify missed appointments and ensure that children and adolescents with mental health or substance abuse concerns (including those not ready to take action) receive appropriate follow up and routine health supervision services.

10	Information Exchange	1	2	3	Primary care practice has office procedures to support collaboration (e.g., routines for requesting parental consent to exchange information with specialists and schools, fax-back forms for specialist feedback, psychosocial history accompanying foster children).
11	Tracking Systems	1	2	3	Primary care practice has systems in place and staff roles assigned to monitor patients' progress (eg, check on referral completion, periodic telephone contact with family and therapist, periodic functional assessment, periodic behavioral scales from classroom teachers and parents, communication to and from care coordinators).
12	Care Plans	1	2	3	Primary care practice includes youth, family, school, agency personnel, and any involved specialists in developing a comprehensive plan of care for a child or an adolescent with mental health problems, including definition of respective roles.
13	Screening Assessment Tools	1	2	3	Office systems are in place to collect and score validated mental health and substance abuse screening and assessment tools at or prior to scheduled routine health supervision visits and visits scheduled for a mental health concern.
14	Functional Assessment	1	2	3	Primary care clinicians use validated functional assessment scales to identify and evaluate children and adolescents with mental health problems and monitor their progress in care.
15	Clinical Guidance	1	2	3	Primary care clinicians have access to reliable, current sources of information concerning diagnostic classification of mental health and substance abuse problems; evidence about safety and efficacy of psychosocial and psychopharmacological treatments of common mental health and substance abuse disorders; and information about the safety and efficacy of complementary and alternative therapies often used by children and families.
16	Protocols	1	2	3	Primary care practice has tools and protocols in place to guide assessment and care and to foster self-management of children and adolescents with common mental health and substance abuse conditions.
17	Screening and Surveillance	1	2	3	Primary care clinicians routinely use psychosocial history and validated screening tools at preventive visits and brief mental health updates at acute care visits to elicit mental health and substance abuse problems and to identify family strengths and risks.

MHPRI Assessment Summary/notes:

Part 3: Supplemental Questions *(To allow ample time for these interview questions, make sure to reach this point in the interview **by the 40-minute mark**.)*

	QUESTION	POSSIBLE RESPONSES
1	What is your practice goal for BH/PH integration?	Screening consistently, good referral, co-location, full integration
2	What main activities are in place to promote integration, if any?	How do medical/health and behavioral resources actually collaborate in a given case to promote, for example, patient screening/assessment, care planning, management, intervention/prevention, progress monitoring, and follow-up
3	In terms of incorporating BH into your practices, what are the major obstacles you currently are encountering that would make this a reality?	Limited time at appointment, follow-up supports/work flow assignments (data entry, referrals, etc.), billing, familiarity with BH issues, knowledge of behavioral health supports in the community, policy issues, other (please describe)
4	What trainings would help to overcome these obstacles?	Follow-up supports/work flow assignments (data entry, referrals, etc.), billing, behavioral health issues, knowledge of community BH support, other (please describe)
5	What changes are needed systemically, to policy or practice, to make integration possible?	
6a	To whom should trainings be delivered?	Which primary care providers will most benefit from Project LAUNCH-supported trainings on integration?
6b	How should trainings be delivered?	On-line, in person, consultation, other (please describe)
7	How do you capture screenings in your medical record?	96110, 99429, & 96127?
8	How do you receive reimbursement for providing BH services?	
9	Do physicians use, and receive reimbursement for, "incident to" billing codes (9921x- series)	
10	Are you aware of resources or toolkits to support BH services in primary care?	E.g.. Addressing Mental Health Concerns in Primary Care: A Clinician's Toolkit
11	Can you provide reports on number of children screened at well-child visits?	Yes, no
12	Can you track the results of well-child visit screenings in your practice and report on the actions taken, if any?	At risk vs. not at risk? Referral? Watchful waiting?
13	Can you track the follow up from referral to BH?	Yes, no, not sure,
14	How would you best like to receive information from BH agencies to which you refer?	Letter, call, email, other (please describe)
15	What should be in the contents of that communication?	Diagnoses, recommendations, medications, follow-up arranged or provided by consultant, other care needed (please describe)

Appendix L: PPIA Baseline Assessment Summary Template

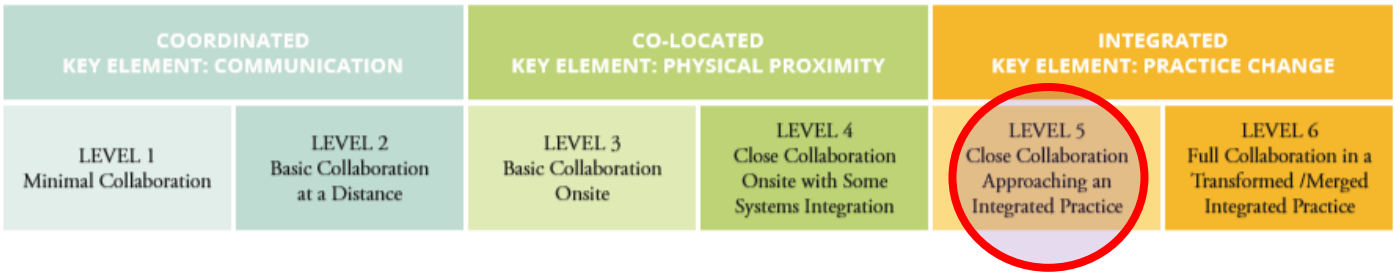
Pediatric Provider Integration Assessment (PPIA)
Baseline Assessment Summary
[Example Template]

[Site Name]
Date of Interview:
Location:

- Project LAUNCH team members present:
  -
  -
  -
- Site team members present:
  -
  -
  -

Part I: Integrated Practice Assessment Tool (IPAT) [Example]

IPAT Result: Level 5



To move to level 6, the following would need to change from "no" to "yes"

- 8e: "Is there only 1 treatment plan for all patients and everyone has access to the treatment plan?"

Part II: Mental Health Practice Ready Inventory (MHPRI) [Example]

Total score: 27 (range is 17 to 51; lower is better)

"We do this well (substantial improvement is NOT needed)"	**"We do this to some extent (improvement is needed)"**	**"We do not do this well (significant practice change is needed)"**
(9 x 1 point each)	*(6 x 2 points each)*	*(2 x 3 points each)*
○ Mental Health Promotion ○ Referral Assistance ○ Special Populations ○ Quality Improvement ○ Recall & Reminder Systems ○ Screening & Assessment Tools ○ Functional Assessment ○ Clinical Guidance ○ Protocols	○ Collaborative Relationships ○ Engagement ○ Care Coordination ○ Information Exchange ○ Tracking Systems ○ Screening & Surveillance	○ Registry ○ Care Plans

[Enter key ideas from site interviews below.]

Part III: Qualitative Summary
Practice Goals
Integration Activities
Obstacles
Training
Screening
Tracking
Payment
Information sharing:
Follow-up needed

Appendix M: Decision Tree and Program Information Template

PA LAUNCH **Selection of Outcome Program Options**

DECISION POINT A	Program 1	Program 2	Program 3	Program 4	Program 5	Program 6
	YES/NO	YES/NO	YES/NO	YES/NO	YES/NO	YES/NO
1: Is this intervention attributable to LAUNCH?						
2. **If "NO**", can it be adapted so it is attributable to LAUNCH? If so, what is the criteria and what needs modification?						
3. **Eliminate any intervention with two "NO" responses and continue to Decision Point B.**						

DECISION POINT B (INSERT REMAINING INTERVENTIONS→)						
	YES/NO/TBD	YES/NO/TBD	YES/NO/TBD	YES/NO/TBD	YES/NO/TBD	YES/NO/TBD
1. Is LAUNCH funding required for implementation of this project?						
2. If "NO", does the YCWC need to vote on this option?						

DECISION POINT C (INSERT REMAINING INTERVENTIONS→)																		
	YES	NO	TBD	YES	NO	TBD	YES	NO	TBD	YES	NO	TBD	YES	NO	TBD	YES	NO	TBD
1. Program uses an evidenced-based intervention or promising practice that is implemented with sufficient intensity to bring about measureable outcomes in the setting	1	0	?	1	0	?	1	0	?	1	0	?	1	0	?	1	0	?
2. Participant pre-/post outcome data is collectible	1	0	?	1	0	?	1	0	?	1	0	?	1	0	?	1	0	?
3. Intervention dosage & fidelity data is collectible	1	0	?	1	0	?	1	0	?	1	0	?	1	0	?	1	0	?
4. The number of intervention participants is at least 30	1	0	?	1	0	?	1	0	?	1	0	?	1	0	?	1	0	?
5. Comparison data is collectible (comparison group or archival pre-/ post data)	1	0	?	1	0	?	1	0	?	1	0	?	1	0	?	1	0	?
6. Tally "YES" responses.																		

DECISION POINT D (INSERT INTERVENTIONS→)						
	YES/NO	YES/NO	YES/NO	YES/NO	YES/NO	YES/NO
1. From an evaluation perspective, is this a good option?						

DECISION POINT E (INSERT INTERVENTIONS→)						
	YES/NO	YES/NO	YES/NO	YES/NO	YES/NO	YES/NO
1. If Decision Point D is "YES", is the council willing to support (fund) this intervention?						

Evaluation Criteria

To be able to meet SAMSHA's requirements for an evaluation of a LAUNCH-related outcome on the social-emotional development or mental health of individual participants, certain circumstances need to be present.

The intervention activities. The intervention activity needs to have evidence or at least a reasonable *rationale* for, and be implemented with sufficient *intensity* to, produce measurable improvements in children's social-emotional development or mental health. The intervention might be newly introduced to a specific population, an additional intervention to an existing service, an existing intervention given to a new type of participant, or an existing intervention given to an expanded group of participants.

Number of children involved. There needs to be *sufficient numbers of children* who receive the intervention activities. How many is "sufficient" depends on the extent to which the activities produce benefits (bigger benefits, fewer children are needed), but 30 or more children is likely a minimum.

Measurements. Ideally, the agencies participating have administered over the last few years a relevant *intake and an outcome assessment* to children participating in their service before the new intervention is introduced. If not, it would be helpful if the agencies would agree to administer such assessments as a routine part of implementing the new intervention, as well as assessments on the intervention's implementation. Otherwise, there would be considerable costs involved if LAUNCH has to conduct the assessments, and in either case this would require IRB approval.

Some comparison condition. It is necessary to compare the outcomes of the children exposed to the new intervention to a group of children who receive some other service, so that we can say that the new intervention produced benefits compared to "something else." It is nearly impossible to get children who received no intervention. Determining this comparison group can get rather technical, but it will be a criteria eventually.

Decision Tree Timeline

	Due Date	Point Person
Decision Point A		
Decision Point B		
Decision Point C		
Decision Point D		
Decision Point D		

Description of Outcome Intervention Options

Intervention	Attributable to LAUNCH Component	LAUNCH Funds Req'd.	Identified EB Intervention or Promising Practice	Available Outcome Data	# of Program Participants	Evaluation Needs
Program 1 [Insert Name]						
Program 2 [Insert Name]						
Program 3 [Insert Name]						
Program 4 [Insert Name]						
Program 5 [Insert Name]						

Appendix N: Smart Beginnings Measures

Smart Beginnings Data Collection Measures

Construct	Measure	Baseline	6m	18m	21m
Parenting					
Parent-child interaction	Videotaped interactions (office-6m; home-18m)		x	x	
Cognitive stimulation	StimQ: Reading, teaching, play		x	x	x
Harsh parenting	Discipline Survey		x	x	x
Relationship quality	Adult Child Relationship Scale		x	x	
Parent Psychosocial Resources and Adjustment					
Depression	Center for Epidemiological Studies – Depression (CES-D)		x	x	
Parenting stress	Abidin Parenting Stress Index (PSI) P-Ch Dysfunctional Interaction Subscale		x	x	
Parenting hassles	Parenting Daily Hassles scale related to everyday events		x	x	
Family Measures					
Sociodemographic characteristics / risks	*Demographics* (e.g., parent income, age, educational attainment, marital status, language, substance use)	x			
Risk	*Literacy* (word reading: Woodcock-Johnson III /Batería-III Letter-Word	x			
Risk	*Neighborhood danger:* Me and My Neighborhood Questionnaire (MMNQ)	x			
Relationship satisfaction	Dyadic Adjustment Scale. (short version)		x	x	
Social stress/support	General Life Satisfaction Questionnaire	x	x	x	
Child Development and Early School Readiness					
Self-regulation					
Self-regulation	Infant Characteristics Questionnaire: Temperament		x		
Executive function)	1) *EF scale:* Children are asked to categorize cards by more than one dimension with increasing complexity by age*;* 2) *Snack delay:* Present is placed under a transparent cup and children must wait for bell before retrieving; 3) *Fruit Stroop:* Children are shown cards of fruit pictures and asked to point to the smaller fruit inside a larger (mismatched) fruit picture; 4) *Bear/dragon:* A go/no go task in which children are asked to do what the bear says and not what the dragon says.				x
Self-regulation	Preschool Self-Regulation Interviewer Assessment (PSRA). Assessor ratings of child's attention/emotional regulation during <u>all</u> DA tasks				x
Pre-academic skills					
Early language	MacArthur Communicative Development Inventory (CDI)			x	
Early cognition	Woodcock-Johnson III Cognitive Abilities and Batería III Woodcock-Muñoz: – processing speed (Rapid Picture Naming); – visual memory (Picture Recognition)				x
Social-emotional					
Behavioral problems	Child Behavior Checklist (CBCL/1 ½-5)			x	x
Prosocial behavior	Infant-Toddler Social Emotional Assessment (ITSEA): Prosocial			x	x
Special services	EI referrals, services				
Other					
Biological risk (MR)	Medical risks/complications, acute/chronic medical problems, growth	x	x	x	x
Program Fidelity					
	Curricular & facilitator checklists		x	x	
	COACH Fidelity Protocol		x		

Appendix O: Meeting Minutes Template

LOCAL S&A WORKGROUP NOTES

Please complete and turn in after every work group meeting

Screening & Assessment

Date:	**Time/length of meeting:**	**Note Taker:**

Members in attendance:

Please mark with an "X"

	Maisha Howze		Alacia Eicher
	Deb Ferraro		John O'Connell
	Barb Willard		Joe Martin
	Robert Gallen		Makeda Vanderpujie
	Kaleigh Bantum		Jil Hawk
	Joanne Smith		

Write the names of anyone in attendance NOT listed to the left:	**If substituting for a workgroup member, please note member's name here:**

PLEASE CIRCLE OR HIGHLIGHT THE NAMES OF ANYONE WHO IS ATTENDING HIS/HER FIRST MEETING

Meeting Purpose:

Indicate the Objective(s) Your Group is Addressing at this Meeting

(Please mark next to the Objective with an "X")

	Objective 1.1: Increase usage of the most appropriate instruments for screenings and assessments in all early childhood settings for children ages birth to 8 years, their families, and pregnant women.
	Objective 1.2: Increase providers' skills around implementing high-quality screening and assessment processes, including referral and follow-up.
	Objective 1.3: Increase parent and community awareness of the importance of screening and assessments.

Briefly Describe the Activities/Tasks Your Group is Addressing at this Meeting

Meeting Decisions

Action Items	Person(s) Responsible	Deadline

Challenges/Barriers *(If none, write "none")*

System-level Coordination & Policy Implications *(How can the State support our work in terms of advocacy, information-sharing, tasks, etc.?)*

New Services, Resources, Initiatives, etc. *(If none, write "none")*	**Person Reporting**

Next Meeting Date & Location:

The Wilder Collaboration Factors Inventory

Name of Collaboration Project _____ Date _____

Statements about Your Collaborative Group:

Factor	Statement	Strongly Disagree	Disagree	Neutral, No Opinion	Agree	Strongly Agree
History of collaboration or cooperation in the community	1. Agencies in our community have a history of working together	1	2	3	4	5
	2. Trying to solve problems through collaboration has been common in this community. It's been done a lot before.	1	2	3	4	5
Collaborative group seen as a legitimate leader in the community	3. Leaders in this community who are not part of our collaborative group seem hopeful about what we can accomplish.	1	2	3	4	5
	4. Others (in this community) who are not a part of this collaboration would generally agree that the organizations involved in this collaborative project are the "right" organizations to make this work.	1	2	3	4	5
Favorable political and social climate	5. The political and social climate seems to be "right" for starting a collaborative project like this one.	1	2	3	4	5
	6. The time is right for this collaborative project.	1	2	3	4	5
Mutual respect, understanding, and trust	7. People involved in our collaboration always trust one another.	1	2	3	4	5
	8. I have a lot of respect for the other people involved in this collaboration.	1	2	3	4	5
Appropriate cross section of members	9. The people involved in our collaboration represent a cross section of those who have a stake in what we are trying to accomplish.	1	2	3	4	5
	10. All the organizations that we need to be members of this collaborative group have become members of the group.	1	2	3	4	5
Members see collaboration as in their self-interest	11. My organization will benefit from being involved in this collaboration.	1	2	3	4	5
Ability to compromise	12. People involved in our collaboration are willing to compromise on important aspects of our project.	1	2	3	4	5

Factor	Statement	Strongly Disagree	Disagree	Neutral, No Opinion	Agree	Strongly Agree
Members share a stake in both process and outcome	13. The organizations that belong to our collaborative group invest the right amount of time in our collaborative efforts.	1	2	3	4	5
	14. Everyone who is a member of our collaborative group wants this project to succeed.	1	2	3	4	5
	15. The level of commitment among the collaboration participants is high.	1	2	3	4	5
Multiple layers of participation	16. When the collaborative group makes major decisions, there is always enough time for members to take information back to their organizations to confer with colleagues about what the decision should be.	1	2	3	4	5
	17. Each of the people who participate in decisions in this collaborative group can speak for the entire organization they represent, not just a part.	1	2	3	4	5
Flexibility	18. There is a lot of flexibility when decisions are made; people are open to discussing different options.	1	2	3	4	5
	19. People in this collaborative group are open to different approaches to how we can do our work. They are willing to consider different ways of working.	1	2	3	4	5
Development of clear roles and policy guidelines	20. People in this collaborative group have a clear sense of their roles and responsibilities.	1	2	3	4	5
	21. There is a clear process for making decisions among the partners in this collaboration.	1	2	3	4	5
Adaptability	22. This collaboration is able to adapt to changing conditions, such as fewer funds than expected, changing political climate, or change in leadership.	1	2	3	4	5
	23. This group has the ability to survive even if it had to make major changes in its plans or add some new members in order to reach its goals.	1	2	3	4	5
Appropriate pace of development	24. This collaborative group has tried to take on the right amount of work at the right pace.	1	2	3	4	5
	25. We are currently able to keep up with the work necessary to coordinate all the people, organizations, and activities related to this collaborative project.	1	2	3	4	5

Factor	Statement	Strongly Disagree	Disagree	Neutral, No Opinion	Agree	Strongly Agree
Open and frequent communication	26. People in this collaboration communicate openly with one another.	1	2	3	4	5
	27. I am informed as often as I should be about what goes on in the collaboration.	1	2	3	4	5
	28. The people who lead this collaborative group communicate well with the members.	1	2	3	4	5
Established informal relationships and communication links	29. Communication among the people in this collaborative group happens both at formal meetings and in informal ways.	1	2	3	4	5
	30. I personally have informal conversations about the project with others who are involved in this collaborative group.	1	2	3	4	5
Concrete, attainable goals and objectives	31. I have a clear understanding of what our collaboration is trying to accomplish.	1	2	3	4	5
	32. People in our collaborative group know and understand our goals.	1	2	3	4	5
	33. People in our collaborative group have established reasonable goals.	1	2	3	4	5
Shared vision	34. The people in this collaborative group are dedicated to the idea that we can make this project work.	1	2	3	4	5
	35. My ideas about what we want to accomplish with this collaboration seem to be the same as the ideas of others.	1	2	3	4	5
Unique purpose	36. What we are trying to accomplish with our collaborative project would be difficult for any single organization to accomplish by itself.	1	2	3	4	5
	37. No other organization in the community is trying to do exactly what we are trying to do.	1	2	3	4	5
Sufficient funds, staff, materials, and time	38. Our collaborative group had adequate funds to do what it wants to accomplish.	1	2	3	4	5
	39. Our collaborative group has adequate "people power" to do what it wants to accomplish.	1	2	3	4	5
Skilled leadership	40. The people in leadership positions for this collaboration have good skills for working with other people and organizations.	1	2	3	4	5