Pennsylvania Project LAUNCH

Year Three Evaluation Report

SM061548 PA Project LAUNCH Partnership
October 1, 2016 – September 30, 2017
Submitted December 29, 2017

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

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EXECUTIVE SUMMARY

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. In October 2014, the Pennsylvania Office of Mental Health and Substance Abuse Services (OMHSAS) was awarded a Project LAUNCH grant. 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.

Evaluation Objectives

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, their families, and pregnant women, particularly in three target regions in AC. Our evaluation therefore focuses on documenting the process of providing that infrastructure support, and the outcomes of those support activities. Below we present an overview of Year Three process evaluation findings and outcome evaluation findings. An overview of key recommendations is included as well.

Year Three Activities and Process Evaluation Progress

PA Project LAUNCH has operated as a highly collaborative process involving more than 130 individuals serving on Local and State Young Child Wellness Councils, Work Groups, and the Implementation Team. As per the Strategic Plan, the goals and activities of PA Project LAUNCH involve a comprehensive, locally-driven, state supported approach. This involves targeted work across all of the domain areas identified in the broader LAUNCH initiative (i.e, Screening and Assessment [SA], Behavioral Health and Physical Health Integration [BHPH], Early Childhood Mental Health [ECMH], Home Visiting [HV], Family Support and Parent Skill Building [FS]), as well as local and state infrastructure goals. This has resulted in a project with great breadth and complexity. As such, the early years of the project were devoted to planning, outreach, and information sharing. Year Three represents a key shift in this process, as the local and state teams have engaged in the targeted implementation of a wide range of activities across all project domains. We provide an overview of key activities below.

Table 1 provides an overview of the major activities in Year Three by domain area. We used the cross-cutting themes (i.e., workforce development, cultural competency, health disparities, public awareness), plus an additional systems change and sustainability category, to examine each activity (see page 19 for operational definitions). These represent critical areas of focus for PA Project LAUNCH that apply across domain areas. We also note the number of activities that were planned, to provide a more accurate overview of effort across domains.

Table 1: Overview of Year Three Major Activities across Domain Areas

Cross-Cutting Themes	Domain/Goal Areas				
	SA	*BHPH*	*ECMH*	*HV*	*FS*
Workforce Development	0	3 (30%)	8 (38%)	3 (25%)	3 (23%)
Cultural Competency	0	0	0	1 (8%)	0
Health Disparities	5 (42%)	1 (10%)	0	0	0
Public Awareness	0	1 (10%)	2 (10%)	3 (25%)	3 (23%)
System Change and Sustainability	5 (42%)	4 (40%)	13 (62%)	4 (33%)	6 (46%)
Planning Efforts	3 (25%)	6 (60%)	4 (19%)	4 (33%)	4 (31%)

Although many of the activities captured above align with local and state infrastructure efforts, there were additional infrastructure activities in Year Three that were not specific to domain area. Table 2 provides an overview of these major infrastructure efforts. We used the systems-activities and outcomes categories from the Multi-site Evaluation (MSE) of Project LAUNCH (i.e., coalition building, public information campaign, advocacy, funding and sustainability), plus an additional council governance category, to examine these additional infrastructure activities (see page 42 for operational definitions). This allowed us to delve deeper into systems- and infrastructure support, using a framework that aligns with other LAUNCH evaluation efforts.

Table 2: Overview of Year Three Major Infrastructure Activities

Systems and Infrastructure Activities	Domain/Goal Areas	
	Local Infrastructure	*State Infrastructure*
Coalition Building	16 (64%)	10 (67%)
Public Information Campaign	1 (4%)	2 (13%)
Advocacy	2 (8%)	0
Funding and Sustainability	1 (4%)	3 (20%)
Council Governance	5 (20%)	3 (20%)

It is important to note that quantifying these activities in these ways does not provide a measure of impact, however it does provide a snapshot of the ways in which LAUNCH efforts are targeted across the cross-cutting themes and systems-change categories. Across this wide range of Year Three activities, several warrant mention. In particular, this includes a project-wide focus on scaling up workforce development efforts by investing in Michigan's *Endorsement for Culturally Sensitive, Relationship-focused Practice Promoting Infant and Early Childhood Mental Health®* (Endorsement®) framework, and expanding outreach and service delivery opportunities within local communities.

In addition, project members spearheaded many successful activities and forged a number of important collaborations. Year Three activities also included more intentional focus across work groups on the three targeted pilot communities identified in Year One of the project. Other key accomplishments include increased school district representation, broader engagement with the pediatric community, planning around in-depth, cross-sector workforce development supports, and reinvigoration of local council and work group structures.

Several key activities in Year Three aimed to address the unique challenges that the extraordinary breadth and complexity of PA Project LAUNCH have brought to both the Implementation and Evaluation Team. These include the hiring of additional LAUNCH staff to support implementation, and revisions to the Strategic Plan and Evaluation Plan in Year Three. Prioritizing goals and activities still represents a major task for Year Four.

Year Three Outcome Evaluation Overview

Year Three also brought about several key outcomes in terms of increasing direct services at the systems-level (i.e., training, assessments aimed at improving practice; workforce development efforts), and for individuals and families. Some activities (e.g., targeted public awareness campaign for the Allegheny Link) resulted in both systems-level and individual child and family direct services outlines. We provide an overview of these outcome findings below.

Year Three Systems-Level Direct Services

Workforce development was a major focus of system-level direct service efforts in Year Three. Across domains, PA Project LAUNCH supported five trainings, serving over 400 providers. These trainings covered a range of activities, including early childhood behavioral health, supporting families dealing substance abuse, increasing provider cultural competency, and strengths-based parenting supports.

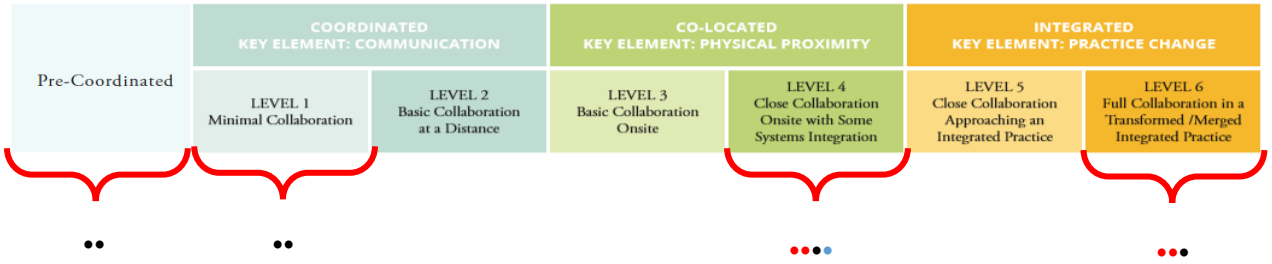
There were several other notable systems-level direct services focused on workforce development. At both the local and state-level, multiple activities involved complex planning to implement and sustain the use of the Endorsement® framework, including coursework development, planning and developing scholarship and funding supports to support candidates in the credentialing process, developing sustainable PD opportunities, and outreach to align higher education standards with the endorsement competencies.

Another important systems-level workforce development activity was the use of the Pediatric Practice Integration Assessment (PPIA) with 11 local practices that collectively serve over 80% of children in AC. Anecdotally, practices reported that engaging in this type of guided self-assessment served as an intervention in and of itself. The PPIA data collected in Year Three corroborate this, in that practices participating in follow-up assessments showed improved integration across time. These data have also provided the local BHPH Work Group with information to help focus workforce development efforts in Years Four and Five. Table 3 provides an overview of scores for the first section of the PPIA.
Another key system-level direct service outcome in Year Three was a targeted marketing campaign to increase the public's awareness of available service referrals, including the Allegheny LINK, a coordinated referral line.

Table 3: PPIA IPAT Summary

PPIA Part I: Integrated Practice Assessment Tool (IPAT)

IPAT Results:



Note: Pediatric Practices (PP) participating in Follow-Up are represented by a red dot; the PP that is participating in Baseline is represented by a blue dot; Federally Qualified Health Centers participating in Baseline are represented by a black dot.

Year Three Direct Services for Individuals and Families

A major focus on Project LAUNCH is the delivery of direct services (e.g., screening, referrals, interventions) to individuals and families. Table 4 provides an overview of the direct services that PA Project LAUNCH enabled in Year Three for individual children and families by domain.

Table 4: Overview of Year Three Direct Services for Individuals and Families

Direct Services	Domain/Goal Areas				
	SA	*BHPH*	*ECMH*	*HV*	*FS*
Screening	135	0	0	48	83
Referrals	48	0	0	732	27
Interventions	0	0	0	116	83

The majority of children and families who received direct services in Year Three were served through the Allegheny LINK. The Smart Beginnings team also enrolled 83 families, providing them with a wide range of important services and intervention. Community Screening events represent important work in terms of building cultural competency in the workforce (e.g., collaboration between screeners and translators; examining the cultural relevancy of existing measures) and community outreach. These activities represent an important area for understanding replication and generalizability issues, both locally and across the state.

Recommendations

Recommendation 1: *Continue to increase focus on identifying and implementing priority activities.* The breadth, depth, and overall complexities of PA Project LAUNCH continue to be both a strength, and a challenge, in terms of implementation and evaluation. Year Four activities should focus on targeted implementation activities that build on existing work group and council efforts, with project-wide concentration on supporting the priorities identified and begun in Year Three. We suggest that the project focus on "deliverables"---new policies, events, interventions, trainings, products, and procedures – and targeted outreach and partnership that support the implementation of those priority deliverables.

Recommendation 2: *Continue to prioritize sustainability and generalizability efforts.* Although both sustainability and generalization have been important considerations for all planning and activities from the start, these should become critical priorities in Year Four, given the breadth of the project, and timing in the grant's lifespan. Toward this purpose, we recommend increased focus on activities and planning to support sustainability and generalizability.

Recommendation 3: *Continue to examine and support local and state infrastructure efforts.* In Year Three, both the State and Local YCWCs focused on important structural and process efforts to support effective council governance. These activities represent important steps in this process, but Year Three evaluation results indicate that this is an area for continued growth. Targeted work has already begun in this area, but given the shifts that will be occurring at the State Council in Year Four, we recommend continued focus on family engagement, communication efforts, and cross-collaboration among Work Groups.

Recommendation 4: *Integrate implementation and evaluation frameworks.* As noted above, the breadth and complexity of PA Project LAUNCH represent strengths and challenges for both implementation and evaluation. As PA Project LAUNCH engages in more and more activities, documenting and evaluating the full range of these efforts in ways that provide the Implementation Team with timely and rich data is important area for partnership between evaluation and implementation. Toward this purpose, we hope to partner with the Implementation Team to leverage existing evaluation structures to support these focused efforts.

PA Project LAUNCH Logic Model

The logic model, which is provided in Table 5, was created in Year One in conjunction with the Strategic Plan. It summarizes the linkages between Pennsylvania (PA) Project LAUNCH's goals, objectives, activities, indicators, and anticipated outcomes. The model was updated in Year Three to reflect project partnerships with Smart Beginnings, the Allegheny Link (coordinated referral line) and the Pennsylvania Association for Infant Mental Health (PA-AIMH). The updated model also reflects the project's investment in *Endorsement for Culturally Sensitive, Relationship-focused Practice Promoting Infant and Early Childhood Mental Health®* (Endorsement®) as a statewide workforce development strategy.

Table 5: 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	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 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	PA & AC Work Groups 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 IMH and 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 Allegheny Link, coordinated referral line Evidence-Based Practices (e.g., PW-PBIS, Smart Beginnings/FCU, Parent Cafes) Endorsement® Framework PA-AIMH	Develop and provide training opportunities for HV providers on cultural competence, best practices, and high quality support processes 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	Home visiting staff trained in home visiting best practices and high quality support processes and culturally competent practices 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	Home visiting staff will have increased knowledge about best practices in home visiting within evidence based or evidence informed programs 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	Home visiting programs will provide behavioral and physical health resources to meet the needs of families and support home visiting staff 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

Table 5: Pennsylvania Project LAUNCH Logic Model (continued)

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 (Linking Actions for Unmet Needs in Children's Health) 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 eight years of age and their families, and pregnant women at risk for mental health concerns. Toward this purpose, Project LAUNCH focuses on five core prevention and promotion strategies: 1) screening and assessment, 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.

In October 2014, the Pennsylvania Office of Mental Health and Substance Abuse Services (OMHSAS) was awarded a Project LAUNCH grant. OMHSAS selected Allegheny County (AC) 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's Office of Child Development (OCD). See Appendix A for a list of Implementation Team members and Appendix B for key PA Project LAUNCH member's roles. OCD was selected as the subcontractor responsible for conducting the project's Environmental Scan, facilitating Strategic Planning activities, and completing Evaluation activities over the course of the grant.

The general purpose of PA Project LAUNCH is to enhance local and state infrastructure to support services for children birth to eight years of age, their families, and pregnant women. Broadly speaking, this involves services that aim to support the social-emotional development, behavioral health, and overall wellness of children who reside in these areas. This purpose was informed by the completion of an Environmental Scan in Year One. Scan results identified a variety of exemplary services and programs across the core Project LAUNCH goal areas, but indicated that the primary challenge was to coordinate and expand such model programs to meet the needs of families with young children who are facing multiple risk factors. Given its purpose of enhancing local and state infrastructure, PA Project LAUNCH has taken a broad approach, and focuses these efforts across all five of the Project LAUNCH prevention and promotion goal areas identified above. These, coupled with local and state infrastructure, represent the key *domains* of PA Project LAUNCH:

- ***Screening and Assessment [SA]***
- ***Behavioral Health and Physical Health Integration [BHPH]***
- ***Early Childhood Mental Health [ECMH]***
- ***Home Visiting [HV]***
- ***Family Strengthening [FS]***
- ***Local Infrastructure***
- ***State Infrastructure***

The PA Project LAUNCH Implementation Team used this framework to create five Local Work Groups (SA, BHPH, ECMH, HV, FS) that focus on each specific goal area; local and state infrastructure are the focus of the State and Local Young Child Wellness Councils (YCWC). The State and Local YCWC were established at the beginning of the grant and have been critically involved in planning and implementation activities since that time. These domains represent critical Implementation and Evaluation frameworks, and are used throughout the remainder of this report to structure and report results. In addition to these domains, we identified four *cross-cutting themes* (workforce development, cultural competence, health disparities, public awareness) in Year One that represent critical areas for PA Project LAUNCH. These themes are part of efforts that cut across domains, activities, and levels (i.e., local, state). These continue to be an important focus for the project, and are used in conjunction with the domains to report Evaluation findings.

The Strategic Plan

In Year One, the Work Groups, State and Local Councils, and Implementation Team worked collaboratively to create a project-wide Strategic Plan that detailed goals, objectives, and activities across the key domain areas and cross-cutting themes. This Strategic Plan was revised in Year Three at both the state and local-level as part of targeted efforts to realign implementation activities with project goals, and the long-term sustainability of the project. This revision process is described below.

Strategic Plan Revision

The PA Project LAUNCH Strategic Plan revision process began at the start of Year Three at the November 2016 State YCWC meeting. The Council's members created three state subgroups focused on supporting different components of state-level infrastructure: Communication and Collaboration, Prevention and Intervention, and Workforce Development. The three groups discussed current needs and began the revision of the state-level objectives and activities. The full Council then reviewed the suggested revisions and reached consensus on the initial modifications to the original Strategic Plan. This work continued at the state-level at the March 2017 State YCWC meeting and through a Qualtrics survey of all members, each targeting the activities of their selected subgroup area. Results of those discussions and surveys were used to create the state tables for the Strategic Plan. It should also be noted that the State YCWC Strategic Plan will be revised further in Year Four, given a newly planned shift of the work of statel-level project activities to the OCDEL Early Learning Council in Year Four (see Appendix C for a brief overview of this plan).

A parallel process took place with the Local YCWC. Local key members representing each of the five Work Groups submitted suggested revisions to the local objectives and activities. The Local YCWC Coordinator reviewed and modified these suggested revisions. In January 2017, the Work Groups met to provide the whole Local YCWC three pieces of information to move the Strategic Plan forward. This included a clear and succinct statement for what that Work Group had been working on, a list of anticipated activities to accomplish in six months, and questions for the Local YCWC to use in framing their ideas for progress in this goal area. In February 2017, the Local YCWC met to review each Work Group's draft from a multidisciplinary perspective (e.g., ECMH Work Group members sat in on the SA discussion to provide additional insights). This was done to ensure that the Plan had broad, project-wide considerations embedded in each domain area. Other discussions during this meeting included policy impact, workforce implications, lists of collaborators (at the local and state-levels), minimizing behavioral health disparities, and sustainability strategies. In March 2017, each Work Group met again to finalize their Strategic Plan sections. Each Work Group identified targeted goals and activities to prioritize in the short-term (i.e., six months), and long-term (i.e., Years Four and Year Five).

Once this work was completed a draft revised Strategic Plan was submitted to the PA Project LAUNCH Young Child Wellness (YCW) Expert, Coordinator, and Partner for editing. It should be noted that the template used for these revisions was modified from the original template provided by the Substance Abuse and Mental Health Services Administration (SAMHSA). This was done by the Work Groups with approval from PA Project LAUNCH staff to make the documents more functional for use by the members at both the state and local-levels. The modified template simplified the format and listed work to be done by including the goals, objectives, and activities for the next half of the five- year project by domain area.

The Evaluation Plan

Although the Strategic Plan was revised over the course of Year Three, this year's evaluation is based on the original Evaluation Plan, which was developed in conjunction with the original Strategic Plan in Year One. A revised Evaluation Plan will be submitted in Year Four that aligns with the updated Strategic Plan.

Our original Evaluation Plan was developed with input and support from the Implementation Team, Government Program Officer (GPO), and Technical Assistance (TA) providers, and aligns strongly with the key goals of the project. Namely, the primary intent of PA Project LAUNCH is **to promote and build infrastructure to services, practices, and policies that promote social-emotional wellness for children birth to eight years, their families, and pregnant women**, **particularly in three target regions in AC.** As such, the evaluation focuses on **documenting the process of providing that infrastructure support and the outcomes of the support activities**. Thus, **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, and
- regulations and policies created.

The outcomes of these support activities include changes in the knowledge, skills, and /or attitudes of the child, family, and providers as a result of the processes 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 Three Evaluation Report. What follows here and in other sections of the report represents plans established in Years One-Three and implemented in Year Three. A complete list of acronyms can be found in Appendix D. The evaluation methods described below apply to all the activities proposed in the initial Strategic Plan. All activities implemented in Year Three are described under Results by domain area, and key activities and evaluation recommendations are summarized with a focus on PA Project LAUNCH Year Three impact.

Methodologies for Specific Goal Areas

In this section, we describe the evaluation methodologies for each of the PA Project LAUNCH domain areas. We start generally by describing the process and outcome evaluation strategies that apply to all potential activities, and then we specify specific activities for each domain area in Table 6. Process evaluation activities across domain areas include record reviews, count data analyses, surveys, and targeted interviews. 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. Table 6 describes the Process Evaluation Activities, Outcome Evaluation Activities, and Highlighted Evaluation Efforts Moving Forward.

Process Evaluation Methodologies

Across all domain areas, 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 E for Meeting Minutes Template) and project records (e.g., GPO Summary reports, membership counts, meeting attendance), and completion of an online end of quarter survey (See Appendix F: End of Quarter Survey), by the current YCW Coordinator, YCW Expert,

YCW Partner and other key PA Project LAUNCH staff. This survey was adapted in Year Three to a quarterly format in order to facilitate reflection across the year. In addition, the Evaluation Team also attends targeted Work Group and YCWC meetings, and PA Project LAUNCH activities in order to document and probe implementation processes. These mixed-methods approaches are referred to as "Core Process Evaluation Activities."

Outcome Evaluation Methodologies

The Evaluation Team uses a mixed-methods case study approach across all domain areas to measure outcomes of key activities, when appropriate. It is important to note that many of the activities in PA Project LAUNCH involve creating targeted systems-level outcomes, such as increased trainings or infrastructure efforts. Although these outcomes are different than traditional intervention efforts, they align with the sustainability goals of the project, so we include measures of these efforts in our outcome evaluation, when appropriate.

This approach includes targeted examinations of change in knowledge, skills, practice, or activities, using various methods such as self-reports and surveys, pre-post assessments, and longitudinal record keeping. The Evaluation Team developed training surveys for general use, since training is likely to occur across project domain 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 G: 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; 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 H: Follow-Up Training Survey) is administered by email approximately three months after the training for those trainings that emphasize specific practice techniques. It assesses the extent to which the training increased participants' knowledge, confidence, and access to resources; the extent to which the information was implemented in their practice; and the nature of that usage (open ended).

In addition, we will continue to partner with Smart Beginnings to assess individual-level child and family outcomes. Smart Beginnings is investigating the use of the Family Check-Up (FCU)[1] intervention, in conjunction with the use of a tier 1 videotaped parent-child interaction with feedback intervention (VIP)[2]. Our evaluation will utilize the Smart Beginning study's rigorous experimental design that examines impacts across three conditions (VIP Only, VIP + FCU, no treatment) on a wide range of child and family outcomes. The comparison of VIP Only and no treatment families will provide evidence for the effectiveness of the VIP intervention for various aspects of child and parent characteristics and parent-child interactions. The VIP + FCU vs. VIP Only intent-to-treat comparison will assess the additional benefit of the FCU intervention at this young age. 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.

[1] 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.

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

[3] **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

Table 6: Evaluation Activities by Goal Areas

Goal Area	Process Evaluation Activities	Outcome Evaluation Activities	Highlighted Evaluation Efforts Moving Forward
Screening and Assessment	• Core Process Evaluation activities • Documentation of screening processes and perceptions through the most appropriate method for the event or agency setting.	• Direct service screening and referral data collection • Collaboration with provider agencies to facilitate data collection through the most appropriate method for each agency. • Post-event surveys for family members	• Use of Data Matrix Tool to streamline data collection and drive data-based decisions (see Appendix I for an overview). • Deeper-dive follow-up on community events to support development of Replication Manual.
Behavioral Health and Physical Health Integration	• Core Process Evaluation activities • Completion of PPIA summaries to identify themes that will guide the major activities of subsequent BHPH Work Group meetings and collaborations	• Completion of PPIA with 11 local practices (4 main pediatric health practices in the region completed follow-up assessments; 7 additional practices completed baseline)	• Use of Data Matrix Tool to streamline data collection and drive data-based decisions • Integrating CHADIS evaluation into existing PPIA assessment and MSE:DSS systems.
Early Childhood Mental Health	• Core Process Evaluation activities • Completion of training surveys	• Post- and Follow-up training surveys	• Use of Data Matrix Tool to streamline data collection and drive data-based decisions • Development of organizational intake survey system to examine training impact on organizational capacity. • Collaborating to align evaluation of PA Endorsement® process with broader national evaluation efforts. • Collaborating to align evaluation of Conscious Discipline scholarships with broader national efficacy study.
Home Visiting	• 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	• Use of Data Matrix Tool to streamline data collection and drive data-based decisions
Family Strengthening	• Core Process Evaluation activities • Collection of Smart Beginnings data on the # of families, # of interventions completed, implementation fidelity • Completion of training surveys	• Parent, child, & family assessments • Post- and Follow-up training surveys	• Use of Data Matrix Tool to streamline data collection and drive data-based decisions • Collaborating with Parent Café Training Institute to collect training evaluations
Local Infrastructure	• Core Process Evaluation activities • Completion of MSE: Systems survey	• Completion of Wilder Collaborative Factors Inventory with current and past local YCWC and Work Group members	• Use of Data Matrix Tool to streamline data collection and drive data-based decisions. • Local infrastructure and systems change efforts will be reorganized in Year 4 (see Year 4 Evaluation Plan for more details)
State Infrastructure	• Core Process Evaluation activities • Completion of MSE: Systems survey	• Completion of Wilder Collaborative Factors Inventory with current and past State YCWC and Work Group members	• Use of Data Matrix Tool to streamline data collection and drive data-based decisions. • State infrastructure and systems change efforts will be reorganized in Year 4 (see Year 4 Evaluation Plan for more details)

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 Three. 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, domain, purpose) when appropriate.

Surveys

Much of the qualitative information in Year Three is from the Monthly GPO Reports and End of Quarter Surveys, as these offer contextualized reports of critical activities, such as events, collaborations, stakeholders, and infrastructure considerations. Other measurements provide quantitative scores (e.g., Wilder Inventories, pediatric provider assessments, training questionnaires). Mean ratings averaged over participants are presented and comparisons across years are investigated for assessments that are repeated over time. We conduct statistical analyses of longitudinal or cross-sectional change across time when appropriate; but sometimes sample sizes limit the statistical analyses available, and we simply plot average scores or provide frequencies.

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

The main source of individual child, parent, and family outcome data comes from our partnership with Smart Beginnings. 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, VIP Only, and VIP +FCU. The comparison of VIP Only and Control families will provide evidence for the effectiveness of the VIP intervention for various aspects of child and parent characteristics and parent-child interactions (See Appendix J: Smart Beginnings Measures). 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 Year Three, the project team focused on participant recruitment, delivery of the VIP and VIP + FCU interventions, and baseline data collection. The Smart Beginnings team will share data with the PA Project LAUNCH evaluation team, after a significant number of families have been assessed.

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

Gaps and Limitations

The Evaluation Team is dependent on cooperating agencies and participants to provide process and outcome data throughout the project year. Agencies and participants vary in the nature of the information they collect and the extent of their cooperation in providing it to us. As such, the analyses of process and outcome data for Year Three are limited by the nature and extent of data that are made available to the Evaluation Team by cooperating agencies.

Much of the evaluation data expected in subsequent years will continue to be frequencies and percentages. The exceptions are the Smart Beginnings and PPIA data sets. Smart Beginnings 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) 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 Family Check-Up intervention is only given to a subsample of VIP families who are identified as at-risk at 6 month and consent to participate in the intervention. VIP families not offered the FCU intervention are 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.

The local pediatric community will continue assessing the extent to which they are able to integrate behavioral health strategies into their practices. Five pediatric groups completed follow-up Pediatric Provider Integration Assessment (PPIA) measures in Year Three and we anticipate that an additional six programs will complete follow-up assessments in Years Four and Five. The Evaluation Team will assess change over time at an individual level for each pediatric provider group or health center, rather than aggregating results, in light of the small sample size.

There are several additional limitations and constraints to this evaluation that warrant mentioning. Small sample sizes (e.g., overall, lack of buy-in from some trainees on post- and follow-up surveys), the fact that each goal area takes the form of a case study, and response rate variations on longitudinal measures (e.g., Wilder Collaboration Factors Inventory) limit the viability of some statistical analyses, and the generalizability of project findings.

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 many service agencies and participants and covers a large geographical area. For these reasons, most of Years One and Two were 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 during the first years of the grant, particularly considering the project's breadth and complexity.

In Year Three, PA Project LAUNCH focused intently on scaling up workforce development efforts by investing in the *Competency Guidelines for Endorsement in Culturally Sensitive, Relationship-Focused Practice Promoting Infant and Early Childhood Mental Health*® (Endorsement®). This is a multifaceted endorsement and professional development system developed by the Michigan Association for Infant Mental Health's (MI-AIMH) (see Appendix K for an overview; we refer to this system generally as Endorsement® throughout this report). Additional efforts involved expanding outreach and service delivery opportunities within local communities. Project members spearheaded many successful activities and forged many important collaborations. Key accomplishments include increased school district representation; broader engagement with the pediatric community; planning around in-depth, cross-sector workforce development supports; and reinvigoration of local council and Work Group structures. We present evidence next of the collaborative spirit, hard work, and multiple interest areas of PA Project LAUNCH members and partners.

As is discussed above, many of the outcomes of this process are the very activities themselves. In reviewing and analyzing the copious amounts of data collected in Year Three, we have chosen to present these findings by domain area. Whenever possible, with an eye toward synthesis and accessibility, we combine and code activities into larger units. In this way, we can document the breadth and complexity of PA Project LAUNCH activities without losing sight of the big picture and larger impacts the project is having on the County or the Commonwealth. Toward this purpose, in the next section we provide a table with a summary of the activities that occurred in each domain area. We have coded these activities by the cross-cutting themes identified in Year One (i.e., workforce development, cultural competency, health disparities, public awareness, system change and sustainability), as these represent critical areas of focus for PA Project LAUNCH that apply across domain areas. Each theme is defined below.

(a) *Workforce Development (WFD)*: Any activities that promote workforce development through: 1) trainings (i.e., professional development, workshops, conferences, professional learning communities, coaching, consultation, supervision); 2) assessments; 3) the development or dissemination of resources or materials; and 4) infrastructure to support workforce development (i.e., training trainers, policies around training and certification, building training systems).

(b) *Cultural Competency (CC)*: Any activities that promote increasing cultural competency in the workforce through: 1) trainings, 2) interventions, 3) assessments, or 4) resources and materials.

(c) *Health Disparities (HD)*: Any activities that 1) increase access or direct services for populations experiencing health or behavioral health disparities, and/or 2) decrease disproportionate representation of children or families across various health or behavioral health areas.

(d) *Public Awareness (PBA)*: Any activities that promote project goals through: 1) dissemination and public relations efforts, or 2) outreach efforts.

(e) *System Change and Sustainability (SCS)*: Any activities that promote the development of systems or supports that promote long-term sustainability through 1) funding, 2) policy, 3) infrastructure, 4) collaboration and outreach, and 5) other sustainability efforts (e.g., replication, maintenance, generalization).

(f) *Planning:* These are activities that contribute to the planning of the types of activities listed above.

Each summary table also indicates the evaluation approach that was used to document and measure activity outcomes (i.e., process or outcome approach, described above), and a code for whether the activity occurred at the local or state-level. Key themes and findings are then presented in more detail in the text for each domain area

Findings by Domain Area

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.

Table 7: Year Three Screening and Assessment Activities

Activities		Targeted Area	Evaluation Method	Level
SA1.	Trained screeners and interpreters for community screenings. Provided screenings in fall for the Nepali community	HD	Process Outcome	Local
SA2.	Conducted activities to inform planning of future screening events including post-event reflections and collaboration with a psychologist on the content of child development informational sessions	HD	Process	Local
SA3.	Gathered feedback from Nepali mothers that participated in fall screenings via focus groups	Planning	Process	Local
SA4.	Planned and conducted a child development information session in the fall with Nepali families	HD	Process Outcome	Local
SA5.	Planned and provided developmental screenings at a spring Nepali screening event	HD	Process Outcome	Local
SA6.	Planned a final event with the Nepali community to support continued efforts/provided materials on community leadership and advocacy	SCS Planning	Process	Local
SA7.	Connected Nepali families interested in becoming licensed home care providers with Keystone STARS support	SCS	Process	Local
SA8.	Engaged Somali Bantu tribal elders in discussions on providing screenings and child development events for their communities	Planning	Process	Local
SA9.	Planned and conducted a child development event for Somali Bantu families and other community members; 200+ community members attended	HD	Process	Local
SA10.	Engaged Local YCWC on additional "populations" to support through SA Work Group activities; suggested populations: children experiencing homelessness and high lead exposure	SCS	Process	Local
SA11.	Helped PA revise rules and guidelines around ECE performance standards (Keystone STARS Program Performance Standards)	SCS	Process	State
SA12.	Offered to extend the TA and consultation support provided by LAUNCH and ACDHS, around screening and referral , to a wider audience of Child Welfare staff	SCS	Process	State

Year Three SA Activities and Process Evaluation Progress

Local

Community Screening

The SA Work Group planned, implemented, and assessed a series of community screening events for Nepali families in one local community (see Table 7, SA1-7) and planned a series of Year Four events for Somali Bantu families in a second community (SA8-9). Key activities included: (1) engaging families and community leaders, (2) developing and orienting staff on culturally appropriate screening and parent

support processes, (3) conducting screening and parent information events, (4) assessing and refining community event procedures, and (5) collaborating with families and leadership on strategies to advance community screening and advocacy efforts independent of PA Project LAUNCH support. This last step has also involved targeted outreach to connect interested families with the Keystone STARS program, and has resulted in seven providers working toward becoming licensed home care providers (SA7). This activity was driven by conversations with Nepali families highlighting the fact that their community highly values home-based care where children are strongly connected to their home culture and language. In addition, this Work Group and project leadership started exploring opportunities to support additional communities (i.e., children experiencing homelessness and high lead exposure) through community screening activities.

System Change Activities

This year, the SA Work Group engaged in two system-level activities (SA11, 12). The first of these activities involved offering additional support to a local staff member[4] that provides TA to child welfare workers on the Ages and Stages Questionnaires® , Third Edition (ASQ-3), the Ages and Stages Questionnaires: Social-Emotional®, Second Edition (ASQ: SE-2), and general screening and referral processes. The second system change activity involved assisting in the revision of state-level quality rating system for early care and education programs.

State

Workforce Development Policies

PA Project LAUNCH participated in revising the state's quality improvement rating system for ECE programs (i.e., Keystone STARS Program Performance Standards) through the state's Race to the Top Early Learning Council (RTT-ELC) grant (SA11). The revised standard enables STAR 3 and 4 programs to earn points by providing professional development to new staff, within one year of hire, and annual refreshers or advanced training opportunities to existing staff as needed. These revised standards also include specific screening and assessment criteria (e.g., all children screened with a research-based screening tool within 45 days of enrollment, professional development requirements for staff around screening), which the SA Work Group helped inform. The inclusion of these screening criteria is particularly notable given state-level policy shifts that result in all licensed programs being awarded a STAR 1, with opportunities to participate in ongoing quality improvement to obtain a STAR 2, 3, or 4. In the past, programs could opt in or out, but this policy shift provides importance incentives for programs to invest in screening, given its inclusion in the revised standards. The state released the updated standards in June 2017. See Appendix L for a brief description of the STAR program levels.

Workforce Development Resources

Local PA Project LAUNCH efforts provided consultation and technical assistance support to child welfare staff in Allegheny County's Office of Children, Youth, and Families (OCYF; SA12). In addition, after Local staff attended trainings in which outdated screening kits were used, the YCW Expert engaged in outreach that resulted in the RTT-ELC purchasing updated ASQ-3 and ASQ:SE-2 kits. The YCW Expert also extended offers to support these activities and provide training support to additional child welfare offices where needed.

[4] DHS staff liaison jointly supports goals of the SA Work Group through her TA activities.

Year Three SA Outcome Evaluation Progress

Individual Child and Family Direct Service Outcomes

As noted above, PA Project LAUNCH supported screening and assessment activities through local- and state-level efforts in Year Three. Project screening and assessment activities extended across multiple domains, and are reported as such (e.g., outcomes associated with screening via the Link are reported in the HV section; outcomes associated with the Smart Beginnings project are reported in FS). For the SA Work Group, we report outcomes associated with community screening events, and outcomes associated with the partnership between the Alliance for Infants and Toddlers (AFIT), and early intervention (EI) program, and the OCYF.

The SA Work Group's support resulted in 234 completed screens for 135 children and service referrals for 48 children (see Table 8). Staff from the AFIT/OCYF partnership administered both developmental and social emotional screens to 93 children ages birth to five years. They most frequently screened and referred children under three years of age. The age distribution for this group of children was as follows: birth-two years: 66 children (71.0%) screened and 27 children (65.9%) referred; three-five years: 27 children (29%) screened and 14 children (34.1%) were referred.

Staff administered screens to 42 children (31.1%) at two Nepali community screening events. Most children received ASQ-3's or developmental screens (*n* = 40). However, staff also completed eight behavioral screens (i.e., ASQ: SE-3's). Demographic information for this group of 42 children was as follows: 100% were Asian, 45.2% were male, 54.8% were female, 42.9% were under two, 47.6% were three-four years-old, and 9.5% were five-six years old.

Table 8: Number of Screens Facilitated by SA Work Group Efforts

Year Three SA Activities	# Children				# Completed Screens				Total Screens
	Screened		Referred		ASQ 3		ASQ:SE 2		
	N	%	N	%	N	%	N	%	N
Y3 Community Screening Days	42	(31.1%)	7	(14.6%)	40	(30.1%)	8	(8%)	48
Y3 EI/Child Welfare Partnership (AFIT/OCYF)	93	(68.9%)	41	(85.4%)	93	(69.9%)	93	(92%)	186
Y3 Total Across Collaborations	**135**		**48**		**133**		**101**		**234**

A central goal of the SA Work Group has been to develop and implement culturally sensitive screening, referral, and communication processes. In Year Two, they made cultural and linguistic adaptations to screening procedures with input from local community members. They also oriented both screeners and translators to the overall process and adaptations developed for the Nepali community, ensuring that screeners were familiar with the cultural considerations, and that translators were familiar with the screening procedures.

In Year Three, the SA Work Group organized one outreach event, one child development events, and two community screening days for the Nepali community. During the outreach event, 25 families pre-registered their children for the first community screening. Twelve mothers and 21 children attended the first screening event in November 2016. Sixteen parents and 21 children attended the child development information event held after the first screening. Seven parents pre-registered their children at this event for the May 2017 community screening. Twenty-one 21 mothers and 25 children attended this screening event.

Many parents who were involved in the various screening events did not speak English. As such, the team of interpreters played a pivotal role in this effort's success. The SA Work Group engaged six interpreters from Echo International. A brief questionnaire was conducted to gather information on the interpreters (*n* = 6) who assisted at these events. Across the group, 5 of the interpreters were from Bhutan while 1 was from Nepal. All of the interpreters rated themselves as good/proficient in English (100%). Many (83%) had received training as interpreters, and a third (33%) had experience in education or early childhood contexts. These interpreters had worked as in the field for an average of 5 years, and had lived in the United States for an average of 5.7 years. The interpreters translated communications (e.g., screening questions, responses, directions, concerns, results, and next steps), between screeners and parents, and administered screening activities with families with support from the screeners.

The Work Group surveyed mothers at the first community screening on the support provided by interpreters. Interpreters translated and recorded these responses. All mothers (*n* = 12) reported that the interpreters were helpful and eight of the twelve mothers shared that the interpreters helped them understand, communicate with, and feel comfortable with the screeners and the screening process. This survey was not completed at the second event as the Work Group felt that asking the interpreters to support evaluation of their own work biased results. Screeners and an evaluator also assisted at each event. Screeners guided the process, scored and interpreted measures, addressed concerns, and made referral recommendations when warranted. The evaluator captured information on key processes, demographics, areas that worked well, and areas for future refinement.

To inform planning efforts, the Work Group surveyed mothers at each community screening day and documented key aspects of parent and staff experiences (see Appendix M for the complete survey). Mothers at both community screenings shared their perceptions of the screening experience and its potential influence on their future actions. All mothers (*n* = 31) reported that they enjoyed, felt welcome, and found the experience worthwhile and helpful. Most mothers (*n* = 30) felt they were understood by their child's screener and all reported that screeners took their concerns and questions seriously. When asked to share the extent to which the screening experience would influence their actions in the future, many mothers (61-77%) indicated that they would follow-up on referral recommendations and suggestions, and try new things with their children. Furthermore, most mothers (81-89%) reported that they would share information from the event and recommend the experience to others. Table 9 provides a summary of mothers' survey responses about their future actions[5].

[5] Survey comments were translated and recorded by the translator. There appear to have been some language barriers with the survey though, as one person at each session selected all options on the checklist. These have been dropped from the analyses so as not to skew the data.

Table 9: Community Screening Events Family Feedback Survey Results

Family Survey Questions:			
As a result of today's event I will:	Overall	Session 1 (*n* = 11)	Session 2 (*n* = 20)
Follow-up on a referral for my child, if one was given.	19 (61%)	8 (73%)	11 (55%)
Follow-up on a suggestion for my child, if any were given.	22 (71%)	8 (73%)	14 (70%)
Try something new at home with my child.	24 (77%)	9 (82%)	15 (75%)
Share information with someone I know.	27 (89%)	9 (82%)	18 (90%)
Refer someone I know to an event like this.	25 (81 %)	9 (82%)	16 (80%)
I am not sure at this time.	2 (6%)	0	2 (10%)
I will do nothing differently.	0	0	0

Additional Family Comments

- I feel good. After, my kids did follow up with screener.
- This event is so much helpful to do the overall development of my child.
- I'm first mother of my child. Thank you so much [for the] ideas [you] give to me [to] give my baby [for] upbringing.
- I am able to concern my question. Event was very helpful. Thank you everyone.
- Interpreter is all helpful. I understand the kids' concerns and questions. Very helpful. Thank you.
- I enjoy event a lot.
- Everything done today was really helpful.
- Mom says to help her child speak. Mom wants to do the full evaluation.

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 eight years, pregnant women, and their families.

Table 10: Year Three Behavioral and Physical Health Integration Activities

Activities		Targeted Area	Evaluation Method	Level
BHPH1.	Conducted PPIA with 11 practices	WFD HD	Process Outcome	Local
BHPH2.	Used PPIA results to plan targeted focus on supporting FQHCs	Planning	Process	Local
BHPH3.	Developed and shared resources with multiple practices and audiences	WFD PBA	Process	Local
BHPH4.	Developed Universal Electronic Screening (CHADIS) RFP	SCS	Process	Local
BHPH5.	Targeted outreach to gather information from local payers and other states on different payment models and reimbursement	SCS Planning	Process	Local
BHPH6.	Partnered with local parent advocacy network to develop parent focus groups exploring family perspectives on sharing child health information	Planning	Process	Local
BHPH7.	Targeted outreach with multiple organizations to explore promising practices and tools that support integration work through electronic health record systems	Planning	Process	Local
BHPH8.	Supported the Behavioral Health Conference	WFD	Process	State
BHPH9.	Targeted outreach with multiple key stakeholders	SCS Planning	Process	State
BHPH10.	Partnered with PA-AIMH board members to create integrated BHPH workgroup focused on IMH Endorsement® system	SCS Planning	Process	State

Year Three BHPH Activities and Process Evaluation Progress

Local

PPIA

In Year Three, the BHPH Work Group continued and expanded their assessment of levels of behavioral and physical health integration to 11 practices in Allegheny County (see Table 10, BHPH1). This included five pediatric practices (PP) that collectively provide services to about 80% of all children within AC; four of these PP were participating in a follow-up assessment after completing a baseline assessment in Year Two. The other six practices were federally qualified health centers (FQHC) that provide care to uninsured and underinsured individuals in underserved communities; these FQHC collectively provide services to about 5% of children within AC. All six FQHC and one PP were participating in baseline assessments in Year Three. 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). Members of the BHPH Work Group conducted these assessments, and then members of the Evaluation Team analyzed results (see Outcomes below). After reviewing these results, the BHPH Work Group has decided to focus on targeting federally qualified health centers for assessment and integration support (BHPH2).

CHADIS

Another major focus of the BHPH Work Group in Year Three was the decision to fund up to three pediatric/primary care practices to implement a universal electronic screening intervention with their pediatric population. After targeted outreach with multiple electronic health record providers (BHPH7), the Work Group decided to partner with Child Health and Development Interactive System (CHADIS), an

electronic health record screening system. These efforts have culminated in the draft of a request for proposals (RFP); the award will include one year of CHADIS support (e.g., programming, training, electronic equipment), and funding for a short-term CHADIS Support Partner to assist the practice with program and process implementation.

Public Awareness
The BHPH Work Group also engaged in a number of activities that raised awareness and shared important resources over the course of Year Three (BHPH3). These included the development and sharing of a resource listing validated screening tools, and the development of a list of BHPH policy recommendations for a wider state audience. This also included targeted public awareness activities that aimed to ensure that all local primary care providers are aware of the Children's TiPS (telephonic psychiatric consultation service) on-call psychiatry service.

Outreach
The BHPH Work Group also engaged in a number of targeted outreach efforts to increase collaboration, and build the sustainability of BHPH work locally. Of note are several efforts (BHPH5) to reach out to local payers to discuss issues such as reimbursement for behavioral screening, and to build payer awareness of the importance of care coordination and the services needed to support effective BHPH integration. Other outreach efforts (e.g., BHPH5, 6) have included reaching out to other states to learn about successful payment models in an effort to inform policy recommendations, and collaboration with family advocacy groups to ensure that parents' perspectives on sharing children's health information across Behavioral Health and Physical Health sectors.

State
Outreach and Workforce Development
State-level activities in support of the BHPH Work Group in Year Three largely focused on various forms of outreach (e.g., connecting with researchers, program coordinators, attending conferences). Additionally, support was provided to PA OMHSAS in their System of Care (SOC) Expansion grant application to embed the tenets of Project LAUNCH in a broader SOC framework across new counties. There was also planning support for a Behavioral Health conference that aimed to increase pediatrician's awareness of integration practices.

System Level Direct Service Outcomes
Pediatric Practice Integration Assessment Summary
As noted above, in Year Three, 11 practices were assessed with the PPIA. Table 11 provides an overview of the practices that participated in Year Three. The PPIA, which is presented in Appendix N, is adapted from the *Integrated Practice Assessment Tool* (IPAT) and the *Mental Health Practice Readiness Inventory* (MHPRI). It provides a snapshot of the nature and extent of each practice's integrated care services. The PPIA is completed by the practice group's director and major professional staff to give a composite picture of the entire practice group; actual practices within the group may vary for different physicians and different locations. These key members also participated in an interview where they discussed integration challenges and successes in more depth.

Table 11: Overview of PPIA Participants

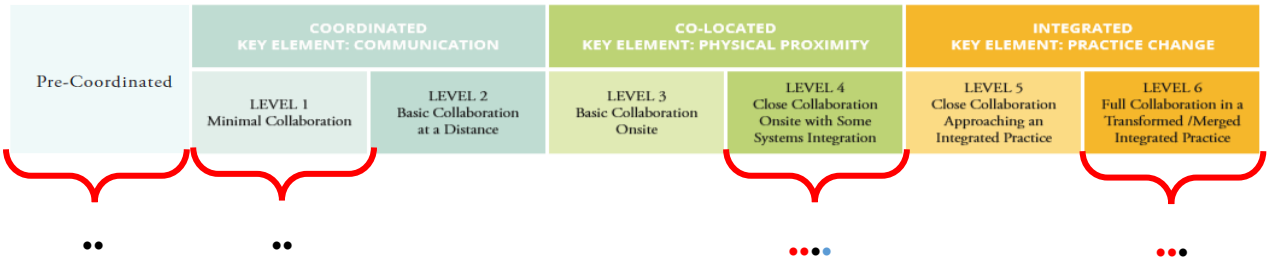
PPIA Participants	**5** Pediatric Practices (PP) **serving 80% of AC Children** **6** Federally Qualified Health Centers (FQHC) **serving 5% of AC Children**	• ***4*** *PPs were participating in a Follow-Up assessment after completing Baseline in Year 2* • ***1*** *PP and all* ***6*** *FQHCs were participating in Baseline*

Table 12 provides an overview of IPAT results across practices. Overall, the results indicate that the PP, who provide services for a large majority of children in the County, are attempting to integrate behavioral health services in their practices, some with great success. There is more variability with the FQHC. Anecdotally, the PP participating in follow-up assessments reported that engaging in this type of guided self-assessment served as an intervention in and of itself. Structural differences between the practice types (e.g., focus on systems of support specifically for young children, regulatory and payment differences, resource differences) may also contribute to differences among the practice types.

Table 12: PPIA IPAT Summary

PPIA Part I: Integrated Practice Assessment Tool (IPAT)

IPAT Results:



Note: PP in Follow-Up = red dot; the PP in Baseline = blue dot; FQHCs in Baseline = black dot.

Table 13 provides an overview of results across practices for the MHPRI results. Overall, the results indicate that there is significant variability across practices and practice-types (i.e., PP, FQHC) in terms of level and areas of integration. Overall, practices participating in follow-up identified more strengths, whereas practices participating in Baseline identified more areas for improvement.

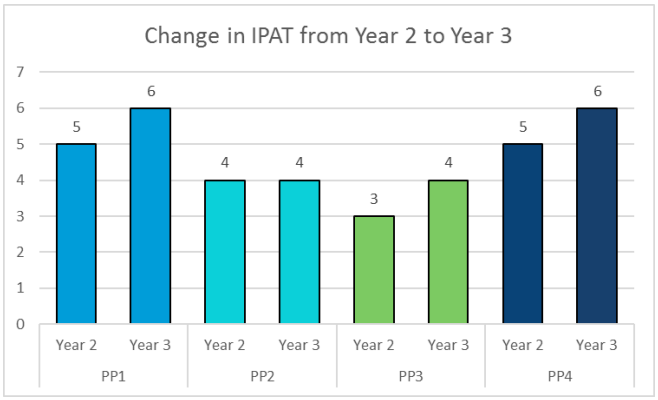
Table 13: PPIA MHPRI Summary

PPIA Part II: Mental Health Practice Readiness Inventory (MHPRI)				
Item	**We do this well**	**We do this to some extent**	**We do not do this well**	**TOTAL**
Referral Assistance	●●●●●●●●	●●●		14
Clinical Guidance	●●●●●●●	●●●●		15
Recall and Reminder Systems	●●●●●●●	●●	●	15
Tracking Systems	●●●●●●●	●●●	●	16
Information Exchange	●●●●●●●	●●	●●	17
Engagement	●●●●●●	●●●●	●	17
Screening & Assessment Tools	●●●●	●●●●●●●		18
Care Coordination	●●●●	●●●●●●		18
Special Populations	●●●●	●●●●●	●●	20
Screening and Surveillance	●●●	●●●●●●	●	20
Functional Assessment	●●●●	●●●●●	●●	20
Quality Improvement	●●●●●	●●	●●●●	21
Collaborative Relationships	●	●●●●●●●●●		21
Mental Health Promotion	●	●●●●●●●	●●	23
Protocols	●●	●●●●	●●●●●	25
Registry	●●	●●●	●●●●●●	26
Care Plans		●●●●	●●●●●●	29

Note: PP in Follow-Up = red dot; the PP in Baseline = blue dot; FQHCs in Baseline = black dot. MHRI cross-practice item scores are categorized based on the following cut off scores: *Green/Strength* = 11-18; *Yellow/Area of Improvement* = 19-25; *Red/Area of Change* = 26-33. Some items (e.g., Quality Improvement, Collaborative Relationships) may have the same cross-practice score, but represent different patterns of practice.

Figure 1 provides an overview of IPAT and MHRI changes for the pediatric practices who participated in baseline and follow-up assessments. Three out of the four practices improved on the IPAT (e.g., went from a score of five to score of six), whereas all four practices improved on the MHPRI (e.g., dropped from a score of 36 to a score of 39). Again, practices reported that completing the PPIA helped them to self-reflect and plan for improvement, indicating that the assessment itself may serve as a type of intervention.

Figure 1: Change in PPIA Summary



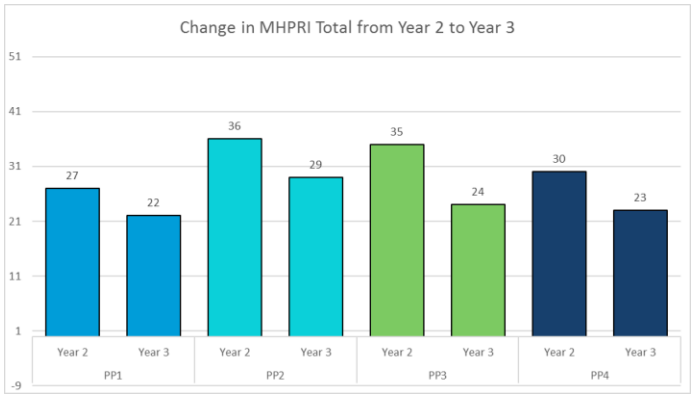


Table 14 provides an overview of interview results across practice types (for a more in-depth review of these data by practice type, see Appendix O). Results indicate that the significant structural differences between practice types may impact integration (e.g., differences in payment and reimbursement processes and regulations, family practices vs pediatric practices), but there are some challenges that are consistent across the board. Anecdotally, self-ratings on the PPIA appeared to reflect the way practices adapt to work within given systems, but interviews highlight more reflection and additional areas for change (e.g., most practices rated Tracking systems as strengths, but all also noted challenges in working within these systems).

Table 14: PPIA Qualitative Summary

Qualitative Summary of Differences between PPs and FQHCs
• PP report more consistent/higher levels of integration. • FQHC report more variable levels of integration, particularly for young children, but many appear to have some level of integration or system in place for adolescents and adults. • Reimbursement challenges are structurally different for FQHC than PP (e.g., some, but not all behavioral health services are covered as part of per-visit reimbursement for FQHC; reimbursement is a major obstacle for PP) • FQHC cite more regulations and requirements (e.g., hiring requirements) as obstacles toward integrating behavioral health • Both PP and FQHC note that there are challenges related to the variability in electronic health record systems (e.g., some systems only share certain screens or records), and inconsistencies in the way that screens and referrals are reported and shared • Both PP and FQHC highlight the need for more streamlined and coordinated referral processes. Different practices report different follow-up approaches (e.g., following up by calling or faxing outside agencies), but many note that variability and inconsistency are issues given the staffing time and individual approaches involved • FQHC report limited pediatric behavioral health services and limited availability of qualified providers as a major obstacle, but PP also note this as an area of concern and area for possible training

Early Childhood Mental Health Findings

PA Goal 3: Strengthen existing ECMH consultation and extend services to children, birth to eight years, and pregnant women in multiple early childhood settings.

Table 15: Year Three Early Childhood Mental Health Activities

Activities		Targeted Area	Evaluation Method	Level
ECMH1.	Hired ECMH Learning Collaborative Project Manager	SCS	Process	Local
ECMH2.	Planned and provided trainings for the Student Assistance Program	WFD	Process Outcome	Local
ECMH3.	Piloted program in target community (Woodland Hills) to reduce stigma around mental health	PBA WFD	Process	Local
ECMH4.	Created and implemented Differentiated Supervision Action Project (DSAP) courses	SCS WFD	Process	Local
ECMH5.	Selected initial "Implementation Cohort" for Endorsement® process	SCS WFD	Process	Local
ECMH6.	Curated early childhood materials that will be incorporated in Mental Health First Aid trainings	WFD	Process	Local
ECMH7.	Created scholarship opportunities to send professionals to conferences	WFD	Process	Local
ECMH8.	Facilitated a meeting to discuss the possibility of reimbursing FCU services through Medical Assistance	SCS	Process	Local
ECMH9.	Developing plan to bring reflective supervision/consultation to local systems	Planning	Process	Local
ECMH10.	Developed and distributed needs surveys to identify and gauge needs/interests on various topics	WFD	Process	Local
ECMH11.	Collaborated with the Children's Hospital of Pittsburgh's efforts on trauma-informed schools	SCS	Process	Local
ECMH12.	Presented and shared information on Endorsement® framework and competencies with various audiences	PBA	Process	Local
ECMH13.	Finalized plans to create sustainable professional development opportunities that support the Endorsement®	SCS Planning	Process	Local
ECMH14.	Added the Endorsement® competencies to the RTT-ELC RFA for innovative programs	SCS WFD	Process	State
ECMH15.	Collaborating with PA-PBS Network around the statewide expansion of program wide PBIS	SCS	Process	State
ECMH16.	Received onsite training and TA on the Endorsement® process from the Alliance for the Advancement of IMH	SCS	Process	State
ECMH17.	Informed state application for SAMHSA Center of Excellence in I-ECMH Technical Assistance opportunity.	SCS	Process	State
ECMH18.	Developed a dedicated online presence and online assessment strategies for the Endorsement®	SCS	Process	State
ECMH19.	Aligned a variety of professional development course offerings with the Endorsement® competencies	SCS WFD	Process	State
ECMH20.	Collaborated with OCDEL to inform the development of a consultation and coaching model for ECE programs (pending)	SCS	Process	State

Year Three ECMH and Process Evaluation Progress

Local

Workforce Development

This year, the ECMH Work Group focused intensely on supporting professionals' understanding of early childhood issues, needs, and supports through training, coursework, and focused support. The ECMH Work Group members trained Student Assistance Program (SAP) liaisons on early child development, mental health issues in young children, and interventions for teachers' use in the classroom during two separate trainings (ECMH2). The group also spearheaded the Differentiated Supervision Action Project (DSAP) with PA Project LAUNCH's three targeted school districts (ECMH4). The Work Group has been on planning and developing online learning courses for early elementary teachers and engaging support of district personnel. In addition, various Work Group members met with stakeholders to discuss integrating early childhood content into Mental Health First Aid trainings (ECMH6) and met to discuss providing in-depth support to staff working in Child Protective Services, early care, and education settings. Conversations around targeted staff support focused on reflective supervision, consultation and coaching models, and group support for direct service personnel.

Planning and Collaboration around Service Delivery to Children and Families

The ECMH Work Group supported various initiatives to provide access and deliver behavioral support services to families. Key examples of these efforts include (a) a pilot program, to reduce stigma around mental health issues, services, and supports in one targeted school district (ECMH3) and (b) collaboration support around reimbursement of FCU services through Medical Assistance (ECMH8). As a result of this collaboration, one local service provider, Wesley Family Services, will be determining a billing code in concert with a managed care provider as they move forward with offering FCU services.

Infant Mental Health Endorsement® and Credentialing Framework

Local

PA Project LAUNCH's work to bring the Endorsement® framework to the Commonwealth has been an example of strong state and local collaboration (see Appendix K for a detailed description of the Endorsement®). In Year Three, Local Work Group, state-level, and Implementation Team activities focused on a number of planning and development activities toward this effort. In light of the strong collaborative focus, this section is organized in terms of local, local and state, and state activities. Key local activities involved hiring personnel to organize, implement, and finalize plans around sustainable professional development opportunities that support the Endorsement® and credentialing process. Toward this end, the Work Group developed online resources (e.g., website, Facebook site, surveys) to promote, support, and assess participation. In addition, the ECMH Work Group identified candidates for the first and second learning cohorts who will participate in a range of classes as they work toward Endorsement® credentialing. Overarching plans include (a) offering online training programs, (b) providing scholarships to support Endorsement® candidates, (c) supporting the integration of infant and early childhood mental health content in higher education pre-service programs, and (d) developing additional learning opportunities to address targeted gaps in existing pre-service and professional development options.

Local and State

Joint local and state activities focused on outreach, information gathering, and system building. The project team administered a needs assessment and aligned content for the learning collaborative, local professional development offerings, Pennsylvania's OCDEL and university coursework with Endorsement® framework. In addition, they (a) identified the first "Implementation Cohort" (n = 8) to participate in the IMH Endorsement® process who will support Endorsement® capacity-building across

time, (b) were selected as an Endorsement® pilot site, and (c) presented and shared information on the Endorsement® framework. The Work Group shared information at meetings with home visiting administrators, substance abuse treatment programs, at the Pennsylvania Head Start Association Conference, and at the Pennsylvania National Alliance for Mental Illness Conference.

State

State-level PA Project LAUNCH activities focused on providing a foundation to guide and support initial and ongoing planning and development. In Year Three, PA Project LAUNCH-initiated efforts resulted in onsite training and TA on the Endorsement® process. In addition, other collaborations resulted in three years of intensive TA around systems to support Infant and Early Childhood Mental Health Consultation starting in April 2017. PA Project LAUNCH also contributed to integrating the Endorsement® into an RTT-ELC proposal request. The focus of this request was on aligning higher education coursework with key early care and education standards and competencies.

Year Three ECMH Outcome Evaluation Progress

System Level Direct Service Outcomes

As noted above, PA Project LAUNCH supported several workforce development efforts through the ECMH Work Group in Year Three. Five school-based professionals were able to attend the inaugural Mid-Atlantic Social Emotional Learning Conference in March 2017. Furthermore, PA Project LAUNCH supported two workforce development trainings that led to approximately 22[6] individuals receiving training. These trainings, titled *Understanding Early Childhood Behavioral Health*, were to help participants understand the developmental function of children ages K-8, review common behavioral health concerns for children K-8, and to provide examples of different treatment and referral options to agencies and services that specialize with children in this age range. Table 16 provides an overview of the participants and the outcomes of these trainings.

Table 16: ECMH Training Participant Information and Outcomes

Training Name	Attended (% Surveyed)	Agency Type[7]						Percentage Reporting Knowledge Increased	Percentage Rating Training Info As:		
		MHC	HV	Med.	SS	Edu	Other		Valuable	New	Usable
Understanding Early Childhood Behavioral Health	13 (100%)	4	0	0	6	1	0	85%	92%	69%	85%
Understanding Early Childhood Behavioral Health	9[12]	1	0	0	5	0	3	89%	89%	89%	89%

Participants indicated that these trainings provided useful and valuable information, and widely reported knowledge increases in relation to their professional work (see Table 16). The quotes in Table 17 highlight the participants' plans to use the training in their work. Specifically, participants were asked: *"What information form the training will you use in your work?"*

[6] We have limited data on the second training, and are basing this count on the number surveyed

[7] MHC = Mental Health Consultant; HV = Home Visiting Program; Med. = Medical; SS = Social Services; Edu. = Education

Table 17: Post-Training Participant Quotes

ECMH Post-Training Participant Quotes	
Training	***Sampling of Participant Quotes***
Understanding Early Childhood Behavioral Health	I work mostly in prevention, so I especially enjoy intervention strategies. They can often be used proactively.
	Using information about development to support teachers with understanding students and find interventions to increase student development
	Developmental stages, behaviors, mental health disorders, and interventions. Please offer a continuing series- [we] need more "little kid" trainings.

Home Visiting Findings

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

Table 18: Year Three Home Visiting Activities

Activities		Targeted Area	Evaluation Method	Level
HV1.	Disseminated resources and PR materials on home visitation to medical providers and other community agencies	PBA WFD	Process	Local
HV2.	Launched the "Open Doors to Home Visiting" marketing campaign	PBA	Process	Local
HV3.	Implemented an information technology enhancement for providers using the Link	SCS	Process	Local
HV4.	Meeting with providers offering services to those dependent on opioids to foster referrals and create a training	Planning SCS	Process	Local
HV5.	Co-hosted a symposium on substance abuse and early childhood mental health	WFD	Outcome	Local
HV6.	Co-hosted a conference on delivering culturally competent and sensitive services	WFD CC	Outcome	Local
HV7.	Informed NurturePA outreach staff about the availability and processes for accessing local home visiting services	PBA	Process	Local
HV8.	Engaged in discussions about using and supporting home visitor ambassadors	Planning	Process	Local
HV9.	Consulted with Children's Hospital of Philadelphia around developing a coordinated referral line for home visiting services in Philadelphia	SCS	Process	Local
HV10.	Facilitated initial discussions with ACDHS Child Welfare Leadership Fellows	Planning	Process	Local
HV11.	Planning additional strategies to increase the public's awareness of the Link	Planning	Process	Local
HV12.	Shared information with state-level home visiting program about the Link for replication purposes	SCS	Process	State

Year Three HV Activities and Process Evaluation Progress

Local

Public Awareness

The HV Work Group focused considerable efforts on sharing information, materials and resources with professionals, parents, and other community members (HV1). The Work Group shared information with home visitors on topics such as free tax assistance services to share with the families the home visitors serve. Information was also shared in regards to Parent Child Interaction Therapy playrooms located throughout the Pittsburgh region and managed by Wesley Family Services. In addition, materials and resources were distributed (e.g., medical tool kits and referral forms) to help physicians streamline the referral process and effectively communicate with patients about home visiting services.

The Work Group also used webinars to share information about home visitation with other professional communities. Dr. Karen Hacker, the Allegheny County Health Department Director, conducted a webinar for medical professionals and the general public on the County's coordinated referral line, the Allegheny Link (the Link), and the process for referring families to home visiting services. In addition, a webinar format was used to orient NurturePA mentors on home visitation (HV7). NurturePA is a text-based

outreach and support program for new mothers. Looking to the future, the HV Work Group has begun working on other strategies to increase family engagement in home visiting. The first effort involves working with Child Welfare Leadership Fellows to identify engagement strategies (HV10). These Fellows are a group of welfare professionals who participate in a yearlong program focused on how to use data to recognize issues and make recommendations. The second efforts involves using home visiting ambassadors in collaboration with the medical community (HV8).

County officials organized a press conference to launch the "Open Doors to Home Visiting" marketing campaign (HV2). The goal of this campaign was to encourage families to enroll in home visiting programs and to encourage others (e.g., caregivers, medical providers) to learn more about these services. The campaign and public awareness efforts also included iHeart radio and Pandora ads, social media posts, targeted location mobile phone advertising (mobile geo-fencing), billboards and transit shelters ads, and informational signs directing individuals to Family Support Centers (i.e., family support "To Go" signs) (see Appendix P for an example of the campaigns' advertisements). The above-noted communications were provided in English and Spanish. The group has begun planning additional strategies (e.g., website, social media campaign) to increase public awareness around home visiting (HV11).

Workforce Development

In Year Three, the HV Work Group offered two professional development opportunities. In late spring, the Work Group (a) co-hosted a symposium for home visiting programs and providers offering services to those dependent on opioids on the topic of substance abuse and early childhood mental health (HV5) and (b) co-hosted a conference on culturally competent and sensitive service delivery for home visitors (HV6). Child welfare staff also participated in the training on cultural competence. In addition, the HV Work Group is planning a spring 2018 training (HV4) for home visitors and early intervention service coordinators on opioid dependency and Neonatal Abstinence Syndrome (NAS), which is when a baby is exposed to drugs in the womb before birth.

System Change Activities

Children's Hospital of Philadelphia (CHOP) expressed interest in developing a coordinated referral system, similar to the Link (HV9). This year, the HV Work Group consulted with CHOP physicians on the AC model and shared a variety of materials (e.g., PR materials, process forms, data variables, and job descriptions). The HV Work Group also launched a new information technology enhancement to "close the referral loop" when medical providers refer families to home visiting programs (HV3). Through the latter part of Year Three the Work Group began a series of meetings with providers offering services to those dependent on opioids, including clinics at AC's two largest birthing hospitals, in order to foster referrals (HV4).

State

Public Awareness and System Change Activities

State-level efforts continued to focus on outreach to the medical community about home visiting and state-level organizations around replication opportunities (e.g., professional development strategies, coordinated referral line). There was also targeted outreach to Pennsylvania's Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program to share information about the Link model (HV12). The State PA Project LAUNCH team shared information and resources in support of PA MIECHV's efforts to develop and issue an RFA for reauthorized grantees around this initiative and well as other local PA Project LAUNCH initiatives (e.g., reflective supervision, endorsement process, mental health competencies).

Year Three HV Outcome Evaluation Progress

System Level Direct Service Outcomes

The Allegheny Link

The Link is a coordinated referral line designed to simplify and streamline access to services for Allegheny County residents. Options counselors (i.e., referral line counselors) share information on available resources and help callers determine the programs and services that best fulfill their needs. PA Project LAUNCH's involvement with the Link initially focused on referrals to home visiting providers. However, this project year, PA Project LAUNCH supported a marketing campaign to increase the public's awareness of a broader range of service referrals. As such, we will also report outcomes on this expanded range of service referrals.

Home Visiting Referrals

In Year Three, options counselors referred 678 families with children between birth and five years of age to one or more home visiting services. Families typically received one to two referrals (96.8%), although counselors provided up to eight referrals for one family (0.1%) over the course of Year Three. Of the families with children 0-5 years who contacted the Link, 95.4% were headed by females, 38.5% had experienced homelessness, 2.2% were military veterans; 65.3% of parents who reported their primary language noted it to be English. Most results align closely with findings reported in Year Two. However, it is important to note that the number of families that sought home visiting services through the Link increased from 453 to 678, and the number of families that reported prior homeless experiences decreased from 51% in Year Two to 39% in Year Three. Families received referrals around adult and child support needs. Fifty-one percent (51.3%) of the 1,000 children in these families were male, 48.6% were female[8], and the distribution of children ages birth to 5 years was fairly even (i.e., 15.9% - 21.1%). In Year Two, the Link consumers tended to be parents of younger children (i.e., infants and toddlers).

Table 19 provides a summary of the number and percentage of referrals made to families in Years Two and Three. Counselors made 899 home visiting referrals and most frequently referred callers to one of the following four programs that provide home visits: Family Support, Healthy Start, the Special Supplemental Nutrition Program for Women, Infant, and Children (WIC), and Early Head Start. This pattern was consistent across both years and accounted for 83% of all home visiting referrals in Year Three and 84% of all home visiting referrals in Year Two. Table 20 provides a complete list of program types and referrals made over the past two project years.

Table 19: Number of Home Visiting Referrals per Family

Timepoint	Number of Referrals							
	1	2	3	4	5	6	7	8
Year Three (*n*=678 total families)	**520**	**136**	14	7	0	0	0	1
	(76.7%)	**(20.1%)**	(2.1%)	(1.0%)	(0%)	(0%)	(0%)	(0.1%)
Year Two (*n*=453 total families)	**222**	**167**	46	13	0	3	1	1
	(49%)	**(40%)**	(10%)	(3%)	(0%)	(0.70%)	(0.20%)	(0.20%)

[8] Gender was not indicated for one child

Table 20: Number and Percent of Referrals by Program

Program	Program Focus	Year 3 Referrals		Year 2 Referrals	
		Number	Percent	Number	Percent
Family Support	To support the healthy development and growth of young children by supporting the families and communities in which they live.	**289**	**(32.1%)**	**270**[1]	**(35%)**
Healthy Start	To improve the quality of life of infants, toddlers and their families by supporting pregnant women, new parents and families.	**183**	**(20.4%)**	**140**	**(18%)**
Early Head Start	To support the healthy development of infants, toddlers, pregnant women and their families and promote self-care and self-sufficiency.	**140**	**(15.6%)**	**90**	**(12%)**
WIC	To promote health and provide supplemental nutrition for pregnant women, mothers, and young children.	**133**	**(14.8%)**	**146**	**(19%)**
First Steps	To provide families, parents, and children with resources to be happy, healthy, and efficient.	47	(5.2%)	39	(5%)
Reach Out to Families	To provide life skills education and training around skills needed to perform safely activities of daily living.	41	(4.6%)	30	(4%)
Title V	To provide support to pregnant, new parents, and families of young children through a nurse-led program.	37	(4.1%)	39	(5%)
Head Start	To promote school readiness through education, health, social and other services to preschool-age children and their families.	29	(3.2%)	24	(3%)
Healthy Families America	To promote child well-being and prevent the abuse and neglect of children through home visiting services.	0	(0.0%)	1	(0.1%)
Total		**899**	(100%)	**779**	(100%)

In Year Three, AC personnel provided additional details on services and outcomes associated with Link referrals. This data included (a) home visiting program enrollments resulting from Link referrals, (b) developmental screenings completed within six months of program enrollment, (c) children identified for early intervention (EI) monitoring services, and (d) non-home visiting behavioral health and family assistance services. As a result of the support provided by the coordinated referral line, 116 referrals resulted in enrollments in home visiting programs. Slightly over half (57.9%) led to enrollments in family support or Healthy Start programs. Table 21 provides a summary of Year Three enrollments. These outcomes are notable on multiple levels, but the referrals to EI tracking warrant mention. Identifying support needs has the potential to critically impact the healthy development of young children. In Year Three, the Link counselors identified 1,477 children as eligible for EI tracking services and in the fourth quarter of Year Three home visiting program staff completed 53 developmental screens for 48 children birth to five years of age.

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

Table 21: Families Enrolled in Programs that provide Home Visits as a Result of an Allegheny Link Referral in Year Three

HV Program Type	Program Focus	Families Enrolled in HV Programs[9]	
		Number	Percent
Family Support	To support the healthy development and growth of young children by supporting the families and communities in which they live.	**36**	**(31.0%)**
Healthy Start	To improve the quality of life of infants, toddlers and their families by supporting pregnant women, new parents and families.	**30**	**(25.9%)**
WIC	To promote health and provide supplemental nutrition for pregnant women, mothers, and young children	17	(14.7%)
Title V	To provide support to pregnant, new parents, and families of young children through a nurse-led program.	11	(9.5%)
First Steps	To provide families, parents, and children with resources to be happy, healthy, and efficient.	9	(7.8%)
Reach out to Families	To provide life skills education and training around skills needed to perform safely activities of daily living.	8	(6.9%)
EHS	To support the healthy development of infants, toddlers, pregnant women and their families and promote self-care and self-sufficiency.	4	(3.4%)
Head Start	To promote school readiness through education, health, social and other services to preschool-age children and their families.	1	(0.9%)
Total		**116**	**(100.0%)**

Non-Home Visiting Allegheny Link Referrals

PA Project LAUNCH collaborated with ACDHS to increase community awareness on the vast array of service referrals accessible through the Link. Services ranged from housing and utility assistance to behavioral health and parenting supports. However, only non-home visiting referrals that closely align with Project LAUNCH goals will be reported by the Evaluation Team.[10] Since the beginning of 2017, counselors made 95 referrals to families for such services. Service referrals ranged from developmental and EI supports to mental health and substance services. Counselors referred families to many different agencies for support. Counselors most frequently made referrals for Crisis (20%), Education-Related (12.6%), and Mental Health Outpatient (10.5%) services, and Parent/Grandparent Resources (10.5%). (See Appendix Q for an overview of additional service referrals).

Workforce Development

As noted above, PA Project LAUNCH supported two workforce development trainings through the HV Work Group in Year Three. The first training, *Emotionally Unavailable: The Effects of Substance Abuse on Early Childhood Mental Health,* was co-hosted by PA Project LAUNCH in partnership with Healthy Start, Inc. and focused on a number of topics including maternal addiction, early childhood mental health, home visiting, and nontraditional and community based approaches to treatment. The second training, *Cultural Competency: Increasing Awareness and Capacity for Compassionate and Collaborative Service Delivery,* was partially sponsored by PA Project LAUNCH and was designed to equip home visiting staff, human service professionals and early childhood providers with added skills and cultural awareness to work compassionately, and collaboratively with immigrant and the refugee families they serve. A

[9] Referrals for Six families that received LINK referrals enrolled in two programs. Multiple enrollments varied with respect to program type.

[10] Key LAUNCH areas: Social emotional wellness, MH, BH, Education, Crisis Intervention, Parenting Support, etc.

combined total of three hundred twenty-five individuals were trained in these efforts. Table 22 provides an overview of the participants and the outcomes of these trainings.

Table 22: HV Training Participant Information and Outcomes

Training Name	Attended (% Surveyed)	Agency Type[11]						Percentage Reporting Knowledge Increased	Percentage Rating Training Info As:		
		MHC	HV	Med.	SS	Edu	Other		Valuable	New	Usable
Emotionally Unavailable: The Effects of Substance Abuse on Early Childhood Mental Health	155 (82%)	3	62	12	13	5	20	88%	91%	87%	96%
Cultural Competency: Increasing Awareness and Capacity for Compassionate and Collaborative Service Delivery	170 (76%)	0	82	3	15	7	17	97%	93%	86%	92%

These two trainings had wide reach in AC in terms of participant numbers, and although participants generally worked in home visiting, there was still a broad base in terms of participants from other service sectors, such as social service and medical professionals. Participants indicated that these trainings provided useful and valuable information, and widely reported knowledge increases. The quotes in Table 23 highlight the participants' plans to use the training in their work. Specifically, participants were asked: *"What information form the training will you use in your work?"*:

Table 23: Post-Training Participant Quotes

HV Post-Training Participant Quotes		
Training	Quote Theme	*Sampling of Participant Responses*
Emotionally Unavailable: The Effects of Substance Abuse on Early Childhood Mental Health	Community-Based Treatment Approaches	*Complicated grief, contingency management, MI training information*
		MIO approach in which the home visitor is wondering and reflecting with caregiver as well as for infant/toddler provider trainings for all staff in regards to substance abuse and mental health
	Early Childhood Mental Health	*Competence of infants. Language to use for kids when talking about death and addiction.*
	Substance Abuse/ Treatment	*I have a better understanding of substance abuse and pregnancy*
		Grief in maternal addiction. Dealing with mothers and addictions during pregnancy and postpartum. Importance of breastfeeding for all but especially for black women.
	Resources	*Providing information/referrals to clients and families*
		Information about the Pregnancy Recovery Center at Magee. Information about Pittsburgh Black Breastfeeding Circle. Information about Project LAUNCH (endorsements and competencies)
Cultural Competency: Increasing Awareness and Capacity for Compassionate	Working across Cultures and Languages	*Cultural humility, reframing visits to build collaborations*
		I will use it in creating a cultural training for my agency
		Making sure I remember there is no "right way" to parent and to always remember to think about my clients' culture throughout working with them
	Collaborating with Interpreters	*Keeping communication open with interpreter and client*

[11] *MHC = Mental Health Consultant; HV = Home Visiting Program; Med. = Medical; SS = Social Services; Edu. = Education.*

and Collaborative Service Delivery	Unique Needs of Immigrant and Refugee Families	*I may not work with immigrant populations now but I am prepared to do so in the future. I feel confident to share with co-workers*
		I feel like if I were to obtain a refugee family I will understand how to communicate more effectively with them
	Resources	*The resources available to families in the community*

Family Strengthening and Parent Skill Building Findings

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

Table 24: Year Three Family Strengthening Activities

Activities		Targeted Area	Evaluation Method	Level
FS1.	Shared early childhood materials	PBA	Process	Local
FS2.	Engaged the University of Pittsburgh Graduate School of Public Health in developing parent engagement strategies and materials	SCS	Process	Local
FS3.	Discussed strategies with community agencies around disseminating materials to families	Planning	Process	Local
FS4.	Facilitated collaborations with and between organizations that provide support and intervention services for families	SCS	Process	Local
FS5.	Planned and conducted a training on the Strengthening Families Protective Factors Framework	WFD	Process Outcome	Local
FS6.	Wrote and issued an RFP for parent cafes	SCS	Process	Local
FS7.	Developing a proposal on utilizing Quick Response (QR) bar codes	Planning	Process	Local
FS8.	Developed a proposal to create signage that helps families identify family support centers	Planning	Process	Local
FS9.	Resumed work on a screening information packet for families	Planning	Process	Local
FS10.	Incorporating protective factors presentation targeting cross-sector audience	WFD SCS	Process	Local
FS11.	Disseminated materials at a family back-to-school event hosted by a local parent-run family support agency	SCS PBA	Process	Local
FS12.	Shared Early Learning Guiding Parents Smoothly (GPS) website at a state meeting with child librarians	PBA	Process	State
FS13.	Aligned the Strengthening Families professional development course with the IMH Endorsement® competencies	SCS WFD	Process	State

Year Three FS Activities and Process Evaluation Progress

Local

System Change Activity

The FS Work Group engaged in activities and pursued collaborations with a number of individuals and organizations. Their activities included learning about the Parenting Journey, a facilitated parenting group model[12] and learning about Vroom[13]'s approach to family outreach (FS3). Other activities included (a) working with the University of Pittsburgh's Graduate School of Public Health to produce social media

[12] The model *encourages parents to reflect on childhood experiences before developing relationship goals with their own children.*

[13] Vroom is an outreach initiative that focuses on "brain building basics" with communities.

posts and "press kit" materials around parent engagement and upcoming parent cafes (FS2), (b) facilitating collaborations between Working for Kids, NurturePA, Wesley Family Services, and the FCU (FS4), and (c) hosting a table at an parent-run family support agency (Allegheny Family Network) back-to-school event to disseminate early childhood resources to families (FS11). The Work Group also gathered information from stakeholders to inform their parent café RFP (FS6). They released the parent cafe RFP in August 2017, received eight applications, and accepted four applications.

Public Awareness

The FS Work Group participated in an early childhood extravaganza in the Baldwin-Whitehall School District, which is one of our three pilot communities. The focus of their activities was around raising awareness and disseminating materials to families (e.g., "Parenting in a New Country" translated into Nepali and published by Bridging Refugee Youth and Children's Services) (FS11). The group resumed work on a screening information packet (i.e., the Young Child Wellness Champions folder) for families, which they hope to distribute at community events and settings that parents frequent (e.g., pediatric offices) (FS9). In addition the FS Work Group developed proposals to (a) spearhead a public awareness campaign on social emotional health (FS7), (b) to create signage for easier identification of local family support centers (i.e., "To Go" signs) (FS8), and they met to discuss effective strategies for disseminating "PBS Kids" and "Fred Rodgers" social emotional curricula in the community (FS1).

Workforce Development

The FS Work Group conducted a cross-sector training for early childhood professionals and medical personnel from Kids Plus Pediatrics, an independent physician-owned/family-focused pediatric provider, on the Protective Factors Framework that was developed by the Center for the Study of Social Policy (FS5). Fifty-three participants attended the training. In addition, efforts are underway to incorporate this framework into trainings for case workers and medical outreach efforts (FS10).

State

Public Awareness

The YCW Expert shared the Early Learning Guiding Parents Smoothly (GPS) website with children's librarians at the PA Library Association Conference, and discussed ways for librarians to promote families' usage of the tool (FS12). A number of librarians later contacted the YCW Expert to obtain promotional packets about the website. It was also suggested that libraries may be a great place to host community screening events or speaker events to highlight home visiting or early intervention service providers targeting the families that frequent this environment.

System Change Activities

The YWC Expert has collaborated on aligning the Pennsylvania Strengthening Families professional course, *Bringing the Protective Factors to Life in Your Work*, with the IMH Endorsement® competencies (see Appendix R for the outline of the alignment). The Pennsylvania Strengthening Families Leadership Team is a group that works to sustain and weave protective factors into policies, programs, and practice across child and family service systems.

Year Three FS Outcome Evaluation Progress

Individual Child and Family Direct Service Outcomes

Smart Beginnings

The Smart Beginnings team enrolled 83 parent-child dyads in the VIP Intervention condition and 76 parent-child dyads in the Comparison condition by the end of Year Three. Parents in both conditions completed a comprehensive battery of social, emotional, and family functioning measures six months

following project enrollment. Five mothers in the Comparison condition scored at-risk for depression on the 6-month battery and received referrals for supportive services. Twenty-seven participants in the VIP condition scored at-risk and were offered the additional option to participate in the FCU Intervention (VIP + FCU). By the end of Year Three, 16 families were enrolled in the VIP + FCU Intervention (58.7% of FCU referrals) and 93 families completed 6-month assessments[14].

Table 25: Participant Service Assignments, Assessments, and Referrals

Participant Info	Assignment by Study Condition and Intervention Services				Parents that Completed 6-Month Assessments			Referrals Based on 6-Month Assessments	
	VIP Only	VIP + FCU	Comparison	Total	VIP	Comparison	Total	VIP Dyads Referred for FCU	Comparison Mothers Referred Support
Number of Parents	83	16	76	159	46	47	93	27	5
Percent of Parents	(52.2%)	(10.1%)	(47.8%)	159	(49.5%)	(50.5%)	93	(58.7%)	(10.6%)

Smart Beginnings staff delivered 264 VIP sessions to families at well-child visits and 45 FCU sessions to families in their homes during Year Three. Most VIP participants (78.3%) engaged in two to four VIP sessions and most VIP + FCU participants (87.6%) also engaged in one to three FCU sessions. Across the year, the number of sessions delivered to families ranged from 1-5 for VIP's parent education component and 1-11 for FCU's intervention component[15].

Table 26: Number of Intervention Participant VIP and FCU Sessions

Intervention Type	Number of Intervention Sessions Received by Families							
	1	2	3	4	5	6-10	11	# of Families
VIP Sessions (*n*=264)	6	18	26	21	12	0	0	83
	(7.2%)	(21.7%)	(31.3%)	(25.3%)	(14.5%)	0	0	
FCU Sessions (*n*=45)	3	7	4	0	1	0	1	16
	(18.8%)	(43.8%)	(25.0%)	0	(6.2%)	0	(6.2%)	

As noted previously, 83 parent-child dyads were randomized to the VIP condition. The initial report on the demographics for children in this condition indicate that the large majority (86.8%) were identified as Black/African American; the remainder were identified as White (7.2%), Hispanic/Latino (3.61%), and other/unknown racial origins (2.4%). Of the 16 parent-child dyads that participated in the VIP + FCU condition, 87.5% of the children were Black/African American and 12.5% were White.

The Smart Beginnings team will share individual level outcome data with the PA Project LAUNCH Evaluation Team after the collection of additional assessment results. This information should be available in Year Four and by the end of the grant period the Smart Beginnings team will provide information to address the overarching research questions listed below.

- *To what extent does the VIP intervention impact children's social emotional and developmental skills in comparison to children in the no treatment condition?*

[14] Study protocol: Family measures administered at 6, 18, and 21 months after study enrollment.
[15] FCU sessions are based on family interest and needs. Most families participate in 2-4 sessions, however there is no set limit to the number of sessions available.

- *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?*
- *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?*
- *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?*
- *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?*

System Level Direct Service Outcomes

Workforce Development

As noted above, PA Project LAUNCH supported one workforce development training through the FS Work Group in Year Three. The training, *Understanding the Strengthening Families Protective Factors Framework,* provided a brief background and description of the development of the protective factors, used multimedia to deepen understanding of specific factors, and employed multiple break-out groups for trainees to create their own definitions and representations of the protective factors. Fifty-three individuals were trained in this effort. Table 27 provides an overview of the participants and the outcomes of this training.

Table 27: HV Training Participant Information and Outcomes

Training Name	Attended (% Surveyed)	Agency Type[16]						Percentage Reporting Knowledge Increased	Percentage Rating Training Info As:		
		MHC	HV	Med.	SS	Edu	Other		Valuable	New	Usable
Understanding the Strengthening Families Protective Factors Framework	53 (94%)	1	30	4	4	0	5	90%	96%	56%	100%

Participants widely indicated that these trainings provided useful and valuable information, and reported knowledge increases. The following quotes in Table 28 highlight the participants' plans to use the training in their work. Specifically, participants were asked: *"What information form the training will you use in your work?"*:

Table 28: Post-Training Participant Quotes

FS Post-Training Participant Quotes		
Training	Quote Theme	*Sampling of Participant Responses*
Understanding the Strengthening Families Protective Factors Framework	Protective Factors	*Incorporating the protective factors even more into the work and relationships with families*
		Help parents think about their strengths by looking at the protective factors
	Creating Connections	*I would be able to better plan group connections and home visit better*
	Training and Coaching	*Training new caseworkers on how to engage and strengthen families (implementing material into existing material)*

[16] *MHC = Mental Health Consultant; HV = Home Visiting Program; Med. = Medical; SS = Social Services; Edu. = Education*

		Will consider building protective factors training into our existing training for new mentors. Will build concepts of protective factors into conversation prompts mentors use to build relationships with families
	Bias & Judgment	*The information regarding accepting help myself and how I unknowingly may be judging those whom may ask for help*
		To be conscious that my beliefs may taint my view of the families I work with
	Resources	*I think that the information will help when dealing with young parents that have doubts about parenting*

Local and State Infrastructure Findings

PA Project LAUNCH is inherently focused on building local and state infrastructure and supporting systems change. As such, many of the activities and findings reported above for each domain area also align with local and state infrastructure efforts. This is captured by our coding scheme above (i.e., using the cross-cutting themes to account for activities focused on systems change and sustainability); given this, in order to not report redundant findings, we focus here only on additional Local and State YCWC and general activities that support PA Project LAUNCH infrastructure efforts.

Toward this purpose, in this section we report these findings using the systems-activities and outcomes categories from the Multi-site Evaluation (MSE) of Project LAUNCH. This allows us to expand upon systems-change and sustainability efforts in a way that aligns with other Project LAUNCH evaluation efforts. We also include council governance activities in this section. Each category is described 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; 6) establishing or enhancing education and training, or building capacity for technical assistance and consultation; and 7) 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 (ADV):* 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 and Sustainability (F/S):* 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.

(e) *Council Governance (CG):* Any activities or efforts that focus on supporting the functioning, sustainability, or capacity of the Local and/or State YCWC.

In addition to reporting these infrastructure efforts, we provide an overview of the Local and State YCWCs, which are the governing bodies for PA Project LAUNCH. We report on their activities and the nature of their collaborative functioning.

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 eight years, pregnant women, and their families.*

Table 29: Year Three Local Systems Change Activities

Activities		Targeted Area	Evaluation Method
LSC1.	Collaborated to ensure that all home visiting programs perform post-partum screenings and have knowledge of referral options	ADV	Process
LSC2.	Collaborated with neuroscientist to disseminate accessible content on the importance of early childhood for brain development	CB	Process
LSC3.	Facilitated partnership between a local parent peer support organization and 3 elementary schools from 2 school districts	CB	Process
LSC4.	Partnered with ACDHS to create EC/parenting support materials, and explore options for funding hiring of staff to support dissemination	CB ADV	Process
LSC5.	Discussed and planned for sustainability of the Local YCWC and work groups	CG	Process
LSC6.	Facilitated connection between local advocacy group and Allies for Children to address concerns about impacts of current federal immigration policies on local families' health insurance	CB	Process
LSC7.	Identified two youth support partners (YSP) to become EC/parent resource specialists on broader ACDHS YSP Team	CB	Process
LSC8.	Facilitated connection between FCU staff and local home visiting program	CB	Process
LSC9.	Updated strategic plan	CG	Process
LSC10.	Presented at state representative's annual MH/BH conference	CB	Process
LSC11.	Created billboard of resources for YSP team	PIC	Process
LSC12.	Connected with developers of Pittsburgh CAP4Kids website to discuss efforts to post PA Project LAUNCH materials for pediatric providers	CB	Process
LSC13.	Targeted outreach to re-engage former PA Project LAUNCH family members	CG	Process
LSC14.	Implemented a recommitment process with Local YCWC members to increase attendance and plan for sustainability	CG	Process
LSC15.	Connected with multiple new local agencies and foundations	CB	Process
LSC16.	Connected with PA DOE initiative (PA Safe Schools/Healthy Students) to share local approach to data sharing and data-based program decisions	CB	Process
LSC17.	Updated plan for Healthier Allegheny Advisory Council	CB	Process
LSC18.	Connected with a national network (Aspen Institute) to discuss using the 2Gen (2-Generation Approach) framework in ACDHS programming	CB	Process
LSC19.	Facilitated connection between ACDHS and ACHD	CB	Process
LSC20.	Connected with local organizations to discuss training interests	CB	Process
LSC21.	Implemented new onboarding process for new LAUNCH family members	CG	Process
LSC22.	Shared SAMHSA grant meeting materials with local Fatherhood groups; pursuing purchase of 10,000 kits based on positive reception	PIC	Process
LSC23.	Facilitated connection between AC CYF and TN CYF about Family Treatment Court Model and Infant Court model	CB	Process
LSC24.	Developed resource that will be added to all future Mental Health First Aid trainings on topics related to IECMH	CB	Process
LSC25.	Renewed discussions to integrate PA Project LAUNCH with SOC grant activities	F/S	Process

Year Three Local (Allegheny County) Activities and Process Evaluation Progress

Coalition Building Activities

In Year Three, the large majority of local system change activities focused on coalition building, through efforts aimed at increasing collaboration. This has been a consistent focus of PA Project LAUNCH, particularly at the local-level, given the unique context of resource-rich AC, and aligns with the needs

identified in the Environmental Scan to support cross-collaboration and integration among these diverse providers, sectors, and organizations. Within this general focus on coalition building, there are different stages (e.g., initial outreach and partnership development, actively identifying shared goals, purposeful collaboration and implementation). In Year Three, PA Project LAUNCH maintained its focus on continuing outreach with a range of organizations (e.g., LSC3, 6, 8, 15 in Table 29), however there were also more targeted coalition building activities. One example is PA Project LAUNCH's partnership with FCU (LSC8), where LAUNCH has played a major role in supporting the FCU team in their efforts to grow the FCU as an evidence-based program for use in AC. This work includes collaboration to determine appropriate billing codes for mental health services in PA, a critical step in efforts to increase the accessibility of this evidence-based practice locally. In addition, this partnership has been instrumental in facilitating critical connections with key stakeholders; these efforts have also led to partnerships and proposals for broader FCU implementation projects. Other examples, such as PA Project LAUNCH's partnership efforts that aim to develop or disseminate materials or resources (e.g., LSC4, 12, 24), increase workforce development efforts (e.g., LSC20), or support infrastructure efforts and collaborations (e.g., LSC14) represent coalition building activities where targeted and shared goals are being identified and pursued collectively.

Council Governance Activities

In Year Three, several local activities also focused on supporting the functioning and sustainability of the Local YCWC. This involved a membership outreach effort, in which members were asked to review their ability to commit to the work of PA Project LAUNCH. This resulted in some shifts in council membership, but also appears to have led to a stronger, more tightly aligned and committed council based upon attendance records. Targeted efforts at increasing and maintaining family membership were also conducted. There were also concentrated efforts to update the Strategic Plan, and align goals and activities with long-term and sustainability efforts in mind.

The Local Young Child Wellness Council

Membership

During the first two years, the Council membership increased from 37 to 48. At the end of Year Three, Council Membership decreased to 43 members. The percentage of family representatives decreased from 35% in Year One to 29% in Year Two to 18% by the end of Year Three. Organizational representatives increased from 64% to 70% to 81% across Years One-Three. In Year Three, 21 non-active members were identified, and 13 new members joined.

During Year Three Quarter Three, a survey was sent out to those affiliated with the Local YCWC (*n* = 81) to gauge membership commitment. The survey was completed by 65 individuals. Of those 65, 42 committed/re-committed to Local YCWC membership, 21 did not commit to membership but asked to receive council minutes and updates, and 2 asked to be removed from the Local YCWC distribution list all together. At the end of Year Three, this survey helped to condense the Local YCWC to a more committed and devoted group of members.

Attendance

The Local YCWC met five times in Year One, eight times in Year Two, and six times in Year Three. The number and percentage of members attending each meeting in Years One, Two, and three are presented in Table 30. The average attendance decreased from Year One (48%) to Year Two (29%) but increased from Year Two to Year Three (35%). This pattern in attendance from Year One to Year Three was similar for family representatives (45% to 30% to 37.5%) and organizational representatives (50% to 28% to 34.3%). It is possible that the increase in Year Three attendance is due to the decrease in meetings, meaning that attending meetings was less of a burden. An average attendance of 35% could

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 30: Attendance at Local Young Child Wellness Council Meetings (Year One-Year Three)

Member Category	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%
Organizational	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%**

Member Category	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%
Organizational	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%**

Member Category	Year Three Meeting Date					
	10/2016	*12/2016*	*2/2017*	*5/2017*	*7/2017*	*9/2017*
Family	3/11	3/11	4/7	3/8	3/8	3/8
	27%	27%	57%	38%	38%	38%
Organizational	10/38	12/38	17/42	13/38	13/35	13/35
	26%	32%	40%	34%	37%	37%
Total	**13/49**	**15/49**	**21/49**	**16/46**	**16/43**	**16/43**
	27%	**31%**	**43%**	**35%**	**37%**	**37%**

Year Three Local Outcome Evaluation Progress

The Local YCWC Wilder Collaborative Factors Inventory

The Local Wilder Collaborative Factors Inventory is used to examine council collaboration (see Appendix S for the measure). Group members individually rate 40 characteristics of collaboration on a five-point scale (1= Strongly Disagree, 5= Strongly Agree). These characteristics are clustered into 20 factors; scores are averaged across items within a factor, and a cross-factor total score is calculated. Two open-ended questions were added this year. Overall Year Three and longitudinal Local Wilder Collaborative Factors Inventory results are described below; see Appendix T for more in-depth descriptions and sub-group analyses.

Response Rates

In Year Three the Local Wilder Collaborative Factors Inventory was sent to all current members, as well as any members who had left the project over the course of the year, totaling 75 altogether. The overall

number of respondents increased in Year Three (*n* = 39), however the response rate decreased (52%). This pattern reflects our increased sampling of past members, who had a much lower completion rate (*n* = 3 out of 27 sampled past members; 11%) than current members (*n* = 36 out of 48 sampled current members; 75%). Across Years One-Three, family representative's (54%, 67%, 47%) response rates clustered around the 50% mark, with an exception of a Year Two increase; organizational representative's (81%, 65%, 65%) response rates have dropped since Year One, but remained consistent in Years Two and Three.

Year Three Results

Table 31 provides and overview of Year Three Local Wilder Collaborative Factors Inventory ratings by factor across all respondents. Overall, these ratings were generally moderate to high, with a total average of 3.89. Members rated ten factors as strengths (i.e., 4.0 or higher; green), and ten as borderline (i.e., 3.0-3.9; yellow); no factors were listed as concerns (i.e., less than 3.0; red). The *Roles and Guidelines* factor received the lowest rating; this factor measures members' sense of the clarity of roles and responsibilities and decision-making processes. The *Self Interest* and *Skilled Leadership* factors received the highest ratings; these factors measure members' sense that the collaboration is beneficial to their organizations and perspectives on the leadership of the collaboration, respectively.

Table 31: Year Three Overall Local Wilder Results

Factor	**Overall** (*n* =39)	
	Mean	*SD*
Members See Collaboration as in their **Self Interest**	4.21	0.73
Skilled Leadership	4.21	0.7
Mutual Respect, Understanding, and Trust	4.15	0.53
Unique **Purpose**	4.14	0.68
Shared Vision	4.13	0.41
Members have a **Shared Stake** in Both Process and Outcome	4.12	0.53
Flexibility	4.08	0.63
Open and Frequent **Communication**	4.03	0.57
Ability to **Compromise**	4.00	0.69
Favorable **Political & Social Climate**	3.95	0.67
Established Informal **Relationships** and Communication Links	3.94	0.68
Concrete, Attainable **Goals & Objectives**	3.90	0.58
Adaptability	3.83	0.54
History of Collaboration or Cooperation in the Community	3.79	0.69
Appropriate **Pace** of Development	3.78	0.56
Appropriate **Cross Section** of Members	3.73	0.55
Sufficient **Funds**, Staff, Materials, and Time	3.56	0.6
Collaborative Group Seen as a Legitimate Leader in the Community	3.55	0.47
Multiple **Layers** of Participation	3.50	0.5
Development of Clear **Roles & Policy Guidelines**	3.35	0.74
TOTAL Average	**3.89**	**0.33**

During Year Three, two open-ended questions were added in order to gain additional insights and contextual information. Current members were asked to identify what they hoped to see come out of the project over the next year. Past members were asked what led to their decision to end their membership in the project.

Though very few past members participated, those who did (*n* =3) all indicated that their decision to leave was due to a lack of time. Two organizational representatives noted that they were able to have other colleagues fill in for them. The one family representative who completed this noted the following:

> *...I feel I did not have enough time or knowledge to input. I don't fully understand what is needed, or how I can help to do any work that everyone does on their daily bases... I fully support their efforts & respect anyone involved.. I never felt inadequate going to meetings or talking with any member... I just don't have the time to do what they do...*

Eighteen current members provided open-ended responses indicating what they would like to see come out of the project over the next year (see Table 32 for an overview). Overall, these responses provide insights into Local members' interest and commitments to broader goals of the project (e.g., systems change, sustainability, generalizability to state, cross-collaboration and communication between sectors), and they highlight some of the challenges, and possible ways forward toward achieving these goals.

Table 32: Overview of Local Current Members' Open-Ended Responses[17]

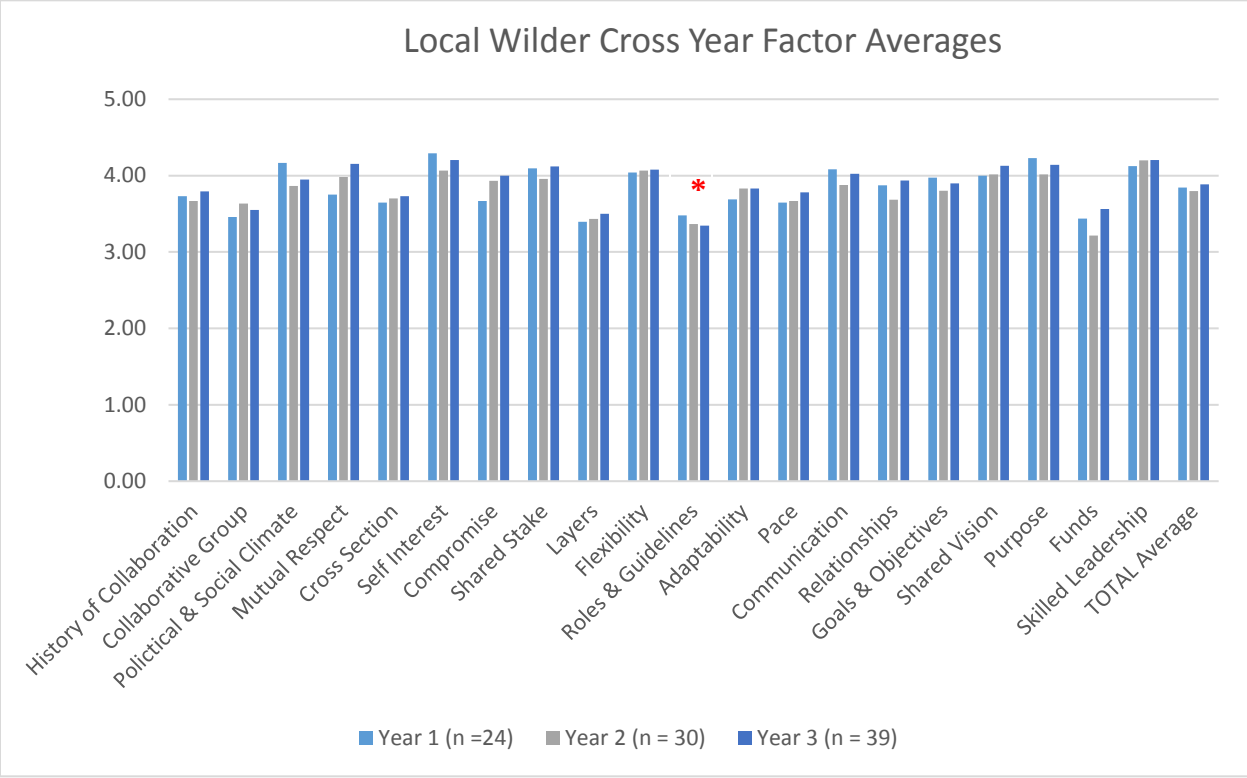
Theme	*n*	Sampling of Participant Responses
1. Cross-collaboration	4	*Continued forward progress on the projects and goals already set; continued commitment to cross-pollination between service areas that typically are "siloed" within their own interest/community groupings.*[3]
2. Meeting goals	3	*I like how we have informed other work groups about our goals and progress and how we have asked for feedback from them to get a different perspective. I would like to see us continue to focus on the goals that have been set and make modifications if necessary.*
3. Final goals and outcomes	3	*I want to be sure that we have a series of "solid" events and projects under us to report on. I would like to make sure that the things we start have some sustainability and longevity, ways to do this may be to insure that all those that are dedicated to similar goals within identified communities are at the table with a discussion of resources are allocated, we don't want to reinvent the wheel but we do want to make sure that wheels are available where we need them and that everyone that has a wheel knows how to get the most out it!*[7, 1]
4. Systems change	2	*A consistent approach to families served in Allegheny County that uses strength based approaches to assure children are appropriately cared for.*
		Policies and recommendations that would establish a path for the projects and efforts.
5. Generalizability to other parts of PA	2	*I would like to see some of what we have learned begin to benefit others in PA. It seems also like a good time to include other counties in some of our activities to begin strategizing for taking things to scale. Also, I would like to see more collaboration between depts. at a state-level, sharing resources and coordinating training and quality activities so all depts. are benefitting from the knowledge gained through this collaborative.*[6, 1]
6. Broader awareness/ communication	3	*More concrete steps and information shared with wider community.*[3]
7. Planning for sustainability	2	*It would be great to hear about what are the final "products" of the project and how these efforts can be sustained once the project is over.*[3]
8. Family Engagement	1	*More parent participation and meaningful input.*

[17] Eighteen participants completed the open-ended questions. Some answers included more than one theme – these are noted with a superscript with the number of the theme in the examples above.

Cross Year Analyses

Figure 2 provides an overview of factor scores across Years One-Three. At Year Three, Local Wilder Collaborative Factors Inventory scores improved or stayed stable on all but two factors (Collaborative Group, Roles & Guidelines) despite the changing composition of the group. Across factors, there is also a notable pattern whereby scores increased after a Year 2 drop. The only score with a consistent downward trend across years is the Roles and Guidelines factor. This may indicate that the group is be increasingly aware of this challenge as the grant continues, and the work becomes more actionable. Given the small sample size of this group, these patterns and described in simple terms while noting that these results align with the overall positive tone of the group.

Figure 2: Local Wilder Cross Year Factor Average[18]



[18] The only factor where we observed a decrease in scores across all three years is noted with an asterisk

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 eight years, pregnant women, and their families.*
- *Create and maintain a governance structure to promote social-emotional and physical wellness for PA children birth to eight years, pregnant women, and their families.*

Table 33: Year Three State Systems Activities

Activities		Targeted Area	Evaluation Method
SSC1.	Attended annual meeting of national AIMH alliance as PA-AIMH representative	CB	Process
SSC2.	Held multiple council meetings with focus on strategic planning	CG	
SSC3.	Presented at multiple conferences, meetings, and workshops on ECMH content	PIC CB	Process
SSC4.	Connected with private foundations	CB	Process
SSC5.	Coordinated connection between PA DOE initiative (PA Safe Schools/Healthy Students), York County Early Intervention, and ACDHS to discuss AC Integrated Data System and possible collaboration opportunities	CB	Process
SSC6.	Attended a learning institute at the Harvard Graduate School of Education focused on policy development	CB	Process
SSC7.	Held an exploratory integrated State YCWC and Early Learning Council meeting	CG	Process
SSC8.	Partnered with OMHSAS on funded SOC grant application to provide TA on implementation and adaptation of PA Project LAUNCH strategies	F/S	Process
SSC9.	Launched PA Project LAUNCH website	PIC	Process
SSC10.	Attended multiple conferences, summits, and learning collaboratives focused on EC and ECMH	CB	Process
SSC11.	Connected with other county-level entities (DE county ECMH advisory board, SOC counties) to share updates and replication opportunities	CB	Process
SSC12.	Partnered with Early Learning Council (ELC) to explore options for integrating State YCWC and ELC in order to reduce duplication of efforts	CG F/S	Process
SSC13.	Held an exploratory integrated State YCWC and Early Learning Council meeting	CG	Process

Year Three State Activities and Process Evaluation Progress

Coalition Building Activities

In Year Three, as with local infrastructure efforts, the large majority of general state infrastructure efforts focused on coalition building, via efforts aimed at increasing collaboration. At the state-level, this included attending and presenting at many conferences, often in collaboration with other state representatives (e.g., SSC1, 3, 6, 10). These types of activities represent opportunities to reach and connect with larger audiences, and many of these presentations represented public information campaign activities via their focus on providing education around early childhood mental health. These types of activities also represent opportunities to integrate PA Project LAUNCH work with other existing state-level initiatives. One example of this integrated, state-level work is the learning institute at the Harvard Graduate School of Education (SSC6), where the YCW Expert was part of a PA team that focused on the Preschool Expulsion-Suspension policy statement. State-level coalition building work in Year Three also included increased focus on training and technical assistance opportunities (e.g., SSC3), and align well with other project efforts focused on workforce development.

Funding/Sustainability Activities
Another notable state-level infrastructure activity in Year Three is the partnership with OMHSAS on their successful SOC Expansion grant application (SSC12). This aligns strongly with PA Project LAUNCH sustainability goals, and represents an opportunity for the project to support the replication and generalizability of local efforts into other state contexts. This highlights one way funding and sustainability efforts, with state-level supports, can be integrated to support local goals. The targeted coalition between PA Project LAUNCH and RTT-ELC also has resulted in several funding/sustainability activities (see ECMH Findings for additional examples). As noted above, this partnership has resulted in a major shift (upcoming in Year Four) to the structure of the State YCWC (SSC13), in efforts to support the sustainability of this work at the state-level.

Council Governance Activities
As noted above, in Year Three the State YCWC set the stage for a major shift in council structure. This work has been done in an effort to reduce the duplicate efforts occurring between the State YCWC and the PA ELC; future evaluation efforts will examine how these activities impact shifts in membership and council collaboration.

The State Young Child Wellness Council
Membership
The membership of the State YCWC changed frequently throughout the first two years of PA Project LAUNCH. 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. During Year Three, the main core of state members seems to have been established, as three members left, but all three were replaced by a member from the same agency. A total of four new members joined the State Council giving the State YCWC a total membership of 26 at the end of Year Three, with four members identified as family representatives.

Attendance
Table 34 presents the number of attendees out of the total membership and the percentage of the State YCWC attending each meeting in Project Year One, Year Two, and Year Three by family representatives, organizational representatives, and the total membership.

During Year One, attendance was quite high (average attendance 83%), especially for family representatives, although it started to drop off for organizational representatives 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 organizational representatives. In Year Three there were once again only three State YCWC meetings and although the average attendance increased to 61%, this is skewed since the first meeting had an unusual high attendance. It should also be noted that in Year Three attendance by family representatives significantly decreased to an average of 43%, which is nearly half of the average family representative's attendance from Year Two.

Progressive declines in attendance are common among volunteer groups, but this trend was likely exacerbated by a number of factors including state budgetary delays, pending state system change proposals, cancellation/modification of face to face meetings given the lack of robust agenda items, the time and monetary impact of having to travel to attend the meeting (for some members being 2-4+ hours travel time), and the generally busy schedules of the State Council members in their respective organizations or state/local government.

Table 34: Attendance at State Young Child Wellness Council Meetings (Year One-Year Three)

Member Category	YEAR ONE Meeting Date			
	1/29/15	3/31/15	5/26/15	8/11/15
Family	3/3	5/5	5/5	5/5
	100%	100%	100%	100%
Organizational	18/22	18/22	17/21	17/23
	82%	82%	81%	74%
TOTAL	**21/25**	**23/27**	**22/26**	**22/28**
	84%	**85%**	**85%**	**79%**

Member Category	YEAR TWO Meeting Date		
	11/10/15	3/16/16	8/18/16
Family	5/5	3/5	5/6
	100%	60%	83%
Organizational	19/23	7/21	11/29
	63%	33%	46%
TOTAL	**19/28**	**10/26**	**16/30**
	68%	**38%**	**53%**

Member Category	YEAR THREE Meeting Date		
	11/18/16	3/23/17	6/8/17
Family	2/5	2/5	2/4
	40%	40%	50%
Organizational	19/20	13/21	13/23
	95%	62%	57%
TOTAL	**21/25**	**10/28**	**16/26**
	84%	**38%**	**62%**

Year Three State Outcome Evaluation Progress

The State YCWC Wilder Collaborative Factors Inventory

Response Rates

In Year Three the State YCWC Wilder Collaborative Factors Inventory was sent to all current members, as well as any members who had left the project over the course of the year, for a total of 29. The overall number of respondents slightly increased when compared to Year Two from 14 (52%) to 16 (57%) in Year Three, although it is still lower than Year One in which 23 (89%) members responded. Across Years One and Two, family representatives (100%, 67%) responded at slightly higher rates than organizational representatives (86%, 48%); in Year Three the family representative's response rate dropped significantly (33%), whereas the organization representative's response rate increased (58%).

Year Three Results

Table 35 provides and overview of Year Three State YCWC Wilder Collaborative Factors Inventory ratings by factor overall across all respondents (see Appendix U for more in-depth descriptions and sub-group analyses). Overall, Year 3 the ratings were generally moderate to high, with a total average of 3.84. Members rated seven factors as strengths (i.e., 4.0 or higher; green), and 13 as borderline (i.e., 3.0-3.9; yellow); no factors were listed as concerns (i.e., less than 3.0; red). The *Sufficient Funds* factor received the lowest rating; this factor measures members' sense of whether the group's financial and human resources align with its goals. The *Skilled Leadership* and *Self Interest* factors received the highest

ratings; these factors measure members' perspectives on the leadership of the collaboration, and sense that the collaboration is beneficial to their organizations, respectively. Overall, these findings indicate that members rate the collaboration of the State YCWC and its sub-groups positively.

Table 35: Overview of Year Three State Wilder Ratings

Factor	**Overall** (*n* = 16)	
	Mean	*SD*
Skilled Leadership	4.44	0.73
Members See Collaboration as in their **Self Interest**	4.31	0.60
Unique **Purpose**	4.25	0.68
Mutual Respect, Understanding, and Trust	4.09	0.58
Flexibility	4.09	0.61
Members have a **Shared Stake** in Both Process and Outcome	4.04	0.50
Shared Vision	4.00	0.52
Ability to **Compromise**	3.94	0.57
Concrete, Attainable **Goals & Objectives**	3.90	0.53
Favorable **Political & Social Climate**	3.88	0.85
Open and Frequent **Communication**	3.88	0.61
History of Collaboration or Cooperation in the Community	3.84	0.65
Appropriate **Cross Section** of Members	3.72	0.60
Adaptability	3.72	0.41
Appropriate **Pace** of Development	3.66	0.40
Established Informal **Relationships** and Communication Links	3.66	0.70
Collaborative Group Seen as a Legitimate Leader in the Community	3.59	0.55
Multiple **Layers** of Participation	3.59	0.49
Development of Clear **Roles & Policy Guidelines**	3.47	0.59
Sufficient **Funds**, Staff, Materials, and Time	3.16	0.68
TOTAL Average	**3.84**	**0.41**

Ten current members provided open-ended responses indicating what they would like to see come out of the project over the next year (see Table 36 for an overview). Overall, these responses provide insights into state members' interest and commitments to broader goals of the project, and the state-level supports needed (e.g., sustainability, local/state collaboration, communication and dissemination).

Table 36: Current Member Open-Ended Responses

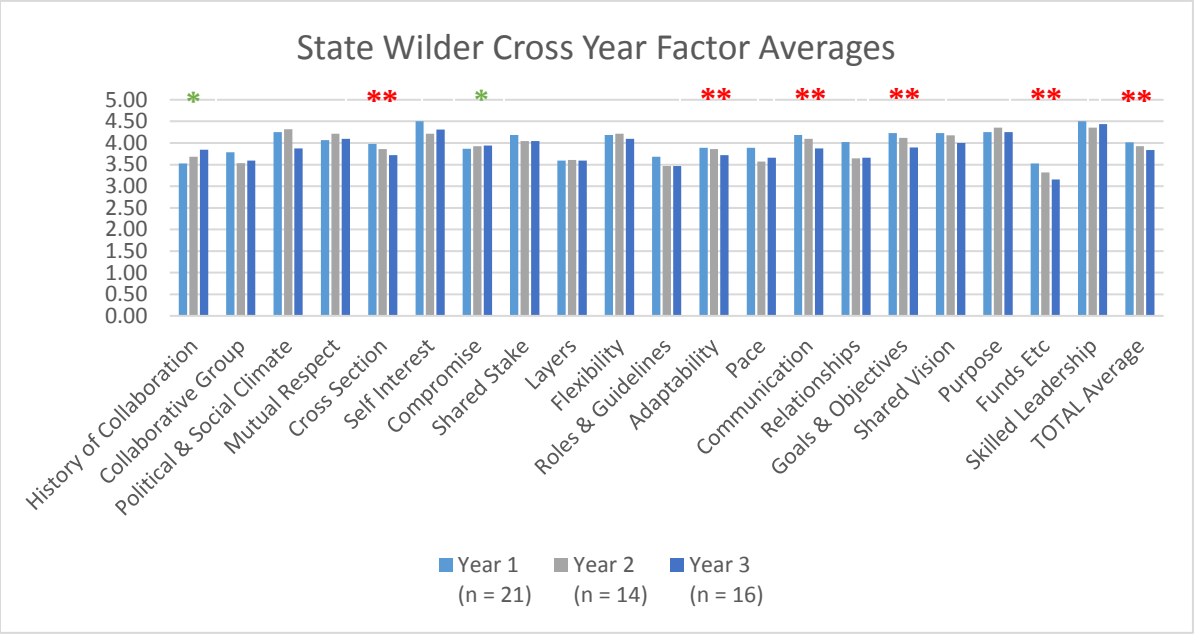
Theme	*n*[19]	Sampling of Participant Responses
1. Increased clarity (goals, outcomes, roles)	4	*To clarify the how this project directly benefits behavioral health services for children who are enrolled in Medical Assistance, and more specifically, how does this project directly benefit children and families enrolled in Head Start and Early Head Start programs in Pennsylvania.*[2]
		Realistic goals and a clear timeline.
2. Increased communication and dissemination	4	*More communication and connection of the work from the local-level to inform the state. Looking to strategies for sustainability and next steps once grant is finished.* [3, 4]
		Dissemination of best practices
3. Planning for sustainability	2	*Solidify plans and think about steps to keep this going once grant is done.* [1]
4. Increased local/state connections	2	*I'd like to see the leadership of the project and state-level leaders from health, behavioral health, education and child welfare share the project's tools and "lessons learned" with county and community level leaders across Pennsylvania. / I would also like state-level leaders to develop a strategy and implementation plan to support local communities in implementation of integrated/co-located health, behavioral health and family support screening, identification and service planning and delivery.* [3]
5. Cross-collaboration	2	*Continued/enhanced collaboration between service organizations to ensure all of the needs of the individuals being served our met.*
		I would like to see a longer-term more strategic relationship between Early childhood Education partners and their school-age counterparts.

Cross Year Analyses

Figure 3 provides an overview of state factor scores across Years One-Three. When looking across the first three years of the project, the State YCWC Wilder Collaborative Factors Inventory scores show some variability, though all scores remain in the moderate to high categories. Two factors improved (History of Collaboration, Compromise), and several stayed relatively stable; six factors had consistent downward trends across time however. This variability may highlight some of the challenges involved with maintaining and sustaining system-level work across various fields; and fiscal constraints that impact communications and governance activities, particularly at the state-level. Here again, these patterns are described in simple terms rather than relying on statistical analysis given the small sample size.

[19] Ten participants completed the open-ended questions. Some answers included more than one theme – these are noted with a superscript with the number of the theme in the examples above.

Figure 3: Overview of State Factor Score Across Years One, Two, And Three[20]



[20] Factors where we observed an increase in scores across all three years are noted with a one asterisk symbol (*); factors with a decrease in scores across all three years are noted with two asterisks (**).

Overall Year Three Key Findings

Table 37 outlines the overall key findings from Year Three, and key considerations for the impact these activities are having at the local- and/or state-level.

Table 37: Year Three Key Findings

Domain	Activity	Impact Considerations
SA	✓ Planned, implemented, and assessed a series of community screening events for Nepali families	✓ SA community screening events, and their planned replication with additional communities in Year Four, represent a targeted area for understanding replication and generalizability issues, both locally and across the state.
BHPH	✓ Conducted PPIA with 11 practices	✓ PPIA represents an efficient, high-yield intervention, whereby practices participating in follow-up assessments showed improved integration across time. The additional assessments of FQHC increased the variability and range of information available about the needs of local practices. Year Three results led to planned targeted support for FQHC in Year Four.
	✓ Developed Universal Electronic Screening (CHADIS) RFP	✓ The development and planning of the RFP for CHADIS represents a critical intervention opportunity in response to the needs practices identified in the PPIA.
ECMH	✓ Planned and initiated the PA Endorsement®	✓ Project LAUNCH's work to bring the Endorsement® framework to PA has been an example of strong state and local collaboration across many activities. This work sets the stage for the use of the Endorsement® to provide integrated and systematic content across multiple sectors at both the local and state-level. PA LAUNCH Endorsement® activities have been instrumental in planning and preparing for the development of sustainable PD opportunities, the alignment of higher education coursework with the Endorsement® framework, and onsite training and TA on the Endorsement® process. Collectively, these activities provide critical supports for the IMH-E® endorsement and credentialing process.
	✓ Created and launched DSAP courses	✓ The DSAP project, with its focus on developing and delivering online learning courses for educators in the three target communities represents an important, sustainable PD resource for these partners, and highlights the ways in which targeted outreach with various stakeholders (e.g., superintendents, administrators, teachers) can lead to system-level change
	✓ Trained Student Assistant Program Liaisons	✓ SAP liaisons fill a critical prevention and intervention role in many PA schools, yet very few have a background in early childhood. The multiple SAP trainings represent an important workforce development opportunity with these practitioners, with targeted and integrated early childhood, developmental, and mental health content support.
HV	✓ Targeted support for the LINK	✓ The Link represents a major systems-level asset to AC, and several targeted activities have supported its use and improvement. The "Open Doors" marketing campaign effectively raised public awareness of the LINK and other services, and serves as an important model of the use of multifaceted strategies for reaching broad audiences. The IT enhancement work addressed a critical project-wide concern to assist in "closing the referral loop" when families are referred to HV programs by medical providers.

Table 37: Year Three Key Findings (continued)

Domain	Activity	Impact Considerations
HV (continued)	✓ Provided targeted, cross-sector trainings	✓ These trainings offered targeted supports on critical issues for direct service providers (i.e., supporting families with substance abuse challenges; developing cultural competency), and resulted in effective cross-sector collaboration (and workforce development.
FS	✓ Provided targeted, cross-sector training	✓ This training offered targeted supports for direct service providers (i.e., strengths-based family support using the Protective Factors framework), and resulted in effective cross-sector collaboration and workforce development.
	✓ Wrote and issued an RFP for parent cafes	✓ The development release of the parent café RFPs resulted in the selection of 4 applications. These sites will host parent cafes, which represent a unique approach to providing parents with support, training, resources, and connections, using a strengths-based, parent-driven approach.
	✓ Aligned the Strengthening Families professional development course with the Endorsement® competencies	✓ This activity aligns with other Endorsement® work, and represents additional evidence of the ways in which the Endorsement® framework is being used to inform integration and alignment across sectors at the state and local-levels.
	✓ Partnered with Smart Beginnings	✓ The Smart Beginnings team enrolled 83 families in the VIP intervention, and 16 families were enrolled in the FCU intervention. These represent critical direct services, and contribute to important research into the feasibility and adaption of these programs into different contexts and younger age groups.
Local Infrastructure	✓ Facilitated numerous collaborations and the implementation of many activities	✓ This has been a consistent focus of PA Project LAUNCH, and aligns with the needs identified in the Environmental Scan to support cross-collaboration and integration among the diverse providers, sectors, and organizations across AC.
	✓ Hiring key implementation support staff across work groups	✓ This represents a critical step in providing Implementation Team support to address the breadth and complexity of PA Project LAUNCH in targeted areas (e.g., ECMH planning and development).
	✓ Updated strategic plan	✓ This effort has resulted in a clearer alignment between goals and activities, aimed at long-term sustainability. This represents an important effort to address the unique challenges brought by the breadth and complexity of PA Project LAUNCH.
	✓ Targeted membership campaigns with families and existing members	✓ Although these targeted campaigns have led to some shifts in council membership, attendance and Wilder data indicate that they have also led to a stronger, more tightly aligned and committed council. Family membership campaigns continue to be a priority in Year 4.
State Infrastructure	✓ Launched PA Project LAUNCH website	✓ Although the website is in its early phases of development, this represents an important step in developing a resource that can be used for multiple communication purposes, across multiple audiences. This resource has the potential to serve as a critical dissemination source, and to facilitate access across multiple stakeholders, particularly families.
	✓ Updated strategic plan	✓ This effort has resulted in a clearer alignment between goals and activities, aimed at long-term sustainability. This represents an important effort to address the unique challenges brought by the breadth and complexity of PA Project LAUNCH.

Recommendations

In Year Three, PA Project LAUNCH has made great strides, and implemented a wide range of activities across all project domains to support the social, emotional, behavioral, physical, and cognitive needs of young children, their families, and pregnant women. The state and local teams have both updated the Strategic Plan, and clarified goals, outcomes, and activities. With this in mind, in this next section, we make recommendations to support this work, based on our evaluation of Year Three activities, particularly with an eye toward long-term sustainability. These recommendations are built on our process and outcome analyses across each domain, and also build on the recommendations from previous years. The recommendations, in this sense, focus strongly on how to *continue* targeted efforts, as many of our Year Two recommendations have been implemented or initiated. Each recommendation is described below.

Recommendation 1:

Continue to increase focus on identifying and implementing priority activities. Although Year Three represents a major increase in activities and implementation efforts, the breadth, depth, and overall complexities of PA Project LAUNCH continue to be both a strength, and a challenge, in terms of implementation and evaluation. Year Four activities should focus on targeted implementation activities that build on existing work group and council efforts, with project-wide concentration on supporting the priorities identified and begun in Year Three. The updated and revised Strategic Plan represents an important step in this direction, and this tool should continue to serve as a guiding document across all work group and council activities.

Despite the increase in implementation activities in Year Three, there was still a significant amount of effort spent on coalition building, collaboration, and outreach. Although this represents an important goal of PA Project LAUNCH, it serves the larger objective of creating long-term, sustained, purposeful and goal-oriented partnerships. With this in mind, we continue to suggest that the project focus on "deliverables"---new policies, events, interventions, trainings, products, and procedures – and targeted outreach and partnership that support the implementation of those priority deliverables. Important planning and coalition building work has been done in Year Three to set the stage for this type of work (e.g., ECMH efforts around the IMH Endorsement®; BHPH efforts in developing CHADIS RFP); Year Four represents a critical time in the grant lifespan for bringing these efforts to fruition.

Recommendation 2:

Continue to prioritize sustainability and generalizability efforts. Sustainability has been a key goal for PA Project LAUNCH from the start. State support for the generalizability of activities and findings in resource-rich AC to the larger Commonwealth has also been a project-wide focus. Although both sustainability and generalization remain as important considerations for all planning and activities, these should become critical priorities in Year Four, given the breadth of the project, and timing in the grant's lifespan.

Toward this purpose, we recommend increased focus on activities and planning to support sustainability and generalizability. This can include targeted focus and increased evaluation of activities that have a larger impact (e.g., the Link, IMH Endorsement®), which can also be used to design and complete follow-up activities and collaboration aimed at increasing long-term sustainability. Generalizability efforts may include targeted efforts to document and support replicability. For instance, Work Groups may engage in efforts to document the activities, collaborations, and resources that were required to implement activities and meet targeted outcomes. The SA work group is engaged in this type of work currently, as is a broader PA Project LAUNCH communication team that has been brought on for Year Four; these may serve as models for the ways in which local activities can be replicated and adapted to support broader

state-wide implementation. The State Council and subgroups can also play a critical role in supporting this level of work.

Recommendation 3:

Continue to examine and support local and state infrastructure efforts. In Year Three, both the State and Local YCWCs focused on important structural and process efforts to support effective council governance (e.g., local efforts to increase family membership and targeted recommitment campaigns with existing members; initial efforts to combine the State YCWC with the State ELC). These activities represent important steps in this process, but Year Three evaluation results (e.g., Wilder responses, reviews of YCWC meeting notes and discussions) indicate that this is an area for continued growth.

For instance, members have expressed interest in understanding certain areas more deeply. These include project goals and outcomes, and in developing more cross-collaboration across Work Groups. Family members in particular expressed interest in having a clear sense of membership expectations, roles, and activities. Targeted work has already begun in this area, but given this thoughtful and fruitful discussion, and the shifts that will be occurring at the State council in Year Four, we recommend continued focus on family engagement, communication efforts, and cross-collaboration among Work Groups. Communication efforts in particular are an important area of focus in supporting this work. The creation of the PA Project LAUNCH communication team, noted above, represents an important step in this area, but project-wide focus on documenting and disseminating results across different stakeholder audiences represents an important opportunity for the remainder of the grant. Toward this purpose, we suggest the development of a local- and state-level Communication Plan that specifies targeted dissemination and stakeholder outreach goals and activities.

Recommendation 4:

Integrate implementation and evaluation frameworks. As noted above, the breadth and complexity of PA Project LAUNCH represent strengths and challenges for both implementation and evaluation. As PA Project LAUNCH engages in more and more activities, documenting and evaluating the full range of these efforts in ways that provide the Implementation Team with timely and rich data is important area for partnership between evaluation and implementation.

Toward this purpose, we hope to partner with the Implementation Team to leverage existing evaluation structures to support these focused efforts. This will include using embedded structures, such as the system-level targets identified in the Multi-Site Systems Activities and Outcomes Survey (MSE SAOS) (e.g., coalition building, funding and sustainability), and the cross-cutting themes (e.g., workforce development, health disparities, system change and sustainability), to create a framework that provides guidance around data-based decision making. We are submitting a revised Evaluation Plan for Year Four that includes a newly developed tool, the Data Matrix (see Appendix I), that will help with this work. We designed this tool to provide a snapshot of the full range of activities that occur across the project, while also rating impact at the domain- and cross-cutting theme level. This tool also reframes our evaluation of state-level activities across local domain areas, in an effort to capture the project's locally-driven, state supported framework. As such, this tool will provide the team with a clear picture of the project that can be used to identify and communicate priorities across multiple project levels and areas (e.g., domain, local, state, cross-cutting themes), which will support the team in making data-based decisions. This tool will also help us know where to take "deeper dives" with evaluation, and where to target communication efforts.

References

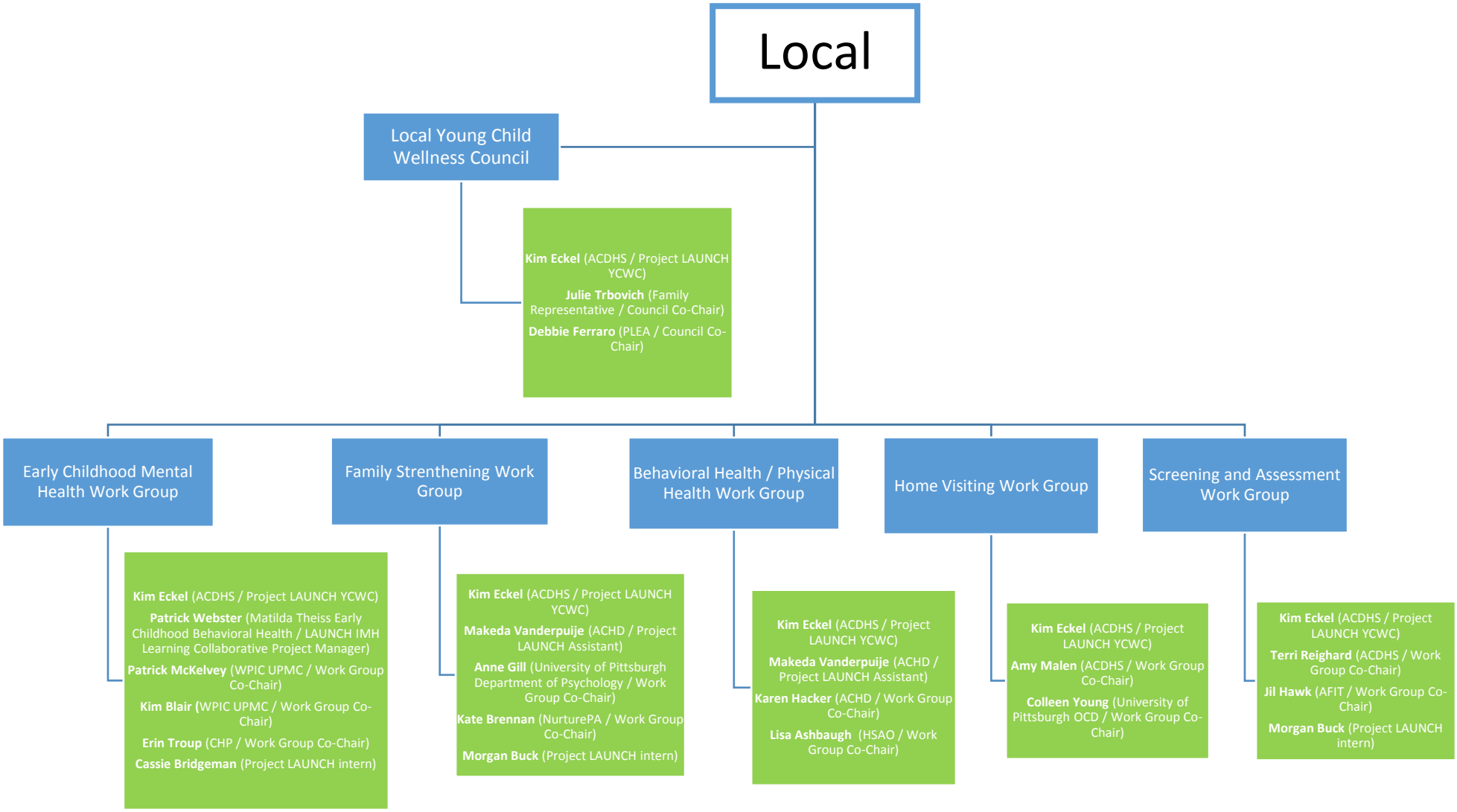
Mattessich, P., Murray-Close, M., & Monsey, B. (2001). *Wilder Collaboration Factors Inventory*. St. Paul, MN: Wilder Research.

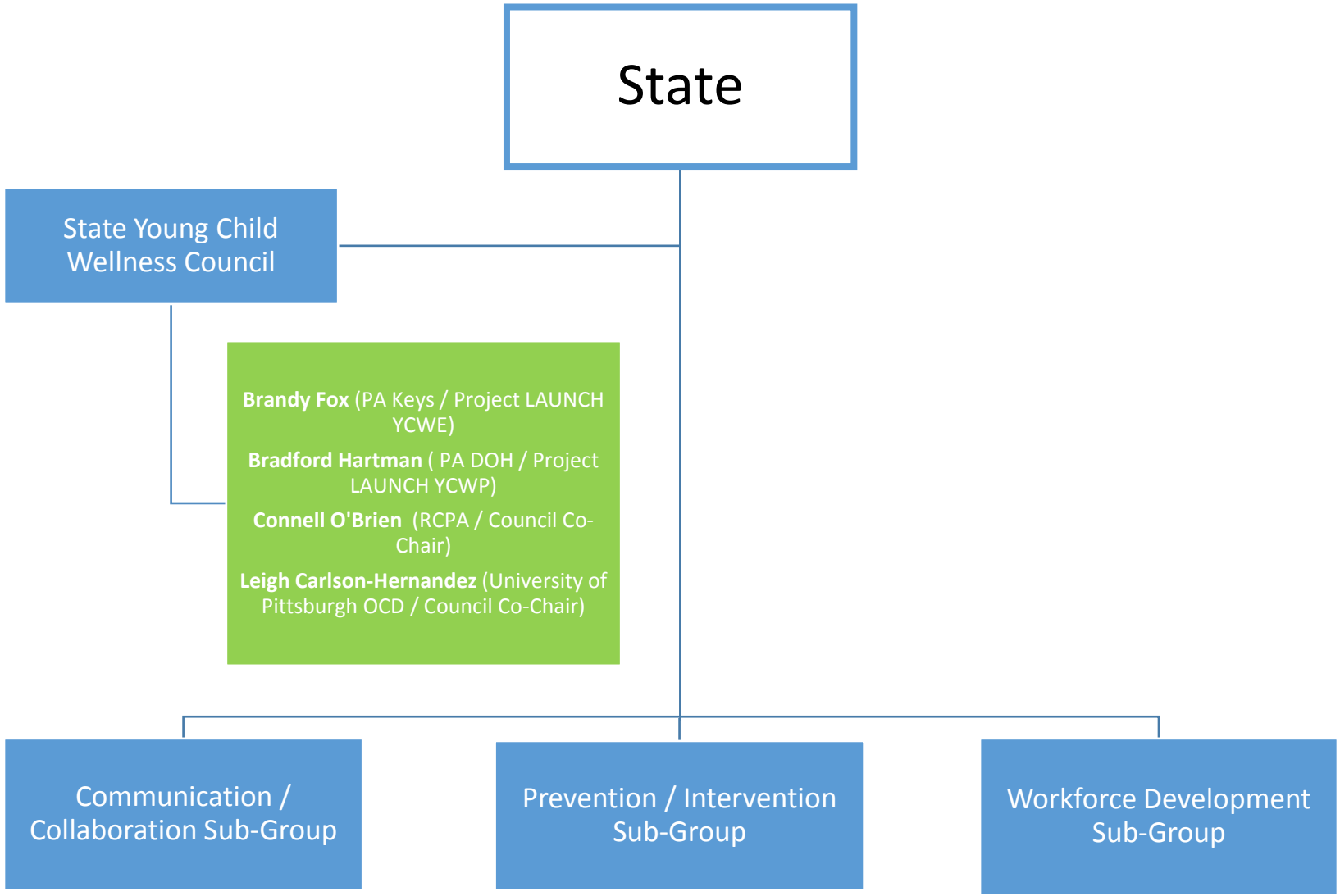
Waxmonsky, J., Auxier, A., Romero, P.W., & Heath, B. (2014). Integrated Practice Assessment Tool (IPAT) Version 2.0. Colorado Access, Value Options Axis Health Systems. Retrieved from https://ncc.expoplanner.com/files/13/SessionFilesHandouts/ D13_Waxmonsky_1.pdf

Appendix A: Current Implementation Team Members

Name	Affiliation
Steven Christian-Michaels	Family Services Western Pennsylvania
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
Kimberly Goldstein	University of Pittsburgh Office of Child Development
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
John Kim	University of Pittsburgh Office of Child Development
Jeanine Rasky	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
Caitlin Spear	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
Shannon Wanless	University Of Pittsburgh Office of Child Development
Patrick Webster	Matilda Theiss Early Childhood Behavioral Health

Appendix B: Key LAUCH Member Roles




State
State Young Child Wellness Council
Brandy Fox (PA Keys / Project LAUNCH YCWE)
Bradford Hartman (PA DOH / Project LAUNCH YCWP)
Connell O'Brien (RCPA / Council Co-Chair)
Leigh Carlson-Hernandez (University of Pittsburgh OCD / Council Co-Chair)
Communication / Collaboration Sub-Group
Prevention / Intervention Sub-Group
Workforce Development Sub-Group

Appendix C: Description of Planned Changes to State YCWC in Year Four

As PA Project LAUNCH approached grant year four, we have been looking for opportunities to sustain the lens of "linking actions for unmet children's health" within existing council or committee structures, as September 2019 draws near. There has been increased focus on integration and consolidation of efforts from governmental leadership, therefore, Project LAUNCH staff have been exploring ways to consolidate the work of the State YCWC into an existing and sustainable body. As a result of that effort, the remaining work of the YCWC will shift to the established Early Learning Council (ELC) whose purpose is "to plan for the expansion of effective early learning and development services for young children and make recommendations to ensure the plans are implemented successfully." Many of their tasks align directly with the Project LAUNCH core strategies (see Executive Order, https://www.pakeys.org/uploadedContent/Docs/ELinPA/Executive%20Order%202008-07.pdf).

Additionally, both the ELC and the State YCWC share council members and system representatives which further supports the merge of the work of Project LAUNCH within the ELC. A streamlined version of state level priorities has been provided and will be presented to the ELC during their February 2018 meeting in an effort to determine how to embed these priorities into the existing committee work of the council.

Appendix D: List of Acronyms

List of Acronyms

AC	Allegheny County
ACDHS	Allegheny County Department of Human Services
ACHD	Allegheny County Health Department
ADV	Advocacy
AFIT	Alliance for Infants and Toddlers
AIU	Allegheny Intermediate Unit
ASQ-3	Ages & Stages Questionnaires, Third Edition
ASQ-SE	Ages and Stages Questionnaire - Social-Emotional
BH	Behavioral Health
BHPH	Behavioral Health Physical Health
BRYCS	Bridging Refugee Youth and Children's Services
CB	Coalition-Building
CC	Cultural Competency
CG	Council Governance
CHADIS	Child Health and Development Interactive System
CHOP	Children's Hospital of Philadelphia
CHP	Children's Hospital of Pittsburgh
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
CYF	Office of Children, Youth and Families
DARE	Office of Data Analysis, Research and Evaluation
DART	Discovery, Assessment, Referral and Tracking
DHS	Department of Human Services
DOE	Department of Education
DOH	Department of Health
DSAP	Differentiated Supervision Action Project
EBP	Evidence-Based Practice
EC	Early Childhood
ECE	Early Care and Education
ECMH	Early Childhood Mental Health

ECMHC	Early Childhood Mental Health Consultation
EHS	Early Head Start
EI	Early Intervention
ELC	(Pennsylvania) Early Learning Counsel
FCU	Family Check Up
FQHC	Federally Qualified Health Center
F/S	Funding/Sustainability
FS	Family Strengthening
GPO	Government Project Officer
GPS	Guiding Parents Smoothly
HD	Health Disparities
HFA	Healthy Families America
HSAO	Human Services Administration Organization
HV	Home Visiting
IECMH	Infant Early Childhood Mental Health
IMH	Infant Mental Health
IPAT	Integrated Practice Assessment Tool
IT	Information technology
LAUNCH	Linking Actions for Unmet Needs in Children's Health
LSC	Local Systems Change
MH	Mental Health
MHC	Mental Health Consultation
MHPRI	Mental Health Practice Readiness Inventory
MIECHV	Maternal, Infant, and Early Childhood Home Visiting program
MSE	Multi-Site Evaluation
NAS	Neonatal Abstinence Syndrome
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
PBA	Public Awareness
PA-AIMH	Pennsylvania Association of Infant Mental Health

PA-PBS	Pennsylvania Positive Behavior Support Network
PBS	Public Broadcasting Service
PBIS	Positive Behavioral Intervention and Supports
PEDS	Parents Evaluation of Development Status
PIC	Public Information Campaigns
PP	Pediatric Providers
PPAR	Pittsburgh Action Against Rape
PPIA	Pediatric Provider Integration Assessment
PR	Public Relations
QR	Quick Response
RFA	Request for Application
RFP	Request for proposal
RTT-ELC	Race to the Top- Early Learning Council
SAMHSA	Substance Abuse and Mental Health Services Administration
SA	Screening and Assessment
SAP	Student Assistance Program
SCS	System Change and Sustainability
SS	Social Services
SSC	State Systems Change
STARS	Standards, Training/Professional Development, Assistance, Resources, and Support
TA	Technical Assistance
TiPS	Telephonic Psychiatric Consultation Service Program
TN	Tennessee
UPMC	University of Pittsburgh Medical Center
VIP	Video Interaction Project
WFD	Workforce Development
WG	Work Group
WIC	Women, Infants, and Children
WPIC	Western Psychiatric Institute and Clinic
YCW	Young Child Wellness (Expert, Coordinator, Partner)
YCWC	Young Child Wellness Council
YSP	Youth Support Partners

Appendix E: Meeting Minutes Template

Behavioral Health/Physical Health Work Group Meeting Notes

Please complete and turn in after every work group meeting

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

Check off the status of attendees. Add names not listed:

Name	Current member	New Member	Left Workgroup	Non-member/ Visitor	Notes (organization, start / end date, etc.)
Heather Hoeke					
David Kolko					
Anthony Lucas					
Todd Wolyn					
Makeda Vanderpuije					
Lynne Williams					
Joan Scheider					
Patty Schake					
Julia Trbovich					
Nicole Van Alsytne					
Kim Eckel					

Meeting Purpose:	
Check the Objective(s) Your Group is Addressing at this Meeting	
	Objective 2.1: Increase number of validated behavioral health screens with validated instruments as part of healthy development check-ups in primary care offices caring for children.
	Objective 2.2: Increase the number of physical health and behavioral health providers trained in topics related to integration, including but not limited to, infant and child behavioral health, behavioral health tools and resources, and practice integration models (e.g., pediatricians, pediatric staff, and behavioral health staff).
	Objective 2.3: Increase the number of primary care and pediatric practices that integrate behavioral health resources to meet the needs of young children and their families

MEETING NOTES

FOLLOW UP STEPS

DATE OF NEXT MEETING

Appendix F: End-Of-Quarter Survey (administered through Qualtrics)

Year 3 Quarterly Evaluation Report Interview Questions

Please answer the following questions to the best of your knowledge, considering ONLY PA Project LAUNCH activities occurring October 1, 2016 through June 30, 2017.

Screening & Assessments

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

2. What systems have been promoted to support (or increase) the use of high quality screening and assessment practices?

Behavioral Health & Physical Health Integrations

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

    a. In reference to the question above, what strategies and models have been identified and communicated to support the integration of behavioral health and physical health?

4. What resources and strategies have been promoted to support usage of high quality screening & assessment tools in physical health settings?

5. What systems efforts have been promoted to support the integration of behavior health and physical health into primary care and agency strings?

ECMH Consultation

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

    a. Referencing the question above, where is LAUNCH at in this process of identifying best practices? What has LAUNCH done during this period to build on LAUNCH prior work?

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

8. What system efforts have been promoted to expansion and/or quality improvement in ECMH consultation?

Home Visiting

9. What new efforts and/or progress has PA Project LAUNCH made to engage more families in the home visiting programs?

10. What system efforts have been promoted to engage more families in home visiting programs?
    a. Home many homevisiting program are (or to what extent are home visiting programs) providing behavioral and/or physical health resources to their families? (by type)
    b. To what extent are families (racial, ethnic, and special population groups) engaged in home visiting service

Family Strengthening & Parent Skill Building

11. 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?

12. 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?

13. What activities are being supported by LAUNCH to increase parent involvement in social networks?

Infrastructure

14. What efforts, collaborations, and/or relationships created during this period because of LAUNCH stand out to you?

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

16. What strategies have been implemented [or are being discussed] for sustainability?

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

18. What policies have been changed or added (or are being discussed) to support long-term strategy implementation?

19. What policy/system/infrastructure obstacles or environmental changes have you encountered that have impacted the work of PA Project LAUNCH? Please explain how and how they are being addressed?

Public Awareness

20. Looking back on the outreach activities within this period, 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 specific audience(s)?

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

Behavioral Health Disparities

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

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

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

Cultural Competence

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

Workforce Development

26. What has been done to promote workforce development, if not mentioned in previous sections?

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

Evaluation

28. Please identify any individual(s) whom you would like to be interviewed for qualitative data – Name, Organization, Title, Contact Info, Explanation of their relationship to LAUNCH, Target interview questions:

Name	ORG	Title	Contact Info	Relationship to LAUNCH	Target Questions

29. Please identify any memorable statements/quotes, and their source, context, and approximate date to be used for qualitative data

Other

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

Appendix G: 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

If Other, Please specify:

_____

7. What is your position job?

☐ Health Provider ☐ Educator ☐ Administrator

☐ Mental Health Provider ☐ Social Service Provider ☐ Parent

☐ Other

If other, 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!

Appendix H: Follow-Up Training Survey

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!

Appendix I: Data Matrix Tool

	Home Visiting (HV)		Screening and Assessment (SA)		ECMH		BH/BH		Family Strengthening (FS)	
	Indicator	TOTAL Score	*Indicator*	TOTAL Score	*Indicator*	TOTAL Score	*Indicator*	TOTAL Score	*Indicator*	TOTAL Score
Workforce Development (WFD)	Training	1.33	Training	0	Training	3.5	Training	2	Training	0
	Assessment	0	Assessment	2.5	Assessment	0	Assessment	3	Assessment	0
	Resources	4	Resources	2	Resources	3.33	Resources	0	Resources	2
	Infrastructure	0	Infrastructure	0	Infrastructure	4	Infrastructure	0	Infrastructure	0
	State Supports	3	State Supports	1.33	State Supports	4	State Supports	2.5	State Supports	1.5
	Total HV WFD	1.67	**Total SA WFD**	1.17	**Total ECMH WFD**	2.97	**Total BH/PH WFD**	1.50	**Total FS WFD**	0.70
Cultural Competency (CC)	Training	1	Training	0	Training	0	Training	0	Training	0
	Intervention	0	Intervention	0	Intervention	0	Intervention	0	Intervention	0
	Assessment	0	Assessment	0	Assessment	0	Assessment	0	Assessment	0
	Resources	0	Resources	0	Resources	0	Resources	0	Resources	0
	State Supports	0	State Supports	0	State Supports	0	State Supports	0	State Supports	0
	Total HV CC	0.20	**Total SA CC**	0	**Total ECMH CC**	0	**Total BH/PH CC**	0	**Total FS CC**	0
Health Disparities (HD)	DS: Assessment	3	DS: Assessment	2.5	DS: Assessment	0	DS: Assessment	4	DS: Assessment	0
	DS: Referrals	4	DS: Referrals	3.5	DS: Referrals	1.5	DS: Referrals	3	DS: Referrals	0
	DS: Intervention	2	DS: Intervention	0	DS: Intervention	4	DS: Intervention	0	DS: Intervention	0
	DP: Services	0	DP: Services	2.5	DP: Services	0	DP: Services	0	DP: Services	0
	DP: Training	0	DP: Training	0	DP: Training	4	DP: Training	0	DP: Training	0
	DP: Resources	0	DP: Resources	3	DP: Resources	4	DP: Resources	0	DP: Resources	0
	State Supports	1.33	State Supports	0	State Supports	1.33	State Supports	1.33	State Supports	0
	Total HV HD	1.48	**Total SA HD**	1.64	**Total ECMH HD**	2.12	**Total BH/PH HD**	1.19	**Total FS HD**	0
Public Awareness (PA)	Dissemination	2.33	Dissemination	2	Dissemination	0	Dissemination	0	Dissemination	0
	Outreach	2	Outreach	2.33	Outreach	2.5	Outreach	2.33	Outreach	0
	State Supports	2	State Supports	1.33	State Supports	4	State Supports	1.33	State Supports	0
	Total HV PA	2.11	**Total SA PA**	1.89	**Total ECMH PA**	2.17	**Total BH/PH PA**	1.22	**Total FS PA**	0
System Change & Sustainability (SCS)	Funding	0	Funding	0	Funding	4	Funding	0	Funding	0
	Policy	0	Policy	0	Policy	4	Policy	0	Policy	0
	Collaboration	3	Collaboration	2.67	Collaboration	2.5	Collaboration	3	Collaboration	2
	Infrastructure	4	Infrastructure	0	Infrastructure	4	Infrastructure	0	Infrastructure	0
	Other	0	Other	0	Other	4	Other	3	Other	0
	State Supports	2.5	State Supports	0	State Supports	4	State Supports	1.33	State Supports	1.33
	Total HV SCS	1.58	**Total SA SCS**	0.45	**Total ECMH SCS**	3.75	**Total BH/PH SCS**	1.22	**Total FS SCS**	0.56

The *Cross PA LAUNCH Data Matrix Tool* is designed to integrate evaluation data and internal implementation planning needs. It is designed to provide a snapshot of where PA LAUNCH local and state efforts are concentrated, and to give an indicator of impact across those efforts.
Impact ratings are based on a multifactor rating system that includes:

a) Data on Work Group efforts
    i. Occurrence/Non-Occurrence
    ii. Exploration, planning, and in progress status
    iii. Completion status
b) The number efforts across areas
c) Implementation and outcome data on completed efforts
d) An impact factor that will be rated by multiple Evaluation and Implementation Team members to provide a more nuanced view of these PA LAUNCH efforts.

The scores above are purely examples, rather than actual PA LAUNCH data, but they are based on the current formula. The color codes are as follows:

0	0.1-1.0	1.1-2.0	2.1-3.0	3.1-4.0
No completed efforts occurred in the given timeframe	Efforts that occurred received a low impact rating.	Efforts that occurred received a low-moderate impact rating.	Efforts that occurred received a high-moderate impact rating.	Efforts that occurred received a high impact rating.

We have operationalized all indicators across cross-cutting themes, and are finalizing our impact criteria. We are also developing follow-up questions for areas where we want to take a "deeper dive," including:

- What went well?
- What were the challenges?
- What would you change?
- What's the biggest change from the status quo?
- What reached the broadest range of families? What has the highest potential for sustainability?
- What has achieved most engagement across families and providers based on LAUNCH goals?

We also plan to create a flow chart that outlines the data collection, compilation, and rating process, and will open this up for feedback from the Implementation Team upon completion.
We anticipate that this will be completed yearly in Years 4 and 5, and our hope is that this tool will be used to serve multiple purposes across the Evaluation and Implementation teams, including:

- Streamlined data collection
- Guidance for data-based decision-making
    - Data-based decisions on where to target "deeper dive" evaluation efforts
    - Data-based decisions on where to focus specific implementation efforts
- Communication
    - Across work groups for Implementation Team
    - "Broad snapshot" communication for Evaluation Team

Appendix J: Smart Beginnings Measures

Construct	Measure	Baseline	6m	18m	24m
PARENTING					
Parent-child interaction	Videotaped interactions (office-6m; home-18m, office-24m)		x	x	x
Cognitive stimulation	StimQ: Reading, teaching, play		x	x	x
Home environment	HOME Inventory: Infant-Toddler			x	
Harsh parenting	Discipline Survey		x	x	x
Relationship quality	Adult Child Relationship Scale		x	x	
Routines & activities	Feeding, sleep, media		x	x	x
Planning/Supporting and Enjoying Parenting	Parenting Your Baby (PYB) (6M), Parenting Your Toddler (PYT) (18M, 24M) planning and supporting and enjoying subscales based pm the Parenting Young Children (PARYC)		x	x	x
Parent Self Efficacy (PS)	Karitane Parenting Confidence Scale	x			
PARENT PSYCHOSOCIAL RESOURCES AND ADJUSTMENT					
Sociodemographic characteristics / risks	*Demographics* (e.g., parent income, age, educational attainment, marital status, language, substance use)	x	x	x	x
Risk	*Neighborhood danger:* Me and My Neighborhood Questionnaire (MMNQ)	x	x	x	x
Risk	*Literacy* (word reading: Woodcock-Johnson III / Batería-III Letter-Word	x			
Depression	Edinburgh Postnatal Depression Inventory	x	x	x	
Depression	Patient Health Questionnaire-9		x		
Anxiety	Generalized Anxiety Disorder (GAD-7)	x	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	
Social stress / support	General Life Satisfaction Questionnaire	x	x	x	x
Relationship satisfaction	Dyadic Adjustment Scale (short version)		x	x	
Parenting regulation of negative emotion	Emotional Equilibrium Scale			x	x
Parenting hassles	Parenting Daily Hassles scale related to everyday events		x	x	
Locus of control	Health Locus of Control Measure adapted for parents' LOC for locus of control related to child's behavior and school readiness		x	x	
Chaos	Chaos Scale related to home environment	x			
Mindfulness	Interpersonal Mindfulness in Parenting			x	

Discrimination	Experiences of Discrimination (EOD) scale		x	x	x
CHILD DEVELOPMENT AND EARLY SCHOOL READINESS					
Self-regulation	Infant Characteristics Questionnaire: Temperament (Difficultness)		x		
	Preschool Self-Regulation Interviewer Assessment (PSRA). Assessor ratings of child's attention/emotional regulation during all DA tasks				x
Pre-academic skills					
Early language	MacArthur Communicative Development Inventory (CDI)			x	x
Expressive/receptive language (DA)	Receptive and Expressive One-Word Picture Vocabulary Tests, Fourth Edition				x
Communication (PS)	Communication and Symbolic Behavior Scale (CSBS)		x		
Social-emotional skills					
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	x	x	x	x
Other					
Biological risk (MR)	Medical risks/complications, acute/chronic medical problems, growth	x	x	x	x
PROGRAM FIDELITY					
	Curricular & facilitator checklists				
	COACH Fidelity Protocol				

Appendix K: Endorsement for Culturally Sensitive, Relationship-Focused Practice Promoting Infant & Early Childhood Mental Health® from the PA-AIMH website

http://www.pa-aimh.org/endorsement.html

Endorsement® provides recognition of specialized knowledge and expertise in professionals working with or on behalf children, birth through six, and their families.

The Pennsylvania Association for Infant Mental Health (PA-AIMH), with support from the Pennsylvania Project LAUNCH Partnership, will be implementing the ***Competency Guidelines for Endorsement in Culturally Sensitive, Relationship-Focused Practice Promoting Infant and Early Childhood Mental Health®,*** developed by the Michigan Association for Infant Mental Health (MI-AIMH). The implementation process will be a collaborative effort between PA Project LAUNCH and PA-AIMH and will be "launched" in early 2018. Pennsylvania has joined 27 US states and 1 international territory in the movement toward the promotion of infant mental health principles and practices, influenced in PA greatly by the recommendations of the Early Childhood Mental Health Advisory Committee (2009) who indicated PA should *"adopt and promote a set of early childhood mental health competencies for all professionals and across all levels of service provision for families with children from conception through age five."*

Endorsement® is meant to honor professionals who apply infant & early childhood mental health principles to their practice. It is granted through documentation and verification of the required specialized education, work, in-service training, and reflective supervision/consultation experiences. Endorsement® is not a license but an overlay that complements one's professional license and/or other credentials.

The Infant Mental Health Endorsement® (IMH-E®) system is one of the first and most comprehensive efforts, nationally and internationally, to identify best practice competencies across disciplines and practice settings, offering multiple career pathways for professional development in the infant, early childhood and family field. As of December 2016, there are 1,864 professionals who have earned IMH-E® across the world.

The Early Childhood Mental Health Endorsement (ECMH-E®) is a workforce development initiative with the potential to positively impact the depth and breadth of knowledge, understanding and skills of early childhood mental health professionals across multiple disciplines and service sectors. Similar to the IMH-E®, which has provided professionals working with or on behalf of infants, toddlers and families a credential that recognizes their specialized knowledge and skills in the infant-family field, we want to recognize the professionals working with and on behalf of children ages 3 up to 6 years old and their families who are also applying important infant and early childhood mental health principles into their work. The ECMH-E® will provide a pathway to Endorsement® for professionals who incorporate key infant and early childhood mental health competencies into their work with and on behalf of children ages 3 up to 6 years old and their families.

Appendix L: STARS Program Levels

https://www.pakeys.org/uploadedContent/Docs/STARS/Revisioning/Keystone%20STARS%20Performance%20Standards%20-%2006.21.2017-%20v43.pdf

STAR 1: Certification and Compliance

Performance Standard
Certification and Compliance Early care and education program holds a Full Certificate of Compliance from Pennsylvania's Department of Human Services Early Head Start and Head Start programs are in substantial compliance with no deficiencies Preschool programs licensed by the Pennsylvania Department of Education are in good standing with the Department of Education

STAR 2: Required Performance Standards

Performance Standard
Staff Qualifications and Professional Development
Program Leadership and Staff complete NEW Keystone STARS Orientation Part 1 and 2 (within 90 days of hire) Part 1 – Overview of STARS System and CQI Principles Part 2 – Elements of Assessing and Building Quality • The Pennsylvania Core Knowledge Competencies (CKC) • Pennsylvania Big Ideas Framework • Continuous Quality Improvement (CQI) • PA Early Learning Standards • Using Caring for our Children Basics (CFOCB) to Support Practice • Assessment tools that support program quality • Supporting interactions with children and families
Program Leadership and Staff are registered in the Professional Development Registry (within 60 days of hire).
Individualized annual professional development plans are developed for Program Leadership and Staff to support educational achievement and professional growth. Annual written professional development plans are based on needs identified in the Big Ideas and Individual Professional Development Plan (IPDP). Plan includes goals to support further education.
Early Care and Education Program
Program conducts self-assessments using evidence-based tools and creates a CQI Plan with goals and action items to support improvement
Pennsylvania's Early Learning Standards are used as a resource for staff to support planning and documentation of children's learning. Lessons plans reflect a balance of activities that support developmentally appropriate learning through play.
A research-based developmental screening tool is used within 45 days of enrollment to identify children who may need additional evaluation and/or intervention strategies.
Program adopts Pennsylvania's Office of Child Development and Early Learning state policies, practices and supports regarding inclusion. The Program develops a process to address the local steps in the OCDEL Inclusion Announcement. Programs may choose to collaborate with the local Early Intervention Program to support this activity.

Program adopts Pennsylvania's Office of Child Development and Early Learning state policies, practices and supports regarding suspension and expulsion and has policies and practices in place to support the social and emotional development of children served. Programs may choose to collaborate with the local Early Intervention Program to support this activity.
Partnerships with Families and Communities
IEP or IFSP written plans, and/or special needs assessments are utilized as appropriate to inform practice. Participants at IEP/IFSP meetings include family members, the child's teacher, specialists and director or administrator.
Program has a written policy to support a child's transition from one classroom/group or program to the next and from preschool to kindergarten. The policy includes a plan for the program to share information with families regarding transitioning plans. Includes a plan to support school age children in transitioning to self-care.
Programs have a policy and/or practice in place to support and encourage family engagement and a minimum of one family conference is offered per year to discuss children's progress and behavioral, social, and physical needs.
A Family Handbook is distributed to outline program policies and practices beyond those required by Certification. (See Appendix D Keystone STARS Policy Manual)
Leadership and Management
A financial record keeping system for revenue and expenses is in place.
A policy manual is provided to staff to support their understanding of program policies, procedures, roles and responsibilities.
Program uses documents for tracking child and staff illnesses and injuries, including plans of action to prevent further occurrences.
A system of site safety review is in place including strategies for supervising children.
Program uses Caring for our Children to establish policies and practices regarding care plans for children with special needs, asthma, medical needs, food allergies, and medication administration.

STAR 3&4: Maintain STAR 2 Performance Standards AND Points Earned in Each Standard Category

Performance Standard
Staff Qualifications and Professional Development-All Staff
Required Indicator; Annual individualized professional development (PD) plans for each staff member are included in the program's CQI Plan. PD Plans include a system to support the staff's education and career development and are developed based on needs identified in the Big Ideas and Individual Professional Development Plan (IPDP). PD Plans: • align with the Career Pathway; • show a progression in meeting professional development goals; • support educational advancement; and • identify credit bearing education opportunities that address the needs and goals identified.
25% or more of all staff members are enrolled in or have completed an academic program to support achievement of their next education level and a member of the program's on-site leadership team is enrolled in or holds a current PA Director's Credential OR 50% or more of all staff members are enrolled in or have completed an academic program to support achievement of their next education level and a member of the program's on-site leadership team is enrolled in or holds a current PA Director's Credential OR 75% or more of all staff members are enrolled in or have completed an academic programs to support achievement of their next education level and a member of the program's on-site leadership team is enrolled in or holds a current PA Director's Credential OR 75% of all teaching staff hold a minimum of an

Associates Degree in child development, early care and education or related field (with coursework in child development) and 75% of all administrative staff hold a minimum of an Bachelor's degree in child development, early care and education, business or related field.
All teaching staff and program leadership complete professional development related to planning and implementing activities that support language development and academic achievement of children who are culturally and linguistically diverse within the past 3 years. As needed, staff complete refresher or advanced modules.
All teaching staff and program leadership complete professional development regarding the support of social and emotional development of children. Possible topics include: Pyramid Model; Social and Emotional Development; and Infant Early Childhood Mental Health within 1 year of hire. Annually, as needed, staff complete refresher or advanced modules.
All teaching staff and program leadership complete professional development that promotes positive interactions with children and families within 6 months of hire. Annually, as needed, staff complete refresher or advanced modules.
All teaching staff and program leadership have received professional development in the curriculum selected by the program within 6 months of hire. Annually, as needed, staff complete refresher or advanced modules.
All teaching staff and program leadership have received professional development in the administration of the adopted developmental screening within 1 year of hire. Annually, as needed, staff complete refresher or advanced modules.
All teaching staff and program leadership have received professional development in the administration of observation-based assessment of children's development within 1 year of hire. Annually, as needed, staff complete refresher or advanced modules.
All teaching staff and program leadership have professional development that prepares them to work with young children who have special needs. Topics should include: strategies for supporting inclusion; special needs; supporting teacher-child interactions; supporting English language learners (ELL); cultural competence; transition; and the Strengthening Families' Protective Factors within 1 year of hire. Annually, as needed, staff complete refresher or advanced training.
Non-instructional staff receive information and professional development on: developmentally appropriate practices; diversity; age-appropriate standards; and appropriate child-adult interactions. Note: Non-instructional staff include: lunch assistants, bus drivers, maintenance staff and volunteers
Early Care and Education Program
Program implements an emerging developmentally and culturally appropriate learning curriculum that is responsive to the emerging and changing interests of young children, aligns with the PA ELS, play based, and represents a balance of active and passive learning opportunities.
Program utilizes valid and reliable observation-based assessments of children's development, maintains internal data regarding child outcomes, and is prepared to share this data with Pennsylvania state partners for research and evaluation.
Results from developmentally appropriate observation-based assessments of children's development are used for curriculum planning, individual child planning, and referral to community resources. Teachers modify practices based on child assessment data. Accommodations are based on individual strengths /needs.
Program policies and practices are in place to support the language development and academic achievement of children who are culturally and linguistically diverse.
Children whose first language isn't English are encouraged to use home language, gestures, communication devices, sign language, and pictures to communicate when needed.
Observation-based assessment results are shared with families.
REQUIRED INDICATOR A reliable observation instrument (ERS, CLASS, Other) that includes indicators for staff child interactions and responsive teaching practices is used to assess the learning environment and to inform the program's CQI Plan and technical assistance goals. Staff have opportunities to work together and in small teams to support CQI goals. ERS, CLASS, or other applicable observation-based assessment demonstrate that the program has met or exceeded technical assistance goals set in CQI. Minimum score thresholds are based on the instrument utilized.
Partnerships with Families and Communities
A plan is written and implemented describing procedures to refer families to appropriate social, mental health, educational, wellness, and medical services.

A minimum of two family conferences are offered per year to discuss children's strengths, progress and behavioral, social, and physical needs.
Transition activities (between classrooms) are developed to support long-term relationships with teachers (continuity of care).
A family group is established to engage families, support their participation in the education of their children, and includes activities to promote multicultural learning.
System in place to communicate and document child observations to families (daily for infants and toddlers and weekly for preschool).
Education workshops for families are held on topics such as: early literacy; adult/family literacy; positive family-child interactions; cultural awareness; developmental issues; health and safety; and/or other topics that address the identified needs and interests of enrolled families. Translation/Interpreters are provided for families as needed. 1x yr =1 pt 2x per year 2 pts
The Strengthening Families Protective Factor Framework or similarly focused evidence based tool is used to assess engagement of and interactions with families.
A community resource handbook or materials are available to all families and includes community and school-based resources and/or information about direct services to promote child/family safety, health, and stability
A variety of methods are used to communicate with families about curriculum objectives, early care and education goals, and effective strategies to support learning at home.
Leaderships and Management
Program utilizes an operations and/or staff policy manual to support practices
Risk management and emergency preparedness policies and procedures are included in program policy manual to support the identification of potential operational risks. Policies specify ways to reduce or eliminate risks. Implementation is demonstrated.
Teaching Staff are provided paid curriculum and lesson planning/preparation time away from children. Daily – 3pt Weekly – 2pt Monthly 1pt
Annually, at least two classroom observations (per classroom) are conducted and feedback is provided to teachers regarding job performance based on the observations. (Each teacher with their assigned group is observed twice per year)
Annual performance evaluations based on job descriptions are provided in writing to all staff.
Employee benefits are available to staff and explained in the program's Policy and Procedure Manual. 1 benefit = 1 pt; 2 benefits = 2 pts; 3 or more benefits = 3 pts i.e. Health insurance, Paid time off, Child Care, Education compensation
Program creates an annual operating budget, including a statement of income and expenditures. Program has an annual operations business plan to address organizational stability.
Staff meetings are held at least once per month. Agendas are focused on professional development activities and include discussions of quality and its impact on the program
A salary scale based on level of education/training and years of ECE experience is utilized.
All staff members are offered regular personal breaks and meal breaks.
Appropriate business and administrative practices are demonstrated.
Program has a marketing/recruitment plan to maximize full enrollment.
Program participates in shared services opportunities which support cost savings, greater efficiencies related to operations, and /or program quality enhancements.
Program utilizes a health care consultant to establish and maintain health policies above those required by certification.

Appendix M: Blank Parent Survey

Family Feedback
Community Screening Event

This information is being collected to assess families' feelings on events like this and how improvements can be made. Your responses will be compiled with those of other families and only used for evaluation purposes. **This survey is voluntary.** Thank you for your time!

The Screening

Did you feel you were understood by the screener assessing your child? Yes No
If no, please explain.

_____
_____
_____

Did you feel the screener took your comments, concerns, and questions seriously? Yes No

Was the information you received today helpful? Yes No

The Event

Did you enjoy today's event? Yes No

Did you feel welcomed at the event? Yes No

Was this event worth your time and effort to attend? Yes No

If no, what would you change to make the event worthwhile?

_____
_____

As a result of today's event I will: (check all that apply)

- Follow-up on a referral for my child, if one was given.
- Follow-up on suggestions for my child, if any were given.
- Try something new at home with my child.
- Share information with someone I know.
- Refer someone I know to an event like this.
- I am not sure at this time.
- I will do nothing differently.
- Other (please write in):

  _____

Please share any other comments you have:

_____
_____

Appendix N: Pediatric Practice Integration Assessment

Pediatric Provider Integration Assessment (PPIA)

HARD COPY ADMINISTRATION GUIDE

Date: _____ Time:_____ Location: _____

LAUNCH Team Member(s) Administering Assessment:_____

LAUNCH Team Member(s) Supporting the Assessor:

_____

_____

Practice Team 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 tele-video 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 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 you engage in a discussion with the provider about the 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 1coordinated - 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. Are provider relationships built and leveraged to increase shared patient care (not just to secure referrals)? ❒"No", then Level 3 co-located - STOP ❒"Yes", then Level 4 co-location – STOP	EXAMPLES can include: coordinated service planning, shared training, team meetings, use of shared patient registries to monitor treatment progress.

Directions: 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."

8. Has integration been sufficiently adopted at provider and practice level as the (indispensable) 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 craft interventions at both the population and individual levels?	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:

Circle the Current Level of Integration (per IPAT):

PRE-COORDINATED LEVEL1 LEVEL2 LEVEL3 LEVEL4 LEVEL5 LEVEL6

Notes:

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).

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)

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)

Notes:

Year Three PPIA Summary Review
June 19, 2017

Allegheny County Pediatric Practice Integration Assessment (PPIA) Summary

A. Pediatric Providers

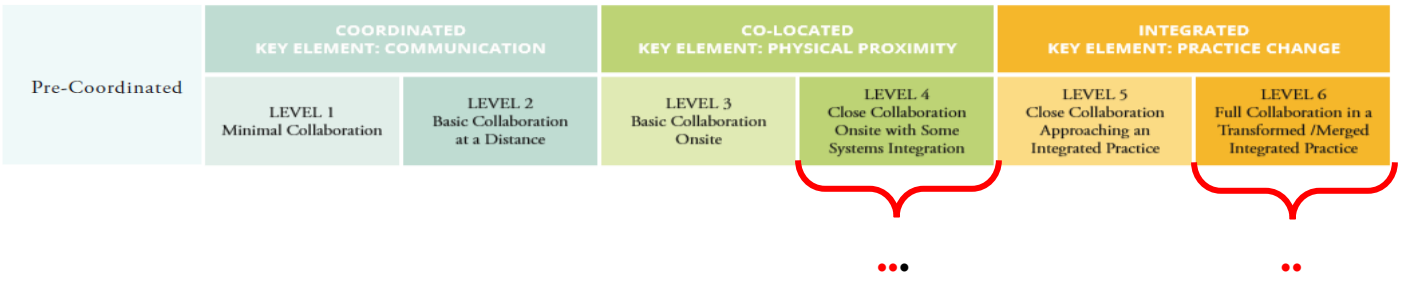
A1. *Year 3* Pediatric Provider Quantitative Results

Organizations that are participating in R2 follow-up are represented by a red dot in parts 1 and 2 below.

Organization that is participating in baseline assessment is represented by a black dot in parts 1 and 2 below.

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
Screening & Assessment Tools	●●●●	●		6
Referral Assistance	●●●●	●		6
Clinical Guidance	●●●●	●		6
Functional Assessment	●●●●	●		6
Information Exchange	●●●	●●		7
Screening and Surveillance	●●●	●●		7
Engagement	●●●	●●		7
Tracking Systems	●●●●		●	7
Quality Improvement	●●●	●	●	8
Care Coordination	●●	●●●		8
Recall and Reminder Systems	●●●	●	●	8
Protocols	●●	●●●		8
Mental Health Promotion	●	●●●●		9
Collaborative Relationships	●	●●●●		9
Special Populations		●●●●●		10
Registry	●	●●●	●	10
Care Plans		●●●	●●	12

Note: MHRI cross-practice item scores are categorized based on the following cut off scores: *Green/Strength* = 5-7; *Yellow/Area of Improvement* = 8-11; *Red/Area of Change* = 12-15. Some items (e.g., Quality Improvement, Protocols) may have the same cross-practice score, but represent different patterns of practice.

A2. Pediatric Providers Qualitative Results (Follow-Up)

Part III: Qualitative Summary of R2 Follow Up PPIA Interviews (PPs)

Identified Strengths/Successes

- There have been improvements in integrating the referral process and EHR systems across PH and BH services

Common Obstacles

- Reimbursement remains a major obstacle to providing fully integrated care
  - Reimbursements don't adequately or consistently cover all services (see below)
  - Reimbursement doesn't adequately reflect the amount of PCP time needed for BH supports
  - The billing processes for BH services are different than for PH services, and staff require training
- Coordinating information from the BH sector can be challenging
  - Promising pilot programs (e.g., Human Services Association Organization) are helpful, but there is a need for long-term, more widely accessible programs
  - Outside providers can be inconsistent; when feedback is received, it may not reach providers.
- Mandated universal screenings can become burdensome and make it difficult to accommodate unfunded services
- BH and PH provider relationships should be strengthened
  - "*There is a great amount of perceived risk for PCPs providing BH care – relationships between PCPs and BH professionals should be fostered and strengthened, creating an environment where both feel supported in providing joint care for a child with BH needs."*
- Space restrictions make co-location and integration difficult for some practices/practice locations

Identified Reimbursement Needs

- Specific screenings, evaluations, and interventions are not adequately or consistently covered across payers
  - Certain behavioral codes aren't recognized by DSM and/or specific payers
- Maintaining a BH provider on staff is not always profitable or sustainable given reimbursement issues
- Extended PCP time and care coordination among team members is not adequately reimbursed
- There is a need for appropriate & billable/reimbursable treatment for kids who miss cut-off for BH diagnoses but are still very much at risk

Data Tracking/Coordinating Information and Practice

- All practices use EHR systems, however there is variability with how these different systems support flexible referral processes, and how accessible these systems are to integrating and coordinating BH/PH information
  - In some EHR systems, specific screens prompt follow up action, and are accessible to both PH and BH providers; in others, the referral process is more rigid and the PH and BH systems do not communicate
  - Availability and cost can be barriers to using some EHR systems
- All practices recognize the value of a universal consent form that could promote bidirectional communication about patients between PH and BH sectors, but some practices have more concerns than others about their use
  - Some practices have forms currently that cover broad services within their networks, but there are challenges when trying to connect with providers outside of the network (e.g., schools, BH providers)
  - There are concerns about families not granting "blanket" permission for consent across agencies
- There are challenges throughout the referral process
  - All practices recognize the need for and are working toward a coordinated referral process, but there is variability in implementation
  - Most concerns with referral focus on reimbursement and coordinating information, but other issues such as patient access, up-to-date referral information, and quality of BH services are also noted

Additional Comments

- There are varying degrees of formal protocols/standards of care to address frequently seen BH conditions
- Practices would like more training and support on working with special populations, trauma-based care, and SUDs

Changes from Baseline to Follow-Up

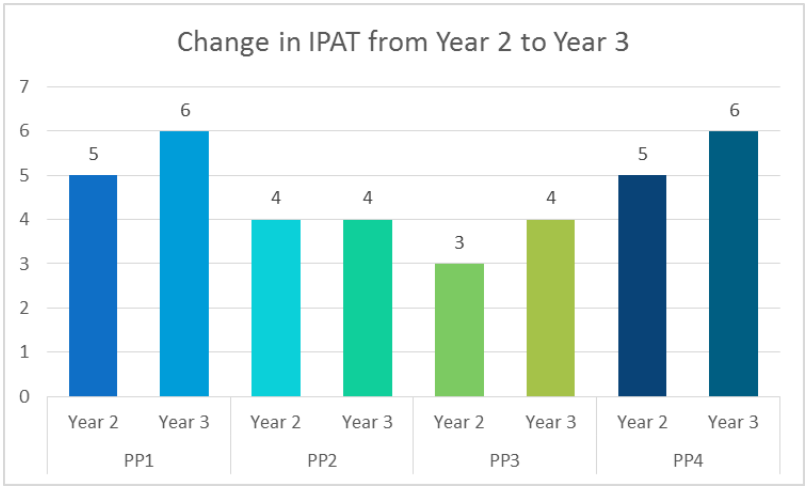
- All practices improved on the MHPRI scale, and 2/3 practices improved on the IPAT

- There appears to be some improvement in the way practices are using EHR systems to integrate and coordinate care, though this is still highly variable and there is still a need for more effective methods
- There was a shift in focus at follow-up on relationship building and communication across BH/PH sectors, in addition to systemic barriers to integration (this may also be due to probes during the interview, but is notable)

A3. Pediatric Provider Quantitative Changes from Baseline (Year 2) to Follow-Up (Year 3)

Part I: Integrated Practice Assessment Tool (IPAT)

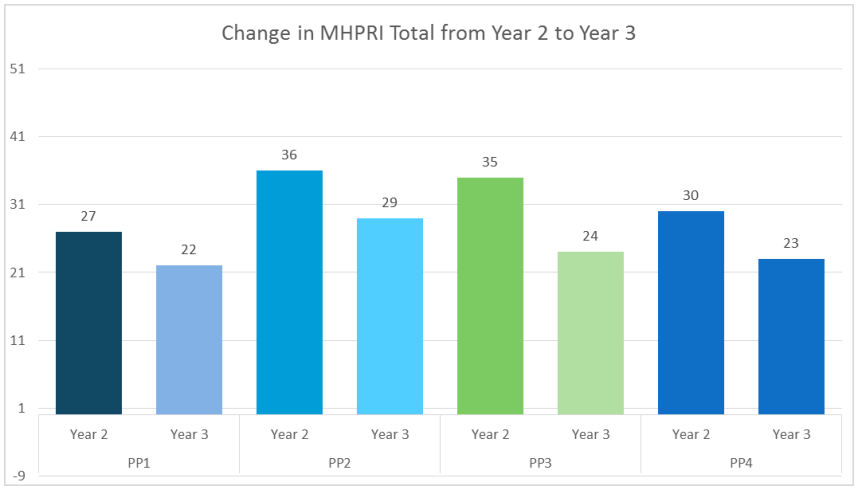
Summary of IPAT Changes:



- 3 out of 4 practices improved
- All stayed within their overarching category (i.e., co-located or integrated care)
    - PP1 and PP4 moved to the highest level of fully integrated care, indicating that providers and patients view the practices as a single health system treating the whole person, and that this approach is applied to all patients, not just targeted groups (Heath et al., 2013). This indicates the greatest amount of integration practice change, and includes integration across resources, team and provider models, the entire patient population, screening, and information sharing.
    - PP2 and PP3 scored at the higher co-location level. This indicates that practices are co-locating with BH providers, but BH providers are not equally involved in standard ways across all patients. The change from level 3 to level 4 for PP3 indicates that they moved from basic referral collaborations to a more team-based approach to care (Heath et al., 2013).

Part II: Mental Health Practice Readiness Inventory (MHPRI)

Summary of MHPRI Changes:



- All practices improved overall on the MHPRI
  - At least one practice improved on each item
  - Most changes were single increments (i.e., 3->2, 2_1)
    - PP3: **3->1** on Clinical Guidance; PP4: **3->1** on Functional Assessment and Protocols
  - The only increases in score were for PP1 (Special Populations: 1->2), PP3 (Information Exchange: 1->2), and PP3 (Collaborative Relationships: 1->2)
  - Items on which at least two practices improved (number indicated in parentheses):
    - Tracking Systems (**3**), Registry (3), Care Plans (3), Engagement (2), Quality Indicators (2), Care Coordination (2), Special Populations (2)

A4. Pediatric Provider Qualitative Results (Baseline)

Part III: PP5 Qualitative Summary
Practice Goals
Ideally, PP5 could employ their BH provider 5 days per week (now sees patients 2 days per week). They are also working with [a provider] to provide Parent-Child Psychotherapy 1 day per week. As much BH collaboration as could be had would be welcomed. PP5 would also like to improve the existing referral system – quality improvement would include examining if screens are done and scored correctly, and that appropriate referrals are being made. -
Integration Activities
PP5 has employed [a provider] to provide BH services to children and families 2 days per week. All providers screen universally (using PEDS, PSC, Edinburgh and PHQ-2 for adolescents). Once a concern has been identified, patients are referred to [the provider] and can make an appointment before they leave the office. [The provider] performs assessments and makes a note of the results in the EHR, which are shared (Epic). PP5 is the only pediatric provider with a bilingual BH provider co-located – there are also bilingual staff at every level of patient engagement.

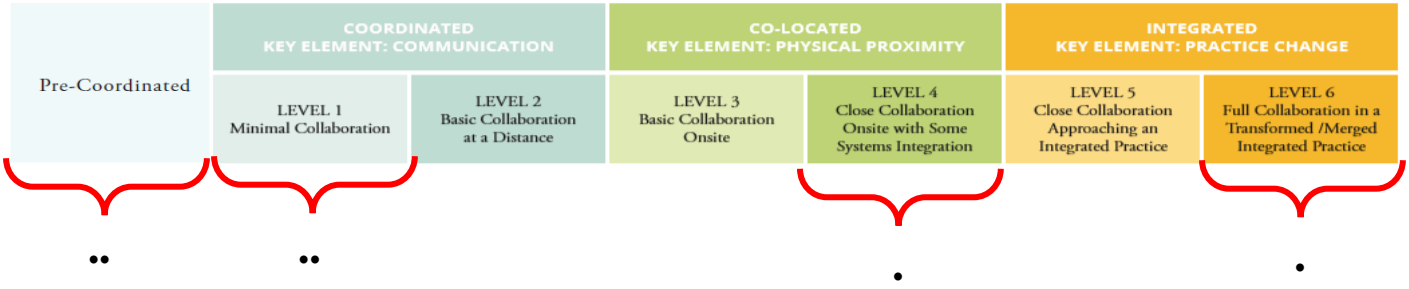
Obstacles
The lack of designated support staff to assist patients with referrals, track and follow up on referral completion are a barrier to more integrated care. Patients need help accessing, navigating, and coordinating their care within the BH system. A care manager/navigator with knowledge of the system and the time to speak one-on-one with families as care is needed would be required for a seamless system that provides feedback to the referring PCP. Being able to bill for BH care coordination and support is necessary to overcome this barrier. There is also a shortage of open/available services for children who need more intensive intervention i.e. wrap-around supports.
Training
PCPs and BH providers receive robust training and information from existing modules (including mental health screening, SUD screening, childhood/adolescent and adult depression) and events. Any training offered should include the entire care team as they currently train together. Web-based trainings are preferred, as in the past seminars and other in-person events experienced about 25% attendance.
Screening
The PEDS is done universally at all recommended visits. The PSC is done universally at ages 4, 6 and 8 (may discontinue use as providers feel it is not sensitive enough – looking into other tools such as the SYCW and SEEK). The PHQ-2 is used to screen teenagers. The Edinburg is done with new moms.
Tracking
Reports can be run on the number of children with a developmental screen that was billed for (e.g. PEDS). The Edinburgh has a place in the EHR, but it not reliably entered by all physicians. The PSC is not tracked and cannot be reported (without chart review). Referrals are generally not tracked – some providers have found ways to flag in system and follow-up, but it is not common practice.
Payment
PCPs do not bill for the PSC or other screens – as majority of patients are covered by Medicaid, they receive a standard rate per visit. The BH provider uses BH codes – 90791 for an initial visit, 90832 and 90834 for a 30- and 45-minute subsequent visit, respectively. PP5 does not utilize “incident-to” codes.
Information sharing:
Access to a shared EHR would be ideal – but WPIC will not share patient chart or notes. Fax is the next best things, when scanned into EHR and flagged for review. PCPs are also open to a phone call or email to discuss specific cases. Right now, PCPs generally receive a simple notice of discharge from WPIC.
Follow-up needed
N/A

B. Federally Qualified Health Centers

B1. *Year 3* Federally Qualified Health Centers Quantitative Results

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**
Recall and Reminder Systems	•••••	•		7
Referral Assistance	••••	••		8
Clinical Guidance	•••	•••		9
Tracking Systems	•••	•••		9
Information Exchange	••••		••	10
Engagement	•••	••	•	10
Care Coordination	••	••••		10
Special Populations	••••		••	10
Screening and Surveillance	•	••••	•	12
Screening & Assessment Tools		••••••		12
Collaborative Relationships		••••••		12
Quality Improvement	••	•	•••	13
Functional Assessment		••••	••	14
Mental Health Promotion		••••	••	14
Registry	•		•••••	16
Care Plans		•	•••••	16
Protocols		•	•••••	17

Note: MHRI cross-practice item scores are categorized based on the following cut off scores: *Green/Strength* = 6-9; *Yellow/Area of Improvement* = 10-14; *Red/Area of Change* = 15-18. Some items (e.g., Engagement, Care Coordination, Special Populations) may have the same cross-practice score, but represent different patterns of practice.

B2. Federally Qualified Health Centers Qualitative Results (Baseline)

Part III: Qualitative Summary of R1 Baseline PPIA Interviews (FQHCs)

Identified Strengths/Successes

- BH services are often covered as part of a bundled per-visit rate for FQHCs.
- All practices appear to value integration, and are working toward it in various stages
    - Practices range from integrated with a BH provider on site; others have goals to co-locate or partner with a BH agency
    - Several practices note that they are partnering with other agencies to support their patients' BH needs
    - All note areas in which they would like to strengthen integration

Common Obstacles

- Regulations are a consistent obstacle to the integration of BH and PH for FQHCs, as regulations impact:
    - Hiring and licensure requirements for BH providers
    - Co-locating with more than one BH agency
- A lack of integrated, or fully integrated, EHRs makes it difficult to coordinate care
    - When practices are partnering with outside agencies to provide BH services, records and treatment communication can be a major obstacle
- Multiple practices noted challenges related to limited pediatric BH services and workforce availability, particularly for children who need more intensive intervention, and long waitlists for evaluation and services
- Cost and reimbursement of services, and the pressure to focus only on billable services can be prohibitive
- Space restrictions make co-location and integration difficult for some practices/practice locations
- Contextual variables, such as transitory populations, populations lacking consistent transportation, and rotating providers can make access and continuous integrated care challenging
- Multiple practices also noted challenges with finding the "right" BH providers who are able to provide services for young children *and* work well in primary care settings
    - Quality of care if BH services are referred externally was also noted as a concern

Training Needs Identified

- BH diagnoses, treatments, BH screenings, and psychopharmacology for children birth to 8 years
- Trauma-informed care, domestic violence, substance use disorders and treatment
- Specific programs (e.g., David Kolko's SKIP program, Mental Health First Aid, Children's TiPS service)
- Available community resources and information on integrated care supports
- Trainings should be available to all members of a practice team as appropriate
- Online trainings may be preferred if broad participation is expected
- Trainings may also occur at individual practices during practice-wide meetings

Data Tracking & Sharing Notes

- Practices report a range of integration in terms of sharing patient information between BH and PH providers, but indicate that this process needs to be improved/streamlined to "close the loop" for referrals and care coordination
    - Some systems only share some records or screens, or only partial information (e.g., EHR notes that screen was done, but results are not reportable) and there is variability in the tracking and referral processes
    - Multiple practices note that they use phone, mail, or fax to follow-up with and correspond with outside agencies. Some note that these systems work well (e.g., benefits of following-up via phone are that questions can be answered) but others note that sharing this information through the EHR would be helpful.
    - Most practices have a system in place to follow up on referrals, but note that there is a lack of consistency

Additional Comments

- Screening practices seem to vary widely (e.g., some practices have universal screens for adolescents, but not young children; some screen universally at specific visits; some screen young children only when concerns arise)

- Several practices note challenges to integrated care based on specific populations (e.g., they have coordinated care for adults and adolescents, but not young children; funding structures don't support the provision of care across multi-generational family units; record sharing is extremely challenging with children in foster care).

C. Overall Comparison:

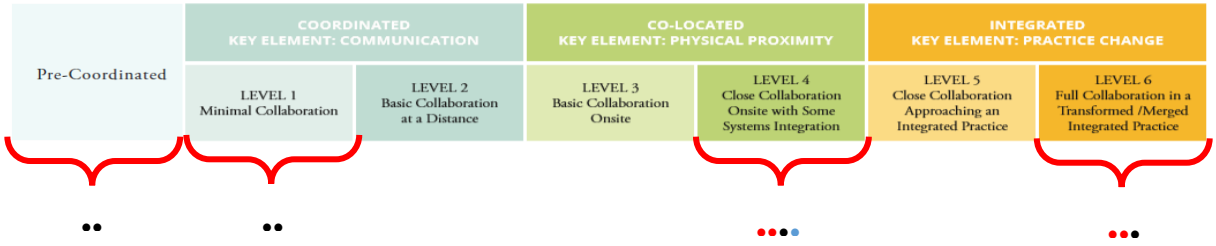
Pediatric Providers/Federally Qualified Health Centers

C1. *Year 3* Overall Quantitative Results

Pediatric Providers participating in R2 follow-up are represented by a red dot in parts 1 and 2 below.
Pediatric Provider that is participating in Baseline assessment is represented by a blue dot in parts 1 and 2 below.
Federally Qualified Health Centers participating in Baseline assessments are represented by a black dot in parts 1 and 2 below.

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	●●●●●●●●	●●●		14
Clinical Guidance	●●●●●●●	●●●●		15
Recall and Reminder Systems	●●●●●●●●	●●	●	15
Tracking Systems	●●●●●●●	●●●	●	16
Information Exchange	●●●●●●●	●●	●●	17
Engagement	●●●●●●	●●●●	●	17
Screening & Assessment Tools	●●●●	●●●●●●●		18
Care Coordination	●●●●	●●●●●●●		18
Special Populations	●●●●	●●●●●	●●	20
Screening and Surveillance	●●●	●●●●●●●	●	20
Functional Assessment	●●●●	●●●●●	●●	20
Quality Improvement	●●●●●	●●	●●●●	21
Collaborative Relationships	●	●●●●●●●●●●		21
Mental Health Promotion	●	●●●●●●●●	●●	23
Protocols	●●	●●●●	●●●●●	25

Registry	●●	●●●	●●●●●●	26
Care Plans		●●●●	●●●●●●	29

Note: MHRI cross-practice item scores are categorized based on the following cut off scores: *Green/Strength* = 11-18; *Yellow/Area of Improvement* = 19-25; *Red/Area of Change* = 26-33. Some items (e.g., Quality Improvement, Collaborative Relationships) may have the same cross-practice score, but represent different patterns of practice.

C2. Comparison of Pediatric Providers and Federally Qualified Health Centers Qualitative Results

Part III: Qualitative Summary of Differences between PPs and FQHCs

Levels of Reported Integration

- PPs report more consistent/higher levels of integration.
- FQHCs report more variable integration, particularly for young children, but many appear to have some level of integration or system in place for adolescents and adults.

Possible LAUNCH Considerations: *Are there differences in the types of supports required for a practice to scale up or expand an existing system to a different population, rather than a practice that is building from scratch or only focused on one population?*

Reimbursement

- Reimbursement challenges are structurally different for FQHC than PPs
  - Multiple FQHC practices note that they receive payment on a per-visit basis, and BH is included. As such, reimbursement is less of a challenge than for other practices, though if multiple BH providers are seen at the same visit only one visit is reimbursed.
  - Multiple FQHCs still note cost and reimbursement can be a challenge, particularly when it comes to services that aren't billable through their established per-visit bundle
  - PPs across the board note that reimbursement is the main obstacle to integration. These obstacles include inadequate and inconsistent coverage of services, inadequate coverage of practitioner time, and issues related to the integration and coordination of systems for billing

Possible LAUNCH Considerations: *How can the differences across these types of practices inform LAUNCH work? For example, FQHCs still report significant obstacles, despite the fact that reimbursement is not a major issue. For PPs, reimbursement is the major challenge, but despite this they are working successfully to provide higher levels of integrated care. How can we use this, and specific-practice PPIA results, to inform to the supports that LAUNCH provides?*

Regulations

- FQHCs cite more regulations and requirements as obstacles toward integrating BH

Possible LAUNCH Considerations: *How do the ways in which various regulations govern practice both support (e.g., less reimbursement challenges for FQHCs) and hinder (e.g., more requirements make it difficult to hire the "right" clinician) integrated BH/PH care? Can LAUNCH efforts effectively influence regulations? Are there other ways (e.g., supporting practice buy-in, capacity) that LAUNCH can address these concerns?*

Coordinating Information and Practice

- Both PPs and FQHCs note that there are challenges related to the variability in EHR systems, and inconsistencies in the way that screens and referrals are reported and shared
    - PPs all recognize the value of a universal consent form, but there are concerns with the practicality and feasibility of its use
- Both PPs and FQHCs highlight the need for more streamlined and coordinated referral processes. Different practices report different follow-up approaches, but many note that variability and inconsistency are issues
    - Follow-ups questions with PPs highlight a great deal of variability in the use of formal protocols/standards of care for addressing specific BH concerns once a referral is made

Possible LAUNCH Considerations: *How will LAUNCH best be able to support varied practices through the pilot with CHATTIS? What level of support will practices need? How can LAUNCH ensure that practices buy-in effectively to using this system?*

Services

- FQHCs report limited pediatric BH services and workforce availability as a major obstacle, but PPs also note this as an area of concern and area for possible training

Possible LAUNCH Considerations: *How do more systemic level barriers (e.g., reimbursement) impact practices' perceptions of other critical challenges to integration? Given the number of children served by FQHCs vs PPs, where should LAUNCH efforts be focused?*

Appendix P: Advertisements from the "Open Doors" Campaign


Open doors
to school readiness.
And resources. And confidence. And a bright future.
When you sign up for one of the free home visiting programs in Allegheny County, you're opening doors for your child. And you.
These free, voluntary programs are available to everyone, starting from pregnancy through school age.
Your link to home visiting: 866-730-2368


Open doors
to answers.
And resources. And confidence. And a bright future.
When you sign up for one of the free home visiting programs in Allegheny County, you're opening doors for your child. And you.
These free, voluntary programs are available to everyone, starting from pregnancy through school age.
Your link to home visiting: 866-730-2368

Appendix Q: Overview of Other Referrals Provided to Families Through the Link

Table 38: Non-Home Visiting Behavioral Health and Family Assistance Referrals Provided to Families through the Allegheny Link: Agencies Associated with the Highest Need Areas

Program Name	Number of Referrals to Non-HV Programs
AIU - DART Program	1
Allegheny County Office of Behavioral Health	1
Center for Victims	2
Crisis Services	3
CYF Intake Line	1
Early Head Start	1
Easter Seals of Western PA	1
Education Related Services	2
Family Services of Western PA	1
Head Start	3
Jeremiah's Place	1
Mercy Behavioral Health	1
MH Outpatient Services	6
Other	12
Parent/Grandparent Resources	5
Pittsburgh Action Against Rape (PAAR)	1
Resolve	6
School Based Liaison	2
Warmline	1
Women's Center and Shelter	2
Woodlands Foundation	1
Total Number of Referrals	**54**

Appendix R: Alignment of State Strengthening Families Professional Course with IMH Competencies

Strengthening Families Protective Factors: "Bringing the Protective Factors to Life in Your Work" Modules

This series of courses was developed by the National Alliance for Children's Trust and Prevention Funds. The content of these courses is helpful for anyone who works with children and families, including parents, practitioners, and supervisors. The seven courses are delivered by qualified trainers. The first course *Introduction to the Protective Factors Framework* is the foundation of the curriculum. The five courses that address each individual protective factor can be offered and experienced in any order that suites the trainer and practitioner. The final course, *Moving from Knowledge to Action: Wrap-Up*, is reflective in nature and is meant to be the final step in completing the curriculum. Throughout the courses you will notice three common threads that are the foundation for this approach. They are:

- The Strengthening Families™ Protective Factors Framework – understanding and communicating the importance of how to use the Framework as we go about our everyday work.
- The Importance of Culture – how culture impacts families as they seek to build protective factors and how our own culture shapes how we individually feel, act and think.
- The Critical Role Parents Play in Strengthening Families – viewing parents as valuable partners in every phase of the work we do.

Course Title	IMH Competencies Addressed
Introduction to the Strengthening Families Protective Factors (2hr) The Strengthening Families™ Approach • Benefits ALL families • Builds on family strengths, buffers risk, and promotes better outcomes • Can be implemented through small but significant changes in everyday actions • Builds on and can become a part of existing programs, strategies, systems and community opportunities • Is grounded in research, practice and implementation knowledge. The five Protective Factors are the foundation of the Strengthening Families™ approach. Extensive research supports the common-sense notion that when these protective factors are present and robust in a family, the likelihood of child abuse and neglect diminish. • Goals of the Course ○ List five protective factors that help keep families strong and prevent child abuse and neglect. ○ Identify multiple strategies and concrete everyday actions that help families build those protective factors. ○ Understand what it means to work with families in a strength-based way.	• Infant/very young child & family centered practice
Parental Resilience (2hr) Parental resilience is the ability to cope and bounce back from all types of challenges. Parents are continually managing different amounts of stress in their daily lives. The challenges parents face can be daunting. In the Strengthening Families framework, we think about two different components of resilience – the ability to cope with stress in general and the ability to parent well in times of stress.	• Infant/very young child & family centered practice • Cultural competence

• Goals of the Course
  ○ Define and recognize signs of parental resilience.
  ○ Identify actions you can take to help parents build their resilience.
  ○ Give examples of program efforts to value and support parents.
  ○ Give examples of program efforts to respond to family crises.
  ○ Identify the steps you will take to integrate these ideas into your work	

Knowledge of Parenting and Child Development (2hr)
Parents need accurate information about raising young children and the appropriate expectations for their behavior. This protective factor helps to define what parenting looks like when families have good information and skills to help their children at every stage of development. It is especially important when parents are committed to change the parenting patterns they experienced as children – and need alternatives for their own children.
• Goals of the Course
  ○ Define what it means for parents to have knowledge of parenting and child development.
  ○ Identify actions you can take to help strengthen parenting among families.
  ○ Create a plan to integrate these ideas into your work.
	• Responding with empathy
	• Life skills

Concrete Support in Times of Need (2hr)
Every family – at some point – needs support. "Times of need" don't only occur in families in poverty and they may not always be related to material needs. All families have times of need, whether it's the birth of a new child, raising a child with special needs, finding academic supports, or dealing with mental illness, substance abuse, or domestic violence. Not knowing where to turn in a crisis or how to find help can be extraordinarily stressful for families – and cause significant trauma for children. When parents build this protective factor they know how to access services and be an advocate for their family.
• Goals of the Course
  ○ Give examples of how you can provide welcoming, non-threatening support to families.
  ○ List several ways you can link to partners in the community to help families in need.
  ○ Identify the challenges and opportunities culture and tradition present as we try to help families.
  ○ Recognize how lack of support, when under stress, can sometimes lead to child maltreatment
	• Service Delivery System
	• Advocacy

Children's Social and Emotional Development (2hr) Social and emotional competence is the foundation of every child's development. It comes through the ongoing interactions between the child and the adults in her life, beginning with parents and other family members. The parent's capability to foster the child's ability to talk, regulate their behavior and interact positively with others is key to the child's development. Nurturing and attachment in the earliest days and months of a baby's life is the beginning point for social and emotional competence that develops over time. • Goals of the Course ○ List several characteristics of children who are emotionally healthy and who demonstrate social skills appropriate for their age or environment. ○ Identify what is realistic to expect in terms of social and emotional skills for children at different developmental stages. ○ Recognize how this protective factor can help make child maltreatment less likely to occur. ○ Give examples of how parents and other caregivers can develop strategies that will help children to grow emotionally and socially.	• Infant/very young child development & behavior
Social Connections (2hr) Friends, family members, neighbors and other members of a community who provide emotional support and concrete assistance are invaluable to parents. Since social isolation is strongly connected to child maltreatment, this protective factor ensures that parents are connected to people who support their parenting. Being new to a community, recently divorced or a first-time parent makes a support network even more important; it may require extra effort from programs to help families build the new relationships they need • Goals of the Course ○ Understand the value of helping parents and families connect to others in a variety of ways that reduce their isolation and increase their social supports. ○ Discuss at least three ways to encourage parents to make these connections. ○ Create some concrete plans to assist parents in developing new friendships and finding new sources of support – in the workplace or the community.	• Building and maintaining relationships • Community Resources
Moving from Knowledge to Action – Wrap-Up (2hr) • Goals of the Course ○ Feel confident in your understanding of the Strengthening Families™ Protective Factors Framework: the five protective factors and everyday actions that help build the protective factors. ○ Recognize the role that systems and policy changes can play in establishing this way of working with families as "the new normal." ○ Begin integrating these ideas into your work, or continue doing so if you have already started.	• Self-awareness • Planning & Organizing

Appendix S: Wilder Collaborative Factors Inventory

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
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

Factor	Statement	Strongly Disagree	Disagree	Neutral, No Opinion	Agree	Strongly Agree
Members share a stake in both process and outcome	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
Open and frequent communication	26. People in this collaboration communicate openly with one another.	1	2	3	4	5

Factor	Statement	Strongly Disagree	Disagree	Neutral, No Opinion	Agree	Strongly Agree
Open and frequent communication	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 T: Local Wilder Collaborative Factors Inventory Findings

The Wilder Collaborative Factors Inventory is a self-report assessment that rates collaboration among members of a group. Year Three data collection differed slightly from Years One and Two in that we sampled past and current members, and we expanded data collection to members of local Work Groups as well as Local Council members. Group members individually rate 40 characteristics of collaboration on a five-point scale (1= Strongly Disagree, 5= Strongly Agree). 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.* Two open-ended questions were also added to the Wilder in Year Three. Current members were asked to identify what they hoped to see come out of the project over the next year. Past members were asked what led to their decision to end their membership in the project.

Response Rates

In Year Three, we sent the Wilder to 75 participants, which included all current members, and any past members who had left during Year Three. Table 39 provides an overview of response rates. Although we saw an overall decline in response rates from Year One to Year Two, Year Three response rates for current members increased above Year One rates. These patterns may reflect the concentrated efforts of the Local team on a membership outreach campaign, as members were asked in Year Three to reaffirm their commitment to Project LAUNCH.

Table 39 also provides an overview of differences in response rates for family members across project years. There was a large decrease in overall family member response rates from Year Two to Year Three, but here again the patterns in response rates reflects our increased sampling of past members. When we look only at family member response rates for current members, the family response rates is comparable to Year One.

Year Three responses included Local Council and Work Group members, whereas Years One and Two Wilder responses only included Council members. Work Group members completed the survey more consistently than Local Council-only members (Work Group only = 100% response rate; YCWC + Work Group = 68% response rate; YCWC Only = 14% response rate). The overall increase in response rates for current members that we noted above may also reflect the inclusion of Local Work Group members in this year's sample, both in terms of increasing our sample, but also as these members are highly involved in the inner workings of the project and may therefore be highly committed.

Table 39: Local Wilder Response Rates across Project Years

Responders	Year 1		Year 2		Year 3	
	n	%	*n*	%	*n*	%
Overall	24	71	30	65	39	52
Current Members Only	24	71	30	65	36	75
Overall Family Members	7	54	10	67	7	47
Current Family Members Only	7	54	10	67	6	55

Note. Percentages are based on category representation, not overall sample (e.g., family response percentage is based on the number of family members who responded compared to the number of family members in the sample, not the overall sample).

Year 3 Results

Table 40 provides and overview of Year 3 Wilder ratings by factor overall across all respondents, as well as by Council membership type. When we examined Year 3 results in terms of Council membership type, other interesting patterns arose. *Roles and Guidelines* was still the lowest, but only for members who are involved in the Local Council; members who are on the Work Groups only have a much higher rating. Anecdotally, after reviewing these data with the Implementation Team and with council members, it appears that the members on the Work Groups may have a clearer sense of specific goals and a clearer sense of their role in the group. Alternatively, members who are on the Work Groups only rated their sense of the overall purpose of the group lower than those members who are on the Council only, or the Council and Work Groups. These patterns highlight some of the inherent tensions involved across the multiple levels and systems involved in this work, and the Local Council engaged in deep and thoughtful conversations about these "tender spots" after reviewing these findings. The Evaluation and Implementation teams are working together to develop communication tools and think through meeting structures that will help the council to navigate these dynamics.

Table 40: Local Wilder Year 3 Factor Average Descriptives Overall and by Council Membership

Factor	Overall (*n* =39)		Local YCWC Only (*n* = 5)		Local WG Only (*n* = 11)		Local YCWC + WG (*n* = 23)	
	Mean	*SD*	Mean	*SD*	Mean	*SD*	Mean	*SD*
Self Interest	4.21	0.73	4.20	0.84	4.18	0.75	4.22	0.74
Skilled Leadership	4.21	0.70	4.40	0.89	4.36	0.50	4.09	0.73
Mutual Respect	4.15	0.53	4.40	0.65	4.18	0.64	4.09	0.44
Purpose	4.14	0.68	4.50	0.61	3.86	0.71	4.20	0.65
Shared Vision	4.13	0.41	4.00	0.35	4.18	0.46	4.13	0.41
Shared Stake	4.12	0.53	4.47	0.38	4.27	0.44	3.97	0.56
Flexibility	4.08	0.63	3.60	0.55	4.05	0.57	4.20	0.65
Communication	4.03	0.57	3.67	0.62	4.33	0.54	3.96	0.53
Compromise	4.00	0.69	3.80	0.84	4.00	0.77	4.04	0.64
Political & Social Climate	3.95	0.67	4.20	0.84	3.73	0.56	4.00	0.67
Relationships	3.94	0.68	3.90	0.65	4.09	0.58	3.87	0.74
Goals & Objectives	3.9	0.58	3.87	0.30	4.06	0.33	3.83	0.71
Adaptability	3.83	0.54	4.00	0.00	3.77	0.41	3.83	0.65
History of Collaboration	3.79	0.69	4.00	0.79	3.77	0.88	3.76	0.58
Pace	3.78	0.56	3.70	0.45	3.91	0.38	3.74	0.65
Cross Section	3.73	0.55	3.80	0.57	4.00	0.50	3.59	0.54
Funds	3.56	0.60	3.70	0.45	3.64	0.64	3.50	0.62
Collaborative Group	3.55	0.47	3.40	0.74	3.50	0.45	3.61	0.43
Layers	3.5	0.50	3.40	0.42	3.64	0.50	3.46	0.52
Roles & Guidelines	3.35	0.74	3.20	0.76	3.86	0.55	3.13	0.73
TOTAL Average	3.89	0.33	**3.90**	**0.35**	**3.97**	**0.31**	**3.84**	**0.35**

Note. Scores of 4.0 or higher are considered a strength (Green). Scores of 3.0 – 3.9 are considered borderline (Yellow) and should be discussed by the group. Scores of 2.9 or lower are considered an area of concern (Red) and should be addressed.

Cross Year Analyses

Given the overall small sample size, and significant variability in membership across years (i.e., only 12 participants are members across Years 1-3), and limited variability in response patterns (e.g., limited range at the factor level) we present basic descriptive analyses of cross-year patterns.

At Year Three, Wilder scores improved or stayed stable on all but two factors. The Collaborative Group score dipped down slightly after a Year Two higher score, but the Year Three score still remains above the Year One rating. Nine factors, plus the overall score, increased after a Year Two drop. See page 50 for graphic.

Family Representatives

Table 41 provides a comparison of overall group and family responses across project years. In Year Three, family representatives have higher perceptions overall, when compared to family representatives in earlier years, and to the group as a whole. Family representatives appear to have higher perceptions of Mutual Respect, Shared Stake, and Communication across all 3 years.

Table 41: Local Wilder Cross Year Factor Average Overall vs Family Descriptives

Factor	Year 1		Year 2		Year 3	
	Overall (*n* = 24)	Family (*n* =7)	Overall (*n* = 30)	Family (*n* = 10)	Overall (*n* = 39)	Family (*n* = 7)
Shared Stake	4.10	4.24	3.96	4.00	4.12	4.33
Mutual Respect	3.75	3.93	3.98	4.20	4.15	4.29
Self Interest	4.29	4.00	4.07	3.90	4.21	4.14
Communication	4.08	3.81	3.88	4.00	4.03	4.14
Skilled Leadership	4.13	3.86	4.20	4.30	4.21	4.14
Shared Vision	4.00	3.86	4.02	4.05	4.13	4.07
Political & Social Climate	4.17	4.14	3.87	3.40	3.95	4.07
Adaptability	3.69	4.00	3.83	3.85	3.83	4.00
Goals & Objectives	3.97	3.81	3.80	3.83	3.90	4.00
Flexibility	4.04	4.21	4.07	4.05	4.08	4.00
Pace	3.65	3.86	3.67	3.60	3.78	3.93
History of Collaboration	3.73	3.50	3.67	3.60	3.79	3.86
Cross Section	3.65	3.64	3.70	3.55	3.73	3.86
Compromise	3.67	3.86	3.93	3.90	4.00	3.86
Relationships	3.88	3.57	3.68	3.30	3.94	3.86
Collaborative Group	3.46	3.29	3.63	3.60	3.55	3.79
Layers	3.40	3.36	3.43	3.35	3.50	3.79
Roles & Guidelines	3.48	3.57	3.37	3.45	3.35	3.79
Purpose	4.23	4.07	4.02	4.00	4.14	3.71
Funds Etc	3.44	3.29	3.22	3.20	3.56	3.43
TOTAL Average	**3.84**	**3.80**	**3.80**	**3.77**	**3.89**	**3.96**

Year 3 Open-Ended Family Responses:

- *I like how we have informed other work groups about our goals and progress and how we have asked for feedback from them to get a different perspective. I would like to see us continue to focus on the goals that have been set and make modifications if necessary.*
- *More parent participation and meaningful input.*
- *I am a hairdresser by trade. I feel I did not have enough time or knowledge to input. I don't fully understand what is needed, or how I can help to do any work that everyone does on their daily bases... I fully support their efforts & respect anyone involved.. I never felt inadequate going to meetings or talking with any member... I just don't have the time to do what they do.....Thank you!!*

Appendix U: State Wilder Collaborative Factors Inventory Findings

The Wilder Collaborative Factors Inventory is a self-report assessment that rates collaboration among members of a group. Year Three data collection differed slightly from Years One and Two in that we sampled past and current members, and we expanded data collection to members of local Work Groups as well as Local Council members. Group members individually rate 40 characteristics of collaboration on a five-point scale (1= Strongly Disagree, 5= Strongly Agree). 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.* Two open-ended questions were also added to the Wilder in Year Three. Current members were asked to identify what they hoped to see come out of the project over the next year. Past members were asked what led to their decision to end their membership in the project

Response Rates

In Year Three, we sent the Wilder to 29 participants, which included all current members (*n* =28), and any past members who had left during Year Three (*n* =1). Sixteen participants completed it, for an overall response rate of 55%; the only participants were current members, so the adjusted current member response rate is 57%.

In Year Three, we opened the Wilder up to Council and Work Group members, whereas Years One and Two Wilder responses only included Council members. Three Council only members completed it, five Work Group only members completed it, and eight Council + Work Group members completed it. At the state level, members have typically been on both the Council and Work Groups, or the Council only. As such, we have not tracked members by this category in broader data collection, and can only report responses by these categories, as these data are not available for non-responders.

Year 3 Results

Table 42 provides and overview of Year 3 Wilder ratings by factor overall across all respondents, as well as by Council membership type. Overall, scores are moderate to high, with the *Skilled Leadership* and *Self-Interest* factors receiving the highest scores. The *Funds, Etc* and *Roles and Guidelines* factors had the lowest scores. When we examined Year 3 results in terms of Council membership type, other interesting patterns arose. Members in Work Groups (i.e., Work Group only, or Council + Work Group) have higher perceptions overall, and notably higher perceptions (i.e., +.5) on multiple factors. Members who are on the Council + Work Groups have higher perceptions on the *Relationships* and *History of Collaboration*

factors, whereas members who were in Work Groups only had higher perceptions of *Political and Social Climate* and *Communication*. Members who were on the Council only had lower perceptions overall. These findings may indicate that Work Group participation plays an important role in state-level members' understanding and perception around the functioning, collaboration, and activities of the group. Some patterns (e.g., *Funds, Etc* being a concern or borderline concern; *Skilled Leadership* being a strength) are consistent across all members.

Table 42: State Wilder Year 3 Factor Average Descriptives Overall and by Council Membership

Factor	Overall (*n* = 16)		State YCWC Only (*n* = 3)		State WG Only (*n* = 5)		State YCWC + WG (*n*= 8)	
	Mean	*SD*	Mean	*SD*	Mean	*SD*	Mean	*SD*
Skilled Leadership	4.44	0.73	4.00	1.00	4.60	0.55	4.50	0.76
Self Interest	4.31	0.60	4.00	1.00	4.60	0.55	4.25	0.46
Purpose	4.25	0.68	3.17	0.29	4.40	0.55	4.56	0.42
Flexibility	4.09	0.61	3.33	0.29	4.20	0.45	4.31	0.59
Mutual Respect	4.09	0.58	3.83	0.76	4.20	0.45	4.13	0.64
Shared Stake	4.04	0.50	3.56	0.51	4.20	0.30	4.13	0.53
Shared Vision	4.00	0.52	3.33	0.29	4.10	0.55	4.19	0.37
Compromise	3.94	0.57	3.67	0.58	4.00	0.71	4.00	0.53
Goals & Objectives	3.90	0.53	3.56	0.51	3.87	0.18	4.04	0.65
Political & Social Climate	3.88	0.85	3.50	0.50	4.20	0.84	3.81	0.96
Communication	3.88	0.61	3.67	0.67	4.00	0.00	3.88	0.80
History of Collaboration	3.84	0.65	3.83	0.76	3.50	0.79	4.06	0.50
Cross Section	3.72	0.60	3.67	0.58	3.60	0.65	3.81	0.65
Adaptability	3.72	0.41	3.33	0.58	3.70	0.27	3.88	0.35
Pace	3.66	0.40	3.50	0.50	3.60	0.42	3.75	0.38
Relationships	3.66	0.70	3.00	0.50	3.50	0.50	4.00	0.71
Layers	3.59	0.49	3.33	0.58	3.30	0.45	3.88	0.35
Collaborative Group	3.59	0.55	3.17	0.29	3.60	0.42	3.75	0.65
Roles & Guidelines	3.47	0.59	3.00	0.00	3.50	0.50	3.63	0.69
Funds Etc	3.16	0.68	2.83	0.76	3.20	0.76	3.25	0.65
TOTAL Average	**3.84**	**0.41**	**3.44**	**0.38**	**3.87**	**0.23**	**3.97**	**0.45**

Note. Scores of 4.0 or higher are considered a strength (Green). Scores of 3.0 – 3.9 are considered borderline (Yellow) and should be discussed by the group. Scores of 2.9 or lower are considered an area of concern (Red) and should be addressed.

Cross Year Analyses

Given the overall small sample size, and significant variability in membership across years (i.e., only 5 participants are members across Years 1-3), and limited variability in response patterns (e.g., limited range at the factor level) we present basic descriptive analyses of cross-year patterns.

At Year Three, state Wilder scores indicate more variable ratings of collaboration across time, though the majority of scores remain in the moderate to high categories (see page 56 for a graphic overview of cross year factor averages). Two factors (*History of Collaboration, Compromise*) steadily improved from Year One, but other factors have much more variable patterns (i.e., four factors remain relatively stable,

six factors have consistent downward trends, eight factors have different increases and drops across time). Overall, these findings generally reflect the positive outlook of the group, but may reflect the types of challenges involved with maintaining and sustaining system-level work across various fields, such as fiscal constraints (e.g., state budgetary delays), resource limitations (time, travel budgets to central state meetings), and pending state systems change proposals.

Family Representatives

Table 43 provides a comparison of overall group and family responses across project years. In Year Three, family representatives have lower perceptions overall, when compared to family representatives in earlier years, and to the group as a whole. In Year Three, family perceptions of the amount of resources (Funds) available are in the concerning range, and several other factors (Political and Social Climate, Shared Stake, Communication) are on the cusp of concerning. These may reflect family concerns and different perceptions around differences in state-level funding and political factors (e.g., families are more concerned with year to year differences, or the long-term impact of fiscal and political challenges than non-family members), but they also may represent an important "outside" view of the ways these types of challenges impact group collaboration and functioning.

Table 43: State Wilder Cross Year Factor Average Overall vs Family Descriptives

Factor	Year 1		Year 2		Year 3	
	Overall (*n* = 21)	Family (*n* = 5)	Overall (*n* = 14)	Family (*n* = 4)	Overall (*n* = 16)	Family (*n* = 2)
Skilled Leadership	4.50	4.40	4.36	4.50	4.44	4.00
Self Interest	4.50	4.80	4.21	4.00	4.31	4.00
Political & Social Climate	4.25	4.20	4.32	4.25	3.88	3.00
Purpose	4.25	4.40	4.36	4.38	4.25	4.25
Goals & Objectives	4.23	4.53	4.12	4.00	3.90	3.83
Shared Vision	4.23	4.30	4.18	4.13	4.00	4.25
Shared Stake	4.18	4.33	4.05	4.17	4.04	3.50
Communication	4.18	4.33	4.10	4.25	3.88	3.00
Flexibility	4.18	4.40	4.21	4.50	4.09	4.25
Mutual Respect	4.07	4.30	4.21	4.38	4.09	3.75
Relationships	4.02	3.90	3.64	3.38	3.66	3.25
Cross Section	3.98	4.10	3.86	4.25	3.72	3.25
Adaptability	3.89	3.90	3.86	3.63	3.72	3.50
Pace	3.89	4.10	3.57	3.63	3.66	3.50
Compromise	3.86	3.80	3.93	4.25	3.94	3.50
Collaborative Group	3.79	3.90	3.54	3.75	3.59	3.25
Roles & Guidelines	3.68	4.00	3.46	3.75	3.47	3.00
Layers	3.59	3.60	3.61	4.00	3.59	3.75
History of Collaboration	3.52	4.00	3.68	3.38	3.84	3.75
Funds Etc	3.52	3.40	3.32	3.25	3.16	2.50
TOTAL Average	**4.01**	**4.14**	**3.92**	**3.98**	**3.84**	**3.53**

Note. Scores of 4.0 or higher are considered a strength (Green). Scores of 3.0 – 3.9 are considered borderline (Yellow) and should be discussed by the group. Scores of 2.9 or lower are considered an area

of concern (Red) and should be addressed. The following list indicates the number of family representatives who also noted a professional affiliation: (a) Year 1 = 1, (b) Year 2 = 0, (c) Year 3 =1.

Year 3 Open-Ended Family Responses:

- *More communication and connection of the work from the local level to inform the state. Looking to strategies for sustainability and next steps once grant is finished.*
- *Now that I have retired as a paid member of the EI work force, I have a little different view since I do not see others as often as did before. I feel information is given on a frequent basis.*