2018 Executive Report

Denver, Colorado

Prepared by
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Graduate School of Social Work
University of Denver
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CONTEXT

LAUNCH Together

LAUNCH Together is a privately funded initiative in Colorado developed to support early childhood social-emotional development. Funding partners include the Buell Foundation, The Ben and Lucy Ana Walton Family Foundation, Caring for Colorado, the Colorado Health Foundation, Community First Foundation, Kaiser Permanente of Colorado, The Piton Foundation at Gary Community Investments, and Rose Community Foundation. LAUNCH Together is modeled after Project LAUNCH, a federal initiative of the Substance Abuse and Mental Health Services Administration (SAMHSA).

In 2015, the LAUNCH Together funding partners awarded planning grants to seven communities across the state, with the intention of selecting four of those communities to receive Phase II implementation grants to conduct the systems-building and service-coordination activities proposed in their strategic plans. In August 2016, funders selected the following communities to receive LAUNCH Together implementation grants:

- Catholic Charities of the Diocese of Pueblo
- Denver’s Early Childhood Council
- Fremont County’s ECHO & Family Center Early Childhood Council in partnership with Chaffee County Early Childhood Council
- Jefferson Center for Mental Health

The LAUNCH Together initiative is based on the theory that widespread changes in children’s social-emotional outcomes require strong community coordination of services within five key strategy areas. This brief focuses on describing implementation progress in the four communities from Year 1 to Year 2.
METHODOLOGY

The Butler Institute for Families at the Graduate School of Social Work, University of Denver, is the evaluation contractor for the LAUNCH Together initiative. Butler has developed an evaluation strategy to collect common data across the four funded communities. The evaluation uses a mixed-methods approach to explore outcomes at the systems, program, provider, and family levels. This approach includes the use of surveys, interviews, focus groups, document review, and reporting of key indicators for each of the five prevention strategies.

The evaluation collects data along a pipeline of LAUNCH-related outcomes, including data at the systems, program, provider, and family levels (see Figure 1). Key sources of data that inform the current report were collected in year one and year two of implementation and include: cumulative program indicators, training surveys, family point-of-service surveys, implementation team surveys, qualitative implementation team interview results, baseline provider surveys and interviews, baseline family surveys and interviews, and coding of year one and year two implementation plans.

Table 1 represents a timeline of when different data collection instruments rolled out. In particular, in Phase 1, the planning year of LAUNCH Together (2015–2016), the evaluation team administered the Hicks-Larson survey to each community’s planning team, so that year’s data serves as baseline for community collaboration data. During the first year of Phase 2 (2016–2017), the project implementation phase of LAUNCH Together, the evaluation team initiated limited systems-, program-, and provider-level data collection. At this point, communities were in the early stages of project start-up and implementation and were not yet ready to collect much data, especially data related to changes in program functioning or provider and family behavior change, which had not yet occurred. Finally, in the second year of Phase 2 (2017–2018), as communities
moved further along in their implementation of planned activities, the evaluation team collected more robust program-level data, as well as initial knowledge and behavior change data from providers and families. For a detailed monthly timeline, see Appendix A.

The implementation of LAUNCH Together programmatic activities has occurred more slowly than originally anticipated; as a result, all data in this report should be interpreted as **preliminary**. The evaluation team expects to collect more robust knowledge-, behavior-, and systems-change data in years three and four of implementation, assuming that community strategies become more developed and consistent during that time.

Table 1. Evaluation timeline

<table>
<thead>
<tr>
<th>Phase 1</th>
<th>Phase 2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Systems Level</strong></td>
<td></td>
</tr>
<tr>
<td>• Hicks-Larson collaboration survey (community planning/implementation teams)</td>
<td>• State stakeholder interviews</td>
</tr>
<tr>
<td></td>
<td>• PARTNER™ survey (state and community implementation teams)</td>
</tr>
<tr>
<td><strong>Program Level</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Common indicators</td>
</tr>
<tr>
<td></td>
<td>• Implementation plan coding</td>
</tr>
<tr>
<td><strong>Provider Level</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Post-training provider survey</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Family Level</strong></td>
<td></td>
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<td></td>
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</tbody>
</table>
The current report focuses on progress made around each strategy across the initiative as a whole, as well as cross-community provider and family results. Community-specific reports provide additional information on progress within each community and community-based context.

RESULTS

How Do Participating Child- and Family-Serving Agencies in Each Community Coordinate and Collaborate?

Partnering Programs
One hundred thirty-seven programs across the four communities engaged in initiative activities. Almost all programs (96%) serve children, while under half (43%) provide services to adults. Data exceed 100% because some programs serve both children and adults. Table 2 shows the types of strategies that participating programs implement. Some programs may offer services that fall under more than one strategy type. The largest proportion of programs (37%) were engaged in implementing mental health consultation in early childhood education (MHCECE), followed by programs implementing screening, assessment, and referral (26%) and enhanced home visitation (24%). Percentages were calculated based on multiple responses.

Table 2. Strategy focus of programs participating in LAUNCH Together (n = 120)

<table>
<thead>
<tr>
<th>Strategy Type</th>
<th>Number of Programs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening, assessment, and referral</td>
<td>31</td>
</tr>
<tr>
<td>Behavioral health in primary care</td>
<td>7</td>
</tr>
<tr>
<td>Home visitation</td>
<td>28</td>
</tr>
<tr>
<td>Mental health consultation in early care and education</td>
<td>42</td>
</tr>
<tr>
<td>Family strengthening</td>
<td>12</td>
</tr>
</tbody>
</table>
Implementation Focus

Implementation teams from each community completed the Hicks-Larson collaboration survey in Phase 1 (2016), the planning phase of the initiative, and again during year two of the implementation phase, referred to in the following graphs as Phase 2 (2018). The survey measures three areas of collaboration on a scale of 1–6 (1 = Strongly disagree; 6 = Strongly agree). Results for both phases paint a picture of strong collaboration, with average scores on all three constructs falling between 4 (Agree more than disagree) and 6 (Strongly agree). Figure 2 shows the mean scores for each of the three collaboration constructs, which include: (1) community vision and readiness to participate in change initiative; (2) community understanding of relevant services and systems; and (3) community commitment and capacity to participate in the initiative.

Communities reported the highest means for their team’s vision and readiness to participate in / implement the initiative. Most communities reported their lowest scores in their commitment and capacity to participate in / implement the initiative. Interestingly, most teams tended to rate these constructs lower in Phase 2 than Phase 1. This trend is most prominent in Denver and Chaffee-Fremont. This may be explained by a significant change in implementation team members in these communities. Chaffee-Fremont’s team in Phase 1 was comprised of 40 members while in Phase 2 there were just 12 members. Denver had 36 members in Phase 1 and 18 members in Phase 2. For both communities, most members in Phase 2 were also members in Phase 1. Members in Phase 2 may represent the most involved individuals who could better rate these constructs than the members in Phase 1 who were potentially not as involved. Jefferson reported an increase in each construct and Pueblo demonstrated fairly constant ratings across constructs, with an increase in commitment and capacity.

Figure 2. Hicks-Larson construct means by community
In addition to completing the Hicks-Larson, implementation team members across the initiative were asked to tell their stories of implementation. Common themes from the interviews revealed a focus on collaboration and communication, particularly across sectors, with an emphasis on the quality and nature of partnering. Across communities, similar challenges were identified, such as gaps in partnerships, particularly within the health sector, and a need for general community awareness. From year one to year two, the primary themes remained largely consistent providing evidence of the initiative’s continued evolution. Table 3 provides a comparison of the themes and key findings that have emerged from year one to year two.

Table 3. Year one to year two key implementation themes

<table>
<thead>
<tr>
<th>Themes</th>
<th>Key Findings YR 1</th>
<th>Key Findings Yr2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Partners</strong></td>
<td>Communities cited logistical barriers, such as time and organizational culture, and differing priorities as slowing partner engagement and creating difficulties in getting partners to buy into the initiative.</td>
<td>Implementation team members highlighted that the LAUNCH initiative has been effective at bringing people together to collaborate around the development of coordinated early childhood social-emotional development services. According to one interviewee, the initiative has helped the community move away from service silos and toward more integrated service provision.</td>
</tr>
<tr>
<td><strong>Collaboration and Coordination</strong></td>
<td>Communities felt they had the support and internal collaboration on their implementation teams to continue to reach their LAUNCH Together goals.</td>
<td>Some communities cited having the right partners at the table and working together, but there were also conversations about needing to move beyond talking and creating more coordination.</td>
</tr>
<tr>
<td>Themes</td>
<td>Key Findings YR 1</td>
<td>Key Findings Yr2</td>
</tr>
<tr>
<td>---------------</td>
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</tr>
<tr>
<td><strong>Commitment</strong></td>
<td>Generally, despite numerous challenges to collaborate with other partners in the community, implementation teams expressed high levels of commitment to the initiative.</td>
<td>Implementation teams continue to express high levels of commitment to the initiative; however, some communities acknowledge that there has been turnover in implementation team membership.</td>
</tr>
<tr>
<td><strong>Successes</strong></td>
<td>Communities cited different markers of success for their LAUNCH Together work. One of the big successes mentioned was an increase in knowledge building through trainings funded through LAUNCH Together.</td>
<td>Implementation team members continue to highlight high volumes of training as a key indicator of success across the communities. This is further supported by quantitative findings, with more than 1,000 attendees of LAUNCH Together–sponsored training this year.</td>
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<tr>
<td><strong>Lessons Learned</strong></td>
<td>During the first year of implementation, the biggest lessons learned were around relationship building.</td>
<td>During the second year of implementation, the importance of relationships continued to resonate with implementation team members, with some communities facing challenges building relationships with champions in the medical community.</td>
</tr>
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</table>
How and to What Extent Do LAUNCH Together Communities Implement the Five LAUNCH Strategies?

Year one and year two implementation plans were coded based on the implementation continuum that was introduced in year one of the initiative (Figure 3). Further information on the implementation continuum can be found in the guide in Appendix B.

Figure 3. Implementation continuum

The implementation continuum provides a framework for long-term systems change, where there needs to be:

- **Readiness** to engage (e.g., identify primary care physicians [PCPs] in target area and conduct outreach)

- Then **participation** (e.g., gather information on PCPs’ current assessment usage, referral protocols, barriers, and technical assistance [TA] needs)

- Leading to **knowledge** gain (e.g., provide training and TA on clinical best practices for early childhood social-emotional health screening)

- Then **behavior** change (e.g., improve clinical protocols and implement standard office procedures for early childhood social-emotional health screening)

- Ultimately resulting in **systems change** (e.g., increase ability to connect children and families to appropriate resources and supportive services)

LAUNCH strategies were compared across implementation years to illustrate movement along the continuum toward systems change. The percentage change in each area of the continuum was calculated for all activities across the initiative and the five strategies. From year one to year two, the initiative saw a substantial reduction in the number of readiness activities (16% decrease) and moderate increases in the number of activities that were aligned with knowledge and behavior change (Figure 4).
Screening, Assessment, and Referral

Key features of the screening, assessment, and referral strategy include: use of valid screening tools and protocols; parent education regarding the importance of screening and screening results; referral to appropriate services, follow-up, and ongoing care coordination; training for providers on screening and assessment using valid tools; and systemic efforts to implement universal screening.

“We want better referrals. We want to increase our referrals and we want better communication with each other. We want to be able to serve our families better by knowing more about what’s going on.”

– Implementation Team Member
Screening, assessment, and referral continues to be a focus of the work throughout the communities. There is clear movement toward behavior change from year one to year two, as seen by a decrease in readiness and participation, and an increase in activities targeting knowledge change and behavior change (Figure 5). Most communities are supporting or expanding approaches that already exist in their communities through enhanced coordination and collaboration activities.

Figure 5. Implementation stages of the screening, assessment, and referral strategy across the initiative

As mentioned above, 26% of programs partnering with LAUNCH Together are implementing the screening, assessment, and referral strategy. Indicators collected from these programs show that during the 2017–2018 grant year (October 1, 2017, to September 30, 2018), a total of 449 screeners across the communities were trained in social-emotional (SE) well-being and behavioral health (BH) of young children, 6,567 unduplicated screenings were completed, and 372 screenings resulted in a referral to additional services (Figure 6).
When discussing approaches to this strategy, community implementation team members generally spoke of:

- Engaging community partners in collaborative activities focused on gathering information and developing resource materials;
- Building the knowledge and capacity of practitioners to participate in the screening and referral process; and
- Ongoing efforts to refine processes for closing referral loops.
Mental Health Consultation in Early Care and Education

One of the core components of mental health consultation in early care and education (ECE) includes the use of a mental health consultant (MHC) to build the capacity of providers, programs, and systems to foster children’s social, emotional, and behavioral health and development. This strategy also includes observation of children and classrooms, classroom management support, modeling, and coaching, as well as screening and assessment to support the early identification of children with or at risk for mental health challenges. Additionally, mental health consultation in ECE may include referrals and follow-up for children and families to community-based services, as well as training and staff development activities to build providers’ knowledge of mental health issues in infancy and early childhood.

Across all communities, this strategy has been successful. Most activities implemented in year one targeted readiness (53%), while most activities in year two targeted behavior change (38%). The one activity coded as systems change in year one was not included in Jefferson’s year two implementation plan and no other communities had activities coded as systems change in year two. The data show a clear trend toward moving more activities along the continuum, resulting in the greater possibility of sustainability after the end of the initiative (Figure 7).

Figure 7. Implementation stage of the MHCECE strategy across the initiative

The mental health consultants have given the teachers great examples, great activities that they can do to bring everybody together instead of everybody . . . being on a different page.”

– ECE provider
Additionally, the majority of community programs in year two were engaged in implementation of MHCECE. Program indicators also further support the communities’ activity within this strategy, with every community reporting on each indicator (Figure 8). Hours that an MHC spends consulting with early educators and families and observing children may exceed the total number of on-site hours of consultation due to the fact that multiple services may be delivered simultaneously (e.g., child observation and teacher coaching).

Figure 8. Mental health in early care and education by community and for all communities combined

When discussing mental health consultation in early care and education, community implementation team members generally spoke of:

- Successful implementation of mental health consultation activities;
- The role of LAUNCH Together as a catalyst for expanding mental health consultation and access within the communities; and
- The importance of strong partnerships with early care and education partners.
Behavioral Health in Primary Care

The integration of behavioral health into primary care (BHIP) refers to cross-sector training on topics such as behavioral health, social-emotional development, and trauma, as well as the use of developmental and social-emotional screenings in primary care settings. Additionally, this strategy may include the use of an infant/early childhood mental health specialist in primary care settings, service referrals and follow-up, care coordination with community-based services, parenting support, and health promotion activities.

Across all communities, this strategy has been challenging. Community implementation activities in year two sought to establish readiness and engage partners in participation, with the majority of implementation plan activities (61%) focused on readiness, almost a quarter securing participation of sites (21%), and a small number focused on knowledge change (18%) (Figure 9). These numbers are similar to year one with the exception of the first year also including some activities targeting behavior change. There may have been no activities focused on behavior change in year two due to the difficulty implementing the activity in year one and a continued focus on engaging partners. Only two activities from the Behavioral Health Integration strategy were coded as behavior change across the communities and they were both in Chaffee-Fremont’s plan. Chaffee Fremont’s team proposed a network-wide utilization of “a model to link families to [early childhood behavioral health] ECBH services and documentation of services” and a “web-based system and screening and referral system” across primary care and behavioral health providers. These activities were not present in year two, and instead more activities to engage practices, “evaluate [their] system and inform next steps,” and develop the workforce were proposed. These activities illustrate a trend toward earlier steps of the implementation plan to create a foundation for their behavioral health work, leading to more sustainable change later in the initiative.

“I think if they had someone directly in every hospital, or every [medical] clinic had one person who could do that referral process, or even that evaluation process, so that it would start from pediatricians to the assessment specialists . . . [that would make a big difference].”

– Parent/Guardian
Program indicators also provide evidence of less activity in this strategy area (Figure 10). Jefferson County reported the majority of data for this strategy, reflecting the number of hours behavioral health was co-located in primary care. However, these numbers should also be interpreted with caution as qualitative feedback from Jefferson suggested these numbers may be inflated due to the fact that reported numbers are calculated estimates from reporting programs in Jefferson County, rather than confirmed records.

Figure 10. Behavioral health integration indicators by community and for all communities combined
When discussing approaches to this strategy, community implementation team members generally spoke of:

- Challenges identifying and recruiting medical partners to participate in community implementation;
- The need to educate practitioners about the screening and referral process and the role of early childhood mental health in medical settings; and
- Communities’ ongoing efforts to secure participation from medical practitioners.

**Family Strengthening and Parent Skills Training**

The key features of the family strengthening strategy include: evidence-based parenting education and skills training; education to increase understanding of parenting and child development; support from program staff as well as peer-to-peer support among parents; linkages to services and resources to help improve overall family functioning; and parents’ leadership and advocacy skills building.

The largest number of planned family strengthening activities across all communities was distributed to readiness in both year one and year two (52% and 35%, respectively), although the number of activities in readiness decreased almost 20% from year one to year two (Figure 11).

Communities implementing family strengthening have also moved activities along the continuum into systems change. Most activity around this strategy occurred in Pueblo, where they incorporated parent education strategies such as Parents as Teachers within home visiting contexts (Figure 12).

“They actually got me to be more stable, stronger, educated . . . and I wish I could keep these people in my life forever . . . so I can actually say once I’ve completed everything—that I’m actually glad that I had that opportunity to have them work with me and my family because it helped teach me a lot.”

— Parent/Guardian
Implementation team members spoke broadly about their knowledge of strategy-specific approaches to family strengthening and the importance of engaging families. When discussing approaches to this strategy, community implementation team members generally spoke of:
The need to engage more families and a particular desire to include families as members of community implementation teams; and

The importance of education and community awareness for engaging families in family strengthening activities.

**Enhanced Home Visiting**

Enhanced home visitation refers to the training of home visitors on the social and emotional well-being and behavioral health of young children and families. It may also include the integration of social-emotional and behavioral health screening into home visiting programs, the provision of reflective supervision and case consultation for home visiting staff, and the delivery of brief interventions for families, such as mental health consultation and crisis intervention, prior to a warm handoff for additional services and supports. Furthermore, this strategy may also include increased coordination and information sharing across home visiting programs.

Communities demonstrated various levels of traction for this strategy. Community implementation activities in year one and year two mainly established readiness (55% and 44%, respectively). There was a move toward behavior change in year two in which 15% of activities fell under this category compared to no activities in year one (Figure 13).

Program indicators (Figure 14) show communities reporting nearly 20,000 hours of home visitation, primarily using evidence-based programs. They also reported more than 1,300 hours of reflective supervision, 780 hours of case consultation, and 1,250 mental health consultations with families.
Figure 11. Implementation stage of the enhanced home visitation strategy across the initiative

Figure 12. Enhanced home visiting indicators by community and for all communities combined
When discussing enhanced home visiting, community implementation team members generally spoke of:

- Strong partnerships with home visiting programs that include robust coordination and collaboration; and
- The importance of LAUNCH in facilitating workforce development, including mental health endorsements and general training.

How Do Service Providers Increase Their Knowledge and Infuse Best Practices Related to the Five Prevention Strategies?

The evaluation team invited providers to participate in an annual survey based on those who attended trainings during the grant year, as well as those who participated in implementing LAUNCH Together strategies, as identified by the grantee. Across all four communities, 102 providers participated in the survey. Providers could choose more than one job title, so percentages exceed 100. Overall, the majority of providers were from the field of home visitation, followed by ECE, and family strengthening. By community, Chaffee-Fremont providers overwhelmingly represented supervisors and administrators from the home visiting and ECE field, most providers from Jefferson reported providing direct home visiting services, SW Denver respondents were mainly direct ECE providers, and most Pueblo providers who completed the survey worked in family strengthening (Figure 15). This is the first year collecting provider surveys, so results should be interpreted with an understanding that many communities were in the very early stages of implementing strategies that would ultimately be expected to change provider knowledge or behavior.
Based on results from the annual provider survey, most providers believe they are fairly knowledgeable about a range of early childhood topics. Across communities, providers felt most knowledgeable about child development, family resources and support services, and parent-child relationships (Figure 16). Almost three-quarters of all providers reported attending a training recently on child development and early childhood mental health, while almost two-thirds of providers recently attended a training on parent-child relationships (Figure 17). There is clear overlap in the reported knowledge of providers and the topic of trainings they recently attended. Providers in the initiative may benefit from trainings on topics embedded in the strategy/strategies of focus for each community.

Figure 14. Reported level of knowledge means: top three topics
Providers responded to several statements about their knowledge and behavior around social-emotional health practices in their organizations and their highest- and lowest-rated three statements are reported here (Table 4). Statements about mental health consultation for home visitors were rated the highest on the annual survey. Home visitors report increasing their knowledge of the social-emotional health of young children and their families and embedding this knowledge into their everyday work due to receiving mental health consultation. The lowest-rated statements on the annual survey addressed the topic of behavioral health access in primary care. This finding further highlights the current lack of behavioral health integration in the communities and the need to more actively engage primary care practices in the initiative to further this work.
Table 4. Knowledge and behavior in practice by strategy type

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Mean Agreement/Frequency</th>
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<tbody>
<tr>
<td><strong>Highest-Rated Statements</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home visitors who indicated receiving MHC (agreement scale)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The ECMH consultation processes helped me to better understand the social-emotional needs of children with whom I work.</td>
<td>18</td>
<td>4.17</td>
</tr>
<tr>
<td>Home visitors who indicate receiving MHC (agreement scale)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The ECMH consultation processes helped me to support families to manage their children’s disruptive or challenging behaviors.</td>
<td>18</td>
<td>4.17</td>
</tr>
<tr>
<td>The ECMH consultation processes helped me to better communicate with parents about their children’s social-emotional development.</td>
<td>18</td>
<td>4.22</td>
</tr>
<tr>
<td><strong>Lowest-Rated Statements</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All providers who indicate receiving MHC (frequency scale)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The MHC(s) conducted more in-depth assessments of children after they had been screened.</td>
<td>19</td>
<td>2.63</td>
</tr>
<tr>
<td>Behavioral health providers or primary care providers (agreement scale)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>When a medical provider refers a patient to behavioral health, that patient is generally seen the same day for treatment.</td>
<td>10</td>
<td>2.20</td>
</tr>
<tr>
<td>We have quick access to a psychiatrist if needed.</td>
<td>11</td>
<td>2.45</td>
</tr>
</tbody>
</table>

Source: Annual provider survey

Notes: All scales are 1–5. Agreement scale: 1 = Strongly disagree, 5 = Strongly agree; Frequency scale: 1 = Rarely/never, 5 = Weekly; Ns for individual items are lower than the total number of survey participants since participants only answered questions related to their area of focus.
Communities also hosted trainings for more than 1,000 attendees during this implementation year. The most commonly reported strategy for provider trainings was integration of early childhood mental health (ECMH) in early care and education (ECE), followed by family strengthening and integration of early childhood mental health in home visitation (Figure 18). Providers can report more than one strategy, so percentages exceed 100. Chaffee-Fremont offered numerous trainings to increase the capacity of ECE providers, offering several CoAIMH and Pyramid Model trainings; they also targeted efforts on screening and assessment trainings related to ASQ, ASQ-SE, and pregnancy-related mental health. Jefferson mainly worked to develop and build the capacity of their home visitation workforce. Southwest Denver focused much of their efforts on family strengthening and training early childhood providers, especially around Conscious Discipline. Almost half of the training opportunities provided by Pueblo addressed mental health integration in early childhood education, working with childcare centers and schools in their target area.

Figure 16. Focus of provider trainings

After attending trainings, providers across all communities reported an increase in knowledge regarding early childhood social-emotional development, as well as an increase in their knowledge about the primary training topic (which was sometimes more targeted than EC social-emotional development, specifically – see Figure 19). Additionally, training participants reported a high expectation to use their new knowledge in practice (Figure 20), and more than half of providers indicated they would use their knowledge of the training topic in their practice a great deal (on a scale of 1 = not at all to 5 = a great deal).
Figure 17. Provider knowledge change

- **Chaffee-Fremont (n = 223-227)**
  - Before Training: Knowledge of EC social-emotional development: 3.4, Knowledge of primary topic of training: 4.09
  - After Training: Knowledge of EC social-emotional development: 3.14, Knowledge of primary topic of training: 4.03

- **Jefferson (n = 368-375)**
  - Before: Knowledge of EC social-emotional development: 3.42, Knowledge of primary topic of training: 4.07
  - After: Knowledge of EC social-emotional development: 3.3, Knowledge of primary topic of training: 3.99

- **Pueblo (n = 506-519)**
  - Before: Knowledge of EC social-emotional development: 3.59, Knowledge of primary topic of training: 4.17
  - After: Knowledge of EC social-emotional development: 3.34, Knowledge of primary topic of training: 4.16

- **SW Denver (n = 226 - 231)**
  - Before: Knowledge of EC social-emotional development: 4.23, Knowledge of primary topic of training: 4.66

Figure 18. Provider expected use of training topic in practice

- **SW Denver (n = 230)**: 4.66
- **Pueblo (n = 505)**: 4.43
- **Jefferson (n = 370)**: 4.35
- **Chaffee-Fremont (n = 226)**: 4.23
How Do Families within Each Community Access Services That Promote Early Childhood Social-Emotional Development? What Are Families’ Experiences with Service Access and Coordination?

Seventy-five families participated in the annual family survey; of these, 31 received a referral for additional services. Though parents or guardians may receive referrals for themselves, only seven families reported referrals for the parents or guardians, while 28 received referrals for their children.

Of the 28 children who received referrals, three of those referrals were for issues related to the child’s growth and development and three were for other purposes, including behavioral or mental health concerns, medical issues, and other unspecified support.

On average, family members reported on a scale of 0–10 (0 = Not at all concerned; 5 = Somewhat concerned; 10 = Extremely concerned) that they were more than “somewhat concerned” (M = 6.80) about their child before the visit that led to their child’s referral. After the referral, they reported that their concern had fallen to 4.62, on average (Figure 21).

ABOUT THE PARENTS

- 96% of parents were mothers
- 67% were between 30–39 years old
- 67% were Caucasian
- 50% of families made less than $60,000 a year
- 38% had “Just enough to make ends meet”
Figure 19. Family concern about child pre-/post-referral

Of the 28 families who received referrals for their children, all except one respondent reported on their experiences with those referrals. Table 5 reflects families' experiences with these referrals. On a scale of 0–10 (0 = Not at all; 10 = Completely), families whose child received services reported that the referred service helped their child almost completely (M = 9.33).

Table 5. Family experience with referrals (n = 28)

<table>
<thead>
<tr>
<th>Experience</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider explained why the referral was made</td>
<td>24</td>
</tr>
<tr>
<td>Family member got all the information needed to follow up on referral</td>
<td>24</td>
</tr>
<tr>
<td>Provider making the referral helped family member make an appointment with the referred service</td>
<td>11</td>
</tr>
<tr>
<td>Provider, or someone who worked with them, contacted family member at a later time to see if they had any problems getting referred services</td>
<td>12</td>
</tr>
<tr>
<td>Child received the referred services</td>
<td>20</td>
</tr>
</tbody>
</table>

*Source: Annual family survey*
More generally, 599 families completed the shorter family “point-of-service” surveys. The majority (76%) of the family point-of-service surveys came from early care and education settings, followed by mental health consultation (24%). Of the families who completed family point-of-service surveys, 149 received referrals. Figure 22 shows the types of referrals made.

Figure 20. Types of referrals made to “family point-of-service” survey respondents (n = 149)

*Other refers to child safety, education, food and housing, speech, and general family services

Family point-of-service surveys indicate that almost all families feel they are receiving needed support and information in a respectful way from their providers, regardless of service type (see Table 6). On average, families are very happy with the services they receive for themselves and their children. Most families who were referred to further services also indicated satisfaction with the information their providers gave them about the referral (94%) and their ability to follow up on that referral (83%).
Table 6. Referral satisfaction based on family point-of-service surveys

<table>
<thead>
<tr>
<th>All families (n = 599)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Received needed support and information</td>
<td>97%</td>
</tr>
<tr>
<td>Felt respected, supported, and understood</td>
<td>99%</td>
</tr>
<tr>
<td>Happiness with provider’s services (scale of 1–4)</td>
<td>3.86</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Referred families (n = 149)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Got all needed information about reason for referral</td>
<td>94%</td>
</tr>
<tr>
<td>Felt able to follow up on referral</td>
<td>83%</td>
</tr>
</tbody>
</table>

Interviews with family members reflected the importance of referrals and service access to families in the community. One parent/guardian explained, “I think it’s tough sometimes because there are so many different organizations; it would be nice to have some type of centralized . . . number you can call to figure out all the kinds of different organizations beyond just early childhood.”
NEXT STEPS

LAUNCH Together is entering the last two years of the initiative, with an emphasis on movement toward behavior and systems change for at least one LAUNCH strategy. Each community is working to identify strategies that are most likely to result in demonstrable changes in the behaviors of the workforce or families and in the operation of the system of services available to support young children. Results of this year’s evaluation show that communities are moving along the implementation continuum; with the greatest gains observed for the Mental Health Consultation in Early Care and Education (MHCECE) strategy. However, continued challenges in movement for the Behavioral Health Integration in Primary Care (BHIPC) strategy were observed. Implementation team members also acknowledge that partnership gaps are most prominent in the health sector, suggesting that communities might benefit from more support on how to engage primary care in these efforts.

The communities have directed many resources at providing training in their communities and providers report an increase in knowledge post-training with an intention of using new knowledge in practice. Going forward, providers in the initiative will benefit from high intensity/dosage training, coaching, and professional development with a clear content focus related to the five strategies, to support knowledge and behavior change.

Families in the community who receive services from providers involved with the initiative report that they are generally satisfied with services and receiving/following-up on referrals. Continued focus on activities that result in behavior change, through concentrated and targeted activities that support the transfer of knowledge to practices and procedures along with a focus on systems change activities, where, practices and procedures related to specific strategies are embedded into the operational infrastructure in the community, will have the furthest potential to impact families.

The evaluation will continue to collect data related to the five strategies and the communities’ movement on the implementation continuum presented in this report to demonstrate how grantee communities develop systems of support for early childhood social-emotional well-being.
APPENDIX A. LAUNCH TOGETHER DETAILED TIMELINE

Implementation Year 1 Begins
- 1st Data Liaison Training
- Implementation Planning Start-up
- State Level Stakeholder Interviews
- YR1 State Partner Survey
- Post-training Surveys Start Continuous Administration
- 1st Implementation Team Focus Groups

Implementation Year 2 Begins
- 1st Common Indicator Data Submission Collected Quarterly
- YR1 Community Partner Survey

Implementation Year 2 Begins
- Family Point of Service Survey Distribution Start Continuous Administration

Implementation Year 3 Begins
- 2017 Annual Report
- Phase 2 Hicks-Larson Annual Survey

Baseline Annual Provider Survey
Baseline Annual Family Survey & Family Interviews
Baseline Provider Focus Groups and Interviews

This Report
2018 Annual Report

Oct - Dec 2016
Jan 2017
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Jul - Aug
Aug - Sept
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Dec

This Report
2018 Annual Report
• **Readiness**: Identifying providers or stakeholders, conducting outreach to potential partners, gathering information, or meeting to plan for later action.

• **Participation**: Engagement of partners or participants in planned strategies.

• **Knowledge**: High intensity/dosage training, coaching, and professional development with a clear content focus, delivered to a specific target audience.

• **Behavior**: Concentrated and targeted activities that support the transfer of knowledge to practices and procedures.

• **Systems Change**: Practices and procedures related to the strategy are embedded into the operational infrastructure in the community.

For long-term systems change, there needs to be:

• **readiness** to engage, ex. identify PCPs in target area, conduct outreach, and gather info (current assessment use, referral protocols, barriers, TA needs)

• then **participation**, ex. at least 3 PCPs sign agreements to participate in training and TA

• leading to **knowledge** gain, ex. provide training and TA on clinical best practices for early childhood social-emotional health screening to PCPs

• then **behavior** change, ex. improve clinical protocols and implement standard office procedures for early childhood social-emotional health screening

• ultimately resulting in **systems change**, ex. increase ability to connect children and families to appropriate resources and supportive services