Pennsylvania Project LAUNCH

Year Two Evaluation Report

SM061548 PA Project LAUNCH Partnership
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EXECUTIVE SUMMARY

Introduction and Background

The purpose of Linking Actions for Unmet Needs in Children's Health (Project 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 (AC) to be the local project site, and state and county leaders created a Pennsylvania (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 completed during Year One, and performing the site-specific evaluation.

Year Two Major Events and Changes

PA Project LAUNCH has operated as a highly collaborative process involving more than 130 individuals serving on Local and State Young Child Wellness Councils and Work Groups as well as on the Implementation Team. Further, the Strategic Plan for PA Project LAUNCH included a great many potential goals and activities that could involve a large number of service agencies and participants and cover a state-wide geographical area. These characteristics make PA Project LAUNCH somewhat different than many other Project LAUNCH projects. For these reasons, most of Year One was devoted to planning, advertising the Project LAUNCH opportunity to potential partners, and information sharing among the diverse affiliates and potential collaborators. We believe this was a natural and necessary set of priorities for Year One.

Year Two has focused on more of the same kinds of activities, undoubtedly in part because of the breadth and complexity of PA Project LAUNCH. These have been successful. However, there have been two major Project LAUNCH Implementation Team personnel changes at the state level and one at the local level. While these transfers have gone smoothly, they rightfully required some transition time. Further, the state legislature and governor failed to pass a budget for most of the state's fiscal year. This meant that service agencies did not receive their state budget and had to scramble to obtain loans and secure other resources (or not) to maintain services or even travel to State Young Child Wellness Council meetings. But mainly this was an all-consuming distraction that diverted agency administrators' attention away from collaborations and extra activities toward self-preservation. Nevertheless, there were a great many activities conducted during Year Two, and we present evidence below that the positive collaborative spirit of Councils has increased and provides a healthy environment for PA Project LAUNCH to become reinvigorated and more focused on fewer priorities and actions in the coming year.

As the work has unfolded, several changes have occurred. First, the original Strategic Plan suggested that Project LAUNCH would initially be focused on three geographic communities, then be expanded to all of Allegheny Country, and in later years spread across the entire state. Although there have been some efforts aimed at the original specific communities especially involving their school districts, it quickly became clear that agencies, services, and other activities could not easily be targeted exclusively or even predominately at specific communities. Thus, the focus on the three communities was muted to varying degrees across goal areas, and Project LAUNCH activities were aimed at Allegheny County during Year Two.

Second, the extraordinary breadth and complexity of PA Project LAUNCH became daunting. The result is that the original Strategic and Evaluation Plans encompass far more proposed activities, evaluation questions, and measurements than were pursued in Year Two. This process occurred organically until it became apparent that there was too much to do and too little time and resources to pursue everything. This realization has emerged at the end of Year Two, and prioritizing goals and activities represents a major task for Year Three (see below).

Third, because formal processes to revise priorities and evaluation questions will continue in the first half of Year Three, this report simply describes the activities that were conducted in Year Two and the evaluations that were performed. In this report, some objectives and activities have remained as originally planned even though not implemented, while others have been omitted.

Fourth, although PA Project LAUNCH does have an experimental service project (a blended funding collaborative with another grant) focused on individual child and family outcome measurements (Smart Beginnings), the nature of the original goals and activities focused on processes and workforce development. The Environmental Scan concluded that Allegheny County had numerous high quality and evidence-based services, but more people needed to know about them and have access to them, the services needed expansion and coordination, workforce needed more development opportunities, and the needs of immigrants and refugees needed to be more appropriately addressed. Thus, implementing such "processes", workforce development, and addressing the cultural and linguistic appropriateness of services have been the primary "outcomes" for PA Project LAUNCH.

Year Two Major Activities and Findings

A complete accounting of Year Two activities and findings are presented in the main report; only highlights of some of the main activities and findings are listed below by major goal domains and cross-cutting priorities.

Goal Areas

Screening and Assessment

Locally, an Early Childhood Screening and Assessment Champions Folder was produced to promote social-emotional health screening aimed at families and providers and distributed at resource fairs. A list of validated screening tools was produced, maintained, and distributed. In collaboration with the Health Enrollment Unit of Child Welfare, Project LAUNCH helped get screening results entered into some health records. In addition, Project LAUNCH served as a liaison between the Office of Children, Youth and Families' (OCYF) Child Welfare Demonstration Project and The Alliance for Infants and Toddlers (AFIT) to enhance screening and referral processes for children involved in the Child Welfare system. Last, the Screening and Assessment Work Group engaged in planning activities to provide free developmental screens in one local Bhutanese community. Two tools have been developed for this purpose and the local Work Group is systematically exploring other refugee populations in the three target communities where this process can be replicated. The preparation, implementation, successes, and challenges of this activity will be documented and serve as a model for conducting similar events for other racial/ethnic groups, as identified. At the state level, Project LAUNCH partnered with Pennsylvania Partnerships for Children to contribute to an infographic to assist in their statewide campaign to get more children screened.

The development of the Allegheny County Link (The Link), a coordinated referral system for families with children 0-5 years (see Home Visiting section below), enabled the local implementation team to create a thorough way of providing families with information on eligibility and screening. The Link service coordinators were trained to provide eligibility information to families looking for certain services who may qualify for at-risk tracking and automatically refer them to the Alliance for Infants and Toddlers for screening and other services. The homeless population, an at-risk tracking category, is also a population of particular interest in the development of this new system. The Link is the clearinghouse for homeless services in Allegheny County. This new process allows for better education and referral for homeless families.

Behavioral and Physical Health Integration

Locally, there was a great deal of activity in this goal area. Four major pediatric practice groups serving approximately 80% of the children in Allegheny County each completed the Pediatric Provider Integrated Assessment, a tool created in Year One by modifying and combining the Integrated Practice Assessment Tool (IPAT) and the Mental Health Practice Readiness Inventory (MHPRI). All four groups were implementing various forms of integration. On the SAMHSA scale from 1 to 6, with 6 indicating the highest form of overall integration, two practices achieved Level 5 (see page 23 in the PA Project LAUNCH Year Two Evaluation Report). The practices were best at referral assistance, information exchange, and screening and assessment, but were less accomplished at collaborative arrangements, engagement, quality improvement, and tracking.

A survey of 64 pediatricians produced a list of needed training topics, which then formed the basis of the agenda for a one-day Pediatric Provider Integrated Care Conference (PPICC) that drew 89 participants. The conference was aimed at pediatricians and affiliated staff, physical and behavioral health professionals and administrators, and others interested in the integration of physical and behavioral health services. The learning objectives were to 1) understand current models for the integration of behavioral health services into primary care settings and how some models have been implemented in local pediatric practices, 2) identify mental/behavioral health conditions in young children through the use of validated screening and assessment tools, 3) learn strategies to enhance facilitated referral for significant behavioral health concerns, and 4) receive skills-based training to increase capacity to address pediatric behavioral health conditions. Participants rated the conference highly on nearly all

dimensions. Major issues for the future were billing and how to pay for behavioral health services, the limits on sharing patient records, the incompatibility of the electronic records in different practices, finding behavioral health professionals, and reducing the stigma of mental health services. These represent potential agenda items for Project LAUNCH to pursue.

Early Childhood Mental Health Consultation

In response to an expressed need for professional, cross-sector competencies in Infant and Early Childhood Mental Health, PA Project LAUNCH purchased the license for *MI-AIMH Endorsement for Culturally Sensitive, Relationship-Focused Practice Promoting Infant Mental Health®*, which will be implemented locally and statewide in 2017. Pennsylvania has joined 25 US states and one international territory in the movement toward the promotion of infant mental health principles and practices. An endorsement in infant/early mental health (I/ECMH) is a verifiable process that supports the development and acknowledgement of infant and early childhood professionals, within a tiered framework that recognizes knowledge, training, and criteria for best practice standards. It is not a license or certification, but instead is an overlay onto a person's professional credentials which recognizes achievement of competence in the area of I/ECMH. Locally, an expansive group of professionals working in the early childhood mental health space was created to begin to identify resources available and future training needs. Plans were made to hire a project coordinator to organize two learning collaborative tracts, one for early childhood professionals without a mental health background and another for those who do. A meeting of representatives from the school districts of the original three target communities was held to identify needs. A well-defined strategy for Year Three was created.

At the state level, Project LAUNCH partnered with the Head Start State Collaboration Office to hold five regional mental health roundtables to discuss issues, identify needed services, and plan professional development activities. Project LAUNCH, in collaboration with the PA Positive Behavior Support Network (PAPBS) also held discussions with the national KinderCare Corporation regarding their interest in supporting their centers nationwide to implement Program-Wide Positive Behavioral Interventions and Supports (PW-PBIS). Both the YCWE and YCWP met with Allegheny County based KinderCare regional representatives to explore their program's interest. These representatives have been linked to the PAPBS Network facilitators to continue this exploration.

Home Visiting

PA Project LAUNCH supported the roll out of The Allegheny Link (The Link), a local hotline designed to help families connect with home visiting services and to fill vacancies in such services. Link counselors provided one or more referrals to 453 families. This approach is significant in Allegheny County where resources are plentiful but systems are complex and difficult for families to navigate. In addition, Project LAUNCH participated in the strategic development of a public information campaign to promote home visiting, first among medical providers and then among families. A Celebrating the Home Visitor two-day motivational conference attended by 188 professionals provided information about The Link, Project LAUNCH, brain development, various services available in the community, and other resources. Participant feedback was quite positive.

Family Strengthening

Smart Beginnings, an innovative two-stage intervention for at-risk families with newborns began in Year Two with Project LAUNCH contributing to the family recruitment process. Mothers will initially participate in a video intervention in which their interactions with their infant is videotaped at well-baby visits and then replayed to them with feedback. After some months, those families at greatest risk will be enrolled in the Family Check Up intervention. The major question is whether these interventions can

be successful if started so early in the child's life. The project, funded predominately by the National Institute of Child Health and Human Development, will provide individual level process and outcome data on a variety of measures. A total of 133 families were screened and 40 were enrolled in the project by the end of Year Two. Some Smart Beginnings outcomes will be collected and reported in Year Three.

In addition, Project LAUNCH provided 20 scholarships to professionals and families to attend the Pennsylvania Association of Infant Mental Health Conference, and Project LAUNCH provided materials to support the Community Engagement Team of the Department of Human Services who investigate abuse and neglect cases.

Cross-Cutting Themes

Several Project LAUNCH priorities cut across the major goal areas. These cross-cutting themes include workforce development, cultural competency, health disparities, public awareness, and system change. The PA Project LAUNCH evaluation activities and findings are described in the Findings section of this report by goal area and also summarized within each cross-cutting theme.

Recommendations

The breadth, depth, and overall complexities of PA Project LAUNCH have become difficult to manage comprehensively and some focusing has begun. Year Three activities should include a **revision of the state and local Strategic Plan** objectives, activities and timelines with an **emphasis on prioritizing**. This revision should be followed by **revisions to the Evaluation Plan** to better align evaluation activities with the new directions and priorities of the Project.

We suggest that these priorities move beyond coalition building and information sharing and **focus on "deliverables"**---new policies, events, products, and procedures. Further, Work Group and perhaps Council meetings themselves might be more "action oriented," not primarily information sharing and updates (although some of that is necessary). Specifically, "what are we going to do, how are we going to do it, and who will spearhead the process of pursuing this course of action?" Members are likely to perceive this kind of meeting to be more worthwhile, attendance might increase, and the Councils may become re-energized. Some of this work has begun near the close of Year Two.

Some recommendations outlined in the Year One Evaluation Report remain pertinent. Entering Year Three, the following recommendations persist:

Local and State activities should continue to **consider long-term sustainability** when prioritizing resources and implementation activities. This includes consideration of procedures to facilitate **data sharing** across systems and an emphasis on **strategic policy initiatives**.

The next three years should also focus on building upon the work already done to create and implement **strategies for how to assess, describe, and address disparities**, including collaborating with agencies specifically focused on special populations, collecting information where possible, 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.

PA Project LAUNCH will also benefit from continued **strategies for efficient communication** between state and local councils and across systems to achieve a smoother, more coordinated early childhood mental health environment.

PA PROJECT LAUNCH LOGIC MODEL

The logic model, which is provided in Table 1, was created in conjunction with the Strategic Plan in Year One. It summarizes the linkages between PA Project LAUNCH's goals, objectives, activities, indicators, and anticipated outcomes. This logic model will be updated in Year Three during the process of updating the Strategic Plan to reflect PA Project LAUNCH's revised direction.

Table 1. Draft Year Two Pennsylvania Project LAUNCH Logic Model

Goal	Inputs	Activities	Outputs	Intermediate Outcomes	Long-term Outcomes
Ensure young children at risk are screened and provided appropriate resources	PA Project LAUNCH Implementation Team PA Young Child Wellness Council Allegheny County Young Child Wellness Council PA & AC Work Groups	Develop, refine/update, and disseminate information on recommended screening and assessment measures & culturally appropriate screening, assessment, and referral practices Track numbers and types of screenings, assessments, & referral	Number of child screens & assessments by setting type Number of referrals & follow-ups	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.	Providers, including primary care offices, will implement high-quality screening and assessment processes (e.g., implementation fidelity, cultural competence, relationship building, and communication).
Enhance integration of physical health and behavioral health practices	Pilot Community School Districts (Woodland Hills, Baldwin Whitehall, Pittsburgh Public) PA Project LAUNCH affiliated providers	Assess training needs of providers on models, services, and issues related to Behavioral (BH) and Physical Health (PH) integration and provide related training and consultation opportunities in identified areas Identify strategies, models, and policies that support BH/PH integration and issues that impede these efforts	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	Physical and behavioral health providers will have knowledge of topics related to integration of services across systems Key stakeholders will have increased knowledge of policy and systemic issues that impact integration	Pediatric practices will integrate behavioral health resources to meet the needs of young children and their families. Stakeholders will initiate and efforts to address key policy and systemic issues
Strengthen existing Early Childhood Mental Health (ECMH) consultation and extend services for children birth to 8 years, their families, and pregnant women	Other federal, state & privately funded projects PA & AC funding SAMHSA Grant Program Officer & Technical Assistants	Identify training and support needs of providers across settings & provide training and consultation opportunities on best practices and related supports for ECMH consultants and providers	Consultants and providers trained in ECMH best practices and supports	ECMH consultants have consistent, uniform knowledge about best practices in ECMH consultation and needs of providers across settings and age groups	ECMH consultants implement consistent, uniform best practices in early childhood settings ECMH consultation services expands to new settings, and new age groups
Promote high quality home visiting services	AC-DHS DARE Data warehouse and county/school data sharing agreements	Develop and provide training opportunities for HV providers on cultural competence, best practices, and high quality support processes	Home visiting staff trained in home visiting best practices and high quality support processes and culturally competent practices	Home visiting staff will have increased knowledge about best practices in home visiting within evidence based or evidence informed programs	Home visiting programs will provide behavioral and physical health resources to meet the needs of families and support home visiting staff
Ensure families with young children are connected to needed information and services	Allegheny Link, coordinated referral line Evidence-Based Practices (e.g., PW-PBIS, Smart Beginnings/FCU, Parent Cafes)	Promote awareness about the Allegheny Link to providers and families Promote awareness about and opportunities for participating in Evidence Based Practices (EBPs) with providers serving young children and families Support Smart Beginnings recruitment efforts; Smart Beginning is an EBP parenting intervention	Link referrals to services Number of providers engaged in informational and training opportunities about EBPs Number of new providers participating in EBP's and number children and families participating in EBPs	The Link will provide families with an increased number of referrals to HV services and at-risk tracking services Providers will have increased knowledge of EBP's and related supports	The Link will provide families with increased number of referrals to HV, medical, homelessness, and other community services EBP's will be more readily available and easily accessed for children and families who need them Children and families receiving direct services will have improved outcomes

Goal (cont.)	Inputs (cont.)	Activities (cont.)	Outputs (cont.)	Intermediate Outcomes (cont.)	Long-term Outcomes (cont.)
Ensure families with young children are connected to needed information and services		Target and prioritize areas to develop messages & materials; identify pathways to disseminate this disseminated to parents and providers Provide MH First Aid trainings to community leaders Identify and utilize appropriate models to provide parents with networking opportunities that increase their leadership skills	Key communication messages and materials to parents, community & key stakeholders Community members trained in mental health issues Number of leadership opportunities and parent leadership networks	Providers will have increased resources on healthy child development and social emotional wellness for parents Community members will have knowledge of mental health issues. Parents will have increased knowledge about networking opportunities that can promote their leadership skills	Parents will have increased access to information and resources to support healthy child development and social-emotional wellness. Parents will be engaged in social networks that promote their leadership skills.
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		LAUNCH council and Work Groups will engage in and/or support community and statewide activities that address targeted policy and systemic issues and goals	PA Project LAUNCH governance structure Data sharing systems 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.	PA Project LAUNCH governance and partners are cross-disciplinary, including parents, and work in close collaboration	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 Relevant data will be collected and available for use by systems serving children birth to 8 years, their families, and pregnant women

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Background and Project History

The purpose of Project 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 below 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) providers. **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**. Thus, the appropriate outcomes are primarily the supports themselves, that is, **the process changes and accomplishments are the outcomes**. They include:

- trainings provided,
- screenings conducted,
- referrals made,
- cross-system business processes created
- 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 perceived cultural sensitivity of services,
- new collaborations arranged,
- regulations and policies created, and
- changes in the knowledge, skills, and /or attitudes of the child, family, and providers as a result of the outcomes noted above.

APPROACH AND METHODS

The Evaluation Plan developed in Year One serves as the foundation for the information collected and summarized in this Year Two Evaluation Report. What follows here and in other sections of the report represents plans established in Year One and implemented in Year Two. A complete list of acronyms can be found in Appendix B. The evaluation methods described below apply to all the activities proposed in the initial Strategic Plan, even though only a subset of activities was implemented in Year Two. Those activities are described under Results, and any changes in evaluation methods made to accommodate to implementation circumstances are also described there.

Methodologies for Cross-Cutting Themes

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) is administered immediately after the training. It captures the extent to which trainees feel they gained new knowledge; 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), administered by email approximately three months after the training, assesses the extent to which the training increased participants' 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). The follow-up survey is only appropriate for trainings that emphasize practice techniques that indeed could be implemented, rather than trainings that emphasize information sharing on broad topic areas, networking possibilities, etc.

Cultural Competence

Cultural competence will be assessed in a sample of Project LAUNCH affiliated agencies in which Project LAUNCH supports improvements in cultural competency, beginning in Year Three. 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 Team will gather baseline information from agency directors, when activities in this area are targeted for implementation according to the updated Strategic Plan.

In Year One, 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.

The self-assessment tool contains 23 items that are common across contexts and six items unique to specific contexts. The greatest concentration of items is 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). 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

Direct assessments of racial/ethnic disparities will be made in LAUNCH affiliated providers in which Project LAUNCH supports deliberate attempts to minimize such disparities. The Evaluation Team developed a demographic data form to supplement the manner in which providers ask participating families to indicate their racial/ethnic identity and membership in special populations. 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 provider agency and may be modified to ensure that clients are not asked to provide agencies/practices with duplicate information on multiple forms.

However, Year Two discussions with LAUNCH affiliated providers revealed that the collection of additional demographic information would create undue burden and would not be possible. As such, the Evaluation Team created specific checklists (See Appendix G) which providers can use as a framework to collect demographic information, which we will report. Thus, the formal assessment described in the preceding paragraph has not been conducted yet. LAUNCH did support some activities of a more focused sort to minimize disparities or serve specific minority participants, which will be described below.

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 Young Child Wellness Councils (YCWC) and Work Groups and the monthly Outreach Activity Logs (See Appendix H: Outreach Activity Log) of the Young Child Wellness (YCW) Expert, Coordinator, and Partner to document public awareness related

activities. In addition, the YCW Expert, Coordinator, and Partner and Project LAUNCH Assistant provide additional key details about the nature and extent of such activities and their intended audience via an online end-of-year survey.

Methodologies for Specific Goal Areas

In this section we describe the evaluation methodologies for each of the five core PA Project LAUNCH goal areas plus the additional goals of Local Systems Change and State Systems Change. For each goal area we describe the process and outcome evaluation activities that apply to all potential activities. Process evaluation activities across goal areas include record review, end of year (EOY) survey, and Outreach Activity Logs. Outcome evaluation activities may include similar processes plus those that match specific activity outcome expectations. As noted above, many of the goals are process-oriented and implementing those processes represents the appropriate "outcome" for that goal. Outcomes that the process would be expected to produce are often implied but not measured as "Outcomes." 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.

Process Evaluation Activities and Major Limitations and Constraints

Across all goal areas, including system change goals (6 and 7), 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 (See Appendix J for Meeting Minutes Template) and project records and completion of an online end-of-year survey (See Appendix K: End of Year Survey), by the current and past YCW Coordinators, 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. These mixed methods approaches are referred to as "Core Process Evaluation Activities". Table 2 describes the Process Evaluation Activities, Outcome Evaluation Activities, and Major Limitations and Constraints by goal area.

Table 2: Evaluation Activities and Major Limitations and Constraints

Goal Area	Process Evaluation Activities	Outcome Evaluation Activities	Major Limitations & Constraints
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*	• Core Process Evaluation activities	• Collaboration with provider agencies to facilitate data collection through the most appropriate method for each agency.	• Referral follow-through: The Team has been informed that such data are not often collected, would be difficult to collect given confidentiality and other concerns, and participant report is likely to be inaccurate. Thus, such data are not collected.
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.*	• Core Process Evaluation activities • Completion of PPIA summaries to identify themes that will guide the major activities of subsequent BH/PH Work Group meetings and collaborations • Completion of training surveys	• Annual completion of PPIA with the 4 main pediatric health practices in the region • Post- and Follow-up training surveys	• Willingness of trainees to complete the post- and follow-up surveys
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.).*	• Core Process Evaluation activities • Completion of training surveys	• Post- and Follow-up training surveys	• Willingness of trainees to complete the post- and follow-up surveys • Evaluation scripts/tips were developed to help ensure that trainees and agencies receive consistent information about the importance of their responses and contributions to the project. • In the future, the willingness of agencies to complete the CLAS Tool questionnaires
Home Visiting *PA Goal 4: Promote integrated, evidence-based, high quality home visiting services and ensure access to those who need it.*	• Core Process Evaluation activities • Collection of LINK (HV coordinated referral line) usage data • Completion of training surveys	• LINK (HV coordinated referral line) referral data • Post- and Follow-up training surveys	• The type of data gathered through the referral line system, which include number of calls, programs referrals, and select client information • Willingness of trainees to complete the post- and follow-up surveys; will utilize evaluation scripts/tips resources
Family Strengthening *PA Goal 5: Ensure families with young children are connected to needed information and services*	• Core Process Evaluation activities • Collection of Smart Beginnings data on the # of families and # of interventions completed with families, implementation fidelity • Completion of training surveys	• Parent, child, & family assessments • Once trainings begin, post- and Follow-up training surveys	• Willingness of trainees to complete the post- and follow-up surveys; will utilize evaluation scripts/tips resources

Systems Change

Local
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.*

State
PA Goals 7a-7c:

a. Disseminate by target audience messages about the importance and benefit of social-emotional wellness and services.
b. 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.
c. 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 Activities
The Evaluation Team uses the Core Process Evaluation Activities to measure system change at the local and state level.

Outcome Evaluation Activities
The Wilder Collaborative Factors Inventory (See Appendix L: Wilder Collaborative Factors Inventory) is administered annually to the members of both the Local and State YCWC and is used to assess the quality of collaboration of parent and professional members of the YCWCs (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 Appendix L.

Major Limitations and Constraints
The members of the YCWC are very busy professionals and parents. Wilder Factor Inventory results are limited to responses collected. As such, the response rate variations may reveal bias and 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) and end of year surveys. However, locally, only projects that can be sustained are pursued, except experimental interventions.

DATA ANALYSIS

Analysis of Planning Information [from Project Records]

A major source of data across PA Project LAUNCH involves record keeping of contacts made, YCWC and Work Group meetings held, 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 parents and professionals represented on Councils in Year Two. The Evaluation Team reports such information as well as changes that have occurred over time in these infrastructure activities and for trainings, screenings, and efforts around disseminating endorsed resources. These counts are broken down by various factors (e.g., setting, goal area, purpose, etc.) when appropriate.

Surveys and Outreach Activity Logs

Much of the qualitative information in Year Two is from the Outreach Activity Logs and end of year (EOY) surveys that reflect simple events, collaborations, attendance, etc. Other measurements provide quantitative scores, usually ratings from the Wilder Inventories and training and conference questionnaires. Mean ratings averaged over participants will be presented and comparisons across years will be investigated for assessments that are repeated over time. We will conduct statistical analyses of longitudinal or cross-sectional change across time when appropriate; but sometimes there will be too few such units 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 focuses on relative improvements over time (i.e., 6, 18, and 21 months) for families participating in the three conditions of the Smart Beginnings project, namely, no treatment, Video Interaction Project (VIP)[1] Only, and VIP+ Family Check-up (FCU)[2]. 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 M: Smart Beginnings Measures). The VIP + FCU vs. VIP Only intent-to-treat comparison will assess the additional benefit of the FCU intervention 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[3] fidelity protocol. This project was primarily engaged in participant recruitment in Year Two, so outcome data will not be available for a year or two. When available, the Smart Beginnings team will share data with the PA Project LAUNCH evaluation team.

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 Two are limited by the nature and extent of these data that are made available to the Evaluation Team by cooperating agencies and participants in trainings and Councils. It is simply too burdensome and expensive for the Evaluation Team staff to collect such information; we must be dependent on cooperating agencies and participants to provide such information and they vary in the nature of the information they collect and the extent of their cooperation in providing it to us.

Much of the evaluation data expected in subsequent years will continue to be frequencies and percentages. The exception is the Smart Beginnings project, which will have individual measures of children, parents, families, and program fidelity available. One anticipated challenge will be 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 anticipated challenge will be comparing the VIP + FCU group to an appropriate comparison group. The FCU

[1] Video Interaction Project (VIP) is a universal primary prevention strategy that provides parents with a developmental specialist who videotapes the parent and child and coaches the parent on effective parenting practices at each pediatric primary care visit.

[2] The Family Check-Up (FCU) for Children is a strengths-based, family-centered intervention that motivates parents to use parenting practices in support of child competence, mental health, and reducing risks for substance use.

[3] **C**onceptual accuracy and adherence, **O**bservant and responsive to client needs,
Actively structures sessions, **C**areful and appropriate teaching, **H**ope and motivation are generated

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 more than 130 individuals serving on Local and State Young Child Wellness Councils and Work Groups as well as on the Implementation Team. Further, the Strategic Plan for PA Project LAUNCH included a great many potential goals and activities that could involve a large number of service agencies and participants and covers a large geographical area. For these reasons, most of Year One was devoted to planning, advertising the LAUNCH Project to potential partners, and information sharing among the diverse affiliates and potential collaborators. We believe this was a natural and necessary set of priorities for Year One.

Year Two has been dominated by more of the same kinds of activities, undoubtedly in part because of the breadth and complexity of PA LAUNCH. These have been successful. However, there have been two major LAUNCH Implementation Team personnel changes at the state level and one at the local level. While these transfers have gone smoothly, they inevitably required some "start-up time" for the transition. Further, the state legislature and governor failed to pass a budget for most of the state's fiscal year. This meant that service agencies did not receive their state budget and had to scramble to obtain loans and secure other resources (or not) to maintain services or even travel to State Young Child Wellness Council meetings. But mainly, this was an all-consuming distraction that diverted agency administrators' attention away from collaborations and extra activities toward self-preservation. Nevertheless, there were a great many activities conducted during Year Two, and we present evidence below that the positive collaborative spirit of the Councils has increased and provides a healthy environment for PA LAUNCH to become reinvigorated and more focused on fewer priorities and actions in the coming year.

The first half of Year Three will include a process to revise the Strategic Plan that will involve the Work Groups at the State and Local levels. Because of its organic nature, the implementation of the objectives and activities outlined in the original Strategic Plan have shifted in priority or been replaced by more pressing and appropriate approaches to community-wide issues as the Project has developed over the first two years. Because the Evaluation Plan was built in alignment with the original Strategic Plan, the evaluation findings do not currently align with the evaluation questions. Therefore, the evaluation questions outlined in the Evaluation Plan do not appear in this report. The Evaluation Team will revise the evaluation questions based on the updated Strategic Plan in Year Three.

Major process evaluation findings by goal area are located in Table 3.

Table 3. Goal Area Specific Process Evaluation Findings

Goal Area	Local Level	State Level
Screening and Assessment	✓ Early Childhood Screening and Assessment Champions Folder was produced ✓ A list of validated screening tools was produced, maintained, and distributed ✓ A screening event for the Bhutanese community was planned for Year Three	✓ Partnered with Pennsylvania Partnerships for Children to contribute to an infographic to assist in their statewide campaign to get more children screened
Behavioral and Physical Health Integration	✓ Four major pediatric practices completed the Pediatric Provider Integrated Assessment ✓ A survey of 64 pediatricians produced a list of needed training topics ✓ Held a one-day Pediatric Provider Integrated Care Conference	
Early Childhood Mental Health	✓ Created an Early Childhood Mental Health Learning Collaborative Planning Group ✓ Held a meeting of representatives from target community school districts to identify needs. ✓ Developed a partnership between the Alliance and The Link for referral of families eligible for at-risk tracking for screening	✓ Purchased Michigan's Infant Mental Health Endorsement Framework ✓ Partnered with the Head Start Collaboration Office to hold five regional mental health roundtables ✓ Held discussions with KinderCare Corporation to encourage them to implement PW-PBIS
Home Visiting	✓ Rolled out The Link (coordinated referral line) ✓ Public information campaign to promote home visiting	✓ Supported the local launch of The Link through public awareness, training for the workforce on behavioral health resources and services, as well as strategies to strengthen the quality of home visitation services provided
Family Strengthening and Parent Skill Building	✓ Smart Beginnings began recruitment of families ✓ Provided 20 scholarships to professionals and families to attend the PA-AIMH Conference ✓ Provided materials to support the Community Engagement Team of the Department of Human Services who investigate abuse and neglect cases ✓ Trained various groups on how they can support their families by referring to social services and the Link.	✓ Moderated a parent panel at the International Parent Child Interaction Therapy (PCIT) Conference

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.

Year Two Activities and Process Evaluation Progress

Local

- Since October 2015, the Screening and Assessment Work Group has taken great care to engage early childhood experts and determine the most appropriate screening tools to promote through training and the development of creatively sponsored events.

- The PA Project LAUNCH Screening and Assessment Work Group created an **Early Childhood Screening and Assessment Champions Folder** containing information about the importance of early childhood development and of screening and subsequent early intervention when needed. Members of the Work Group and Local YCWC distributed this information to families, providers, and stakeholders at resource fairs across Allegheny County. Additionally, PA Project LAUNCH gave presentations to local family and youth organizations, child welfare, and other stakeholder groups about the information in the Champion's Folder and how they can encourage screening of young children in their role as a team member.

- The Screening and Assessment Work Group has been developing a set of **best practice standards for screening with immigrant communities**. The Bhutanese community of immigrants and refugees, primarily settling in the pilot community of the Baldwin-Whitehall School District, was identified as a target population receiving insufficient social services. The nearest Early Head Start centers and Family Support Centers have long waiting lists. In response, the Work Group created two supporting guides: 1) A glossary of terms for interpreters, and 2) a guide on cultural considerations for screeners.

- The Work Group also planned two community events to be held in Year Three: 1) an event to promote **awareness** of the development milestones and services that can be used to support child development, and 2) a **community screening event** in which families could have their children screened with the Ages and Stages Questionnaire-3 (ASQ-3) and ASQ: Social Emotional (ASQ-SE) and be referred to a range of services. Preparation of staff for the event involves not only reviewing the supporting documents but extensive preparation of the interpreters who would be integral to the success of the event. Community members will be able to obtain free developmental assessments of their young children (birth to age 5) and referrals to resources and supports when needed. Preparation for the event focuses on identifying a centralized location with appropriate space; translating handouts for parents and other materials; advertising for the event; arranging for appropriate numbers of screeners, interpreters, and other staff; planning the logistics of the day itself (e.g. scheduling families, "flow" of the event); evaluation of the event; arranging for healthy snacks; and creating play spaces with toys for waiting families.

  The Work Group is working closely with translators and members of the Bhutanese community to align the logistics of the event with appropriate cultural norms, such as offering large blocks of time rather than a specific appointment and ensuring that details of the event are culturally sensitive. For example, consideration of stigma and discrimination around bringing a child with special needs out in public, expecting a follow-up event after the initial event, and nuances around the activities and language used in the screening tools. Bhutanese culture also places value on hearing first-hand experience to lend legitimacy.

Prior to the screening event, in the same location, the Work Group will hold a public question and answer session about the event during community food bank hours where a member of the community will share personal experiences with screening and the benefits he has seen. At that time, families will be able to ask questions about screenings in general and about the event, and pre-register to have their children screened. This represents a focused effort at reducing disparities one immigrant group at a time.

- The Work Group **translated child development summary sheets** for children 0-6 months, 6-12 months, 12-24 months, 24-36 months, and 3-5 years. These materials will be available to families who attend the event and later for those who frequent the South Hills Interfaith Movement (SHIM) Food Pantry in the South Hills. Additional plans for dissemination are being developed.

- The Work Group continues to update the **list of validated screening and assessment tools** being used in various settings in Allegheny County.

- As a result of a former LAUNCH leader and other partners, the Health Enrollment Unit in Child Welfare has begun **including developmental screens in the health record**, monitoring their completion and subsequently a follow up to recommendations. This reinforces the link between physical health and mental health at a programmatic level.

- PA Project LAUNCH also created a **flow chart for Child Welfare** that details the screening process, eligibility for enrollment in early intervention services, and a description of the risk categories that automatically make a child eligible for screening and tracking to assist in understanding the screening process (See Appendix N: Screening Flow Chart for Child Welfare).

State

- PA Project LAUNCH state staff and many Council members collaborated with PA Partnerships for Children (PPC) on their **Screening, Assessment, Referral and Follow-up Initiative**. This project, funded by the David and Lucille Packard Foundation, focused on developing strategies to increase the number of children that receive a developmental screen in the first five years of life in Pennsylvania. PPC reached out to PA Project LAUNCH because of a shared focus on screening, assessment, and referrals. The PPC grant's recommendations are forthcoming and will be reviewed and a determination will be made as to how they can be integrated into the work of PA Project LAUNCH to inform policy issues, professional development, and public awareness. As a result of this work a developmental screening infographic and white paper have been produced by PPC and subsequently shared with State YCWC members to increase awareness of the status of developmental screening and assessment in the state and the steps that can be taken to begin to promote high quality screening and assessment practices across sectors. Both documents were also shared with other grantees via the TA Gateway.

Year Two Outcome Evaluation Progress

AFIT/CYF Collaboration

- The Office of Children, Youth and Families' (OCYF) Child Welfare Demonstration Project is partnering with Part C Early Intervention provider, The Alliance for Infants and Toddlers (AFIT), to complete the Ages and Stages Questionnaire-3 (ASQ-3) and ASQ: Social Emotional (ASQ-SE) screens for children ages 0-5, who have been enrolled in OCYF and accepted for in-home services. Project LAUNCH's role as a liaison between AFIT and OCYF increased staff awareness of the importance of early childhood screening and enhanced screening, tracking, and referral

processes. Through this collaboration, 241 children received ASQ-3 and/or ASQ: SE screens and 25 children received referrals to early intervention services.

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.

Year Two Activities and Process Evaluation Progress

Local

- At the start of Year Two, LAUNCH engaged four pediatric practices that provide services to about 80% of all children within the County. Members of the Evaluation Team and the Work Group assessed their level of behavioral and physical health integration with the **Pediatric Provider Integration Assessment (PPIA)**. The analysis of these assessments was conducted by a sub-committee of subject and evaluation experts, and results (see Outcomes below) were shared with the practices to inform their continued integration efforts.

- Using the findings from the PPIA, a survey was developed by the Work Group and sent to 64 pediatricians in Allegheny County to **assess specific training needs** related to behavioral health and physical health integration.

- The most requested topics were then organized into a full-day integration training event, **Pediatric Provider Integrated Care Conference (PPICC),** on September 21st for pediatric physical and behavioral health providers (see Outcomes below for topics and participant ratings). Additional training events are scheduled for Year Three.

- The Work Group and the Evaluation Team collaborated with three of the four main pediatric providers to **develop data sharing agreements** with PA Project LAUNCH.

Year Two Outcome Evaluation Progress

Pediatric Practice Integration Assessment Summary

- At the beginning of Year Two, the four major pediatric practice groups that are the focus of LAUNCH's efforts toward promoting physical and behavioral integrated practice in Allegheny County completed the Pediatric Practice Integration Assessment (PPIA), adapted from the Integrated Practice Assessment Tool (IPAT) and the Mental Health Practice Readiness Inventory (MHPRI) (See Appendix O: Pediatric Provider Integration Assessment (PPIA)). This provided a baseline assessment and current status of the four practice groups with respect to the nature and extent of their integrated care services. The PPIA is completed collectively by the practice group's director and major professional staff to give a composite picture of the entire practice group, so actual practices within the group may vary for different physicians and different locations. **All four groups were making some attempt to incorporate behavioral health services in their practices**, and two of the four practice groups were rated at level 5 out of 6 (6 being the most integrated) on SAMHSA's scale and within the top category of Integrated/Team Approach. Generally, the practice groups had good scores on referral assistance, information exchange, and screening and assessments. Collaborative arrangements, engagement, quality improvement, and tracking systems were done less well by three groups, and more specific services were unevenly distributed among the practices.

  The practice groups have found ways to bill for some behavioral health services, but they were blocked by policies and regulations from billing for other behavioral services. Other obstacles

focused on the incompatibility of Electronic Medical Record systems and their lack of options for behavioral information, and the lack of time and billing options for a Primary Care Physician to deliver behavioral care. Training needs focused on understanding a variety of behavioral health issues, practices, and resources, and sharing patient information raises several challenges.

The aggregated results for the four practice groups are presented in Appendix P.

CLAS Self-Assessment Checklist

- Two practice groups reported that they did not serve racial/ethnic families in their practice areas, so they were not administered the CLAS Self-Assessment Checklist of culturally appropriate practices. Two other practice groups did serve such families, and the CLAS was intended to provide a baseline against which progress could be charted. However, the two groups rated the vast majority of items on the CLAS as something "they do frequently" or "applies to us to a great degree." Thus, for these two groups, the "baseline" was quite high and general improvement was not needed. Further, some specific practices within these groups had significant numbers of racial/ethnic minorities as clients but others did not, so giving the CLAS to the entire group seemed imprecise and giving it to specific practices would be burdensome and not logistically feasible for PA Project LAUNCH's partner pediatric providers. Collectively, these circumstances led to the conclusion that administering the CLAS to practice groups was not very precise or informative, so this assessment was discontinued with respect to pediatric practices. The Evaluation Team plans to administer this assessment with PA Project LAUNCH Affiliated Providers across other goals areas as appropriate in Year Three.

Pediatric Provider Data

- In Year Two, screening data were collected from three main pediatric providers in Allegheny County to help describe the current state of screens being conducted in pediatric offices on children in the 0-8 year age range and adults when relevant. The data collected showed that the Parents' Evaluation of Developmental Status (PEDS) and Modified Checklist for Autism in Toddlers (M-CHAT) screening tools are routinely being administered to children before age three in all three pediatric practices. Post-partum depression screens (i.e., the Edinburgh) are also routinely conducted across these three pediatric groups. The data collected on these screens will serve as baseline information if the Behavioral Health and Physical Health (BH/PH) Integration Work Group implements activities aimed at expanding screens or introducing new screens within these pediatric practices.

Pediatric Provider Integrated Care Conference

- PA Project LAUNCH partnered with the Pennsylvania Chapter of the American Academy of Pediatrics and Community Cares Behavioral Health to co-sponsor the Pediatric Provider Integrated Care Conference held on September 21, 2016, in Pittsburgh that focused on linking behavioral health and physical health to enhance wellness for young children. The conference was aimed at pediatricians and affiliated staff, physical and behavioral health professionals and administrators, and others interested in the integration of physical and behavioral health services.

  The learning objectives for this conference were to 1) understand current models for the integration of behavioral health services into primary care settings and how some models have been implemented in local pediatric practices, 2) identify mental/behavioral health conditions in young children through the use of validated screening and assessment tools, 3) learn strategies to enhance facilitated referral for significant behavioral health concerns, and 4) receive skills-based training to increase capacity to address pediatric behavioral health conditions.

The conference had 111 preregistered potential participants and 89 signed-in attendees, including several members of the Local and State Young Child Wellness Councils and seven LAUNCH Team members (three State and four Local). Major content themes included social and behavioral factors related to risk level for poor health outcomes, patient-centered medical homes in physical vs. behavioral health, six levels of integrated care, models of integration, Telephonic Psychiatric Consultation Service[4] (TiPS) program at Children's Hospital, screening tools, billing limitations, engaging families, referral information and systems, and other challenges to integration (e.g., stigma, data sharing, and training).

In total, 37 participants (mostly physicians) responded to 11 questions on an evaluation form required for obtaining continuing education credits from the PA American Academy of Pediatrics (AAP). Generally, all but one question was rated between 4.05 ("high") and 4.84 ("very high), which indicated the conference was regarded as providing solid information, especially about models of physical/ behavioral health integration, that was relevant to their practices. Participants on average indicated the conference provided "some" information that was said to be new, and there was a "high" likelihood these participants would make a change in their practice (but these were among the lowest ratings on the questionnaire).

A total of 24 participants (mostly Masters level professionals) completed the non-continuing education questionnaire. These professionals rated nearly all components and aspects of the conference, especially the presenters who they regarded as being well prepared, as contributing equally to their learning and understanding. Further, 87-96% rated as moderate to high the conference's assistance in helping them interpret current physical/behavioral health models of integration, identify behavioral health issues in children through screening, develop strategies for referrals, and address pediatric behavioral health conditions.

Forty-five attendees submitted supplemental evaluation forms. The highest rated items pertained to clarifying reimbursements for socio-emotional screenings and treatments from insurance and government agencies; developing examples of processes to incorporate screening results into the electronic health record; assisting providers in assessing, determining, and identifying the behavioral health services they need; and promoting a shared consent form to facilitate cross-disciplinary care coordination between BH and PH. Other highly rated items included developing standards of care and processes for common behavioral health screening outcomes, and providing behavioral health care referral coordination training for primary care clinical staff. The open-ended responses largely mirrored the ratings. The most frequent topic revolved around billing insurance companies and medical assistance agencies for behavioral health services. Also, some asked how to provide behavioral health services in a sustained, financially viable manner. Similarly, there was concern about regulations regarding two types of treatments within a single day and issues of confidentiality of records.

Extensive detail on the conference can be found in Appendix Q.

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, Early Care and

[4] The local Children's TiPS program (Telephonic Psychiatric Consultation Service) at Children's Hospital of Pittsburgh serves children and adolescents who are insured by Pennsylvania's Medical Assistance programs and offers provider-to-provider contact with a child psychiatrist who can answer questions about medications, diagnoses, screening tools, and resources and refer patients to care coordinators and licensed therapists if needed. This was a major conference component and referred largely to children 8 years and older.

Education (ECE), family support, elementary schools, Early Intervention (EI), afterschool programs, pediatricians' offices, etc.).

Year Two Activities and Process Evaluation Progress

Local

- The local Work Group created an **ECMH Learning Collaborative Planning Group** to engage in activities that enhance, strengthen, and expand Early Childhood Mental Health Consultation (ECMH) in Year Three. The Collaborative will develop partnerships between ECMH providers throughout Allegheny County to share knowledge and resources and to promote seamless and supportive transitions between services for children/families. It will develop and adopt best practices in diverse service settings, provide opportunities for interactive training and skill-focused learning, and capitalize on shared learning and collaboration. PA Project LAUNCH held a kick off meeting with ECMH consultants to discuss future Learning Collaborative group activities, developed a training needs survey, shared information and resources with consultants, and expanded membership in an ECMH Facebook page.

- The local Work Group prioritized activities for Year Three, including hiring a project coordinator to run two tracts of a Learning Collaborative that will use the IMH-E framework.

- PA Project LAUNCH has gone through the process for approval to hire a project coordinator for the ECMH Learning Collaborative. This person will organize professional development trainings that relate to the Michigan competencies (see section on state activities below).

- Two LAUNCH partners felt a need to have **a preschool classroom option** in which a mental health provider works with the teacher and students more extensively than what happens in typical ECMH consultations. LAUNCH brought these two programs together to work on a joint concept. Both entities are interested in pursuing the partnership regardless of LAUNCH financial backing.

- A sub-committee has been convening to explore how proactive ECMH consultation could be **expanded to child care classrooms in high risk communities**.

State

- PA Project LAUNCH invested in learning about and eventually **purchasing a license to use** *MI-AIMH Endorsement for Culturally Sensitive, Relationship-Focused Practice Promoting Infant Mental Health*®**.** An endorsement in infant/early mental health (I/ECMH) is a verifiable process that supports the development and acknowledgement of infant and early childhood professionals, within a tiered framework that recognizes knowledge, training, and criteria for best practice standards. It is not a license or certification, but instead is an overlay onto a person's professional credentials which recognizes achievement of competence in the area of I/ECMH.

- A LAUNCH partnership with the Head Start State Collaboration Office resulted in **five regional Mental Health Roundtables** at which the groups discussed several issues related to behavior, needed services for young children, the need for cross-sector professional development, and the role of mental health consultants. The themes of these five events will help PA Project LAUNCH create professional development opportunities. There may be the opportunity to replicate the ECMH Collaborative Learning group structure in other regions of the state in collaboration with

the Head Start State Collaboration Office. Consideration is also being given to creating an advisory document to help Head Start, Early Head Start, and other grantees determine how best to set up mental health consultation in their programs.

- PA Project LAUNCH has reached out to target community Early Care and Education programs to urge program administrators to **attend the PA Positive Behavior Support (PA-PBS) Network regional training** titled "Prospective Program Wide PBIS Administrator's Institute". This training intends to stimulate progress in implementing PBIS. This outreach resulted in an increase in registered attendees for this event in a county where, at the time of the environmental scan, no ECE programs were enrolled in the Pennsylvania Positive Behavior Support (PA PBS) network or were receiving technical assistance for implementing PW-PBIS.

- Connections were made with the **KinderCare Corporation** regarding the implementation of PW-PBIS in all their centers nationwide. The YCW Expert discussed supporting this effort in their centers in our target communities through Project LAUNCH's collaboration with the PA-PBS Network. Regional KinderCare directors and many program directors plan to attend the PA-PBS Network offering of "Prospective Program Wide PBIS Administrator's Institute" in Year Three to further explore what programs are ready to begin this program.

Year Two Outcome Evaluation Progress

Collaborative Learning Event

- Project LAUNCH contributed to the development and coordination of a half-day Event on Early Childhood Mental Health Consulting (ECMHC) on January 14, 2016. Its goals were to inform participants about Project LAUNCH and its efforts to expand ECMHC in Allegheny County, hear from colleagues providing ECMHC for children birth to 8 years in various settings, discover and contribute to a knowledge base of ECMHC practices, and contribute to the development of best practices and professional development in ECMHC. The primary activity was the description of a variety of programs and strategies that ECMHC use or could use in their work.

  Participants
  The event was attended by 51 participants, about half of whom were direct service professionals working in early care or school settings.

  Immediate feedback
  Immediately following the event, 30 (59%) participants responded to four questions regarding the information that was presented. The majority of participants agreed or strongly agreed that their knowledge of the area increased (83%) and was valuable to their work (90%). Seventy-three percent said some or much of the information was new to them, and 83% indicated that some or much of the information could be used in their work. In response to an open-ended question asking what would be most useful, participants appreciated knowing about the different resources and interventions available. Thus, it appeared that much of the information was new and potentially useful in ECMHC practice.

  Follow-up questionnaire
  A three-month follow-up was conducted but was not successful. Only 10 responses (19%) were received, and the planned questions, which were designed for a workshop that provided specific techniques that could be applied in practice, were deemed less relevant to an informational session such as this.

Home Visiting Findings

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

Activities and Process Evaluation Progress

Local

- The development and implementation of a **coordinated home visiting referral line, The Link, was completed** in Allegheny County through a collaborative grant effort. Its purpose is to maximize use of existing services, provide a better match for those referred, and identify gaps and specific needs for expansion. This is a crucial service in Allegheny County where numerous services exist, including home visiting programs, but identification of appropriate services and navigation of the systems has historically been complex and difficult for families.

  The Link was developed and launched with a thorough marketing strategy. The administrators of The Link worked closely with a marketing firm which utilized market analytics related to geographic data of clients and families that use system services. The marketing strategies also used information from interviews and focus groups.

  The group also worked collaboratively to design cross-system business processes for exchanging information with medical professionals. This allows home visiting referrals to be made by the medical community in a way that will offer the opportunity for follow up, thereby closing the referral loop.

  Participating home visiting programs include family support centers, Early Head Start, Head Start, Healthy Families America (HFA), Nurse Family Partnership (NFP), Maternal Child Health Title V, Healthy Start, First Steps, Reach Out to Families, and Women, Infants, and Children, the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) with a focus on children birth to five. The Link is housed within Allegheny County's Department of Human Services.

- To engage more families in home visiting programs, PA Project LAUNCH and the Allegheny County Health Department collaborated to work with a marketing firm to roll out a **public relations campaign**, first with the medical community and later with the general public.

Year Two Outcome Evaluation Progress

The Allegheny Link

- The Allegheny Link (The Link) is a coordinated referral line designed to simplify and streamline access to services for Allegheny County residents. Services supported through Project LAUNCH for families with young children currently include information sharing, referrals to home visiting services, and counseling on options to help consumers and their advocates decide what programs and services best fulfill their needs based on their values and preferences. Counselors referred 453 families with young children between birth and 5 years of age to one or more home visiting services. Families typically received one to two referrals for services (89%), although counselors provided a small number of families (1%) with as many as six to eight referrals. Table 4 lists the number and percentage of referrals per family. Counselors most frequently provided referrals to one of four types of programs, including family support (35%), the Special Supplemental Nutrition Program for Women, Infant, and Children (WIC) (19%), Healthy Start (18%), and Early Head Start (12%).

Table 5 provides a complete list of provider types and the number and percentage of referrals made to each. Ninety-two percent of the families with children 0-5 years who contacted The Link were headed by females, many (61%) were parents of children 2 years of age or younger, 75% spoke English as their primary language, 51% had experienced homelessness, and 2% were military veterans.

Table 4. Service Referrals Made to Families by Link Options Counselors in Year Two

Number of Referrals	Number of Families	Percentage of Families
1	**222**	**49**
2	**167**	**40**
3	46	10
4	13	3
5	0	0
6	3	.7
7	1	.2
8	1	.2
Total	453	

Table 5. Referrals by Provider Type

Provider	Program Focus	Referrals	
		Number n=779	Percent
Family Support	Family Support promotes the healthy development and growth of very young children by supporting the families and communities in which they live.	270[1]	(35%)
WIC	The WIC Program is a health and supplemental nutrition program for pregnant women, mothers, and young children.	146	(19%)
Healthy Start	Healthy Start is a provider for pregnant women, new parents and families focusing on improving the quality of life of infants, toddlers and their families.	140	(18%)
Early Head Start	The Early Head Start program is a childhood development program for infants, toddlers, pregnant women and their families promoting care and self-sufficiency.	90	(12%)
Title V	The Maternal Child Health parent support program is a nurse-led program that targets women who are pregnant, new parents, and families.	39	(5%)
First Steps	First Steps provide families, parents, and children with resources to be happy, healthy, and efficient.	39	(5%)
Reach Out to Families	Reach out to Families is a life skills education service and training in skills needed to perform the activities of daily living in a safe way.	30	(4%)
Head Start	Head Start, an early learning program, provides family support services to eligible families to create a positive family environment.	24	(3%)
Healthy Families America	HFA promotes child well-being and prevent the abuse and neglect of our nation's children through home visiting services.	1	(0.1%)
Total		779	

Celebrating the Home Visitor: Supporting Your Health, Wellness, and Relationships

- Project LAUNCH inspired and coordinated this two-day motivational and informational event conducted on February 1 and 3, 2016. The major goals were to motivate, support, and inform home visiting professionals. Speakers presented a motivational talk and information on children who experience adverse events and trauma. In addition, information was presented about The LINK and Project LAUNCH. Other sessions focused on brain development, connecting families to resources, networking, and collaboration.

  Participants
  The event was attended by 188 participants, the vast majority of whom were direct service providers working for home visiting programs.

  Immediate feedback

[1] Four families called the Link twice and received additional referrals.

Immediately following the event, 135 participants (72%) responded to four questions regarding the information that was presented. Seventy-eight percent said some or a lot of the information was new to them, and 92% indicated that some or a lot of the information could be used in their work. In response to an open ended question, respondents appreciated learning specifically about The LINK and Project LAUNCH, brain development, and connecting families to resources. Thus, it appeared that the workshop met its goals, and presented new and useful information.

Follow-up feedback
A three-month follow-up was conducted but was not successful. Only 29% of participants responded, and the planned questions, which were designed for a workshop that provided specific techniques that could be applied in practice, were deemed less relevant to an informational session such as this.

Family Strengthening and Parent Skill Building Findings

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

Year Two Activities and Process Evaluation Progress

Local

- **Smart Beginnings** recruitment of participating families began in Year Two, and by October 1, 2016, 133 parent-child dyads were screened for study eligibility (see Appendix R for eligibility screens) and **40 dyads were enrolled in the study and randomized to the intervention or comparison condition.** All adult study participants were female (i.e., mothers), born in the U.S. and reported English as their primary language. Twenty-three percent had experienced homelessness. Most child study participants, were female (63.5% females, 37.5% males); none were of Hispanic origin; 75% were Black or African American, 22.5% were multi-racial, and 2.5% were White. Twenty-seven parent-child dyads were randomized to the VIP condition. Children specifically in this condition were 48% female, 52% male; none were of Hispanic origin; 78% were Black or African American, 18.5% were multi-racial, and 3.7% were White. During well-child visits, one interventionist and one interventionist trainee completed one to two VIP sessions per parent-child dyad with 79% of the parent-child dyads. **Fifty-eight percent of dyads (n=14) completed one VIP session and 21% (n=5) completed two VIP sessions by the end of this report year.**

- PA Project LAUNCH provided **scholarships for 20 family members and professionals to attend the Pennsylvania Association of Infant Mental Health Conference** in 2015 in the Pittsburgh area.

- Project LAUNCH is providing materials to support a new unit at Allegheny County Department of Human Services tentatively called the **Community Engagement Team**. These staff will go out when calls about neglect or abuse are received regarding children six years and under.

- The PA Project LAUNCH Family Strengthening Work Group has **participated in resource fairs** at which a variety of materials were distributed, including:
  - Use Your Words pamphlet
  - Safety for Young Children in the Home
  - When Is It Safe to Leave Your Children Home Alone
  - 5 Important Numbers to Remember about Early Childhood Development
  - Screening and Monitoring Fact Sheet

- Tips for Talking with Parents
- Tips for Your Child's Developmental Assessment.

- The Link hot line **refers families to family support centers** whenever possible, in addition to other home visiting programs.

- Project LAUNCH Implementation Team members **participated in a variety of activities** with other family organizations. Examples in Year Two included:

  - Webinars and information offered through Strengthening Families e-Update, National Responsible Fatherhood Clearinghouse
  - Resource and information fairs, conferences, and meetings that offer learning opportunities
  - Membership in Father's Support Group through Allegheny Family Network
  - Opportunities for participation in focus groups to weigh in on policy development, such as ways to better engage birth fathers who are currently involved in Child Welfare and strategies to address disproportionality
  - Promotion and distribution of information on Competence and Confidence: Partners in Policymaking Early Intervention (C2P2), which is a free leadership development training for families of children in infant, toddler, or preschool Early Intervention (EI) programs
  - Information sharing about support groups available across the county through various family support networks.

- PA Project LAUNCH is exploring the **Strengthening Families' Five Protective Factors** content that could be disseminated broadly so that professionals who work with families share a common framework.

  The Family Strengthening Work Group has begun exploring **The Parenting Journey** for implementation in Allegheny County.

- The local Work Group had leadership turnover in Year Two and is in the process of revisiting and reprioritizing their goals heading into Year Three.

State

- PA Project LAUNCH state and local leadership moderated a parent panel at **the International Parent Child Interaction Therapy (PCIT) Conference** in Pittsburgh at which families who have participated in PCIT educated providers about the strengths of the therapy and ways to make it more accessible for other families.

Year Two Outcome Evaluation Progress

Smart Beginnings

- Smart Beginnings will ultimately provide individual child and family level outcome data on a variety of measures as well as program fidelity assessments. Such data should be available beginning in Year Three.

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.*

Year Two Activities and Process Evaluation Progress

- A **collaboration between Human Services Administration Organization (HSAO) and Kids Plus Pediatrics** was formed in Year Two. These partners are exploring an innovative model of service coordination for families engaged within a primary care setting.

- PA Project LAUNCH partnered with agencies that had prior experience and current connections to training activities for pediatric providers to facilitate the implementation of the **Pediatric Provider Integrated Care Conference** described above.

- The Implementation Team has discussed the use of **informed policy change** to sustain improvement in children's health, especially behavioral and physical health integration. In Year Three, the Behavioral Health and Physical Health Integration Work Group is planning to convene key stakeholders and experts to discuss the current political landscape on this issue and begin to propose specific targets for policy change.

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 Mental Health (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 this report (October 1st, 2015 – September 30th, 2016), a total of **102 outreach activities occurred at the local level** which are described in Table 6. Half of these were coalition building and the remainder were informational in purpose, although five of these were also advocacy (compared to one in Year One). Groups that were targeted spanned a wide

range, including government officials, higher education representatives, community-based organizations, immigrants and refugees, early care and education (ECE) providers, elementary education providers, health-care providers, early intervention providers, child welfare staff, mental health service providers, and funders. Target communities and special populations were strategically targeted to address behavioral health disparities. This happened through a variety of events including training and discussion groups focusing on immigrants and refugee issues (especially with Bhutanese and Latino families), screening and assessment, a doula project, and resources for homeless issues.

Table 6. Local Outreach Activities for Year Two (from Oct. 1, 2015 to Sept. 30, 2016)

Month	Total # of Outreach Activities	Types of Organizations Reached	Number of Participants	*Number Held:Activity Types	Disparities Addressed
Oct 2015	10	International Groups; Government; Law; Physical & Mental Health Providers	629	2: A 5: PIC 3: CB	Latino immigrant issues & expulsion/suspension disparities
Nov 2015	7	Early Care & Education; Government; Elementary Education; Healthcare; Mental Health Providers	101	4: CB 3: PIC	n/a
Dec 2015	6	Early Care & Education; Mental Health Providers; Public Health; School District Staff	254	1: CB 1: CB+FS 2: PIC 1: A 1: FS	Resources for homeless families
Jan 2016	5	Government; School District Staff; Mental Health Providers; Immigrant	110	3: CB 1: CB+FS 1: PIC	n/a
Feb 2016	6	Advocacy; Public Health; Higher Education; Home Visitors; Funders	240	2: CB 3: PIC 1: A	n/a
March 2016	0		0		n/a
Apr 2016	2	School of Public Health; Health Foundation	27	2: PIC	n/a
May 2016	7	Mental Health Providers; Child Welfare; Early Care & Education; Elementary Education; Cultural Group; Healthcare	Information fairs	2: PIC 5: CB	Doula for Latino families; trauma informed care; parent groups for immigrants
Jun 2016	6	Higher Education; Healthcare; Government; Parent Groups; Museum; Funders	28	4: CB 2: PIC	n/a
Jul 2016	13	Family Support; Mental Health Providers; Public Health	145	9: CB 2: CB+FS 2: FS	Screenings and assessments for Nepali families
Aug 2016	15	Early Care & Education; Government; Community Organizations; Mental Health Providers; Elementary Education; Child Welfare; Museum	180	2: PIC 10: CB 1: CB+FS 1: FS 1: A	n/a
Sept 2016	25	Early Care & Education; Elementary Education; Child Welfare; Higher Education; Public Health; Funders; Mental Health Providers; Advocates; Pediatricians	279	6: PIC 15: CB 1: CB+PIC 3: FS	Cultural competency work for Nepali children screening; ECE homeless evaluations
Total	**102**		**1875+**	1: CB+PIC 28: PIC 56: CB 5: CB+FS 5: A 7: FS	

*Activity types: A: Advocacy, CB: Coalition Building, FS: Funding Sustainability, PIC: Public Information Campaigns

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. These discussions focus on 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. Externally, Project LAUNCH 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 Allegheny County Department of Human Services (AC DHS) in formally reviewing and discussing strategies to address racial disparities in the County's Child Welfare system. Descriptions of activities aimed at specific groups follow.

  African Americans
  Project LAUNCH has been involved in an ongoing Disproportionality Planning Work Group for Child Welfare in Allegheny County. This Work Group has developed a 3-year plan to address racial over- and under- representation in Child Welfare. Project LAUNCH assisted in identifying birth fathers whose children are involved in child welfare for participation in a focus group to ensure their voice is included in the process. Project LAUNCH participated in the development of a list of strategies to address Child Welfare staff practices and decision making that may contribute to disproportionality.

  The organization that serves as PA Project LAUNCH evaluators, the University of Pittsburgh Office of Child Development (OCD), has been engaged in numerous projects funded through various organizations to provide a more comprehensive picture of the needs and opportunities for addressing health disparities in the groups identified through our Environmental Scan. One of these projects was the development of a scan and action plan for promoting Positive Racial Identity (PRIDE) in young African American children. PRIDE collected information from focus groups with various early care and education professionals and families and various research materials and documents about the importance of a positive perspective of an individual's own racial identity and the way the world contributes to that perspective beginning at a very early age. Suggested action steps included awareness activities at all levels of involvement in early care and education systems, which Project LAUNCH has already begun to support at national, state, and local levels. Project LAUNCH leadership intends to be involved in additional activities to promote awareness and understanding.

  Immigrants and Refugees
  The Allegheny County DHS Immigration and Internationals Committee has developed a blueprint for addressing the needs of this community. Several members of the YCWC were either co-chairs or participated in Work Groups that developed the blueprint. PA Project LAUNCH leadership met with the facilitators of this group to keep informed of activities that overlap with LAUNCH activities. Project LAUNCH also invited the facilitators to a Council meeting to present the plan and discussed how the stakeholders in Project LAUNCH could be involved in the promotion of the activities identified in the blueprint at an individual agency level, at a system level, and at a Project LAUNCH level.

  Project LAUNCH developed two resources and planned two community screening events for Bhutanese immigrant and refugee groups within the county to promote a "village" atmosphere and screening as a typical event in the life of a young child. In preparation for this event, the PA Project LAUNCH Screening and Assessment Work Group developed guides, met with Bhutanese leaders in the community to seek their suggestions and recommendations regarding comprehension and translation of materials, cultural factors, and ideas to promote

participation. For more detail please see page 21 in the Screening and Assessment section under Findings.

In developing a strategy for training communities in Mental Health First Aid (MHFA), the Family Strengthening and Parent Skill Building Work Group created a partnership with a trainer from the Bhutanese community to help Project LAUNCH consider translation of MHFA training in both language and comprehension.

PA Project LAUNCH participated in a Health Equity Journal Club at a local university where we presented a research study concerning the integration of maternal child health and behavioral health. Attendees included students representing countries from all over the world. The opportunity to learn from their perspectives about the various cultural barriers to integrated health care and to introduce them to Project LAUNCH and its goals and objectives was invaluable. The Health Assistant for the County Health Department continues to attend to maintain the relationships.

Families Experiencing Homelessness
Because the home visiting coordinated referral line, The Link, is the same as the Homelessness support line, families who are homeless have been connected to early childhood resources and supports, including WIC, home visiting, early intervention, and family support centers, to name a few.

Military Families
We added a former mental health clinician who served in Iraq to our YCWC. He has a comprehensive perspective on the needs of military families and numerous connections that will help inform our work.

The Office of Child Development is currently also working on reports that will provide additional information for PA Project LAUNCH on homelessness and on military families. PA Project LAUNCH's environmental scan helped spur the development of these reports, and Allegheny County will benefit from the information gathered.

See Appendix S for information on PA Project LAUNCH Disparities Impact Targets to be revised in Year Three.

The Local Young Child Wellness Council

- The Young Child Wellness Councils (YCWC) at the local and state levels are the governing bodies for PA Project LAUNCH. We report on their activities and the nature of their collaborative functioning in this section by describing the attendance at meetings and the responses to the Wilder Collaborative Factors Inventory. We focus on the changes that have occurred from Year One to Year Two of the project.

Membership
Over the first two years, the Council membership increased from 37 to 48 members. Family members increased from 13 to 14, and non-family members increased from 24 to 34. In Year Two, seven members departed, most of whom were infrequent attenders, and 13 new members were added for a net gain of six members. Two departing members were replaced with representatives of the same agencies.

Attendance

The Local YCWC met five times in Year One and eight times in Year Two, and the number and percentage of members attending each meeting in Years One and Two are presented in Table 7.

Over all, average attendance decreased from 48% in Year One to 29% in Year Two. The decrease in attendance was similar for family (45% to 30%) and non-family (50% to 28%) members. Some decline in attendance in such groups is common, and eight meetings per year plus Work Group meetings represents a fairly substantial obligation for members. An average attendance of 29% can make governing the project difficult if different members attend different meetings; however, in the current case there appears to be a "core subgroup" of members who attend most meetings (see below).

Table 7. Attendance at Local Young Child Wellness Council Meetings

	Year One Meeting Date				
	1/2015	**2/2015**	**3/2015**	**5/2015**	**6/2015**
Family	8/13	7/13	3/13	5/15	8/15
	62%	54%	23%	33%	53%
Non-Family	15/24	13/24	12/24	12/24	8/24
	63%	54%	50%	50%	33%
Total	**23/37**	**20/37**	**15/37**	**17/39**	**16/39**
	62%	**54%**	**41%**	**44%**	**41%**

	Year Two Meeting Date							
	11/2015	**1/2016**	**2/2016**	**3/2016**	**4/2016**	**5/2016**	**6/2016**	**8/2016**
Family	3/14	6/15	2/15	7/15	7/14	3/14	4/14	3/14
	21%	40%	13%	47%	50%	21%	29%	21%
Non-Family	9/28	11/31	9/31	6/31	11/31	5/28	6/28	12/34
	32%	36%	29%	19%	36%	18%	21%	35%
Total	**12/42**	**17/46**	**11/46**	**13/46**	**18/45**	**8/42**	**10/42**	**15/48**
	29%	**37%**	**24%**	**28%**	**40%**	**19%**	**24%**	**31%**

The Local YCWC Wilder Collaborative Factors Inventory

- The Wilder Collaborative Factors Inventory is a self-report assessment designed to rate attitudes toward and actual collaboration that occurs among members of a group. Group members individually rate on a five-point scale from Strongly Disagree (score = 1) to Strongly Agree (score = 5) each of 40 possible positive characteristics. These characteristics are clustered into 20 factors composed of one to three items each. Scores are averaged across items within a factor,

and a total score across all factors is also produced. Factor scores below 3.0 are considered cause for *concern,* whereas scores of 4.0 or better are considered *strengths.*

Response Rates

In Year One, a total of 24 (71%) Council members responded, and in Year Two a total of 30 (65%) members responded. The response rate for family members increased from 54% to 67% across years, whereas the response rate for non-family members decreased from 81% to 65%. The improvement of family member participants likely reflects their increased involvement, comfort in the group, and knowledge of its members, purpose, and activities. The decline in response rate for non-family participants may reflect the increasing work load and time commitment required by Project LAUNCH, especially for organizational representatives.

Average Ratings in Year Two

Across family members and nonfamily members combined, responses indicated that relative strengths include skilled leadership, flexibility to consider new ideas, shared vision, unique purpose, and the project seen in their self-interest. These characteristics appear to reflect the positive perceptions members feel regarding the YCW Coordinator and fellow members, their shared vision, and the unique purpose of PA Project LAUNCH.

No characteristics received average ratings below 3.0 (which would represent serious concerns). The lowest rated characteristic in both years reflects a perception of insufficient funds, staff, materials, and time to conduct Project LAUNCH activities. The second lowest rating in Year Two was given to the apparent lack of clear roles and policy guidelines followed closely by multiple layers of participation. This set of characteristics may reflect the fact that PA Project LAUNCH is very broad, encompassing, and complicated, and it has many Council members and other participant stakeholders. It may also reflect member concerns about the time and effort needed between meetings to plan and implement Project LAUNCH efforts, as well as informal feedback from some members that many activities were discussed at meetings but they were not always assigned priorities or a point person to pursue them.

Change from Year One

As noted above, the average ratings over all factors for Years One and Two were very similar, indicating no pervasive change across years. The biggest improvement in a factor pertained to the ability to compromise, likely a sign of a maturing Council. Relative regressions across factors focused on an increasingly unfavorable political and social climate; insufficient funds, staff, materials, and time; the relative lack of new informal relationships and communication links; less open and frequent communication; and a declining perception that collaboration is in their self-interest. This pattern may reflect the inability of state government to pass a budget for most of Year Two, which forced many human service agencies to borrow money to continue to provide services. Second, this budgetary threat may have compelled members to concentrate on self-preservation rather than to emphasize communication and collaboration with other agencies. Third, members know everyone by Year Two so they do not need to make new relationships. Fourth, members realized the complexity of effecting systemic changes coupled with an insufficient emphasis on specific action in the group dynamics.

Conclusions

Ratings reflect the positive perceptions members feel regarding the Young Child Wellness Coordinator and fellow members, their shared vision, and the unique purpose of Project LAUNCH. However, the lower ratings may reflect the fact that PA Project LAUNCH is very broad, encompassing, and complicated, and it has many Council members and other participant

stakeholders. Members may also be concerned about the time and effort needed between meetings to plan and implement Project LAUNCH efforts and that many activities are discussed at meetings but not always assigned priorities or a point person to pursue them. Thus, Project LAUNCH may benefit from setting priorities, focusing on fewer activities, and insuring that some member(s) will be responsible for seeing that progress on each priority is pursued. This suggestion is also noted in the section on recommendations.

Extensive detail on the analysis and findings of the Local Wilder Collaborative Factors Inventory, including dates of implementation, can be found in Appendix T.

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.*

Year Two Activities and Process Evaluation Progress

- PA Project LAUNCH was represented at the state's Office of Child Development and Early Learning Governor's Institutes. The YCW Expert discussed the core strategies of the grant and offered suggestions to the community teams of what pieces can be integrated into their Prenatal-Third Grade Alignment plans.

- PA Project LAUNCH took over development and management of the Focus on ECMH articles that were originally developed through a collaboration between the Children's Bureau and the Keystone STARS ECMHC project.

- PA's Office of Mental Health and Substance Abuse Services (OMHSAS) has begun to bring all grant related initiative project directors together monthly to identify mutual goals/objectives to increase collaboration, reduce duplication, and pool efforts related to communication.

- PA Project LAUNCH is developing a quarterly newsletter to begin distributing through existing listservs and other avenues.

- Project LAUNCH partnered with state- and county-level entities to develop a proposal for ZERO TO THREE IECMH Policy Convening & TA (was not awarded).

- PA Project LAUNCH continues to work with many state-level, relevant programs to become more integrated.

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 surveys of the YCW Expert and YCW Partner. From October 1, 2015 to September 30, 2016, a total of **44 state level outreach activities occurred**. The outreach activities at the state level were categorized according to the scheme described above for local activities. Essentially 68% of the activities were primarily or partially Coalition Building. The

types of organizations reached included physical and mental health providers, elementary and higher education, advocacy, families, early care and education, child welfare, public health, early intervention, government, Head Start programs, community organizations, and state-wide organizations. The number of participants attending these outreach activities is estimated at 1484+ individuals. These activities are summarized in Table 8.

Table 8. State Outreach Activities from Oct. 1, 2015 to Sept. 30, 2016

Month	Total # of Outreach Activities	Types of Organizations Reached	Number of Participants	Activity Types	Disparities Addressed?
October 2015	5	Head Start Programs; Mental Health Providers; Early Intervention Providers	170+	5:CB	n/a
November 2015	1	Mental Health Providers; Head Start Programs	25	1:CB	n/a
December 2015	1	Mental Health Providers	20	1:CB	n/a
January 2016	3	Mental Health Providers; Head Start Programs	42	2: CB 1: A	n/a
February 2016	5	Child Welfare; Health Care Providers; Early Intervention; Mental Health Providers	165+	3: CB 1: FS 1: A	n/a
March 2016	2	Head Start Programs; Mental Health Providers; PBS	15	1: CB 1: CB/FS	n/a
April 2016	4	Government officials; CSEFEL	69	2: CB 1: PIC 1: CB/FS	n/a
May 2016	3	Government officials; PBS; Community Programs	120	1: CB 1: PIC 1: CB/FS	n/a
June 2016	8	Government; Higher Education	386	1: CB 3: PIC 2: CB/FS 2: FS	n/a
July 2016	5	Government; Community Organizations	198	2: CB 2: PIC 1: CB/FS	n/a
August 2016	4	Government officials; PBS; ECE; Schools; State-wide Organizations	244	3: CB 1: A	n/a
September 2016	3	ECE Providers; PBS	25	2: CB 1: PIC	n/a
Total	**44**		**1484+**	**24: CB** **3: A** **8: PIC** **6: CB/FS** **3: FS**	**n/a**

*Activity types: A: Advocacy, CB: Coalition Building, FS: Funding Sustainability, PIC: Public Information Campaigns

Year Two Outcome Evaluation Progress

Policy Change

- On May 31st 2016, the PA Department of Human Services issued a bulletin that established a process for the enrollment and revalidation of providers in a co-located arrangement. This will allow pediatric providers implementing an integrated care model to bill the Medical Assistance Program for multiple providers on the same day for the same child, which had previously been prohibited and was a major limitation to providing behavioral health services on the same day physical health services were billed. PA Project LAUNCH contributed to work that led to this policy change.

The State Young Child Wellness Council

- *Membership*
  The membership of the State YCWC changed frequently throughout the two-year project period, especially during the second year. Specifically, in Year One two members departed and five were added for a net gain of three; in Year Two, seven departed and nine were added for a net gain of two. All the departures were Non-Family Members. For the most part, departing members were replaced by people who represented the same agency, although in two cases the status and authority of the replacement was less than the departed member. Further, five members have not yet been replaced with someone from the same agency. These trends suggest a slight dilution of authority and representation of state-level agencies in the YCWC during Year Two.

Table 9: Attendance at State Young Child Wellness Council Meetings

	YEAR ONE Meeting Date				YEAR TWO Meeting Date		
	1/29/15	3/31/15	5/26/15	8/11/15	11/10/15	3/16/16	8/18/16
Family	3/3	5/5	5/5	5/5	5/5	3/5	5/6
	100%	100%	100%	100%	100%	60%	83%
Non-Family	18/22	18/22	17/21	17/23	19/23	7/21	11/29
	82%	82%	81%	74%	63%	33%	46%
TOTAL	**21/25**	**23/27**	**22/26**	**22/28**	**19/28**	**10/26**	**16/30**
	84%	**85%**	**85%**	**79%**	**68%**	**38%**	**53%**

Attendance

Table 9 presents the number of attendees out of the total membership and the percentage of the State Young Child Wellness Council (YCWC) attending each meeting in Project Year One and Year Two for Family Members, Non-Family Members, and the Total membership. Project years were October 1, 2014 to September 31, 2015 and October 1, 2015 to September 31, 2016.

During Year One, attendance was quite high (approximately 83%), especially for Family Members, although it started to drop off for Non-Family Members at the fourth meeting. During Year Two, there were only three rather than four meetings and attendance fell off sharply to approximately 53%, especially for Non-Family Members. Progressive declines in attendance are common among volunteer groups, but this trend was likely exacerbated by the failure of state government to pass a budget for most of a fiscal year coinciding with much of the decline in attendance. The lack of a budget meant that social service agencies and schools

were without their state funding and had to borrow money to keep doors open and services functioning. Some YCWC members representing agencies outside of Harrisburg had to curtail travel expenses to attend meetings. However, the budget impasse may have functionally represented more of a distraction than a fiscal limitation on meeting attendance. Now that both last year's and this year's budgets have been approved and renewed effort can be devoted to re-energizing the YCWC, the meeting schedule and attendance in Year 3 should pick up.

Conclusion and recommendation
Attendance and the representation and authority of state agencies on the State YCWC dropped during Year Two. While some decrease in attendance over time is commonplace, both internal and external circumstances may have contributed to this trend. The Council needs to have its membership completed with people with authority who represent missing major relevant agencies, and its agenda and functions need to be revitalized in Year Three.

The State YCWC Wilder Collaborative Factors Inventory

- The State YCWC experienced a good deal of membership turnover during Year Two, so only those individuals who were members at the time the Wilder Inventory was administered were sent the survey. Year One consisted of three meetings over approximately four months, and Year Two had four meetings over a 12-month interval.

Response Rates
In Year One, 23 members (89%) responded to the Wilder survey, but only 14 (52%) responded in Year Two. Family Members (100%, 60%) responded at slightly higher rates than Non-Family Members (86%, 50%).

Average Ratings in Year Two
Highly rated items represented a respect for both the Project LAUNCH grant and its goals as well as for the interpersonal tone of how the Council was operating. Items that received relatively lower ratings and therefore suggest topics that might merit improvement included a perception that there are insufficient funds, staff, materials, and time; a relative lack of clear roles and policy guidelines; and a somewhat slower pace of development coupled with multiple layers of participation. These perceptions likely reflect the state budget impasse that blanketed Year Two and the corresponding decrease in face-to-face meetings leading to a perception that progress was diminishing relative to the size of the Project LAUNCH agenda.

Change from Year One
Over all factors, there was only a small decrease in ratings across years. Two items were perceived as having improved over the years----increased mutual respect, understanding, and trust and an improved political and social climate. The former is a common improvement as group members become better acquainted with each other, and the latter may reflect the state legislature's agreement on a budget after months of stalemate that occurred shortly before the Year Two Wilder was distributed. There was a tendency to perceive a relative lack of clear roles and policy guidelines and a greater insufficiency of funds, staff, materials, and time. Also, the group lost a bit as a leader in the community, and members saw collaboration as being less in their self-interest than they once did. Also, the relatively large turnover in members may have led to the perception that the Council lost some representation of a cross-section of relevant members.

Conclusions
Several observations in these results point to the proposition that the State YCWC lost a little energy and enthusiasm in Year Two. There were fewer meetings, some face-to-face meetings

were replaced by virtual meetings, attendance diminished substantially, and there were frequent resignations and only some of these members have been replaced. Further, the size and breadth of the PA Project LAUNCH project, especially relative to the resources and challenges required to move forward, led to perceptions that roles needed to be defined more clearly and priorities set so that more progress on fewer goals might be achieved.

Some of this might be expected---after the excitement of initiating a new endeavor wears off and the hard work begins, enthusiasm is sobered a bit by the reality of the challenge. Further, the budget impasse cast a statewide depression on human services, both financially and psychologically. In this environment, the Council lost members and attendance and a good deal of energy, commitment, and focus. At the same time, members clearly rated its purpose, interpersonal tone, and collaborative spirit very highly, suggesting that the root elements necessary for success remain. Thus, re-establishing the membership, convening regular face-to-face meetings, focusing Council's agenda on fewer attainable goals, and identifying concrete action steps toward achieving those goals to be led by specified members are likely to be successful.

Please see Appendix U for extensive detail on the analysis and findings of the State Wilder Collaborative Factors Inventory.

Cross-Cutting Themes

Several Project LAUNCH priorities cut across the major goal areas. Activities that pertain to these cross-cutting priorities are detailed above and are only mentioned briefly below.

Workforce Development

Locally, three major educational events were held for large groups of professionals and parents, including the Pediatric Provider Integrated Care Conference, The Early Childhood Learning Collaborative kickoff meeting, and the Celebrating the Home Visitor motivational and informational conference. In addition, Project LAUNCH provided scholarships to 20 professionals and parents to attend the PA-AIMH Conference. Statewide, five regional Mental Health Consultation Round Tables were held.

Cultural Competency

Locally, PA Project LAUNCH does not support many services and does not have many "Project LAUNCH affiliated" service projects. Instead, the Project is focused on creating connections and collaborations across existing services in the county as opposed to creating new services in an area where resources are already plentiful. The four major pediatric provider groups, which serve approximately 80% of children in Allegheny County, were given the CLAS assessment of cultural competency and scored very highly, indicating that little needed to be improved.

Health Disparities

The Link and the Smart Beginnings project have begun sharing demographic data that their programs routinely collect on participating families. Project LAUNCH is planning work with specific groups of racial/ethnic minorities in Year Three. This includes a Bhutanese screening event intended to encourage families in this group to have their young children screened. The general process of engaging this community in this activity is being written as a procedural template to guide similar future events for other racial/ethnic minority groups. Project LAUNCH is also involved with the Disproportionality Planning Work Group of Child Welfare in Allegheny County, and recent scans have been completed identifying the specific needs of immigrant/refugee, homeless, and military families that can provide the basis for future efforts to serve these groups.

Public Awareness

A great deal of effort at both the local and state levels has been devoted to information sharing about Project LAUNCH, and details of these events are listed above. Project LAUNCH also contributed to the public rollout of The LINK, the County's new home visiting hotline. Project LAUNCH has collaborated with several other organizations on their separately funded projects. Locally, this includes Smart Beginnings; at the state level this includes Pennsylvania Partnerships for Children's project to encourage screening of young children, the Head Start Collaboration Office that held five regional Round Tables on mental health, and KinderCare that is considering implementing PBIS in their centers nationwide.

RECOMMENDATIONS

The breadth, depth, and overall complexities of PA Project LAUNCH have become difficult to manage comprehensively and some focusing has begun. Year Three activities should include a **revision of the state and local Strategic Plan** objectives, activities and timelines with an **emphasis on prioritizing**. This revision should be followed by **revisions to the Evaluation Plan** to better align evaluation activities with the new directions and priorities of the Project.

We suggest that these priorities move beyond coalition building and information sharing and **focus on "deliverables"**---new policies, events, products, and procedures. Further, Work Group and perhaps Council meetings themselves might be more "action oriented," not primarily information sharing and updates (although some of that is necessary). Specifically, "what are we going to do, how are we going to do it, and who will spearhead the process of pursuing this course of action?" Members are likely to perceive this kind of meeting to be more worthwhile, attendance might increase, and the Councils may become re-energized. Some of this work has begun near the close of Year Two.

Some recommendations outlined in the Year One Evaluation Report remain pertinent. Entering Year Three, the following recommendations persist:

Local and State activities should continue to **consider long-term sustainability** when prioritizing resources and implementation activities. This includes consideration of procedures to facilitate **data sharing** across systems and an emphasis on **strategic policy initiatives**.

The next three years should also focus on building upon the work already done to create and implement **strategies for how to assess, describe, and address disparities**, including collaborating with agencies specifically focused on special populations, collecting information where possible, 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.

PA Project LAUNCH will also benefit from continued **strategies for efficient communication** between state and local councils and across systems to achieve a smoother, more coordinated early childhood mental health environment.

REFERENCES

Goode, T.D. (June 1989, Revised 2009a). *Self-Assessment Checklist for Personnel Providing Behavioral Health Services and Supports to Children, Youth and their Families*. Retrieved from http://nccc.georgetown.edu/documents/ChecklistBehavioralHealth.pdf.

Goode, T.D. (June 1989, Revised 2009b). *Self-Assessment Checklist for Personnel Providing Primary Health Care Services*. Retrieved from http://nccc.georgetown.edu/documents/Checklist%20PHC.pdf.

Goode, T.D. (June 1989, Revised 2009c). *Self-Assessment Checklist for Personnel Providing Services and Supports in Early Intervention and Early Childhood Settings.* Retrieved from http://nccc.georgetown.edu/documents/ChecklistEIEC.pdf.

Mattessich, P., Murray-Close, M., & Monsey, B. (2001). *Wilder Collaboration Factors Inventory*. St. Paul, MN: Wilder Research.

U.S. Department of Health and Human Services, Office of Minority Health (2013). The National CLAS Standards. Retrieved from http://www.hdassoc.org/wp-content/uploads/2013/03/CLAS_handout-pdf_april-24.pdf.

Waxmonsky, J., Auxier, A., Romero, P.W., & Heath, B. (2014). Integrated Practice Assessment Tool (IPAT) Version 2.0. Colorado Access, Value Options Axis Health Systems. Retrieved from https://ncc.expoplanner.com/files/13/SessionFilesHandouts/ D13_Waxmonsky_1.pdf

APPENDICES

Appendix A: Current Implementation Team Members

Name	Affiliation
Cynthia Dundas	Pennsylvania Department of Health
Kimberly Eckel	Allegheny County Department of Human Services
Shannon Fagan	Pennsylvania Office of Mental Health and 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 Office of Mental Health and Substance Abuse Services
Amy Kabiru	Pennsylvania Office of Mental Health and Substance Abuse Services
Robert McCall	University of Pittsburgh Office of Child Development
Stephanie McCarthy	University of Pittsburgh Office of Child Development
Samantha Murphy	Allegheny County Department of Human Services
Winnie Richards	Pennsylvania Office of Child Development and Early Learning
Janell Smith-Jones	University of Pittsburgh Office of Child Development
Scott Talley	Pennsylvania Office of Mental Health and Substance Abuse Services
Patricia Valentine	Allegheny County Department of Human Services
Makeda Vanderpuije	Allegheny County Health Department

Appendix B: List of Acronyms

List of Acronyms

A	Advocacy
AAP	American Academy of Pediatrics
AC	Allegheny County
ACHI	Allegheny County Health Choices, Inc.
AC-DHS DARE	Allegheny County Department of Human Services Data Analysis and Research Evaluation
AFIT	Alliance for Infants and Toddlers
ASQ-3	Ages & Stages Questionnaires, Third Edition
ASQ-SE	Ages and Stages Questionnaire - Social-Emotional
BH	Behavioral Health
BH/PH	Behavioral Health/Physical Health
C2P2	Competence and Confidence: Partners in Policy Making Early Intervention
CB	Coalition-Building
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
DARE	Office of Data Analysis, Research and Evaluation
DHS	Department of Human Services
EBP	Evidence-Based Practice
ECE	Early Care and Education
ECMH	Early Childhood Mental Health
ECMHC	Early Childhood Mental Health Consultation
EI	Early Intervention
EOY	End-of-Year
FCU	Family Check Up
FS	Funding Sustainability
GPO	Government Project Officer
HFA	Healthy Families America
HSAO	Human Services Administration Organization
IMH	Infant Mental Health
IPAT	Integrated Practice Assessment Tool
LAUNCH	Linking Actions for Unmet Needs in Children's Health
M-CHAT	Modified Checklist of Autism in Toddlers

MHFA	Mental Health First Aid
MH	Mental Health
MHPRI	Mental Health Practice Readiness Inventory
MSE	Multi-Site Evaluation
NFP	Nurse Family Partnership
OCD	(University of Pittsburgh) Office of Child Development
OCYF	Office of Children, Youth, and Families
OMHSAS	Office of Mental Health and Substance Abuse Services
PA	Pennsylvania
PA-AIMH	Pennsylvania Association of Infant Mental Health
PA PBS	Pennsylvania Positive Behavior Support Network
PBS	Public Broadcasting Service
PCIT	Parent Child Interaction Therapy
PEDS	Parents Evaluation of Development Status
PIC	Public Information Campaigns
PPC	Pennsylvania Partnerships for Children
PPIA	Pediatric Provider Integration Assessment
PPIC	Pediatric Provider Integrated Care Conference
PRIDE	Positive Racial Identity
PW-PBIS	Program-Wide Positive Behavior Instructional Support
SAMHSA	Substance Abuse and Mental Health Services Administration
SHIM	South Hills Interfaith Movement
TA	Technical Assistance
TiPS	Telephonic Psychiatric Consultation Service Program
VIP	Video Interaction Project
WIC	Women, Infants, and Children
YCW	Young Child Wellness (Expert, Coordinator, Partner)
YCWC	Young Child Wellness Council

Appendix C: Post-Training Survey

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				
	(c) they may neither be literate in their language of origin nor English.				

#	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
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.				
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.				

#	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
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

Appendix F: Demographics

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: LAUNCH Affiliated Providers Data Checklist

Screening, Assessment, & Referral Information

Child

- Child ID #
- Age
- Gender
- Race
- Ethnicity
- Name of screen(s) administered
- Previously screened between (specified period)
- Screening(s) outcome(s) (i.e., WNL, concerning/further evaluation warranted, borderline/monitoring warranted)
- Referral made
- Referral type
- Name of agency referral was made to
- Referral appointment kept
- Services recommended/diagnosis
- Enrollment in one of more services

Adult/Family

- Adult/Family ID # (need to link child to parent in relation to family background information)
- Family background (if possible/see questions at the end of this checklist)
    - Homelessness
    - Immigrant/refugee
    - Military
- Screen(s) administered
- Screening(s) outcome (i.e., WNL, concerning/further evaluation warranted, borderline/monitoring warranted)
- Referral type
- Diagnosis (Y/N)/recommended for services
- Agency referral was made to
- Referral appointment kept
- Enrollment in one of more services

Intervention Information (*categorical response options will be provided)

VIP & FCU

- Category*
- Brief description (100 words or less)
- Type*
- Number of times activity occurred within (specified data collection period)
- Number of participants in activity
- Types of individuals that participate directly in activity*
- Specific child age ranges to which activity is targeted*
- Location/setting*

- Adaptations made to accommodate unique cultural circumstances
- Number of volunteer workers that supported this activity, if applicable
- Number of volunteer hours, if applicable

Staff Support/PD (*categorical response options will be provided)

- Category*
- Brief description (100 words or less)
- Type*
- Number of participants in activity
- Number of times activity occurred in (specified data collection period)
- Number of volunteer workers that supported this activity, if applicable
- Number of volunteer hours, if applicable

Data Collection Timeline	
Approximate Due Date	**Data Collection Period**
January 7	**(1)** Oct. 1 to Dec. 31
April 7	(2) Jan. 1 to March 31
July 7	(3) April 1 to June 30
October 7	(4) July 1 to Sept. 30

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, Work Groups, 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 Work Groups, 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: Meeting Minutes Template

LOCAL S&A WORK GROUP 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 Work Group 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:

Appendix K: End-Of-Year Survey

PA Project LAUNCH Annual Report – Survey Questions

Screening & Assessments

1. What resources and strategies have been developed and/or promoted since October 2015 to support (or increase) the use of high quality screening and assessment?

Behavioral Health & Physical Health Integrations

2. What work has been done since October 2015 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)?

    a. What strategies and models have been identified and communicated to support the integration of behavioral health and physical health?

3. What resources and strategies have been promoted (since October 2015) to support usage of high quality screening & assessment tools in physical health settings?

ECMH Consultation

4. How is LAUNCH promoting the identification of best practices in ECMH consultation across systems (October '15 until now)?

    a. Where is LAUNCH at in this process? What has LAUNCH done since October 2015 to build on Year 1 work?

5. How are LAUNCH activities moving toward service expansion and quality improvement in ECMH consultation?

Home Visiting

6. 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)

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

8. What efforts/progress has PA Project LAUNCH made, since October 2015, to engage more families in home visiting programs?

Family Strengthening & Parent Skill Building

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

10. Have agencies reported any increase in dissemination of culturally relevant materials?

    a. If yes, what is the increase and what are the indicators of this increase?

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

Infrastructure

12. What efforts, collaborations, and/or relationships created as of October 2015 **because of LAUNCH** stand out to you?

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

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

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

16. What policy/system/infrastructure obstacles or environmental changes have you encountered since October 2015 that have impacted the work of PA Project LAUNCH? Please explain how.

Public Awareness

17. Looking back on the outreach activities completed during the past year (since October 2015), 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?

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

18. Please describe any long-term strategies (or concerns) that relate to public awareness of PA LAUNCH.

Behavioral Health Disparities

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

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

21. Please describe any long-term strategies (or concerns) that relate to behavioral health disparities for PA LAUNCH.

Cultural Competence

22. Please describe any long-term strategies (or concerns) that relate to cultural competence for PA LAUNCH.

Workforce Development

23. Please describe any long-term strategies (or concerns) that relate to workforce development for PA LAUNCH.

Evaluation

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

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

26. Lessons learned from Year One focused on the importance of planning, awareness, collaboration/partnerships, and evaluation. How have the lessons learned from the Year One evaluation impacted the work done in Year Two?

Other

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

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

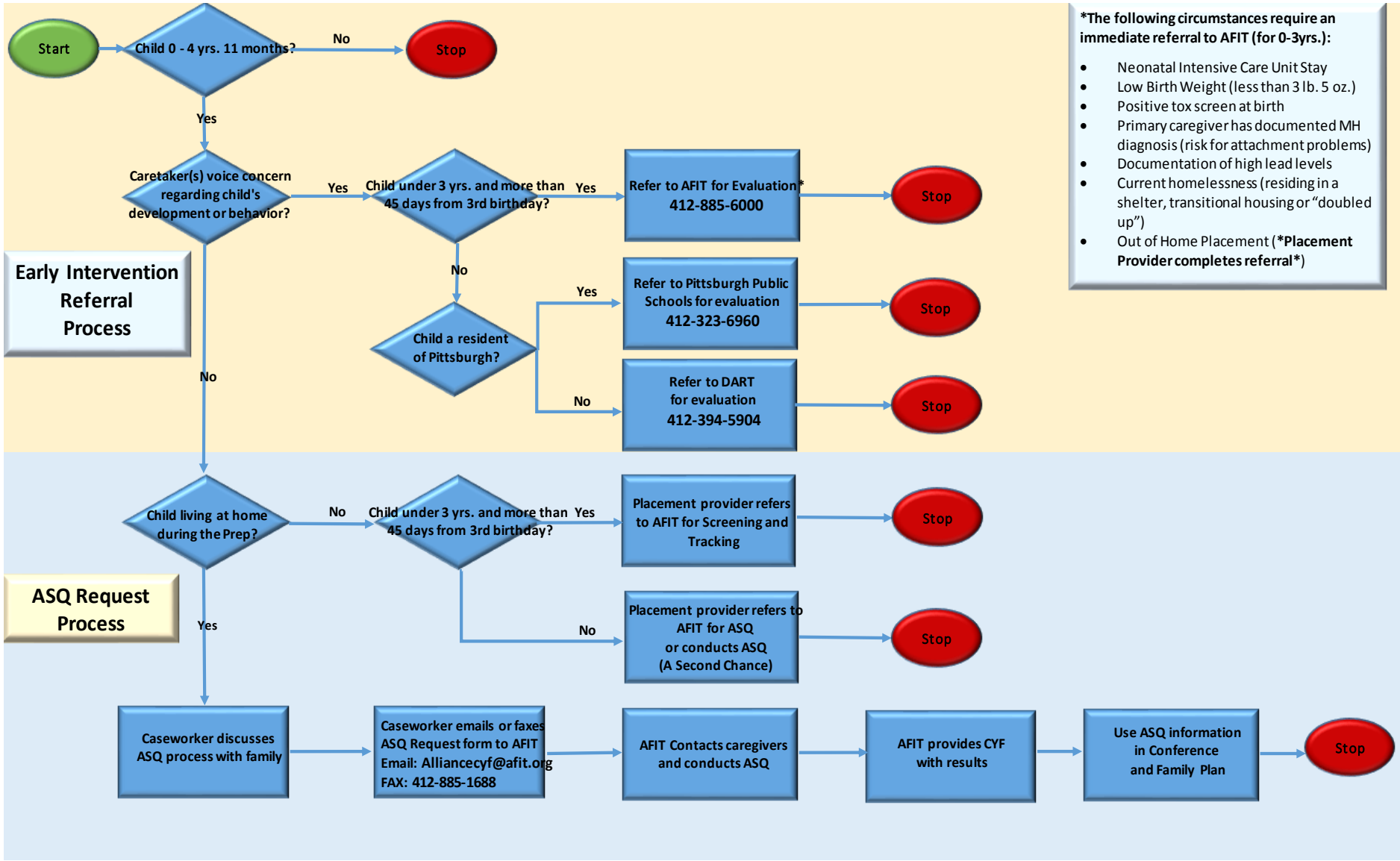
Factor	Statement	Strongly Disagree	Disagree	Neutral, No Opinion	Agree	Strongly Agree
Open and frequent communication	26. People in this collaboration communicate openly with one another.	1	2	3	4	5
	27. I am informed as often as I should be about what goes on in the collaboration.	1	2	3	4	5
	28. The people 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

Appendix M: 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 N: Screening Flow Chart for Child Welfare



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 P: Pediatric Provider Integration Assessment Summary

In Year Two, the four major pediatric practice groups that are the focus of LAUNCH's efforts toward promoting physical and behavioral integrated practice in Allegheny County completed the Pediatric Practice Integration Assessment (PPIA), adapted from the Integrated Practice Assessment Tool (IPAT) and the Mental Health Practice Readiness Inventory (MHPRI). This provided a baseline assessment and current status of the four practice groups with respect to the nature and extent of their integrated care services. The PPIA is completed collectively by the group's director and major professional staff to give a composite picture of the entire practice group, so actual practices within the Group may vary for different physicians and different locations.

General Categorization. The PPIA provides a general score for each practice group corresponding to one of the six levels of integrated practice ranging from Coordinated/Communication, to Co-Located/ Physical Proximity, to Integrated/Team Approach. The categorization of the four Practice Groups is given at the top (Part I) of Table 1. All four groups were making some attempt to incorporate behavioral health services in their practices, and two of the four practice groups were rated at level 5 within the top category of Integrated/Team Approach.

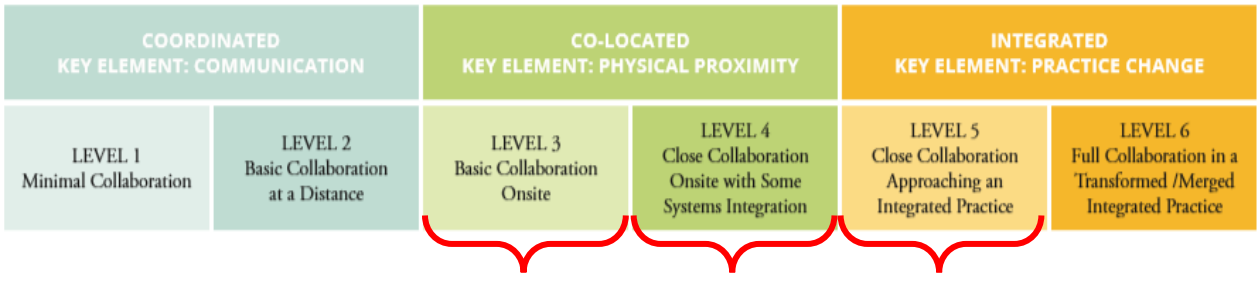
Part II of Table 1 presents the results for the four groups on the Mental Health Practice Readiness Inventory (MHRI) of the PPIA with items at the top representing what the four groups did best and those at the bottom of the list constituting practices that they did less well. Generally, the practice groups had referral assistance and information exchange and conducted screening and assessments. Collaborative arrangements, engagement, quality improvement, and tracking systems were done less well by three groups, and more specific services were unevenly distributed among the practices.

Part III of Table 1 provides a narrative qualitative summary of the strengths/successes, common obstacles, training needs, and data tracking/sharing notes. All practice groups have successfully implemented some forms of PH/BH integration. Further, although the practice groups have found ways to bill for some BH services, they were blocked by policies and regulations from billing for other BH services. Other obstacles focused on the incompatibility of Electronic Medical Record systems and their lack of options for behavioral information, and the lack of time and billing options for a Primary Care Physician to deliver behavioral care. Training needs focused on understanding a variety of behavioral health issues, practices, and resources, and sharing patient information raises several challenges.

Table 1: PPIA Summary Findings

Part I: Integrated Practice Assessment Tool (IPAT)

IPAT Results:



Part II: Mental Health Practice Readiness Inventory (MHPRI)				
Item	**"We do this well (substantial improvement is NOT needed)"** (1 point)	**"We do this to some extent (improvement is needed)"** (2 points)	**"We do not do this well (significant practice change is needed)"** (3 points)	**TOTAL**
Referral Assistance	XXX	X		5
Information Exchange	XXX	X		5
Recall and Reminder Systems	XX	XX		6
Screening & Assessment Tools	XX	XX		6
Collaborative Relationships	X	XXX		7
Engagement	X	XXX		7
Quality Improvement	X	XXX		7
Tracking Systems	X	XXX		7
Care Coordination	X	XX	X	8
Mental Health Promotion	X	XX	X	8
Special Populations	X	XX	X	8
Functional Assessment	X	XX	X	8
Clinical Guidance	X	XX	X	8
Screening and Surveillance	X	XX	X	8
Protocols	X	X	XX	9
Registry		XX	XX	10
Care Plans		X	XXX	11

Part III: Qualitative Summary

Identified Strengths/Successes

- All practices have successfully implemented some form of BH integration into their physical health settings
- PH practices have been able to bill for many BH services in a way that is financially feasible
- PCPs and most practice staff recognize the need for integrated PH and BH services
- The implementation of a team approach to care has been successful in practices

Common Obstacles

- Payment remains a major obstacle, and the potential for increased integration would be greater if policy changes allowed for:
  - full reimbursement of BH services provided by credentialed NPs,
  - BH consultation provided to PCPs,
  - both a BH and PH visit for one patient in the same day (shared space regulations),
  - and BH services provided by PH PCPs within a well-child visit
- The lack of integration of EMRs contribute to persistent problems when disclosing shared patient information and disrupts communication between BH and PH providers
- The time required to provide BH care to patients is problematic for PCPs, this issue is related to payment
- Screenings are often not efficient – cannot be directly entered into EMR and may not be used properly
- BH and PH provider relationships should be strengthened
- Space restrictions make co-location and integration difficult for some practices/practice locations

Training Needs Identified

- BH diagnoses, treatments, and psychopharmacology for children birth to 8 years
- Time-efficient screenings and brief BH interventions like PCIT, CBT and Motivational Interviewing
- Available community resources, including culturally congruent providers and resources
- Understanding of the wide range of influences (social determinants of health) impacting child and family BH, and how to engage families in BH care "pre-crisis"
- Trainings should be available to all members of a practice team as appropriate
- Time required and the provision of CEU/ CE/ MOC part 4 credits are important factors
- Online trainings may be preferred if broad participation is expected
- Trainings may also occur at individual practices during lunch time, or during practice-wide meetings that may take place outside of business hours

Data Tracking & Sharing Notes

- Effective methods for sharing patient information between BH and PH providers must be established
  - May include a data sharing protocol or a universal consent form
- While some practices can readily pull data, including results, for specific screens, some technical assistance and communication with practice IT teams will be necessary to collect the information we request
- UPMC's Clinical Connect is a health information exchange that practices may be able to utilize

Additional Comments

- All practices have expressed interest in Learning Community-type collaboration. The purpose and scope of this initiative should be discussed further with all practices and the work group.

Appendix Q: Pediatric Provider Integrated Care Conference Evaluation Summary

PA Project LAUNCH partnered with the Pennsylvania Chapter of the American Academy of Pediatrics and Community Cares Behavioral Health to co-sponsor the Pediatric Provider Integrated Care Conference held on September 21, 2016, in Pittsburgh that focused on linking behavioral health and physical health to enhance wellness for young children. The conference was aimed at pediatricians and affiliated staff, physical and behavioral health professionals and administrators, and others interested in the integration of physical and behavioral health services.

The learning objectives for this conference were to 1) understand current models for the integration of behavioral health services into primary care settings and how some models have been implemented in local pediatric practices, 2) identify mental/behavioral health conditions in young children through the use of validated screening and assessment tools, 3) learn strategies to enhance facilitated referral for significant behavioral health concerns, and 4) receive skills-based training to increase capacity to address pediatric behavioral health conditions.

Attendance
The conference had 111 preregistered potential participants and 89 signed-in attendees, including several members of the Local and State Young Child Wellness Councils and seven LAUNCH Team members (three State and four Local).

Format
The conference consisted of introductory and closing remarks from Karen Hacker, MD, Director of the Allegheny County Health Department; one plenary speaker and plenary panel of local providers; and four pairs of concurrent sessions. Topics included a description of the new local Telephonic Psychiatric Consultation Service (TiPS), screening tools, diagnosis and treatment of anxiety and depression, medication management, promoting family engagement, the science of integrated health care, trauma informed care, behavioral interventions, and social determinants of health.

Major Conference Content Themes

- A major premise of physical and behavioral integrated care is that social and behavioral factors are major influences on the access, amount, quality, and outcome of health care that people receive. Inequities associated with urban/rural location, income, race, education, gender, housing, neighborhood, health insurance, disabilities, and stress are profoundly associated with the physical and behavioral health care given to people, and these factors---not physical health care---account for 70% of premature deaths, for example. Poverty is a major risk factor. One in five children in Pennsylvania live in households below the poverty line, but 200% of the poverty line is needed to provide basic needs and 42.5% of children under 6 years live in such households.

- Many people have medical “homes”---a single physician or practice that they use over many years---but rarely do people have a behavioral health care “home.” Integrated care seeks to remedy this disparity.

- Integrated care spans six levels from coordinated, to co-located, to team-based integrated care. Research shows that even the lower levels of integrated care are associated with modest effect sizes of general health benefits for participants and numerous “softer” benefits such as greater service use, better satisfaction, less caregiver stress, and some longer-term clinical benefits.

- The local Children’s TiPS program (Telephonic Psychiatric Consultation Service) at Children’s Hospital of Pittsburgh serves children and adolescents who are insured by Pennsylvania’s Medical Assistance programs and offers provider-to-provider contact with a child psychiatrist who can answer questions

about medications, diagnoses, screening tools, and resources and refer patients to care coordinators and licensed therapists if needed. At present, most callers have children 6 years of age or older, but TiPS can serve families with younger children. There are several other referral services available locally as well.

- There are many screening tools available for a variety of behavioral conditions in children across the age range (see the American Academy of Pediatrics website for Assessment Tools for Primary Care). Some are very short and some are questionnaires for parents and children to fill out that do not require a trained examiner; others, including those often administered by behavioral specialists, are longer and do require a trained administrator. There are many reasons why screening is not done in some pediatric practices, including how to pay for it (there are several billing codes that can be used), lack of competence in administering and interpreting the results, uncertainty about who is responsible for doing it, recognition that in many practices most children do not need it, concern about "mental health stigma" for children, and lack of time.

- Local major pediatric groups of providers have moved to varying extents toward integrated care on the continuum of coordinated, co-located, and team integrated practice. Although having a cooperative arrangement with behavioral health professionals was better than nothing, co-location of behavioral health professionals was associated with much more frequent and productive communication and cooperation. Behavioral health professionals need a separate space in a pediatric practice, not just the waiting room, to obtain appropriate rapport with a family, assure privacy, convey professionalism, and be productive.

- One challenge to integration are limitations on billing for behavioral services (especially when needed services involve parenting practices, prevention, and social-economic risks and limitations including food insufficiency, stressful living situations, etc.). However, billing for Medicaid families is state determined, so changes in billing options is a potential agenda item for LAUNCH.

- Other challenges included paying for space, training, and services for behavioral professionals; disparities in professional values, style, roles, and regulations between behavioral and pediatric professionals; limitations in sharing of patient records (and incompatibility of different Electronic Medical Record systems), overcoming the stigma of "mental health services," difficulty finding behavioral health professionals who are trained to deal with issues in children across the entire age range, the burden of time to do all this, and maintaining the quality of services.

- Engaging families is necessary to successfully provide physical and behavioral health services to low-resource and racial/ethnic minority families. It takes time, effort, and much listening to create a relationship of trust, respect, and empathy, which are often easy to agree on as goals but more difficult to implement and obtain.

- Allegheny County has many high quality behavioral services that can be used as referral agencies; the issue is having primary care groups and physicians aware of these opportunities, perhaps by having trained care coordinators available who can help guide families to appropriate referrals and other services.

- Dr. Hacker concluded that the conference exuded confidence that integration was important and the way forward, and she observed that Allegheny Country had made very substantial progress toward integration, but there is still a long way to go. We need stable and sustainable models, and more

favorable reimbursement policies (but this will be difficult as long as pediatric practices operate under a fee-for-services model).

Participant Feedback

Participants provided feedback on the conference through the Course Evaluation required for obtaining continuing education credits from the PA American Academy of Pediatrics (AAP), a feedback questionnaire for participants not seeking continuing education credits, and a supplemental evaluation seeking information about future physical and behavioral health integration agenda.

PA-AAP Course Evaluation. All attendees, whether they sought continuing education credits or not, were encouraged to return the PA-AAP Course Evaluation form.

Respondents. A total of 28 participants seeking continuing education credits and 9 who did not need credits returned the PA-AAP Course Evaluation forms. Nearly all of the 28 participants who sought continuing education credits were physicians who were in pediatric practice or were administrators. In contrast, nearly all of those who returned questionnaires who were not seeking continuing education credits were mental health professionals.

Ratings. The average ratings for the 11 questions for the combined group of 37 are presented in Table 1 in order from highest to lowest rating. The two groups responded largely in the same way, although the mental health professionals had higher ratings for facilitating mental health referrals and perceiving the content of the conference to be relevant to their practice.

Generally, all but one question was rated between 4.05 ("high") and 4.84 ("very high), which indicated the conference was regarded as providing solid information, especially about models of physical/ behavioral health integration, that was relevant to their practices. Participants on average indicated the conference provide "some" information that was said to be new, and there was a "high" likelihood these participants would make a change in their practice (but these were among the lowest ratings in the questionnaire).

Table 1. Course Evaluation Ratings on the PA-AAP Questionnaire

Item	Rating*
To what extent were the speakers' presentations free of commercial bias?	4.84
To what extent did the activity present scientifically rigorous, unbiased and balanced information?	4.46
To what extent was the content of the program relevant to your practice?	4.41
As a result of participation in this activity, I am able to understand current models for the integration of behavioral health services into primary care settings?	4.41
To what extent were you satisfied with the overall quality of the educational activity?	4.31
As a result of participation in this activity, I am able to identify mental/behavioral health conditions in young children through the use of validated screening and assessment tools?	4.14
As a result of participation in this activity, I am able to facilitate appropriate referrals for significant behavioral health concerns?	4.14
To what extent will you make a change in your practice as a result of participation in this activity?	4.05
How much of the information in today's training was new to you?	2.82

** A rating of 4.0 was "high" and a rating of 5.0 was "very high."*

Non-Continuing Education Questionnaire
A brief questionnaire was available for those not seeking continuing education.

Respondents. A total of 24 participants completed this questionnaire. Most were Masters level professionals engaged in mental health practice or administration.

Ratings. These professionals rated nearly all components and aspects of the conference, especially the presenters who they regarded as being well prepared, as contributing equally to their learning and understanding. Further, 87-96% rated as moderate to high the conference's assistance in helping them interpret current physical/behavioral health models of integration, identify behavioral health issues in children through screening, develop strategies for referrals, and address pediatric behavioral health conditions.

Supplemental Evaluation. The Supplemental Evaluation was available to all participants, although LAUNCH Team members and some presenters did not fill it out. This evaluation form consisted of two parts. The first was an open-ended question asking "what additional action step(s) should be taken to improve/enhance integration of BH and PH in pediatric primary care?" This was designed to solicit the most prominent ideas on next steps in this domain and to provide qualitative information on priorities. The second part asked attendees to rate on a 10-point scale (10 = highest) each of ten items with respect to the extent to which the item would help to provide integrated care in the respondent's practice.

Ratings. Forty-five attendees submitted supplemental evaluation forms, although six provided only responses to the open-ended question and did not rate the specific items. In addition, over the 39 sets of ratings, six specific items were left unrated. Unrated items were omitted from the average ratings. It should be noted that some items were given low ratings because that activity was already implemented in the respondent's practice, not necessarily because it was unimportant. Thus, the ratings reflect both the need for and importance of the specific activity.

Table 2 presents the ten items listed from top to bottom according to their rated importance and need. The highest rated items pertained to clarifying reimbursements for socio-emotional screenings and treatments from insurance and government agencies; developing examples of processes to incorporate screening results into the electronic health record; assisting providers in assessing, determining, and identifying the behavioral health services they need; and promoting a shared consent form to facilitate cross-disciplinary care coordination between BH and PH. Other highly rated items included developing standards of care and processes for common behavioral health screening outcomes, and providing behavioral health care referral coordination training for primary care clinical staff.

Open-ended responses. The open-ended responses largely mirrored the ratings. Informal reviews of these comments suggested that the most frequent topic revolved around billing insurance companies and medical assistance agencies for behavioral health services. Also, some asked how to provide behavioral health services in a sustained, financially viable manner. Similarly, there was concern about regulations regarding two types of treatments within a single day and issues of confidentiality of records.

Several respondents encouraged the content of the conference be communicated to a variety of professionals, including other primary care physicians, office staff, pediatric specialists, interns and residents to prepare for the future, and community agencies including schools---across the state not just in Allegheny County. Both PH and BH staff needed sensitivity training regarding the potential stigma of mental health services and how to engage families with respect. Further, there were some requests for lists of possible behavioral health referral agencies to be distributed to pediatric practices.

Table 2. Ratings of Activities That Would Be Most Helpful to Respondent's Practice (10 = Most Help)

Rating	Activity
8.4	Clarify insurance provider positions on reimbursement for socio-emotional screenings and treatments
8.2	Develop examples of processes to incorporate screening results into the electronic health record
8.0	Assist providers in assessing, determining, and identifying the behavioral health services they need
8.0	Promote a shared consent form to facilitate cross-disciplinary care coordination between BH and PH
7.9	Develop standards of care and processes for common behavioral health screening outcomes
7.9	Provide behavioral health care referral coordination training for primary care clinical staff
7.7	Encourage inclusion of behavioral health issues in PCMH registries for tracking and care coordination
7.7	Identify and distribute ICD-10 codes for use when providing behavioral health services
7.7	Provide guidance to identify, hire, and train an integrated behavioral health clinician
7.6	Offer technical assistance to implement new behavioral health screening tools for 0-8 year olds

Smart Beginnings

Screener 1: Known exclusionary criteria (from nursery team)

Screen #: _____
Recruitment ID#: _____
Recruiter initials ____
Week of enrollment (date of most recent Monday): ___ / ___ / 20____
M D Y

☐ No known exclusion criteria
- **Continue to Screener 2**

☐ Exclusion criteria applies
- **Check all exclusion criteria that apply:**

☐ Baby **definitely** not getting pediatric care at the Primary Care Center in Oakland

☐ Private insurance (not medical assistance/Medicaid)

☐ Birth weight <2500gm

☐ Gestational age < 37 weeks

☐ Not singleton birth (twin, triplet, etc.)

☐ Known or suspected significant genetic abnormality

☐ Known neurodevelopmental/neuromuscular disorder likely to affect development, movement, e.g., seizure disorder, microcephaly (low head circumference)

☐ Known sensory defect

☐ Known significant malformation likely to affect development or likely to require significant therapy (however, minor congenital heart malformation such as small VSD is OK)

☐ Meets criteria for Early Intervention at birth

☐ Not in level I nursery at time of enrollment

☐ Significant postnatal complication requiring level II or III nursery stay. Examples: sepsis, significant hypoglycemia, seizures
(Note: brief stay in level II or III nursery not a contraindication; e.g., rule out sepsis for observation only can be enrolled)

☐ Mother with known significant impairment that will be barrier to communication and participation (e.g., intellectual disability, schizophrenia)

☐ Mother and baby will be staying in shelter

☐ Baby not being discharged to mother or father

☐ Mother does not speak English or Spanish

If any exclusion criteria apply: Stop here, do not approach.

☐ Mother does not want to speak to recruiter
- **Stop here, do not approach.**

Week of enrollment (date of most recent Monday): ___ / ___ / 20____
M D Y

☐ Check here if family was not able to be contacted

☐ Check here if caregiver does not want to continue screener

Time of Verbal Consent: ____ : _____ AM/PM

Name of Person Consenting: _____

Signature of Person Consenting: _____

Relation to Study: _____

	I need to check on some things:		
1.	*Where are you planning to have your baby's regular health care check-ups?*	☐ Primary Care Center in Oakland/General Academic Pediatrics [continue to next question (Q2)]	☐ Other – specify:_____ [**STOP!** Caregiver is not eligible, DO NOT CONTINUE] *We can only enroll families who have their baby's regular pediatric care at the Primary Care Center in Oakland. Thank you so much for your time.*
2.	*Is English your primary language, in other words the main language that you speak?*	☐ Yes [continue to Q5]	☐ No [Go to Q3 to ask about Spanish]
3.	*Is Spanish your primary language, in other words the main language that you speak?*	☐ Yes [continue to Q4]	☐ No [IF NO TO BOTH: **STOP!** Caregiver is not eligible, DO NOT CONTINUE] *We are looking for parents who speak English or Spanish. Thank you so much for your time*.
4.	[ONLY if YES to Q3] *Which would you prefer to speak – English or Spanish?*	☐ English [continue to next question (Q5)]	☐ Spanish [Use translation phone to continue screen]
5.	*Are you planning to stay in the Pittsburgh area for at least the next 3 years?*	☐ Yes [continue to next question (Q6)]	☐ No [**STOP!** Caregiver is not eligible, DO NOT CONTINUE] *We can only enroll families staying in Pittsburgh long-term. Thanks so much for your time.*
6.	*Are you or one of your children a past or current participant in the Early Steps Project, the SKY Project, the Health Promotion Project or the Video Interaction Project (VIP)?* →If they participated in the Health Promotion Project, determine whether or not they received the FCU.	☐ Did NOT participate in Early Steps, SKY, VIP or FCU before [continue to next question (Q7)]	☐ Participated in VIP or FCU before [**STOP!** Caregiver is not eligible, DO NOT CONTINUE] *We cannot enroll families that have already participated in these programs. Thanks so much for your time.*

7.	*When you leave the hospital, where will you be staying?*	☐ In an apartment or home [continue to next question (Q8)]	☐ In a shelter / doesn't know yet [**STOP!** Caregiver is <u>not eligible</u>, DO NOT CONTINUE] *We need to have a way to reach families in their homes. Thanks so much for your time.*
8.	*Do you have a regular way to be contacted – do you have a working phone?*	☐ Yes [continue to next question (Q9)]	☐ No [**STOP!** Caregiver is <u>not eligible</u>, DO NOT CONTINUE] *We need to have a way to contact families regularly. Thanks so much for your time.*
9.	If all eligibility criteria above are met, say: *From your answers to these questions, you are a parent that we would like to be in our study. Are you interested in participating in our study?*	☐ Yes [continue to next question (Q10)]	☐ No – Caregiver not interested. *Thank you for your time, can I ask you why you do not want to hear about our study?* Stated reason for declining: _____ _____ _____
10.	*Are you at least 18 years old?*	☐ Yes [continue to next question (Q11)]	☐ No: *Because you are less than 18 years old, we will need both your and your parent's (mother or father) permission for you and your baby to participate in this study.* <u>If parent of baby's caregiver present:</u> Obtain assent from baby's caregiver and consent from parent of baby's caregiver. <u>If parent of baby's caregiver not present:</u> Determine whether there is a good time for you to come back when the parent of the baby's caregiver will be present. Leave the study information and a number where they can reach you.

11.	*I would like to review our consent form.* **GO TO CONSENT FORM**, review with parent.	Signed consent: ☐ Yes If consent signed, assign family a Study ID # (from sticker). Paste sticker below AND on the contact info form. Enter information below and move on to contact info form. Study ID sticker:_____ Study enrollment date: _____ /_____/20_____	Signed consent: ☐ No *Thank you for your time, can I ask you why you do not want to participate in our study?* Stated reason for declining: If they would like more time to think about it, make arrangements to come back to talk to them or fill out a consent to contact form. Signed consent to contact form? ☐ Yes ☐ No Interviewer notes:[leave blank unless special circumstance]

Appendix S: Year Two Disparities Impact Table

The Year Two Disparities Impact Table appears below. However, the "numbers served to date" in the disparities impact table are not reflective of the number of children and families that PA Project LAUNCH has impacted in Year Two. This misalignment is due to a number of factors described below. The Implementation Team will revisit the disparities impact targets and revise along with the Strategic Plan in Year Three and revise to be more reflective of the goals of PA Project LAUNCH. The main factors that impact the inaccuracy of the Disparities Impact Table data are as follows:

1) The Disparities Impact Targets were developed during the application stage of PA Project LAUNCH, before the Environmental Scan information was gathered and before the Strategic Plan or Evaluation Plan were developed. The relevant populations of focus are not reflected in these targets.

2) As mentioned in the Year Two Evaluation Report, PA Project LAUNCH is focused on system-wide change, especially at the local level where the County has plentiful, high quality resources, but a system that is difficult to navigate. Because of this focus, PA Project LAUNCH does not have many "LAUNCH affiliated providers" providing data relevant to the Disparities Impact Table below.

3) A focus of PA Project LAUNCH is workforce development. Numbers of trainees (328 trained in Year Two) are not reflected in the Disparities Impact Table.

4) To minimize the burden on partners, data are collected as available. Not all Project LAUNCH partners currently collect numbers served by race/ethnicity and gender.

Year Two Disparities Impact Table

	Year Two Target	Baseline	Numbers Served to Date
Direct Services: Number to be served	10,250 households (children & families)	N/A	538 households
By Race/Ethnicity (Including Sub-Populations)	7,995 Caucasian 1,497 African American 748 All other racial groups	N/A	27 Caucasian 43 African American 5 More than one race 462 Unknown*
By Gender	5,996 Male 4,254 Female	N/A	81 Males 457 Females

Appendix T: Local Wilder Collaborative Factors Inventory Findings

The Wilder Collaborative Factors Inventory is a self-report assessment designed to rate the extent of attitudes toward and actual collaboration that occurs among members of a group. Group members individually rate on a five-point scale from Strongly Disagree (score = 1) to Strongly Agree (score = 5) each of 40 possible positive characteristics. These characteristics are clustered into 20 factors composed of one to three items each. Scores are averaged across items within a factor, and a total score across all factors is also produced. Factor scores below 3.0 are considered cause for *concern,* whereas scores of 4.0 or better are considered *strengths.*

Sampling
All individuals who were members of the Local YCWC at some time during the preceding year were emailed the Wilder in March of each grant year. In Year One (March 2014-2015), three meetings had occurred before the Wilder was sent, which assessment was considered "baseline." The Wilder was not given before any meetings had occurred, because many of the questions could not be answered without some experience with the group. In Year Two (March 2015-2016), the assessment was conducted after six meetings had occurred.

Response rates
In Year One, a total of 24 Council members responded, and in Year Two a total of 30 members responded. Table 1 reports at the left the response rates (i.e., the percentage of Council members who were sent the Wilder who returned it completely filled out) for Years One and Two for *Family* and *Non-Family members* and for those who were *Frequent Attenders* (attended 2+ of 3 meetings before March in Year One and 3+ of 6 meetings before March in Year Two) and *Infrequent Attenders.*

Note first that the total response rates were nearly the same in the two years; that is, 71% in Year One and 65% in Year Two. Prior to the survey's distribution, the YCW Coordinator and Evaluation Team shared the importance of members' insights and feedback on the tool with the Council; frequent, personalized reminder emails were sent to encourage members to respond; and laptops were made available (in Year One) before and after a Council meeting. Although these response rates are considered fairly high, additional efforts will be made next year to increase response rates.

Table 1. Response Rates and Sample Composition for Local YCWC Wilder Survey for Years 1 and 2

	Percentage Responding		Sample Composition	
	Year One	**Year Two**	**Year One**	**Year Two**
Family Members	54%	67%	29%	33%
Non-Family Members	81%	65%	71%	67%
Frequent Attenders	79%	93%	63%	47%
Infrequent Attenders	60%	52%	38%	53%
TOTAL	**71%**	**65%**		

Percentage Responding = The percent of Council Members in March of the year specified who received the Wilder survey who then returned it completely filled out (i.e., response rate).
Sample Composition = The percentage of the total independent sample who represented various groups of Council members. *Family Members* = Those Council members who primarily represented families. *Non-Family Members* = Those Council members who primarily represented organizations in the community.
Frequent Attenders = Those Council members who attended half or more of the meetings during that year.
Infrequent Attenders = Those Council members who attended fewer than half the meetings during that year. Total sample composition may not add to 100% because of rounding error.

Next, the response rate for family members increased from 54% to 67% across years, whereas the response rate for non-family members decreased from 81% to 65%. The improvement of family member participants likely reflects their increased involvement, comfort in the group, and knowledge of its members, purpose, and activities. The decline in response rate for non-family participants may reflect the increasing work load and time commitment required by LAUNCH, especially for organizational representatives.

Council members who were frequent attenders were substantially more likely to return Wilder surveys than infrequent attenders, a disparity that increased in Year Two. Specifically, frequent attenders increased their response rate from 79% in Year One to 93% in Year Two, whereas infrequent attenders decreased from 60% in Year One to 52% in Year Two. Notably, the frequent vs. infrequent attender difference increased from 19% to 41% across years. Higher response rates are to be expected from frequent attenders, because they are likely more engaged and committed to LAUNCH, and this commitment may have increased over the year. Further, the decrease in non-family response rate coupled with the increase in response rates for frequent attenders suggests that a "core subgroup" of Council members, both family and non-family members, has developed a special commitment to LAUNCH that is associated with frequent attendance and responsiveness to LAUNCH activities and requests. This is not an unusual development in volunteer groups.

Composition of respondent samples

The right-hand side of Table 1 gives the percentages of those who did respond to the Wilder (i.e., the independent samples; see below) in each year who were Family vs. Non-Family Members and who were Frequent vs. Infrequent Attenders of Council meetings.

Approximately 30% (i.e., 29% and 33% in Years One and Two respectively) of the samples were Family and approximately 70% (i.e., 71% and 67%, respectively) were Non-Family Members. This composition of the Wilder samples did not change much across years and approximately reflects Council membership distributions. It also means the Wilder ratings presented here are somewhat representative of the Council Family vs. Non-Family membership frequencies.

The percentage of the Wilder samples who were Frequent vs. Infrequent Attendees of Council meetings changed from Year One to Year Two. Whereas in Year One, most respondents were frequent attenders (i.e., 63%), this dropped to 47% in Year Two. Thus, in Year Two the Wilder sample had approximately equal representation of Frequent and Infrequent Attenders. This likely represents the difference in the number of meetings in the two years (i.e., three meetings before the Wilder in Year One and five meetings before the Wilder in Year Two). Even attending only two meetings in Year Two reflects some degree of engagement in the Council and a willingness to return the survey. This change also means that Wilder ratings in Year One may represent the views of fewer and more initially committed Council members, whereas ratings in Year Two likely represent a broader representation of members.

Ratings of items within factors

When two or three items were clustered within a single factor, respondents tended to rate the individual items similarly. For example, using an arbitrary cutoff of a difference of .60 or more in mean scores to define a substantially different rating for two items, only five of 20 factors in Year One and four of 20 factors in Year Two had mean differences this large between items within factors. These factors were the same factors in the two years, so this likely represents two items that asked about rather different characteristics within that factor's domain. These results indicate that the factors represent relatively homogeneous item sets, and therefore the results below are ratings of factors, not individual items.

Ratings by Family vs. Non-Family Members

There was not a general difference between factor ratings provided by Family vs. Non-Family Members. For Year One, the mean rating across all factors was 3.80 for Family vs. 3.86 for Non-Family respondents. Further, about half (i.e., 11) of the 20 factors were rated higher by Non-Family than Family, and the Family vs. Non-Family difference was more than an arbitrary .40 for only three factors. For example, Non-Family Members were more likely to see collaborations in their self-interest, which was understandable because collaborations might involve the agency or constituency they represented. Also, they were more likely to establish informal relationships and communication links with other members, perhaps because many already knew other members and had similar domains of interest. Similarly, for Year Two, the mean rating over all factors was nearly the same for Family (3.77) and Non-Family Members (3.81), approximately half (i.e., 12) of the 20 factors were rated higher by Non-Family, but only two had a difference of .40 or more. Thus, there was not an obvious difference in ratings between Family and Non-Family Members.

Ratings as a function of frequency of meeting attendance

Generally, those Council members who were Frequent Attenders of the Council meetings during Year One rated nearly all the factors (i.e., 18 of 20) higher than those who attended less frequently. However, this trend was reversed in Year Two when Frequent Attenders rated only 5 of the 20 factors higher than infrequent attenders. This result may be of some concern, especially if it were to continue. It is reasonable to expect frequent attenders to be more committed to a group and perceive it more positively, which they did in Year One. That they viewed it less positively than infrequent attenders in Year Two may reflect rather committed members who perceive the progress of the group to be less than their original, and perhaps high, expectations.

Relative strengths and weaknesses

Table 2 presents the mean factor scores and their standard deviations (i.e., extent to which ratings varied within the group) for Years One and Two and the change in mean ratings across years.

Table 2. Wilder Score for Local YCWC for Project Years One and Two

		All Respondents (N=24,30)		Longitudinal Respondents (N=18)	
Factor	**Year**	**Mean (SD)**	**Change**	**Mean (SD)**	**Change**
Skilled leadership	2	4.20 (0.71)	0.07	4.11 (0.68)	0.00
	1	4.13(0.61)		4.11 (0.58)	
Members see collaboration as in their self-interest	2	4.07 (0.69)	-0.22	3.94 (0.64)	-0.39
	1	4.29 (0.63)		4.33 (0.69)	
Flexibility to consider new ideas	2	4.07 (0.41)	0.03	4.00 (0.30)	-0.08
	1	4.04 (0.44)		4.08 (0.35)	
Shared vision	2	4.02 (0.52)	0.02	3.97 (0.50)	-0.03
	1	4.00 (0.63)		4.00 (0.66)	
Unique purpose	2	4.02 (0.61)	-0.21	4.08 (0.55)	-0.17
	1	4.23 (0.57)		4.25 (0.50)	
Mutual respect, understanding, and trust	2	3.98 (0.55)	0.23	3.78 (0.43)	-0.05
	1	3.75 (0.57)		3.83 (0.57)	
Members share a stake in both process and outcome	2	3.96 (0.50)	-0.14	3.98 (0.45)	-0.12
	1	4.10 (0.52)		4.1 (0.50)	
Ability to compromise	2	3.93 (0.52)	0.26	4.00 (0.34)	0.28
	1	3.67 (0.71)		3.72 (0.16)	
Open and frequent communication	2	3.88 (0.60)	-0.20	3.78 (0.56)	-0.32
	1	4.08 (0.50)		4.10 (0.50)	
Favorable political and social climate	2	3.87 (1.07)	-0.30	3.67 (1.32)	-0.44
	1	4.17 (0.57)		4.11 (0.58)	
Adaptability in face of obstacles	2	3.83 (0.50)	0.14	3.67 (0.34)	-0.05
	1	3.69 (0.55)		3.72 (0.52)	
Total Score	2	3.8 (.34)	-0.04	3.71 (0.35)	-0.14
	1	3.84 (0.29)		3.85 (0.28)	
Concrete, attainable goals and objectives	2	3.8 (0.64)	-0.17	3.78 (0.40)	-0.16
	1	3.97 (0.38)		3.94 (0.40)	
Appropriate pace of development	2	3.67 (0.58)	0.02	3.44 (0.48)	-0.20
	1	3.65 (0.56)		3.64 (0.59)	
History of collaboration or cooperation in the community	2	3.67 (0.75)	-0.06	3.75 (0.83)	0.00
	1	3.73 (0.78)		3.75 (0.79)	
Appropriate cross-section of members	2	3.70 (0.64)	0.05	3.58 (0.65)	0.00
	1	3.65 (0.62)		3.58 (0.67)	
Established informal relationships and communication links	2	3.68 (0.87)	-0.20	3.50 (0.87)	-0.39
	1	3.88 (0.50)		3.89 (0.53)	
Collaborative group seen as a legitimate leader in the community	2	3.63 (0.52)	0.17	3.58 (0.55)	0.16
	1	3.46 (0.57)		3.42 (0.55)	
Multiple layers of participation	2	3.43 (0.73)	0.03	3.31 (0.71)	-0.11
	1	3.40 (0.61)		3.42 (0.62)	
Development of clear roles and policy guidelines	2	3.37 (0.77)	-0.11	3.08 (0.73)	-0.39
	1	3.48 (0.60)		3.47 (0.63)	
Sufficient funds, staff, materials, and time	2	3.22 (0.61)	-0.22	3.06 (0.48)	-0.33
	1	3.44 (0.52)		3.39 (0.53)	

Two slightly different samples are presented in the columns of Table 2. The *All Respondents Sample* includes everyone who responded to the Wilder during that year (*N* = 24 for Year One and *N* = 30 for Year Two). This type of sample provides the largest number of members and represents a picture of the Council characteristics during that year. But the people who responded in one year were not necessarily the same people who responded in the next year, which means that changes from one year to the next might be more associated with different people responding in the two years than with actual perceived change across years. The second sample was a true *Longitudinal Respondents Sample* of *N* = 18 members who responded in both Years One and Two. Change from year to year in this sample cannot be attributed to different respondents in the two years and more likely reflects true changes in perceptions across time, but the size of the sample is smaller and these members may not be representative of the total YCWC membership. When change occurs similarly in both samples, one can have more confidence that change has indeed occurred in the perception of the members.

Factors that appear near the top of the list in Table 2 represent relative strengths of the Council in the perception of its members, and those that are listed at the bottom of the list were perceived less positively. Relative strengths (Year Two ratings of 4.00+ are shaded in blue) include skilled leadership, flexibility to consider new ideas, shared vision, unique purpose, and the project seen in their self-interest. These characteristics appear to reflect the positive perceptions members feel regarding the YCW Coordinator and fellow members, their shared vision, and the unique purpose of LAUNCH. We note that the YCW Coordinator position changed hands after the Year Two ratings were made.

Factors at the bottom of the list in Table 2 represent characteristics that were viewed less positively, but none received average ratings below 3.0 which would represent serious concerns. The lowest rated characteristic in both years reflects a perception of insufficient funds, staff, materials, and time to conduct LAUNCH activities. The second lowest rating in Year Two was given to the apparent lack of clear roles and policy guidelines followed closely by multiple layers of participation. This set of characteristics may reflect the fact that PA LAUNCH is very broad, encompassing, and complicated, and it has many Council members and other participant stakeholders. It may also reflect member concerns about the time and effort needed between meetings to plan and implement LAUNCH efforts, as well as informal feedback from some members that many activities were discussed at meetings but they were not always assigned priorities or a point person to pursue them. Thus, LAUNCH may benefit from setting priorities, focusing on fewer activities, and insuring that some member(s) will be responsible for seeing that progress on each priority is pursued.

Relative improvements and regressions

Changes from Year One to Year Two that can be seen in Table 2 in both samples (i.e., items with changes of +.20 or -.20 or larger in both samples are shaded) provide suggestions of relative improvements or regressions over the last year. As noted above, the average ratings over all factors for Years One and Two were very similar, indicating no pervasive change across years.

More specifically, however, the biggest improvement (green shading) pertained to the ability to compromise, likely a sign of a maturing Council. Relative regressions (red shading) focused on an increasingly unfavorable political and social climate; insufficient funds, staff, materials, and time; the relative lack of new informal relationships and communication links; less open and frequent communication; and a declining perception that collaboration is in their self-interest. This pattern may reflect the inability of state government to pass a budget for most of Year Two, which forced many human service agencies to borrow money to continue to provide services. Second, this budgetary threat may have compelled members to concentrate on self-preservation rather than to emphasize communication and collaboration with other agencies. Third, members know everyone by Year Two so

do not need to make new relationships. Fourth, members realized the complexity of effecting systemic changes coupled with an insufficient emphasis on specific action in the group dynamics.

Statistical note

Traditional tests of statistical significance were conducted on the change data for both samples, but the results did not provide any additional useful information. Only a very few tests were significant. This was because sample sizes were small, and the ratings were quite variable. For example, ratings for any item often ranged from 2 to 5, nearly the entire 5-point scale. Note the standard deviations for factor scores in Table 2 are largely .5 and above, which means that scores for factors as well as individual items spanned more than half the scale. Further, correlations between Year One and Two ratings were quite low (i.e., the correlation of total score was only .37, not significant), indicating a great deal of variability across years likely associated with the very limited experience members had with the Council in Year One.

Summary

The decrease in Non-Family response rate coupled with the increase in response rate for Frequent Attenders suggests that a "core subgroup" of Council members, both Family and Non-Family Members, has developed a special commitment to LAUNCH that is associated with frequent attendance and responsiveness to LAUNCH activities and requests. This is not an unusual development in volunteer groups.

Ratings reflect the positive perceptions members feel regarding the Young Child Wellness Coordinator and fellow members, their shared vision, and the unique purpose of LAUNCH. However, the lower ratings may reflect the fact that PA LAUNCH is very broad, encompassing, and complicated, and it has many Council members and other participant stakeholders. Members may also be concerned about the time and effort needed between meetings to plan and implement LAUNCH efforts and that many activities are discussed at meetings but not always assigned priorities or a point person to pursue them. Thus, LAUNCH may benefit from setting priorities, focusing on fewer activities, and insuring that some member(s) will be responsible for seeing that progress on each priority is pursued.

Appendix U: State Wilder Collaborative Factors Inventory Findings

Table 1. Response Rates and Sample Composition for the State Young Child Wellness Council Wilder Survey for Years One and Two

	Percentage Responding		Sample Composition	
	Year One	Year Two	Year One	Year Two
Family Members	100%	60%	22%	21%
Non-Family Members	86%	50%	78%	79%
Frequent Attenders	92%	60%	96%	86%
Infrequent Attenders	50%	29%	4%	14%
TOTAL	**89%**	**52%**		

Sampling
The State YCWC experienced a good deal of membership turnover during Year Two, so only those individuals who were members at the time the Wilder Inventory was administered were sent the survey. Year One consisted of three meetings over approximately four months (January 29, 2015 to May 26, 2015), and Year Two had four meetings but over an entire 12-month span (August 11, 2015 to August 18, 2016).

Response rates
In Year One, 23 members responded to the Wilder survey, but only 14 responded in Year Two. Response rates (i.e., the percentage of Council members who were sent the Wilder who completed it) for Years One and Two for *Family* and *Non-Family Members* and for those who were *Frequent Attenders* (i.e., attended 2+ of 3 meetings in Year One and 3+ of 4 meetings in Year Two) and *Infrequent Attenders* are presented at the left of Table 1.

Note first at the bottom under "Percentage Responding" at the left of Table 1 that the total response rate declined from a very substantial 89% (23 of 26) in Year One to a rather low 52% (14 of 27) in Year Two. In each year, Council members were personally urged to complete the Wilder and received email reminders to do so. This rather marked decline in response rate may suggest a decrease in the engagement and commitment of members to the Council (see other results below).

Family Members (100%, 60%) responded at slightly higher rates than Non-Family Members (86%, 50%), and Frequent Attenders (92%, 60%) responded at higher rates than Infrequent Attenders (50%, 29%). All groups displayed substantial declines in response rates from Year One to Year Two.

Composition of respondent samples
The right side of Table 1 gives the percentage of those who did respond to the Wilder in each year who were Family vs Non-Family Members and who were Frequent vs. Infrequent Attenders of Council meetings.

The distribution of respondents among Family vs. Non-Family Members and Frequent vs. Infrequent Attenders was essentially the same in both years. That is, 22%-21% were Family Members while 78%-79% were Non-Family Members; 96%-86% were Frequent while 4%-14% were Infrequent Attenders. The percentages for Family Members are approximately the same as the overall Council composition, which

suggests a representative sample in this regard. Frequent Attenders nearly always are more likely to respond and comprise a disproportionately large segment of the sample.

Ratings by Family vs. Non-Family Members
Family Members tended to rate the Council higher than Non-Family Members, and this was consistent from Year One to Year Two. Specifically, Family Members rated 16 and 15 of the 20 factors higher in Years One and Two, respectively. Therefore, ratings for different individual factors are not obviously influenced by member status.

Ratings by Frequent vs. Infrequent Attenders
Differences in ratings between Frequent and Infrequent Attenders could not be meaningfully determined, because only one person in Year One and two people in Year Two who were Infrequent Attenders responded to the Wilder. Therefore, Wilder ratings in both years predominately reflect the views of those who attended half or more of the meetings in that year. Usually, such a disparity is associated with higher ratings than would be expected from a more balanced group, and indeed the Frequent Attenders on average gave higher ratings (especially in Year One) than Infrequent Attenders, although the number in the latter group is quite small.

Relative strengths and weaknesses
Table 2 presents the mean factor scores on the Wilder and their standard deviations (i.e., the extent to which ratings varied within the group) for Years One and Two and the change in mean ratings across the two years. As in the case of the local ratings, these ratings are based on two samples of respondents. At the left of the table are ratings based on all respondents in Year One (*N = 23*) and in Year Two (*N* =14); at the right are ratings provided only by those members who contributed ratings in both Years One and Two (*N* = 10, 9 for two factors). As noted above for the local YCWC ratings, the complete samples provide the best snap-shot-in-time of Council opinion using the maximum number of cases available, but the longitudinal sample of the same individuals during both years provides estimates of change that are not influenced by changes in the specific individuals who respond from year to year.

Table 2. Wilder Score for State YCWC for Project Years One and Two

		All Respondents (N=14, 23)			Longitudinal (N=9-10)		
Factor	Year	Mean (SD)	Std. Deviation	Change	Mean (SD)	Std. Deviation	Change
Total Score	**2**	**3.92**	**0.45**	**-0.07**	3.98	0.52	**-0.09**
	1	**3.99**	**0.45**		4.07	0.56	
Unique purpose	2	4.36	0.69	**0.12**	4.45	0.64	**0.05**
	1	4.24	0.72		4.40	0.52	
Skilled leadership	2	4.36	0.63	**-0.12**	4.40	0.70	**-0.10**
	1	4.48	0.59		4.50	0.71	
Mutual respect, understanding, and trust	2	4.21	0.43	**0.15**	4.25	0.49	**0.20**
	1	4.07	0.59		4.05	0.60	
Members see collaboration as in their self-interest	2	4.21	0.58	**-0.26**	4.40	0.52	**-0.20**
	1	4.48	0.59		4.60	0.52	
Flexibility to consider new ideas	2	4.21	0.67	**0.08**	4.30	0.67	**0.05**
	1	4.13	0.77		4.25	0.79	
Favorable political and social climate	2	4.21	0.58	**0.08**	4.30	0.67	**0.20**
	1	4.13	0.69		4.10	0.74	
Shared vision	2	4.18	0.42	**-0.04**	4.25	0.42	**0.05**
	1	4.22	0.56		4.20	0.75	
Concrete, attainable goals and objectives	2	4.12	0.53	**-0.10**	4.17	0.63	**-0.23**
	1	4.22	0.50		4.40	0.60	
Open and frequent communication	2	4.10	0.48	**-0.06**	4.10	0.52	**-0.20**
	1	4.16	0.56		4.30	0.66	
Members share a stake in both process and outcome	2	4.05	0.58	**-0.10**	4.03	0.69	**-0.10**
	1	4.14	0.64		4.13	0.76	
Ability to compromise	2	3.93	0.73	**0.10**	3.90	0.74	**0.10**
	1	3.83	0.72		3.80	0.79	
Appropriate cross-section of members	2	3.86	0.77	**-0.12**	3.85	0.88	**-0.30**
	1	3.98	0.70		4.15	0.75	
Adaptability in face of obstacles	2	3.86	0.60	**0.01**	3.85	0.71	**0.05**
	1	3.85	0.65		3.80	0.59	
History of collaboration or cooperation in the community*	2	3.68	0.99	**0.18**	3.72	0.97	**0.06**
	1	3.50	0.77		3.67	0.87	
Established informal relationships and communication links	2	3.64	0.72	**-0.31**	3.80	0.63	**-0.05**
	1	3.96	0.77		3.85	0.88	
Multiple layers of participation	2	3.61	0.76	**0.02**	3.80	0.82	**0.15**
	1	3.59	0.63		3.65	0.71	
Appropriate pace of development	2	3.57	0.51	**-0.32**	4.05	0.55	**0.50**
	1	3.89	0.58		3.55	0.55	
Collaborative group seen as a legitimate leader in the community*	2	3.54	0.69	**-0.21**	3.50	0.79	**-0.22**
	1	3.75	0.46		3.72	0.51	
Development of clear roles and policy guidelines	2	3.46	0.89	**-0.19**	3.50	0.85	**-0.35**
	1	3.65	0.79		3.85	0.85	
Sufficient funds, staff, materials, and time	2	3.32	0.54	**-0.20**	3.35	0.58	**-0.25**
	1	3.52	0.70		3.60	0.81	

*N=9 respondents only

Ratings in Table 2 that are shaded in blue are those that received ratings of 4.00 or higher in Year Two, which is ordinarily considered quite good. Ratings below 3.00 are usually regarded as "cause for concern," and it is notable that no factor received such a low rating. Year-to-year changes shaded in green are those that received increases in ratings of approximately +.20, while those changes shaded in red decreased by approximately -.20 in both samples.

At the top of Table 2 one can see that the average rating across all factors was consistently quite high for Years One and Two and for both samples (3.92-4.07). Further, 10 of the 20 factors received ratings of 4.00 or higher. Such high ratings may reflect the very high percentage of respondents who were Frequent Attenders. Highly rated items represented a respect for both the LAUNCH project and its goals as well as for interpersonal tone of how the Council was operating. Items that received relatively lower ratings and therefore suggest topics that might merit improvement included a perception that there are insufficient funds, staff, materials, and time; a relative lack of clear roles and policy guidelines; and a somewhat slower pace of development coupled with multiple layers of participation. These perceptions likely reflect the state budget impasse that blanketed Year Two and the corresponding decrease in face-to-face meetings leading to a perception that progress was diminishing relative to the size of the LAUNCH agenda.

Relative improvements and regressions

Over all factors, there was only a small decrease in ratings across years in both samples (-.07, -.09). Two items were perceived in both samples as having improved over the years----increased mutual respect, understanding, and trust and an improved political and social climate. The former is a common improvement as group members become better acquainted with each other, and the latter may reflect the state legislature's agreement on a budget after months of stalemate that occurred shortly before the Year Two Wilder was distributed.

On the other hand, some factors saw relative regressions of perceptions in both samples. Specifically, there was a tendency to perceive a relative lack of clear roles and policy guidelines; a greater insufficiency of funds, staff, materials, and time; the group lost a bit as a leader in the community, and members saw collaboration as being less in their self-interest than they once did. Also, the relatively large turnover in members may have led to the perception that the Council lost some representation of a cross-section of relevant members.

Summary

Several observations in these results point to the proposition that the State YCWC lost a little energy and enthusiasm in Year Two. There were fewer meetings, some face-to-face meetings were replaced by virtual meetings, attendance diminished substantially, and there were frequent resignations and only some of these members have been replaced. Further, the size and breadth of the PA LAUNCH project, especially relative to the resources and challenges required to move forward, led to perceptions that roles needed to be defined more clearly and priorities set so that more progress on fewer goals might be achieved.

Some of this might be expected---after the excitement of initiating a new endeavor wears off and the hard work begins, enthusiasm is sobered a bit by the reality of the challenge. Further, the budget impasse cast a statewide depression on human services, both financially and psychologically. In this environment, the Council lost members and attendance and a good deal of energy, commitment, and focus. At the same time, members clearly rated its purpose, interpersonal tone, and collaborative spirit very highly, suggesting that the root elements necessary for success remain. Thus, re-establishing the membership, convening regular face-to-face meetings, focusing Council's agenda on fewer attainable goals, and identifying concrete action steps toward achieving those goals to be led by specified members are likely to be successful.