LAUNCH together

Community Evaluation Report: Chaffee County and Fremont County

Denver, Colorado

Prepared by

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CONTEXT

LAUNCH Together

LAUNCH Together is a unique partnership between eight Colorado-based philanthropic foundations and four communities, which includes a mix of five rural and urban counties across the state. Since 2015, LAUNCH Together has been working to improve social, emotional and developmental outcomes for Colorado's young children and their families. By advancing opportunities to improve the local and statewide systems that support early childhood mental health (also referred to as infant and early childhood mental health), this public-private initiative, which concluded in early 2021, has facilitated collaboration across health and mental health, early childhood, and family supports to strengthen local and statewide infrastructure, streamline services, and increase knowledge about early childhood mental health.

Figure 1. LAUNCH Together Strategies Framework

LAUNCH Together is modeled after Project LAUNCH (Linking Actions for Unmet Needs in Children's Health), a federal initiative of the Substance Abuse and Mental Health Services Administration (SAMHSA) which focuses on five core prevention and promotion strategies; (1) screening and assessment, (2) enhanced home visiting (EHV), (3) mental health consultation in early care and education programs (MHCECE), (4) family strengthening and (5) integration of behavioral health into primary care (BHIP) settings (Figure 1).

The COVID-19 pandemic emerged during the final year of the LAUNCH Together initiative, and it is important to understand the significant impact the pandemic has had on the LAUNCH Together communities' services implementation and evaluation

participation. As Governor Jared Polis issued a state-of-emergency order for Colorado in March 2020, LAUNCH Together communities worked urgently to continue providing services and implementing LAUNCH Together activities within the guidelines of the governor's orders and in the face of sudden and lengthy closures across the array of early childhood services.

Overall, community organizations moved to online services whenever possible and experienced significant programmatic changes. Many staff began to work remotely, services transitioned online, and some activities were postponed. Communities shared that helping families' meet basic needs such as securing food and ensuring an income took priority over other activities.

In Chaffee and Fremont Counties, LAUNCH Together implementation team members shared that the system coordination and collaboration developed as a part of the LAUNCH Together initiative helped them respond to COVID-19's impact on their community. Participants shared that the partnerships strengthened through LAUNCH Together allowed them to continue to support programs across the communities and address challenges to providing high-quality resources to families during a pandemic. Many felt that the close relationships and partnerships developed through LAUNCH allowed them to respond quickly to community needs and requests:

> "I think having the shared vision that we put into place through LAUNCH has helped support continuing and strengthening the relationships and the workflow as the community, together. It especially helps us, I think, during this time when we're having to try to find new ways to do the work that we've always done."

Most LAUNCH Together communities were able to pivot toward their community's emergent needs. Overall, services continued across communities even in the face of significant disruption and distress. Given the circumstances, this points to LAUNCH communities' resilience and commitment to their missions and shared vision. As described later in this report, communities' ability to participate in the evaluation varied during this time.

Community

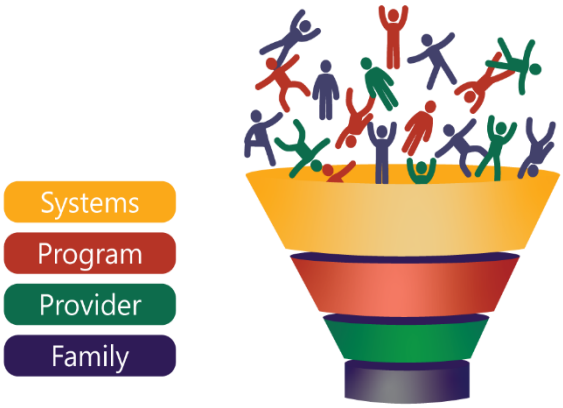
This report focuses on the LAUNCH Together activities of Chaffee County and Fremont County. Chaffee and Fremont are adjacent counties along the eastern edge of the Rocky Mountains in south-central Colorado. Combined, the two counties encompass 2,546 square miles and are home to 68,195 people. Children under age 5 make up 3.7% and 4.1% of the population in Chaffee and Fremont, respectively.[1] For the purposes of the LAUNCH Together initiative, the ECHO & Family Center Early Childhood Council in Fremont County and the Chaffee County Early Childhood Council partnered as the lead agencies for the Chaffee-Fremont grant. As lead agencies, the Early Childhood Councils in Chaffee and Fremont had the strong relationships, cross domain partnerships, and common vision in place to carry the work forward. Thus, many of the initial LAUNCH implementation team agencies were long time council members, with new partners added along the way.

METHODOLOGY

The evaluation used a mixed-methods approach to explore outcomes at the systems, program, provider, and family levels. This approach uses surveys, interviews, focus groups, document review, and reporting of key indicators to evaluate each of the five prevention strategies.

The evaluation collected data along a pipeline of LAUNCH-related outcomes, including data at the systems, program, provider, and family levels (see Figure 2). Key data sources that inform the current report were collected in years one through four of implementation (2017-2020) and include: cumulative program indicators, surveys from LAUNCH-related trainings,

Figure 2. Outcome Pipeline



[1] U.S. Census Quick Facts: https://www.census.gov/quickfacts

family surveys and interviews, provider surveys and interviews, implementation team surveys and interviews, and data on the progress toward systems change reflected in community implementation plans.

Table 1 shows the data collection schedule. In the first year of LAUNCH Together implementation (2016–2017), the evaluation team collected limited data. At this point, communities were in the early stages of project start-up and implementation and were not ready to collect much data since changes in program functioning or provider and family behavior had not yet occurred. In the second year of implementation (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. In the third year of implementation (2018-2019), data collection expanded to include follow-up data on state-system-level coordination and collaboration as well as continued collection of program, provider, and family data. In the final year of implementation, (2020) data collection remained the same as previous years with the exclusion of common indicator data.

Table 1. Data Collection Schedule

	Implementation			
Data Collection	**YR 1 (2016–17)**	**YR 2 (2017–18)**	**YR 3 (2018–19)**	**YR 4 (2020)**
Systems Level				
State-system stakeholder interviews	✓		✓	✓
PARTNER™ survey (state and community implementation teams)	✓			✓
Community implementation team focus groups/interviews	✓	✓	✓	✓
Program Level				
Common indicators		✓	✓	
Implementation plan coding	✓	✓	✓	✓

Provider Level				
Post-training provider survey	✓	✓	✓	✓
Annual provider survey		✓	✓	✓
Annual provider interviews		✓	✓	✓
Family Level				
Family point-of-service survey		✓	✓ (limited)[2]	✓ (limited)[2]
Annual family survey		✓	✓	✓
Annual family interviews		✓	✓	✓

COVID-19 Impact on Data Collection

Most LAUNCH Together communities continued collecting data in the last year of the LAUNCH Together initiative despite the COVID-19 pandemic. Butler staff were in close communication with grantees to help support data collection efforts in light of the pandemic. Communities had to quickly pivot to online programming while juggling multiple competing and urgent community priorities. The consensus of LAUNCH Together funders was to support communities' ability to provide services and offer a flexible and collaborative approach to the LAUNCH Together evaluation requirements. As a result, the initiative eliminated the common indicator requirement from the data collection methodology during the 2020 implementation year, but available data can be

[2] Family point-of-service survey data was limited in year 3 and 4 because community programs were given the option to offer families the family point-of-service survey or an information sheet that would direct families to the annual family survey instead of the family point-of-service survey.

found in Chaffee and Fremont Counties 2020 Brief Appendix. Additionally, some communities experienced a decrease in the number of respondents participating in other elements of the evaluation such as Annual Provider Surveys and Annual Family Surveys. Due to these considerations, findings from the 2020 implementation year should be interpreted in the context of reduced sample sizes and the immeasurable impact of the pandemic.

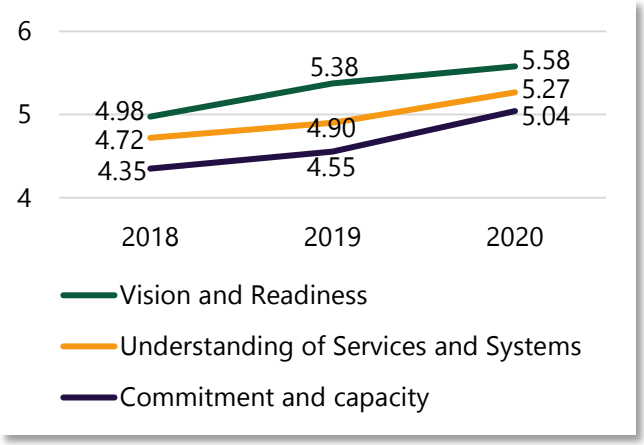
COMMUNITY RESULTS

System Change

Coordination and Collaboration

Each community in the LAUNCH Together initiative convened an implementation team, composed of key early childhood system partners in the community, to guide and implement strategic approaches to improving early childhood social-emotional development. To understand the implementation process and progress in each community, implementation team members completed the Hicks-Larson collaboration survey.

Figure 3. Hicks-Larson Collaboration Survey Results



Implementation teams were surveyed in 2018, 2019, and 2020. Results across years in Chaffee and Fremont Counties demonstrated strong collaboration, with average scores on the three collaboration constructs falling between 4 (agree more than disagree) and 6 (strongly agree). Figure 3[3] shows the average scores between 2018 and 2020 on the

[3] The survey measures three constructs of collaboration on a scale of 1–6 (1 = strongly disagree; 6 = strongly agree).

three collaboration constructs, which include (1) community vision and readiness to participate in the LAUNCH Together initiative; (2) community understanding of relevant services and systems; and (3) community commitment and capacity to participate in the initiative.

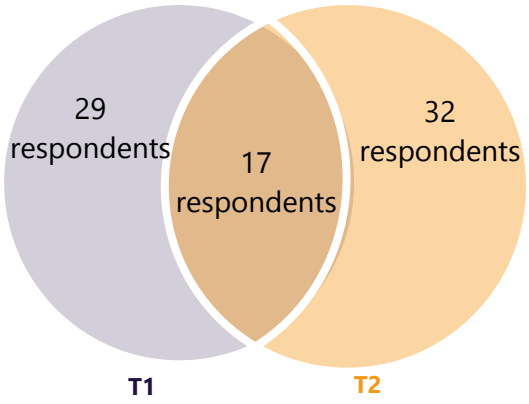
Overall, scores on all constructs were rated below "agree" in 2018 and increased to above "agree" by 2020. The lowest mean scores were on the commitment and capacity construct; however, this score increased the most over time, illustrating the importance of time in building relationships and trust and increasing organizational capacity to engage implementation team members and their programs at the highest level. Mean scores on vision and readiness were consistently rated highly and it remained the highest rated construct in 2020. Qualitative themes from implementation team interviews also supported Chaffee and Fremont's shared vision, understanding of the services in their system, and commitment. One implementation team member explained:

> "Over the course of the grant, and even before that, we really have created a shared vision related to **how important early childhood mental health is**. It starts in pregnancy. There is this community-wide **understanding and commitment** among agencies that we need to work on this."

PARTNERships

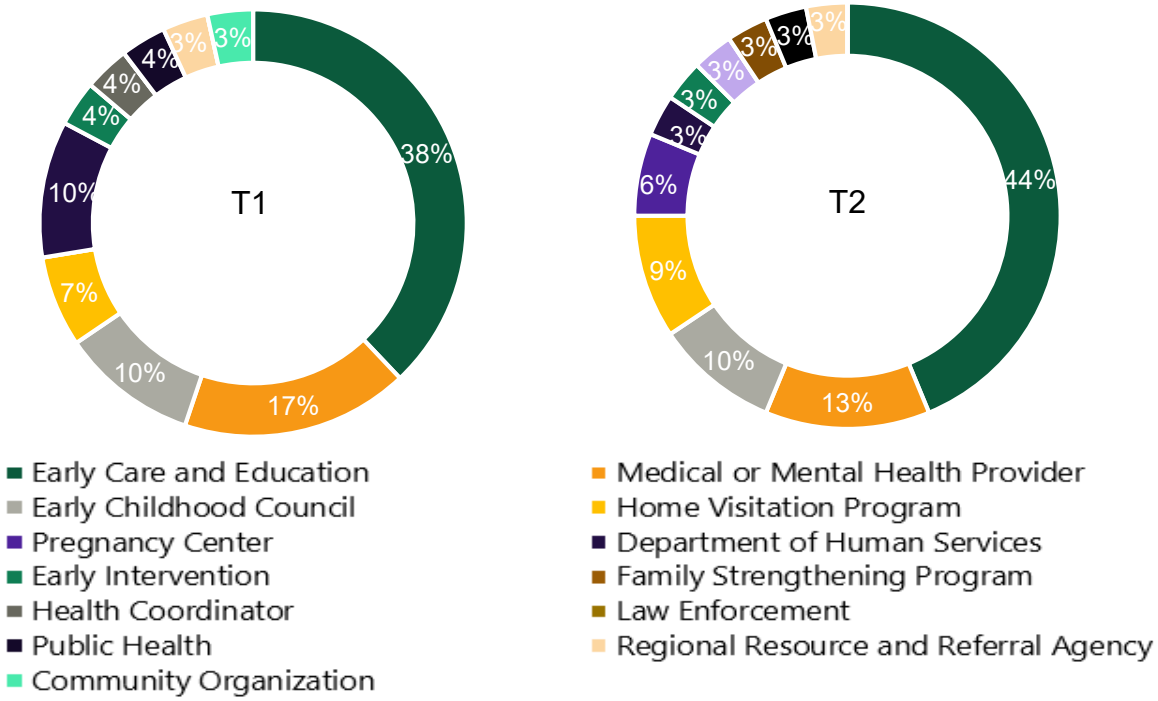
In 2017 (T1) and 2020 (T2), a Social Network Analysis on Chaffee-Fremont's network of early childhood organizational partnerships was also conducted using the PARTNER Tool (www.partnertool.net) to better understand partnerships within the local community system and the impact of LAUNCH Together. The survey was administered to early childhood partners identified by the coordinators of each community's early childhood council. The survey asked respondents to describe themselves and their work in the network, and then to answer

Figure 4. Survey Respondents by Year



questions about their partners. VISIBLE NETWORK LABS[4] analyzed and reported the following data from the PARTNER tool on Chaffee-Fremont's early childhood network. A portion of the analyses are presented here. For more information, refer to VISIBLE NETWORK LABS' full report here.

Figure 5. Types of Participating Organizations Across Timepoints



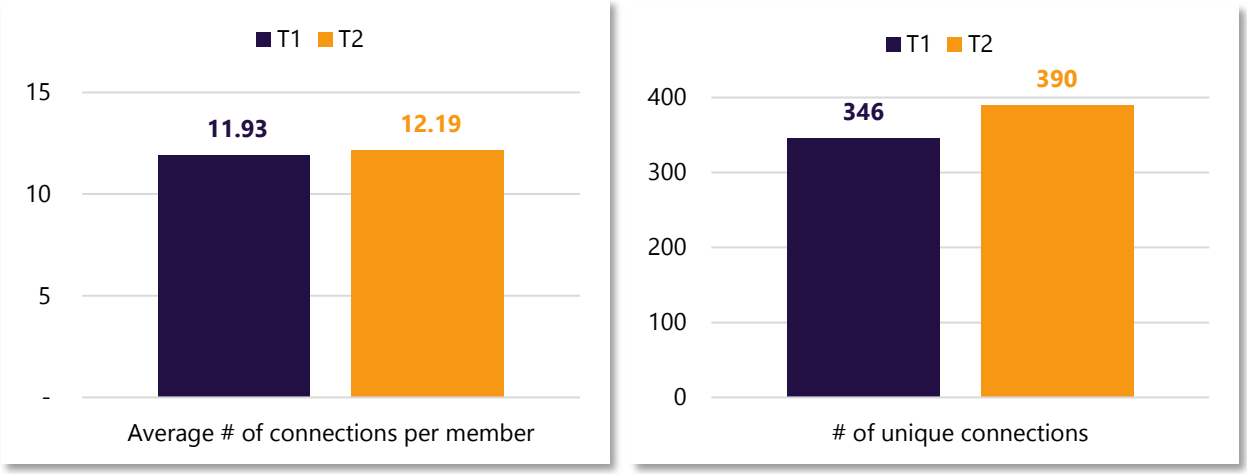
Twenty-nine organizations in the Chaffee-Fremont community completed the PARTNER survey in 2017 and 32 organizations completed it in 2020. There were 17 organizations that completed the survey at both timepoints (Figure 4). The majority of partner organizations represented Early Care and Education, followed by Medical and Mental Health Providers and a variety of other sectors in the community. This diverse set of partners from many sectors demonstrates a cross-sector collaborative initiative (see Figure 5).

[4] VISIBLE NETWORK LABS is a data science company that developed the PARTNER tool, a scientifically validated social network analysis (SNA) data tracking and learning tool.

Connections

Over the course of the LAUNCH Together initiative, the community-built relationships and developed their network connections. Findings from the PARTNER demonstrate that from T1 to T2, there was a 13% increase in the total number of connections between organizations and the average number of connections per organization increased slightly (Figure 6).

Figure 6. Chaffee-Fremont's Early Childhood Network Scores

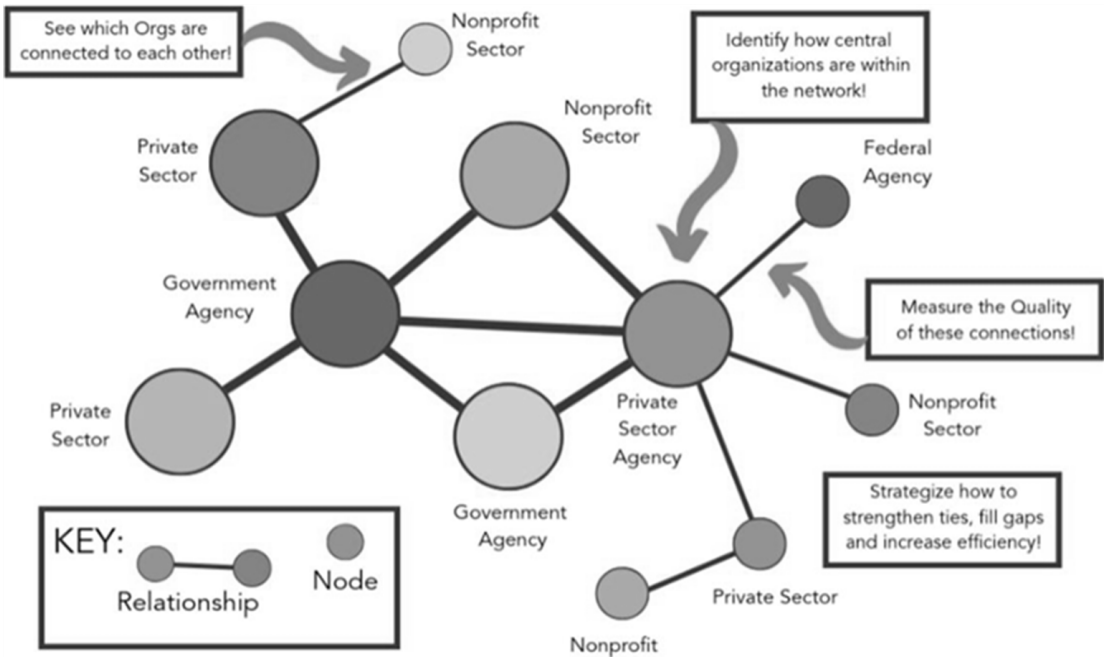


Social network maps of Chaffee-Fremont's LAUNCH Together early childhood system in 2017 and 2020 (see Figure 7 and Figure 8) illustrate how the system has changed over the course of the initiative. Each organization is represented as a circle (node) and the lines shown demonstrate all relationships that were reported. Nodes are colored by partner organization type.

From 2017 to 2020 Chaffee and Fremont's LAUNCH Together lead agencies, Chaffee County ECC and ECHO & Family Early Childhood Council, became more centralized or were more in the middle of the network. The councils, who had formally partnered with organizations throughout their own communities, also became the main touchpoint across the two counties. There were two distinct clusters in the network map in 2017, illustrating the collaboration occurring within counties, but not much connection between the two counties. In 2020, there were still two clear clusters of organizations by county, however, there were more organizational connections across counties illustrated by more organizations moving toward the center of the network map.

In 2017, 40% of all the possible connections in the network were accounted for, while in 2020, the network had 22% of all the possible connections; if every partner in the network was connected to every other partner in the network the network would have 100% of the possible connections. This appears to be a decrease in the connectivity of the network but these numbers are neither good nor bad; they simply provide information about what currently exists so that system partners can discuss whether the network is operating in a way they feel best supports shared goals.

How to Interpret a Network Map



Networks refer to a partnership created between three or more people or organizations to achieve mutually desired objectives. In a network map, partnerships are visualized as "nodes" (circles) and "edges" (lines) which represent the network members and the relationships between them. Nodes may be color-coded by certain organizational characteristics, such as jurisdiction or sector.

Figure 7. Chaffee-Fremont's 2017 Integrated Early Childhood Network

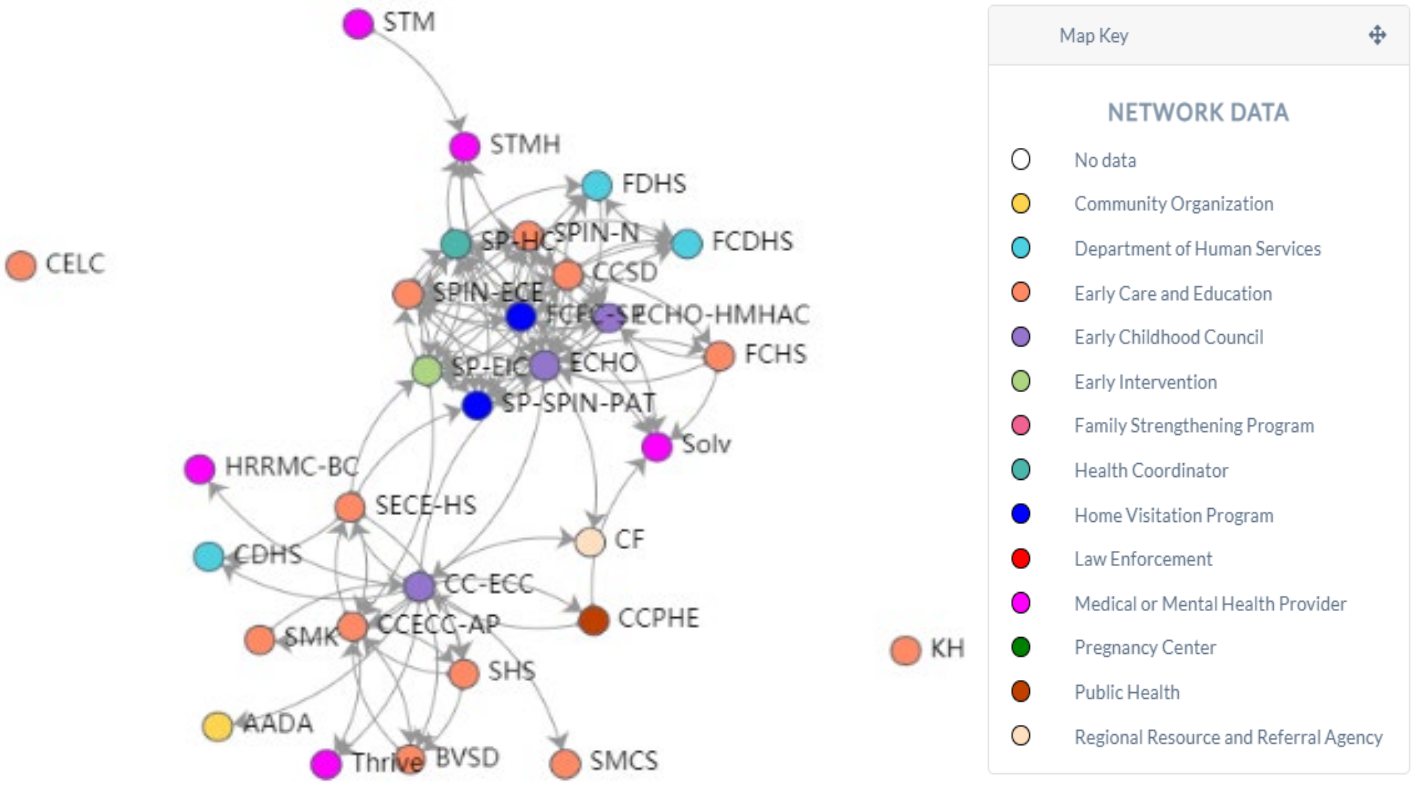
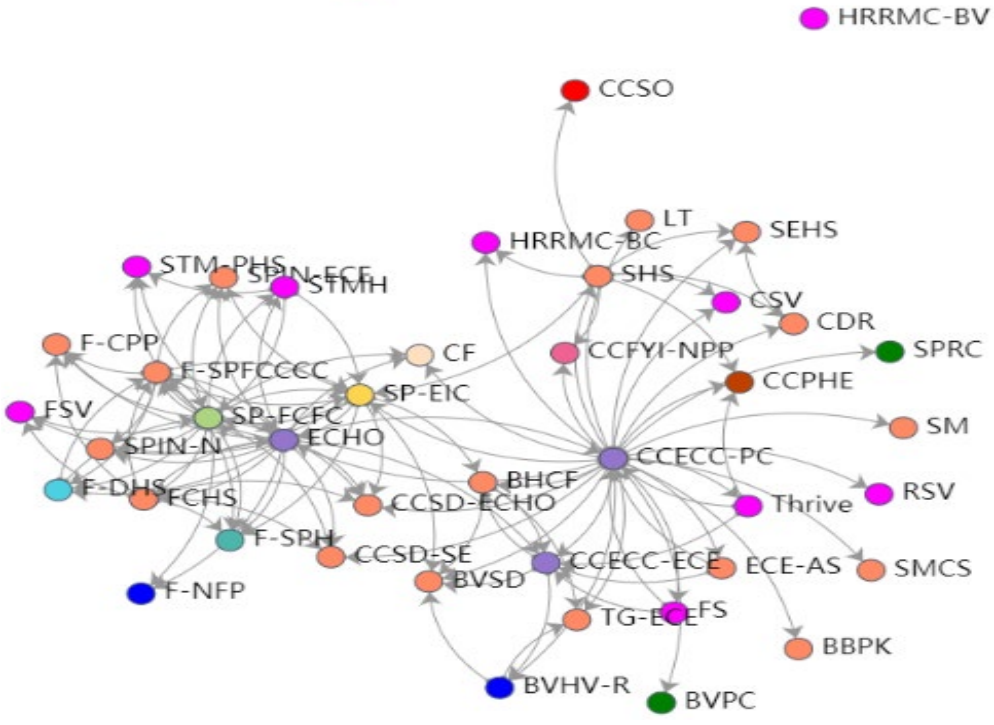


Figure 8. Chaffee-Fremont's 2020 Integrated Early Childhood Network

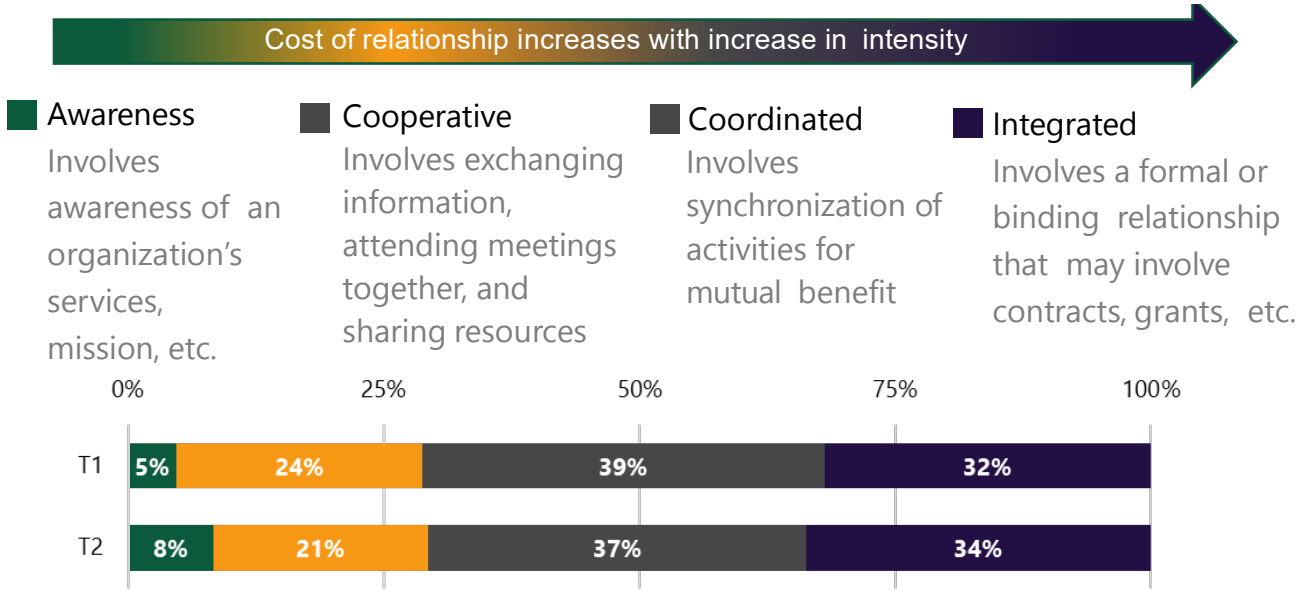


A list of partner organization abbreviations and associated names can be found here.

Nature of Relationships

From T1 to T2, the share of relationships at the awareness and integrated levels slightly increased, while the share of relationships at the cooperative and coordinated levels slightly decreased (see Figure 9). Overall, the intensity of relationships is balanced within the Chaffee-Fremont network. Connections are somewhat distributed across collaboration levels, with most relationships categorized as cooperative or coordinated. If a majority of relationships were at the awareness level that would indicate that the network is not fully leveraging its collaborative advantage. If a majority of relationships were at the integrated level, they would require a greater number of resources to maintain.

Figure 9. Relationship by Collaboration Level (n = 338)

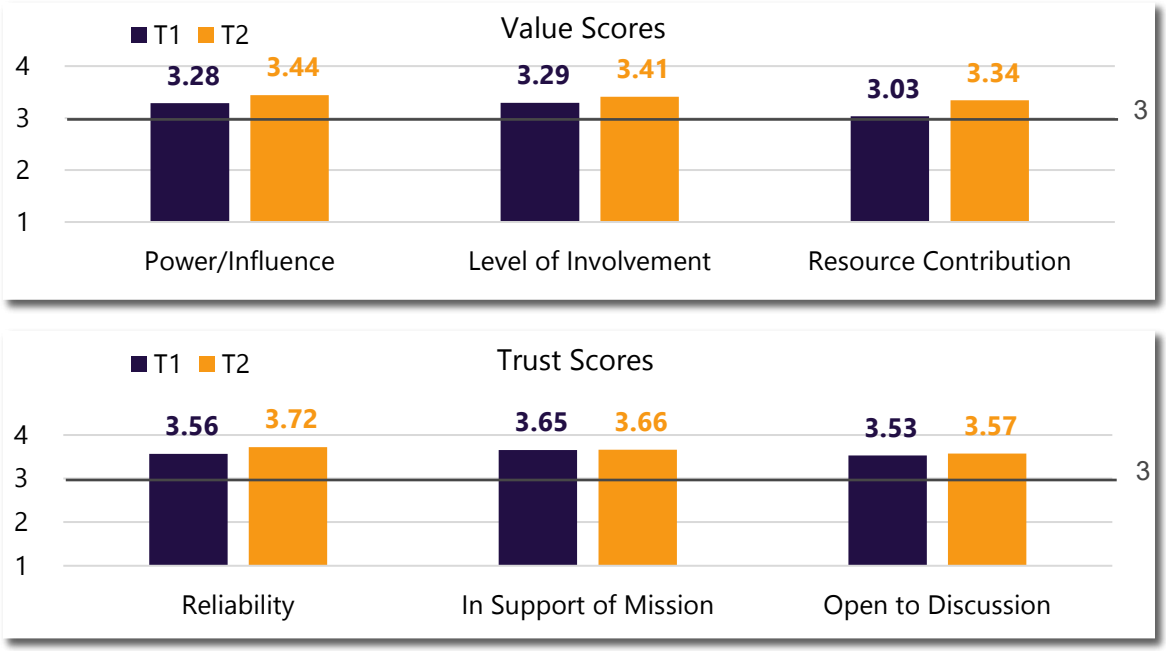


Value and Trust in Relationships

The levels of value and trust that partners perceive to exist in network relationships are important in building and maintaining collaborative capacity. Understanding the perceived value of network relationships is important in leveraging the different ways in which members contribute to the network. Trust in inter-organizational network relationships facilitates effective information exchange and decision-making and reduces duplication of effort among groups that may have previously competed.

The survey measured value and trust between network partners using three validated dimensions for each concept. Survey participants assessed each of their reported relationships on these dimensions according to a 4-point scale, with 1 = Not at all, 2 = A small amount, 3 = A fair amount, and 4 = A great deal. Scores over 3 are considered the most positive. Figure 10 depicts the average value and trust scores in the network. Already strong scores for value and trust increased even more from T1 to T2.

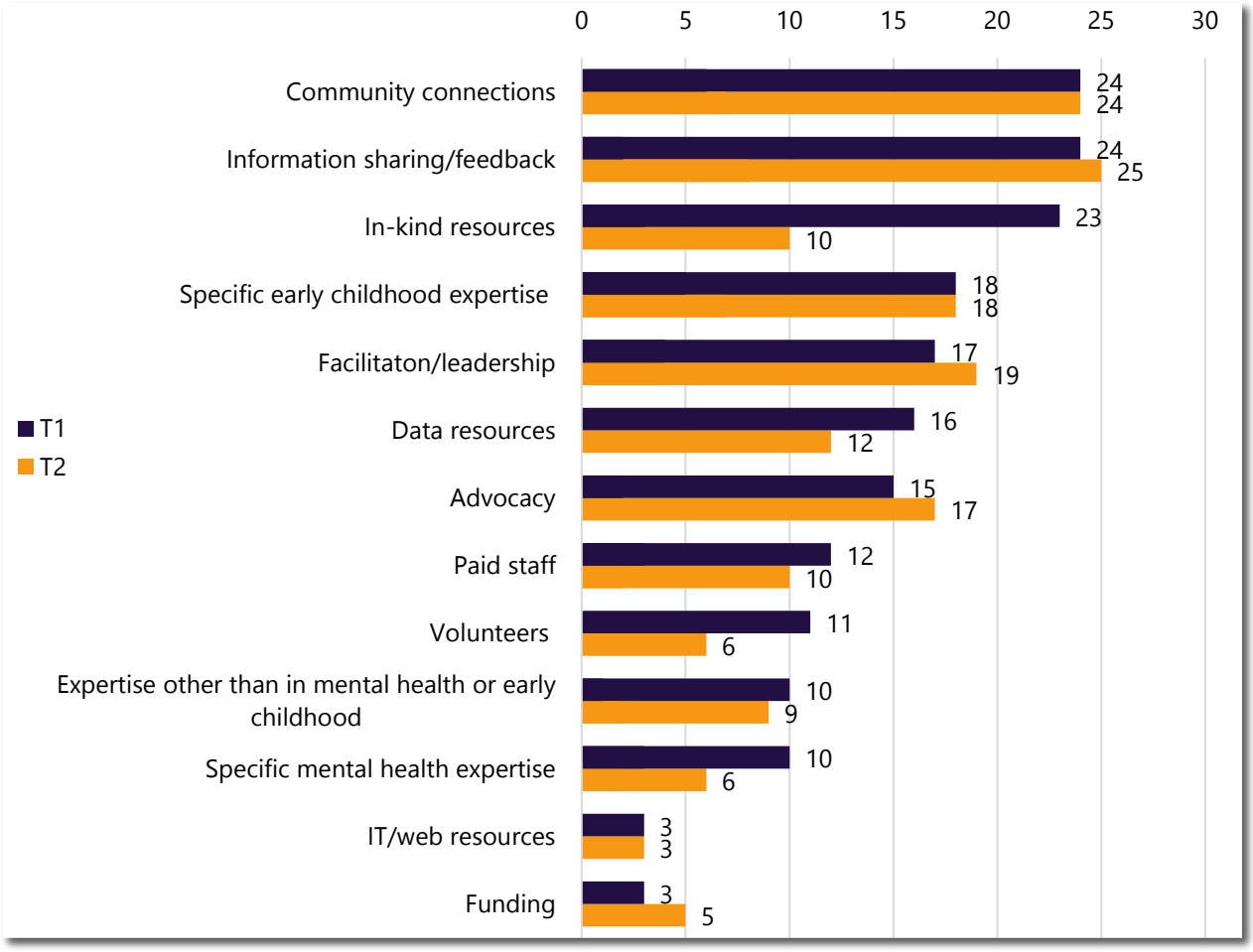
Figure 10. Chaffee-Fremont's Early Childhood Network's Value and Trust Scores



Resource Contribution

The network structure brings organizational members together to share expertise and information and provides access to the collective pool of knowledge and resources that now exists. Partners would not be able to perform their role in the community if they did not leverage the resources of all members. In T1, the most contributed resources among Chaffee-Fremont's LAUNCH partners were community connections, specific, information sharing/feedback, and in-kind resources. In T2, they were community connections, information sharing/feedback, and facilitation/leadership (see Figure 11). Community connections and information sharing/feedback remained some of the most common contributions, but facilitation/leadership increased in 2020, building more leaders in the community and more organizations that could engage others in this important work.

Figure 11. Organizational Contributions (T1 n = 29, T2 n = 32)

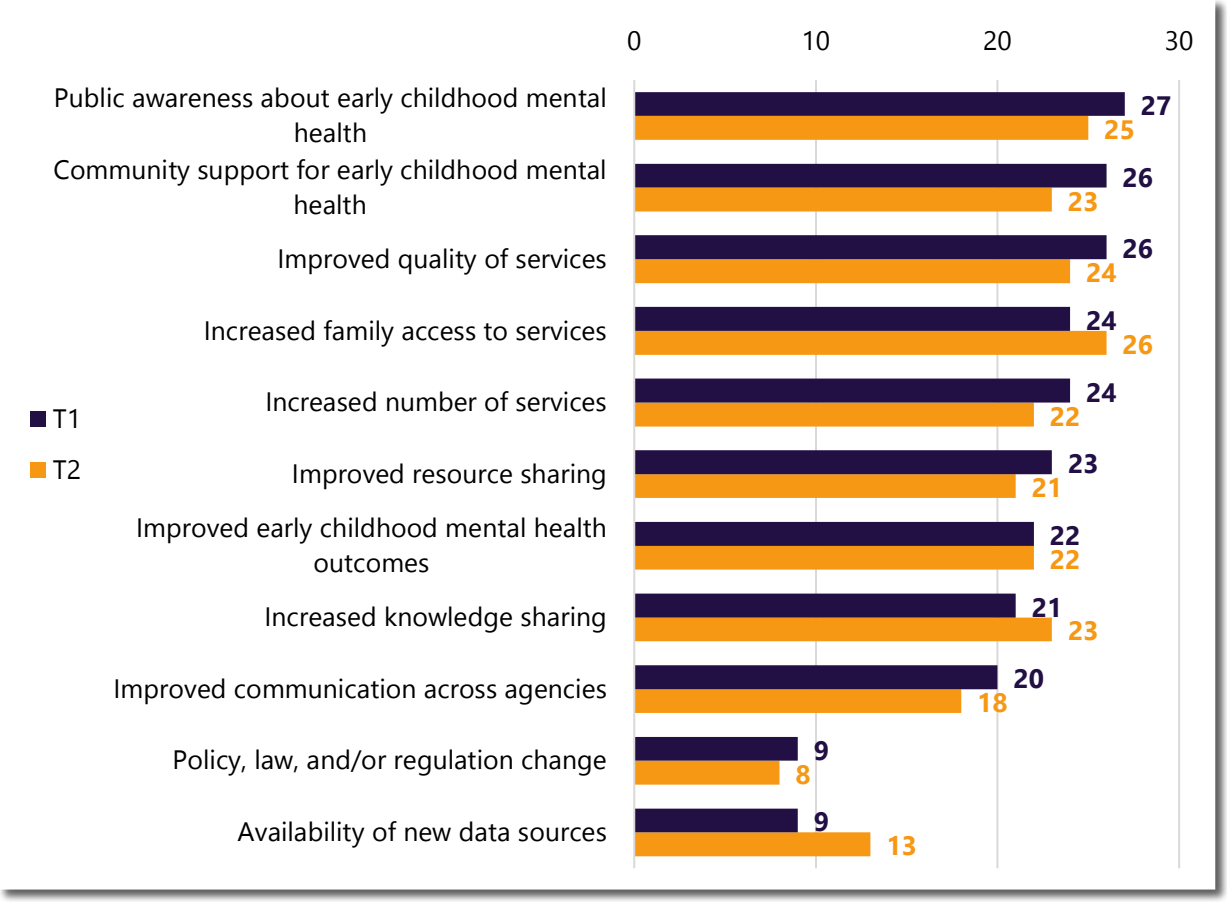


Outcomes

Having outcomes in mind while building and sustaining a network helps keep members accountable and adapt quickly if they are not achieving the outcomes they planned. Chaffee and Fremont organizations worked to increase knowledge and awareness of early childhood social-emotional health and build provider skills and knowledge on this topic. In T1, partners reported the following outcomes as their main point of focus for the initiative: public awareness about early childhood mental health, community support for early childhood mental health, community support for early childhood mental health, and improved quality of services were among the most selected outcomes.

In T2, partners reported the following outcomes due to the initiative: increased family access to services, public awareness about early childhood mental health, and improved quality of services (see Figure 12). In both T1 and T2, the most respondents selected increased family access to services and improved early childhood mental health as the most important outcomes.

Figure 12. Partners' Perceived Outcomes to Advance Comprehensive Early Childhood Mental Health Systems (T1 n = 29, T2 n = 30)



Perceptions of Success

From T1 to T2, the communities' perception of success improved. Half of the T1 respondents find the network to be "somewhat successful, " whereas half of T2 respondents find the network to be "successful" (see Figure 13). In T1, the most respondents selected "exchange information/knowledge" among potential aspects of the collaboration that contributed to the success. In T2, most respondents selected

"sharing resources" (see Figure 14). Chaffee and Fremont have increased their network to have access to and share resources more efficiently and that contributed to organizations finding the network to be "successful."

Figure 13. Success at Reaching Goals Related to Advancing Comprehensive Early Childhood Mental Health Systems (T1 n = 28, T2 n = 30)

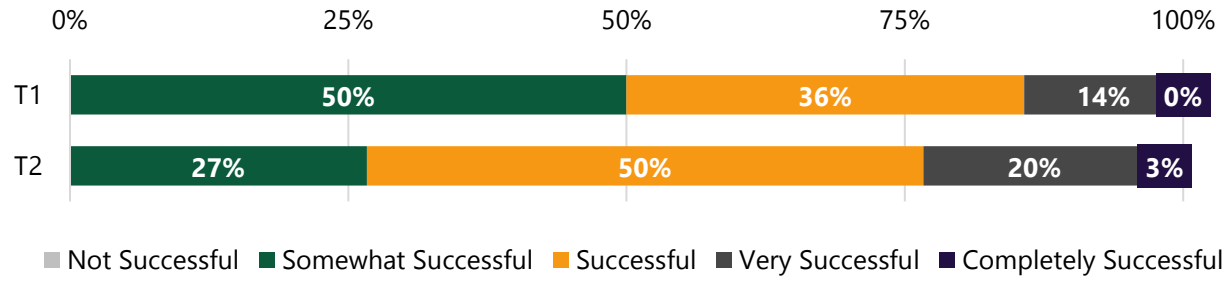
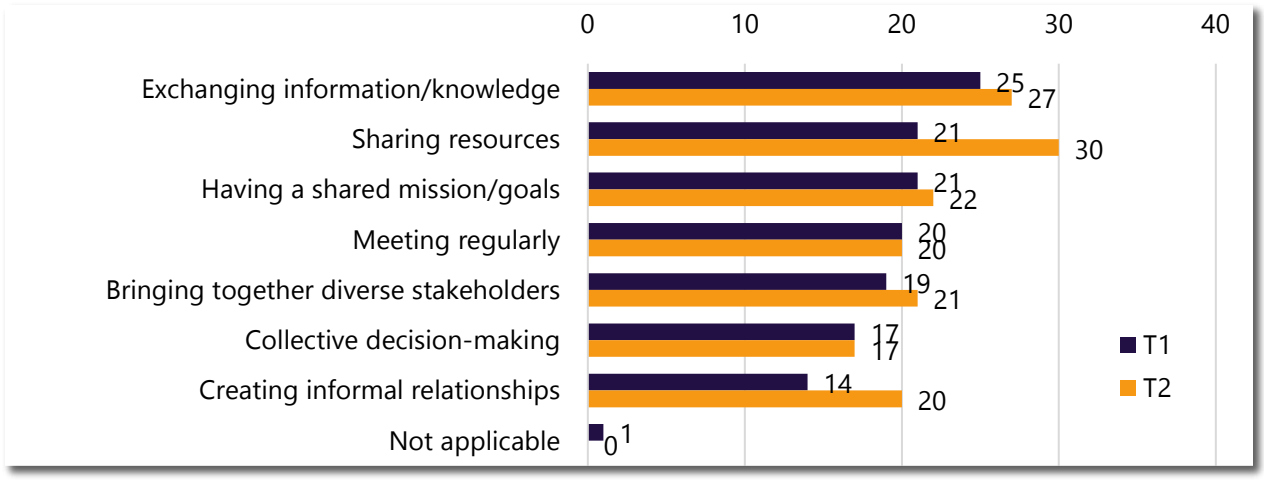


Figure 14. Aspects of Collaboration that Contribute to Success (T1 n = 28, T2 n = 30)



Chaffee and Fremont engaged more programs and increased the value and trust between those organizations over the five years of the LAUNCH Together initiative. Organizations started sharing information and feedback, connecting, and developing leadership and facilitation skills to engage other organizations. Many organizations found the network successfully reached the goals they set at the start of the initiative and did so by sharing information/knowledge and resources. Overall, Chaffee and Fremont's network expanded over the course of the initiative, which will continue to support programs that serve children and families after the end of the grant.

Implementation of the Five LAUNCH Strategies

During the LAUNCH Together initiative, Chaffee and Fremont engaged more than 50 programs in its LAUNCH Together activities. Almost all programs reported serving children less than five years old and about three-quarters served children five years and older (72%). Children were also the main recipients of services (93%) followed by parents and families (59%). Most programs focused on screening, assessment, and referral (51%) followed by mental health consultation in early childhood education (23%).

Throughout LAUNCH Together implementation, Chaffee and Fremont's implementation team developed an implementation plan each year to guide their work. These plans included detailed activities to be completed in the pursuit of achieving the community's goals and objectives. Chaffee and Fremont's LAUNCH Together 2020 implementation plan included the following five goals:

Goal 1. An integrated regional system of primary care, early childhood behavioral health, and community service providers share information, tools and resources and coordinate linkages to support comprehensive prevention and promotion services for young children and their families.

Goal 2. The region will increase universal screening through the use, accessibility, and availability of early childhood and prenatal screenings by medical providers and early childhood community partners in a variety of settings.

Goal 3. Communities in our region will understand and support the importance of social-emotional wellness in preparing children for success in school and life through provision of effective community outreach activities.

Goal 4. Families with children, prenatal to kindergarten entry throughout the region, utilize high-quality, research-based services and supports to promote social and emotional health and well-being.

Goal 5. There is a coordinated, efficient mental health consultation and support system throughout the region.

To assess community implementation of activities that can lead to system-level changes, plans were coded based on an implementation continuum that was introduced in year one of the initiative (see Figure 15).

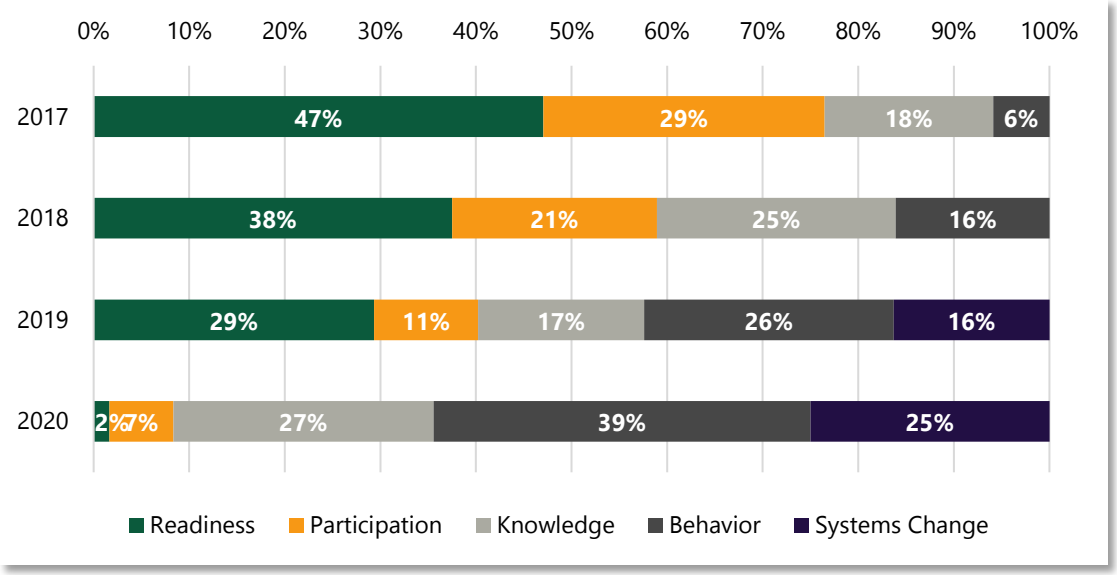
Figure 15. Implementation Continuum

The implementation continuum provides a framework for long-term systems change, including:

- **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)

The percentage of activities falling in each stage of the continuum was calculated. From year one (2017) through year four (2020), there was a decrease in the number of activities focused on readiness and a moderate increase in activities aligned with knowledge and behavior change along with a growing number of systems change activities (see Figure 16). Chaffee and Fremont showed the most movement on the continuum on Goal 1 which focused on behavioral health integration in primary care. In year one, 0% of behavioral health integration in primary care activities were coded as systems change which increased to 38% in year four. This demonstrated a positive shift toward sustainable systems change in Chaffee and Fremont's early childhood system, especially in integrating behavioral health in primary care.

Figure 16. Progress Toward Implementation of Systems Change Activities



Key Strategy Areas

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. The impact of Chaffee and Fremont's LAUNCH Together initiative in each of these areas is explored below.

Screening and Assessment

Key features of the screening and assessment 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.

Half of reporting programs in Chaffee and Fremont indicated screening and assessment as their primary strategy of focus. Activities to support change in this strategy included efforts to improve workforce knowledge and capacity across early care and education, primary care settings, and family support programs. Team members also noted progress in each community's efforts to streamline referral systems. Chaffee increased awareness of community organizations and expanded workforce capacity to cover screening gaps

in their early childhood system. Fremont had a strong screening and assessment system and LAUNCH funding further enhanced the work between ECHO Screening and Access with Fremont County Department of Human Services (DHS), which was described as "another whole system to get some of the most vulnerable children and families at least into screening, and very often into an array of other services that we have." By the end of the initiative, ECHO Screening and Access was working with the community's DHS to screen all children contacted by the Child Protection team and assist them to access services. The Early Childhood Mental Health Hub, composed of mental health specialists and coordinators from six community agencies, expanded during LAUNCH Together to also include the behavioral health integration specialist at St. Thomas More/Centura. This Hub receives all mental health referrals from ECHO Screening and Access and identifies the early childhood mental health specialists who will serve each referral and family. The Hub also created the Family Benefit Half Sheet, an easy-to-use form for families to identify any social, emotional, mental health, or developmental concerns they wanted to discuss with their physician and behavioral health integration social worker. This form is now used in all medical practices.

Enhanced Home Visitation (EHV)

The enhanced home visitation strategy refers to the training of home visitors on the social-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, such as mental health consultation and crisis intervention, prior to a warm handoff for additional services and supports. Additionally, this strategy may also include increased coordination and information sharing across home visiting programs.

Both Chaffee and Fremont had strong home visitation programs and their main focus was to improve home visitor workforce capacity by offering reflective supervision and trainings on early childhood and infant mental health. All home visitors in Chaffee County were trained in the Infant and Early Childhood Mental Health Foundation's course and home visiting programs were offered access to a mental health professional.

Fremont County was able to offer similar supports, and one team member shared:

> "We've partnered across the agencies to still provide reflective supervision with all of our home visitors in the county. They're all trained in Circle of Security and trauma-informed lens. They have a higher-level of social-emotional awareness and training on top of the Parents as Teachers curriculum and other things like that. That's been a lovely partnership that we're still maintaining. One of the lovely things about being a small community is we're able to build really strong community partnerships."

Mental Health Consultation in Early Care and Education (MHCECE)

One of the core components of the mental health consultation in early care and education strategy is the use of a mental health clinician 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, and modeling and coaching as well as screening and assessment to support the early identification of children with or at risk of mental health challenges. Additionally, mental health consultation in early care and education (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.

Mental health consultation in early care and education settings was one of the primary strategies in Chaffee and Fremont. Activities to support changes in this strategy included efforts to improve workforce capacity to provide mental health consultation and expand their reach to early care and education programs throughout the communities. More mental health consultants were trained regionally, and one provider explained the consultants "have started to learn with each other and have done trainings together. These relationships have been built upon, they become stronger. I think that they reach out more and talk and discuss more."

Another interviewee shared how they successfully adapted their consultation model over time to meet the needs of their community:

> "We were able to expand to support sites ongoing because I was using the Kid Connects model, which is a two-year model. Then, we decided to go ahead and offer monthly support after they did the two years because we've built that relationship. So, we've been able to extend that beyond just the sites we're focused in on at the moment. That's been exciting because they've really appreciated this."

Behavioral Health Integration in Primary Care (BHIP)

The behavioral health integration into primary care strategy includes 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; referrals, follow-up, and care coordination with community-based services; and parenting support and health promotion activities.

Behavioral health integration in primary care was one of the most successful strategies in Chaffee and Fremont and "has been moved ahead dramatically" during the initiative according to an implementation team member. During the initial years of the grant, Chaffee and Fremont identified medical providers as the main point of contact for families. The initiative facilitated greater integration of medical providers into the early childhood system by engaging them in trainings, having them participate in workgroups, and helping them network with other providers, especially mental health providers. Both teams learned that primary care was a "sweet spot" for "implementing good interventions where it matters in utero to the first two years of life in rural communities." They highlighted the importance of building strong relationships and engaging champions to successfully implement this strategy. Both communities have integrated a behavioral health provider in medical practices and have piqued the interest of other medical practices in the communities to do the same.

The integration of behavioral health providers in medical practices has streamlined services and referrals so families can easily access the support they need. One behavioral

health provider shared their experience working with a mother who was screened for depression. They explained, "If I had not been on site, she might have gotten lost in the cracks of the system. We can tell people about referrals or resources if they are in the office… but the ability of the mom to follow through if she is already struggling with depression, how much of a challenge is it to call three or four more places and ask for assistance? So, we are here to connect them to those resources right away." Integration of behavioral health in primary care has also helped reduce the stigma around mental health. One provider explained, "It's hard to talk about mental health… Once I leave the space for a mom to express herself, a majority of the time a mom will open up and say, 'You know what? This is really tough. This is really hard, and I do need some help.'" Providers mentioned they "will continue to advocate after the grant is over to have integrated behavioral health... to make this something that's not just the right thing to do, but something that financially makes sense." One interviewee shared a summary of the successes they have had implementing this strategy in their community:

> "[W]e engaged with multiple different physicians' offices... it took time, it wasn't overnight, it involved a long process, a learning process, and that has just been a huge success because of the LAUNCH work. Now we have physicians' offices that are doing screening and referral, they are following up...other programs that receive referrals are following up with physicians' offices. We're starting to see this increased delivery of services, especially behavioral and mental health services. When you visit your physician for your physical health, it's now integrated with also receiving services for your mental health. I think that has increased the number of people and the number of families that have needed services that have been able to receive them. And so, it's all part of this long process. A lot of it might start with well-child checks and screening, but then eventually it can lead to being linked to community resources and that is the success in all that."

To further illustrate and provide context around the success of behavioral health integration in primary care in the communities, the LAUNCH Together project coordinators for Chaffee County and Fremont County developed community features. Each feature is highlighted below.

LAUNCH Together Chaffee

Our Approach, Community Case Study

Prior to LAUNCH Together, the Chaffee Early Childhood Council had a multi-year history implementing the five LAUNCH Together Strategies and a number of their key features. The Council had an established approach for engaging and working with partners. This approach guided our LAUNCH Together effort.

First, Council members and partners worked together to create a community assessment by gathering data and identifying needs and perceptions through surveys, key informant interviews, and subject matter experts. One of the key assessment findings was the importance of working with healthcare providers to surface and address the mental health needs of expectant parents and young children and their families.

Next, we identified respected individuals willing to meet with us including providers at family medical practices, as we have no pediatricians in our community. We met with them to understand what they were seeing in pregnancy-related and early childhood mental health. We showed them the strategies and key features and we asked three questions: What is working well? What could work better? How can we help?

We listened carefully. In rural areas there are lots of needs including: training, referral pathways, access to trusted mental health clinicians, technical assistance, support identifying billing codes. We asked medical providers to set priorities and guide how we worked with them. One practice, First Street Family Health in Salida, became very committed to behavioral health integration in primary care (BHIP). While several of the practice providers were early supporters, they soon identified one person to be the "champion" and liaison with us to guide the work.

First Street requested information on BHIP options. We created and presented evidence-based BHIP options to the practice and soon approaches to developing BHIP were selected and work began on cross-sector training, the integration of additional screening tools, and the building of trusted local referral options. Over time, the practice identified specific needs for an early childhood mental health professional, wanting them at the practice three hours a day, five days a week. A longtime council member and mental health clinician working on LAUNCH Together saw the value of this effort and agreed to meet their needs. The mental health clinician, the practice champion, and LAUNCH Together funded Council staff met monthly with an BHIP subject matter expert to support BHIP implementation at First Street. After piloting the program for one year, First Street Family Health determined BHIP was an essential component of their practice and has taken on sustaining and expanding the position.

Janine Pryor, Coordinator

Chaffee County Early Childhood Council

LAUNCH Together Fremont

Behavioral Health Integration, Community Case Study

The ECHO and Family Center Early Childhood Council recruited and supported the pediatric primary care practice at St. Thomas More (STM)/Centura to integrate behavioral health for the first time. From the beginning, the Fremont LAUNCH Together grant funded a behavioral health integration in primary care (BHIP) Specialist from the Children's Hospital and a local early childhood mental health specialist as consultants to guide the work and provide reflective supervision for the new BHIP social worker. A LAUNCH Together BHIP Team composed of the new social worker, Fremont LAUNCH Together staff, and the consultants met monthly to plan, develop the services, and offer formal training to the pediatricians and community early childhood service providers. A pediatrician champion from the practice worked with her physician partners, the social worker, and the team to implement changes necessary for BHIP success. When the partners invited the social worker to move her desk into their offices, the BHIP team knew she was accepted as part of the pediatric practice team.

During the first two years of LAUNCH Together, the pediatric primary care practice at STM/Centura significantly transformed to deepen behavioral health integration processes and supports for pregnant women and families with children birth to kindergarten. The social worker attended well child visits; offered child development information for families; followed up on screenings for development and pregnancy-related depression; provided counseling for families; and made appropriate service referrals.

Ayelet Talmi, the Children's Hospital consultant, introduced her *Early Childhood BHIP Framework* to guide the pediatric work which also led to the development of the Family Benefit Half Sheet. Families received the Half Sheet as part of each well child visit to identify any social, emotional, mental health, or developmental concerns they wanted to discuss with the physician and BHIP social worker. Half sheet data collection during two time periods in the grant, 10 months in 2019 and 7 months in 2020, indicated that the number of families reporting one or more concerns, doubled from the first to the second period, with the majority of concerns during each period in child behavior.

The BHIP team partnered with physicians and ECHO Council members to also develop a Universal Referral and Feedback Form, used to refer children to the ECHO Screening and Access Program. This program is a coordinated and efficient single process of entry for families into all publicly funded early childhood programs and services. The Universal Form is now utilized by many agencies of the ECHO Council, which has led to significant increases in screening and successful referrals to child and family services. After observing these successes, the BHIP specialist for the family and OB/GYN practices at St. Thomas More/Centura began consulting with the BHIP pediatric social worker and the family practice became interested in hiring their own early childhood BHIP specialist.

The BHIP pediatric social worker completed her Harris Fellowship and worked for one more year before leaving the practice. The pediatric physician champion responded to this loss by calling an emergency

meeting with a STM/Centura administrator, the family practice and their BHIP Specialist, and the LAUNCH BHIP team. The champion proposed that the BHIP specialist who was working full-time in the family practice share her time with the pediatric practice. Within a month, all agreed that the BHIP social worker would divide her time between the family and pediatric practice and also consult with the OB/GYN practice. To ensure the highest quality of care, the shared BHIP social worker received specialized training related to early childhood development and mental health and will finish her Harris Fellowship in August 2021. All of the procedures and processes developed in the first two years were adopted by the family practice including the Half Sheet and Universal Referral Form, and because the family practice BHIP social worker was a full-time Centura Health employee, her salary was completely covered, assuring continuation of BHIP in both practices after the end of LAUNCH Together.

The Director of Colorado HealthySteps contacted the ECHO Council and arranged a call with the STM/Centura pediatric practice to offer a HealthySteps grant to implement the program for two years. The BHIP social worker and physician champion were very interested, but felt it was too much for the BHIP specialist, with only part of her time dedicated to the pediatric practice. The Centura Group Director of Community Health Improvement for the region also contacted the ECHO Council Director the same day after reading the *Community Learning Report for Fremont County* prepared by Early Milestones. He had $70,000 in violence prevention grant funds and wanted to support an early childhood mental health project in Fremont. If awarded, this grant will provide three years of funding, so the BHIP social worker could work full-time in the pediatric, family, and OB/GYN practices, concentrating on young children prenatal to three years and serving them until kindergarten entry. Grant awards will be announced in June 2021.

Pamela Walker, Director

ECHO and Family Center Early Childhood Council

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 building parents' leadership and advocacy skills.

Chaffee and Fremont increased their workforce's capacity to expand the delivery of family strengthening programs like Circle of Security, Conscious Discipline, and Seedlings©, created by Dr. Sarah Watamura for Growing Home, Denver, Colorado. These programs connected the workforce across both counties through trainings and informational meetings. One provider explained, "There were school administrators and police officers and DHS workers, so that gave you that feeling of community purpose and the value that we felt as staff as well as the value that we've been able to show parents through some of our groups and our work. Especially, Seedlings© really gives them a value. When you go through each week, you get a small gift, you get some self-care skills, so it was something, without LAUNCH, that certainly couldn't happen with our limited funding."

Implementation team members also highlighted the impact on families:

> "I think doing the Circle of Security and getting ready to start doing Conscious Discipline, that really strengthens families and understanding how they respond and how to help temper, how they respond in a way that's healthy for them and their kids. And then also it strengthens the families because they are coordinating together, they're communicating together, and I love that. People that are actually going through it, talking back and forth, is a huge help, too. And then giving them the information that helps them make those decisions in a much more stable environment that they can create, that strengthens their family across the boards."

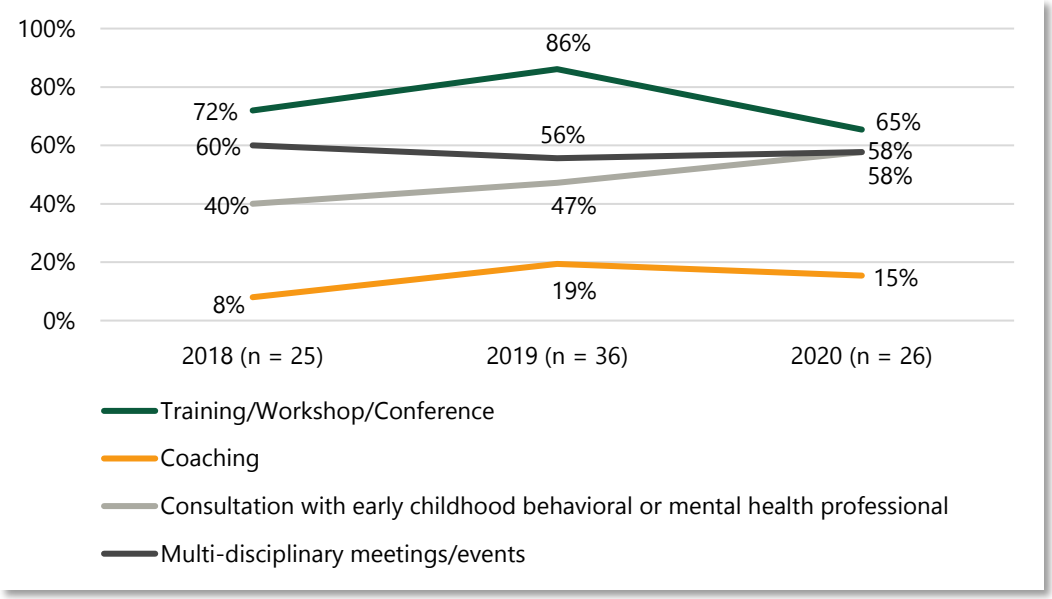
Workforce and Provider Capacity

Chaffee and Fremont's LAUNCH Together initiative invested a great deal of resources and supports in their community's workforce. Across four years, almost 40% of Chaffee-Fremont's implementation plan activities focused on workforce capacity in some way, whether it was identifying professional development needs, providing trainings, or offering consultation or reflective supervision support. Specific workforce capacity-building activities included:

- All medical practices identifying a range of evidence-based professional development trainings to support sustainable Behavioral Health Integration (BHI) system work
- Supporting early childhood professionals across the region as they worked to attain their Infant Mental Health Endorsement through Colorado Association for Infant Mental Health (CoAIMH)
- Completing 2 Colorado Foundations Courses for infant and early childhood service providers
- Providing reflective supervision and case consultation for early childhood educators,infant mental health providers, and home visitors within the communities
- Offer in the community or fund participation in at least one training for the following programs and approaches including: Circle of Security, Diagnostic Classification (DC): Zero to 5, Child Parent Psychotherapy (CPP), Teaching Pyramid, DECA, Relationship Based Coaching, Seedlings, and Branches, Conscious Discipline, Kid Connects, Harris Fellowship, trauma-informed care, ACEs, ASQ/ASQ-SE, etc. to increase capacity for families, childcare providers, ECMH Specialists, health care providers and other professionals to promote positive social and emotional development for young children.Providing ongoing monthly ECMH consultation as needed at two sites that have embedded the Kid Connects Model

Providers received different types of supports across the initiative including trainings, workshops, conferences, coaching, consultation, and multi-disciplinary meetings or events. Trainings were the most accessed workforce support during the grant and were increasingly supplemented over time with coaching and consultation (see Figure 17).

Figure 17. Workforce Supports Reportedly Received Between 2018 - 2020



Training

Across grant years, providers reported trainings improved their knowledge of social-emotional health for young children and positively shifted their behavior in daily practice. Chaffee and Fremont's team responded with more trainings each year, reaching more and more providers (see Table 2). Chaffee-Fremont's LAUNCH team offered training opportunities to over 60 organizations, reaching providers across sectors and roles including medical and mental health providers, home visitors, caseworkers, screeners and early care and education providers.

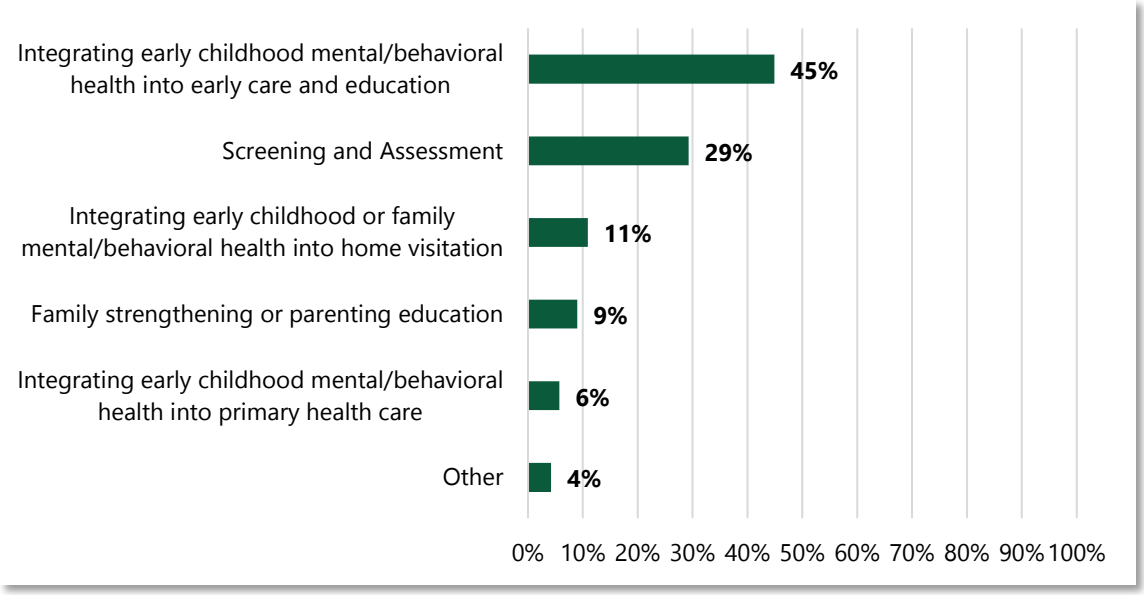
The early childhood care and education systems in Chaffee and Fremont were a large focus of trainings across years, reaching all levels of providers including substitute teachers, paraprofessionals, assistant teachers, lead teachers, directors/owners, special education teachers, and coaches. During the grant, the communities expanded and embedded more mental health consultants in ECE programs and trainings were accessed by not only ECE providers, but also the mental health consultants that were now in their classrooms, making it easier to use the knowledge gained in the training and apply it in the classroom every day.

Table 2. Training and Participation Across Years

Year	Number of Trainings	Number of Training Participants
2017	9	110
2018	19	231
2019	13	148
2020	12	92
Total Across Years	53	581

Across years, Chaffee and Fremont offered trainings that aligned with their identified needs during the planning stage of the grant and associated implementation activities. Most trainings focused on integrating early childhood mental health into ECE (45%) followed by screening and assessment (29%; see Figure 18).

Figure 18. Focus of Provider Trainings (n = 577)[5]



[5] Source: Training Surveys

Between 2017 and 2020, trainings were offered on a variety of topics, and more than two-thirds of providers reported receiving at least one training focused on child development (70%) and early childhood mental health (67%). The trainings that providers found particularly impactful included: ASQ/ASQ-SE, Circle of Security, DC 0:5, trauma-informed trainings, and ACEs. Trainings on the ASQ/ASQ-SE and Circle of Security were prioritized by the communities' team and consistently offered across all years of the initiative. One provider who attended trainings on both Circle of Security and the ASQ explained, "Those are all trainings that I would not have gone to on my own. I might not have even known about them on my own. So definitely that's been a big part of what LAUNCH Together has provided." During 2018 and 2019, the Colorado Foundations of Infant and Early Childhood Mental Health for Early Childhood Professionals and Partners training was also offered to over 50 providers in the community and more providers have completed their early childhood mental health endorsement.

Chaffee and Fremont also invested resources and funding to "train the trainers" in their communities. Several experts are now embedded in their early childhood systems and can train providers directly in the community. One provider explained, "The resources have been necessary because where we live, in this rural community, that's hours away from Denver, which is where a lot of trainings are held. Access is difficult. Also, access to high-quality services. So, being able to move up a lot of our local people and increase their capacity has been key." One program that the communities are looking forward to continuing is Dr. Watamura's Seedlings©. A provider explained why the program has been successful and why it will be sustainable:

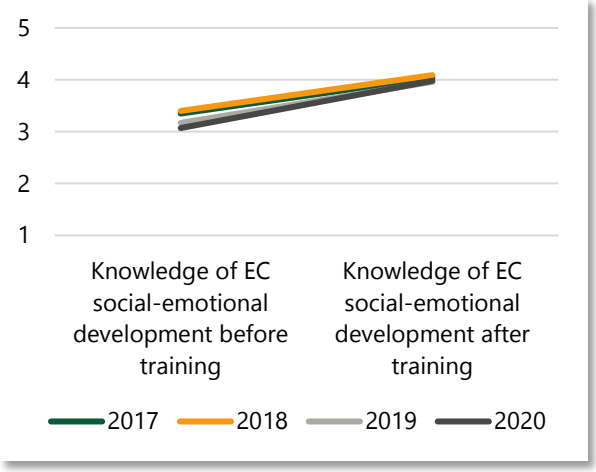
> "[W]hen I think about it and what contributed to the success, it really started with getting trainers in the community trained to provide the parent training here. So, we didn't have to call up somebody from Denver or somewhere else and say, 'Hey, can you come down and do this 10-week training with parents.' We had them come down and do the training so people learned how to give the training to parents, and now we have local trainers who can do those trainings for parents, and we're not having to find someone from out of town to come in. So that's been a big success related to this, getting people locally to be able to work with parents. And it's sustainable in that way, too."

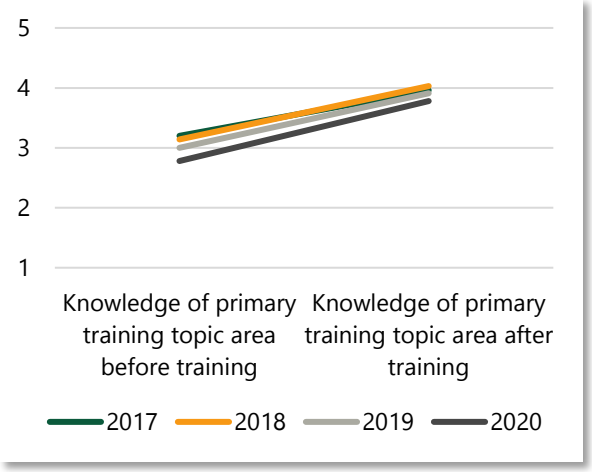
Eight providers, four from each county, also completed the Harris Fellowship during the LAUNCH Together grant. The providers who had the opportunity to participate in the fellowship saw it as one of the most valuable experiences of their career. One provider shared:

> "The Harris Fellowship, it's an intensive and amazing opportunity to really dive deep into a lot of this information that is difficult to do in any other way, especially how far away we are from some of those agencies that can offer that kind of training. I think that was very useful and will continue on. For all of us who had that training, not only are we using it in our own work, but because we share what we've learned and those resources and those connections, it's really impacted our community, far beyond, 'I went and attended for a year.' And now that we're going to have four [Harris Fellows], that's just amazing… that's going to dramatically increase our reach."

Across all trainings, providers reported a change in knowledge before and after the training. Providers typically felt *somewhat* knowledgeable about early childhood social-emotional development and the specified training topic before the training (M = 3.28 and M = 3.06, respectively across all years), but after the training, increased to feeling knowledgeable about both topics (M = 4.03 and M = 3.95, respectively across all years). Figure 19 shows the change in knowledge over time, which has remained consistent across years. The largest increases were seen in 2020.

Figure 19. Training Knowledge Change Before and After Trainings





On the training survey, providers also reported a high expectation they would use what they learned in trainings in their daily practice, with a mean of 4.22 across years.[6] On the annual provider survey administered in 2020, 100% of providers reported they would incorporate what they learned from all of the trainings they attended into their daily practice. Trainings provided on reflective practice or supervision and screening and assessment were most impactful as providers rated these as the top training topics that improved their work (M = 4.40 and M = 4.20, respectively)[7].

Each year, providers reported the same challenges to attending trainings: time limitations and location. In 2020, there was a necessary shift toward virtual trainings, which helped address those challenges. As mentioned above, in 2020 providers reported the highest level of knowledge change and intent to use the training in their daily practice, illustrating the effectiveness of virtual trainings. Currently, the safest way to deliver trainings is virtually, due to the pandemic, but these results show the promising potential of virtual trainings.

Other Supports

The number of providers who reported "individualized coaching" would help them integrate what they learned during training into their daily practice almost doubled from 17% in 2017 to 33% in 2020. Providers were more aware of coaching and became more comfortable asking for that type of support over grant years. Across implementation years, LAUNCH funding embedded coaches and consultants in several early childhood and home visitation programs. Figure 17 also illustrates this change, as more providers reported receiving coaching and consultation from 2018 to 2020.

[6] On a scale of 1-5: 1 = Not at all, 5 = A great deal.

[7] On a scale of 1-5: 1 = did not improve practice at all, 5 = greatly improved practice.

One provider explained the impact of receiving support from a mental health consultant:

> "[Our mental health consultant] has so much information for you, and I can't imagine where I would be if she hadn't come in. [She] clues you into the behavior of the children, because you go to the school and that's not that much addressed unless it's a special needs child. It's just nice to know the information and why something might be happening. That has been so huge."

In 2020, almost all providers reported they would incorporate what they learned from individualized supports like coaching, consultation, and technical assistance (TA) into their daily work. Most providers reported receiving individualized support on screening and assessment and reflective supervision and all said it would help them in their daily practice.

One provider explained how reflective supervision has impacted their program:

> "Our management team gets to sit down as a team and speak with [our mental health specialist] twice a month and that time gives us a sacred space to be able to reflect on what's happening and how we're feeling about things. And it doesn't go past that room, so we can be really honest and frank and open about things that we're frustrated with. A few weeks ago [we got] some really crummy news… but within hours of getting that news, we went into that reflective supervision session [and] our supervisor was with us and said, 'Okay, what do we need to do? How do we talk this out?' In that immediate moment we felt completely supported with our feelings and our discussion. The great thing about that is, then I'm able to create that same space for my staff. So if they come to me and say, 'This is happening with a family,' it's like, 'Okay. Let's sit down and talk about it.' Or they can share their challenges, they can share their successes. It's given me an opportunity to reflect on how I respond to that. So, to be able to recognize that and then to be able to support staff that way, that's been really helpful."

Providers also talked about the importance of organizational partnerships and provider relationships in the community. Relationships were formed or strengthened through LAUNCH Together and helped improve provider knowledge and practice in the field of early childhood. It also gave providers an opportunity to model relationship-building for

families in the community, as explained by one provider, "They see us in these different places and they see us making connections and they see us building relationships and hopefully that will be something that they do." The relationship-building and collaboration during LAUNCH Together was also helpful for referrals. One provider elaborated:

> "Being able to really say, not only is this person well qualified, which we've pretty much always been able to say thankfully in our community, but also to be able to say I understand this person's training and what they've gone through to really be able to make the service possible, and I believe that we can trust them. I think that helps staff especially to know when they're making that referral it's not just, 'well, hopefully this will help the kiddo.' It's truly this person can do what they need to do to help our kids."

The LAUNCH Together retreats held by the community were also cited as an "amazing" opportunity to bring providers together and build relationships. One provider said, "It was everybody from law enforcement to school districts, to public health, to childcare providers, to libraries... we had everybody there and then we brought in the specialist who carefully taught us the science behind the broad need, and then we could sit together say, 'wow, how are we going to make this happen for our families and our community?' And then we were fully committed, all of us, and ready to go forward." Providers have created strong bonds during the initiative and are looking forward to engaging even more community organizations in the future like faith organizations and community health organizations and to further engaging the school system and the Department of Human Services.

Knowledge and Behavior Change

Both professional development and individualized supports have helped providers feel knowledgeable about a range of early childhood topics, and this knowledge has typically improved over the duration of the grant. There were slight decreases over time in knowledge of pregnancy-related mental health and integrating behavioral health practices into primary care. The largest decrease in reported knowledge was on cultural and linguistic responsiveness, which may be explained by fewer trainings that focused on this topic (see Table 3).

Table 3. Reported Knowledge of Early Childhood Topic by Year

Topic	Trend	2018 Mean (n = 24)	2019 Mean (n = 36)	2020 Mean (n = 26)
Child development	↑	4.04	4.08	4.31
Family health and well-being	↑	3.92	4.00	4.15
Parent-child relationships	↑	3.96	4.17	4.19
Early childhood mental health	↑	3.38	3.69	3.69
Cultural and linguistic responsiveness	↓	3.42	3.31	3.16
Screening and assessment	↑	3.83	3.86	3.88
Family resources and support services	↑	4.00	3.89	4.12
Collaboration across services systems and organizations	↑	3.91	3.78	4.12
Reflective practice or supervision	↑	3.57	3.58	3.69
Pregnancy-related mental health	↓	3.83	3.67	3.77
Integrating behavioral health practices into primary care	↓	3.38	3.33	3.27

As discussed previously screening, assessment, and referral remained a focus in Chaffee and Fremont during the length of the grant. The communities offered trainings and technical assistance support on the ASQ/ASQ-SE and DECA, among other tools. As seen in Table 4, over grant years there were fewer trainings on screening and assessment, which accurately reflects Chaffee and Fremont's shift from heavily focusing on screening and assessment trainings in 2017 and 2018 and instead providing support on integration and use of the screening and assessment tool to those who had already been trained on it. They also worked to streamline the screening, assessment, and referral process, targeting fewer providers that would administer screenings and assessment to make the process as efficient as possible. Therefore, fewer providers would have been trained in 2019 and 2020. Even though there were less trainings on screening and assessment in the later implementation years, the trainings and technical assistance that was offered increased provider knowledge of how to use the results of the tools. Providers also felt more knowledgeable about how to refer children for screening and assessment over time (see Table 4).

Chaffee and Fremont's implementation team and LAUNCH Together activities facilitated relationship-building and coordination to improve their referral systems, and one provider explained this shift:

> "Before we had the LAUNCH grant, which provided a very specific time to develop this, we were trying hard, but I felt like I was always playing catch up, trying to make people understand who to call. LAUNCH Together has made a huge difference in screening and referral."

Table 4. Screening and Assessment Knowledge and Behavior Change[8]

Screening and Assessment - Knowledge	**Trend**	**2018 (*n* = 24)**	**2019 (*n* = 36)**	**2020 (*n* = 26)**
I have been trained on the use of screening and assessment tools that are appropriate for children in my care/on my caseload.	↓	4.29	3.97	3.62
I know how to refer children for screening and assessment when appropriate.	↑	4.29	4.33	4.35
I know how to use the results of screening and assessments in my work with children and families.	↑	4.04	4.17	4.15
Screening and Assessment - Behavior				
I have screening and assessment tools available to me for use when working with children and families in my care/on my caseload.	↓	4.42	4.25	3.88
I have conducted screening for children in my care/on my caseload.	↓	3.88	3.81	3.69
I have conducted assessments for children in my care/on my caseload.	↓	3.63	3.72	3.54

[8] *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.

Mental health consultation was also a priority in Chaffee and Fremont. Mental health consultation was embedded in early care and education programs, home visitation programs, and medical practices across both counties. Overall, mental health consultation knowledge and behavior positively increased between 2019 and 2020 (see Table 5). The greatest reported increases over time were on items about mental health consultants conducting in-depth assessments of children (an increase from *once or twice* to *once a month*) and mental health consultants developing services plans for children (an increase from *never/rarely* to *once a month*). Providers talked about the mental health consultant's non-judgmental approach, and one early care and education provider highlighted the impact of this type of support:

> "I have a little guy... his response to frustration was over the top. I wasn't really sure of how to approach that, because you don't want to do something that would damage him in any way but being able to step back and see, first of all, where is he, why is he getting to that point? How can I work through that with him? And [our mental health consultant] coming in and showing that and pointing out things that you wouldn't see or wouldn't know because that's not what you do. He would escalate, and then just be frustrated. Obviously, when you're in a frustrated state, calming down is not your first thing to do. It's just... how do you function with that? That was a huge help with him. I've had a couple more since then, that had been that way, and certainly I was able to work with them a little better, with more knowledge, obviously."

Table 5. Mental Health Consultation Knowledge and Behavior Change[9]

Mental Health Consultation (MHC) - Knowledge	**2019 (n = 12)**	**2020 (n = 9)**
I received formal training from the mental health consultants (MHC).	2.08	2.89

[9] *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.

Mental Health Consultation (MHC) – Behavior	2019 (n = 12)	2020 (n = 9)
The Mental Health Consultants (MHC) conducted group (classroom-if applicable) screenings and observation.	3.08	3.44
The MHC(s) conducted individual screenings of children.	3.10	3.29
The MHC(s) conducted more in-depth assessments of children after they had been screened.	2.25	3.60
The MHC(s) developed service plans for children with special needs (e.g., IEPs).	1.57	3.83
The MHC(s) made referrals for children or families to community services.	3.11	3.50
The MHC(s) attended management team meetings.	3.33	3.86
The MHC(s) met with me/staff teams to discuss specific children or families.	3.71	3.23
The MHC(s) provided direct therapeutic/counseling services to families and children.	3.18	3.40
The MHC(s) talked and met with parents/families.	3.67	4.00
The MHC(s) provided me/staff with support for my/their own well-being.	2.94	3.50
The MHC provided me/staff with informal training and assistance.	3.19	3.75
The MHC(s) met with me/staff teams to talk about general issues.	3.25	3.67

During the planning phase of LAUNCH Together, Chaffee and Fremont County discovered that almost 40% of their communities' needs were related to workforce development. During the implementation phase of the grant, Chaffee and Fremont wasted no time supporting the workforce through more than 50 trainings impacting over 500 non-exclusive participants. Several providers participated in the Harris Fellowship. They offered support across the early childhood sector including embedding mental health consultants and coaches in early care and education programs, offering home visitors access to a mental health consultant, and integrating a behavioral health provider in medical practices in each community. These mental health providers were also given reflective supervision and access to expert technical assistance. Providers in the workforce networked through retreats and collaborative groups that will stay connected after the grant ends. All of these supports improved provider knowledge and behavior and positively impacted how they work with children and families.

Families' Experience of a Coordinated System

Due to the rural setting of Chaffee and Fremont counties, families reported limited access to many essential services. In 2018, families spoke about these challenges:

> "We don't have hardly any, that I know of, physical therapy or occupational therapy within two hours of us… to get into the Denver clinic was a three-hour drive and then it was also like two months out."

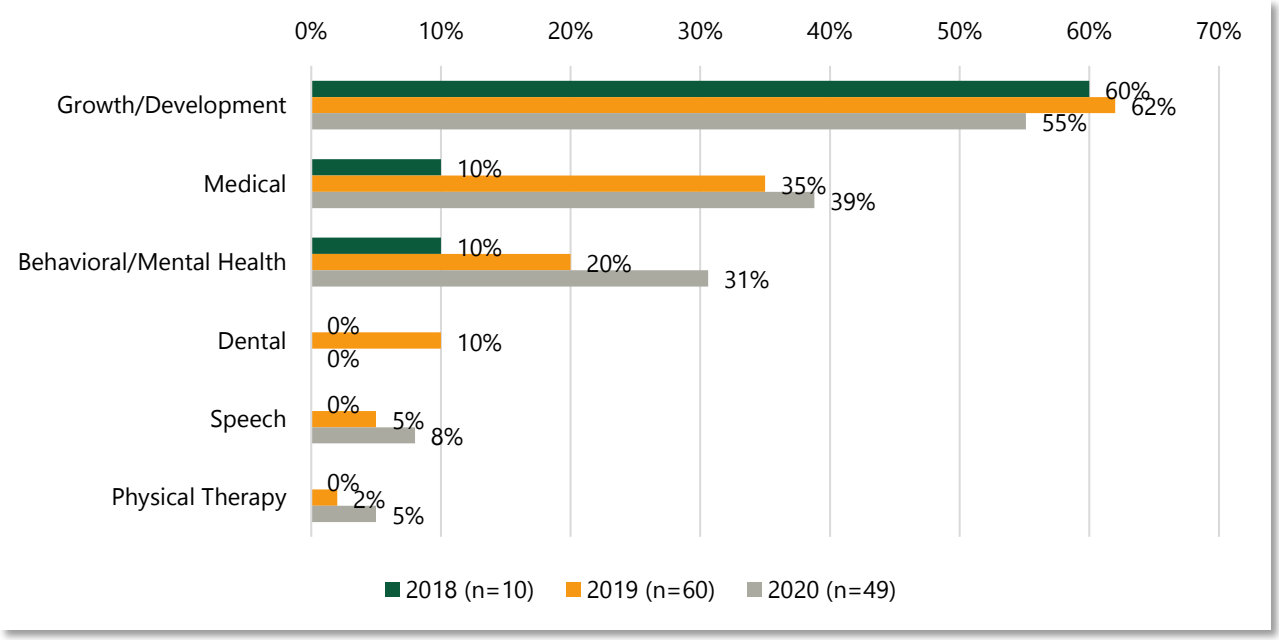
Another family said:

> "It's ridiculous, [that] we don't have a pediatrician in the valley. So, if I wanted to go to a pediatrician, I'd have to drive an hour and a half over a mountain pass."

By implementing LAUNCH Together strategies, both counties have improved families' experiences of referrals and increased access to services.

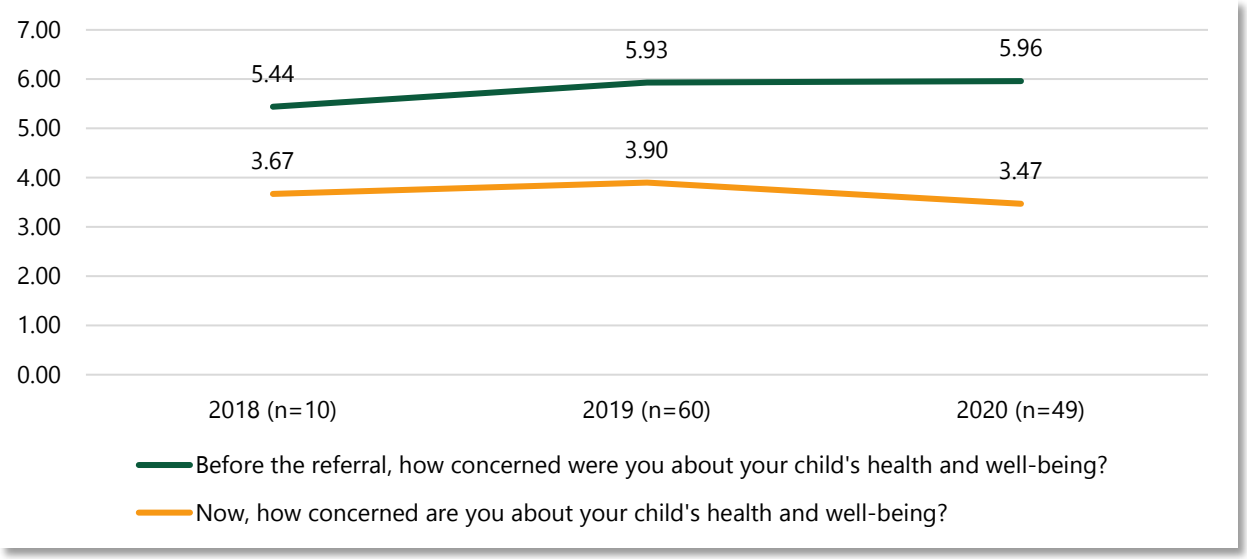
Of the 267 families who participated in the annual family survey between 2018 and 2020, 121 of those families received a referral for their child. Each year of the evaluation, the majority of families received referrals for services relating to their child's growth and development followed by medical and behavioral/mental health services (see Figure 20).

Figure 20. Types of Referrals Received by Annual Family Survey Respondents



Of the families who received a referral for their child, 104 reported their experience with those referrals. On a scale of 0–10 (0 = not at all; 10 = completely), families whose child received services in 2020 reported that the referred service helped their child almost completely with the problem or concern (M=8.38), which was slightly higher than in 2019 (M=7.75) and slightly lower than in 2018 (M=9.17). 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" in 2020 (M=5.96), 2019 (M = 5.93), and 2018 (M=5.44) about their child before the visit that led to their child's referral. After the referral, they reported that their concern had fallen by around 2 points each year, with the greatest change in 2020 (see Figure 21).

Figure 21. Family Concern About Child Pre-/Post-Referral



Additionally, across all 3 years, families felt that referrals were explained (98%) and that they got all the information they needed for the referral (90%; see Table 6). Families also expressed this in interviews along with their gratitude. One parent said:

> "I was able to make an appointment and get him right in, and insurance wasn't a problem. So, I feel like it was a really helpful thing for us, and so… I'm just really grateful."

Another parent shared:

> "I think the biggest thing has been the ECHO screenings that they did in the very beginning because that was how they identified that she had hearing problems. Without that, I don't think that we would have picked up on it. That was huge for us, just making everything available to us, really educating us on all of the different programs, making sure we're not missing anything."

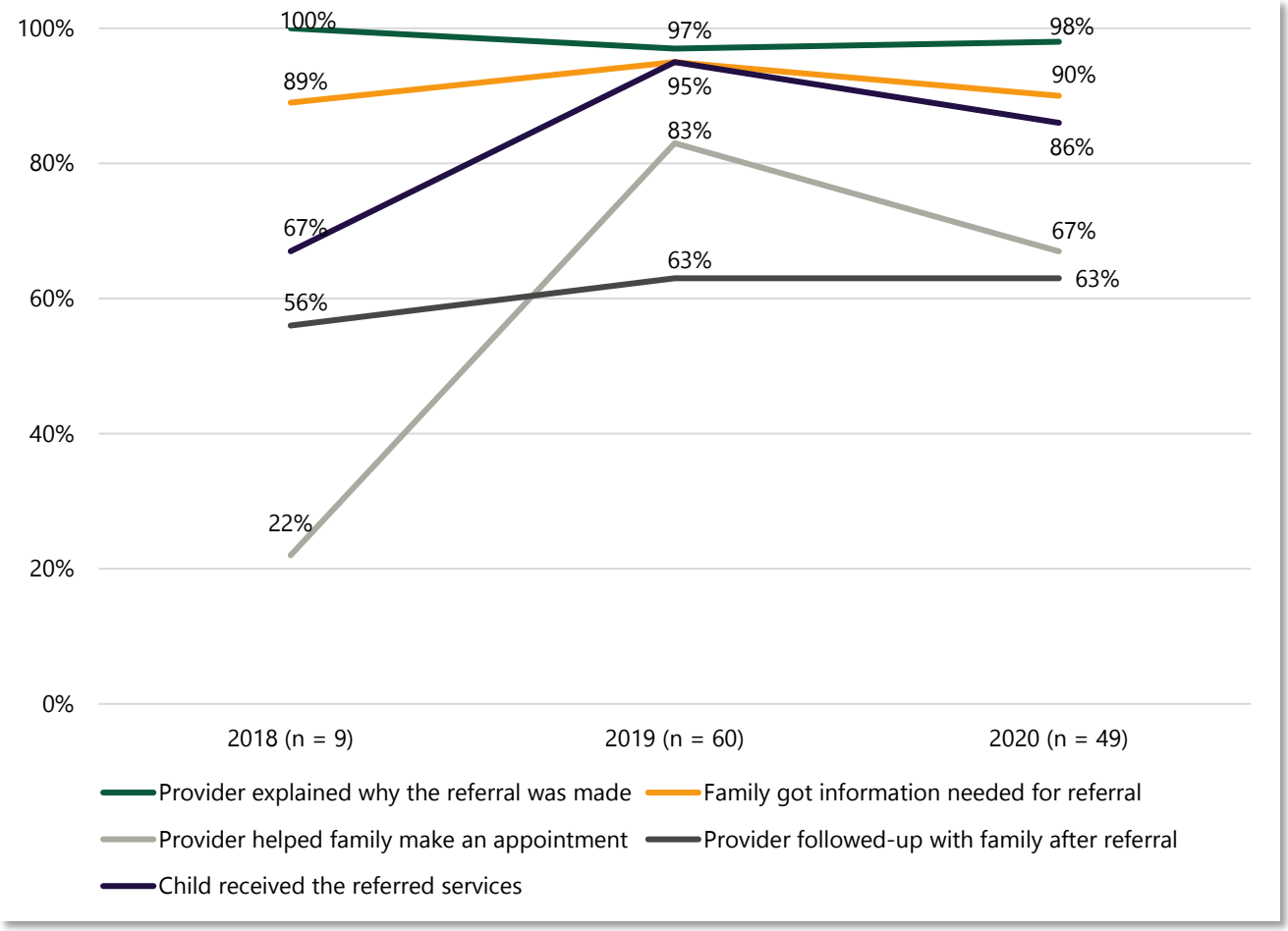
Table 6. Family Experience with Referrals[10]

Experience	***(n=49)***
Provider explained why the referral was made	98%
Family member got all the information needed to follow-up on referral	90%
Provider making the referral helped family member make an appointment with the referred service	67%
Provider, or someone who worked with them, contacted family member at a later time to see if they had any problems getting referred service	63%
Child received the referred service	86%

[10] Source: Annual family survey

The most notable improvement was families reporting that their provider helped them make an appointment with the referral, with a 61% increase between 2018 and 2019. Overall, family experiences of referral practices remained mostly high between 2019 and 2020 despite the challenges of the pandemic (see Figure 22).

Figure 22. Family Experience with Referrals 2018-2020



Impact on Parenting Practices and Children's Social-Emotional Well-Being

Families assessed their strengths by answering questions from the Parents' Assessment of Protective Factors (PAPF) on the annual family survey. The PAPF assesses parent resilience, concrete supports, and social-emotional competence (see Table 7).

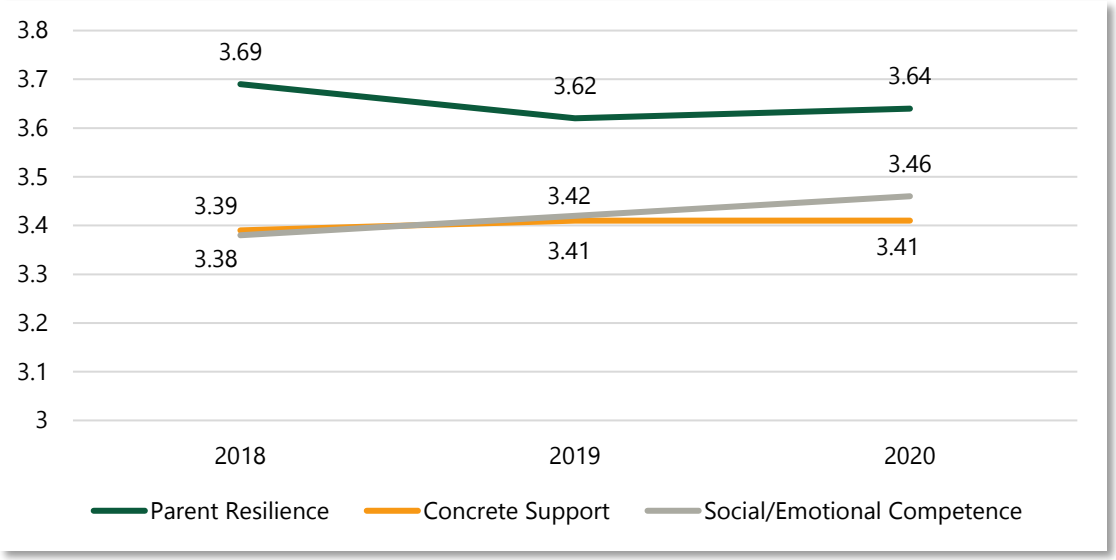
Table 7. Protective Factors Constructs From Annual Family Survey

Construct	Sample items	Scale
Parent resilience	"I feel positive about being a parent/caregiver." "I manage the daily responsibilities of being a parent/caregiver."	1 = Never to 4 = Always
Concrete support in times of need	"I don't give up when I run into problems trying to get the services I need." "I know where I can get helpful information about parenting and taking care of children."	1 = Strongly Disagree to 4 = Strongly Agree
Social and emotional competence	"I play with my child when we are together." "I stay calm when my child misbehaves."	1 = Never to 4 = Always

Across all three years, families rated themselves highest for parent resilience followed by social-emotional competence and concrete supports (see Figure 23). As one parent noted in an interview:

> "We did the Circle of Security [training], and we also did a parenting class, and I felt like it was really helpful because it was for different age levels. So that was nice. And then it was a lot of different information to help us, as parents, how to prepare and then also how to help your child. So, I thought that that was really good, and I learned a lot from both of those, and so I felt like that kind of helped prepare me a little bit better."

Figure 23. Protective Factors Constructs from Annual Family Survey



During family interviews, parents and guardians elaborated on the improvements they saw in accessing services in the community. According to one parent:

> "I believe when my daughter, she's eight years old, but when she was a baby, I think they didn't have an early developmental specialist. I definitely believe that they're doing such a good job now, from mental, to behavioral, to social programs to help these kids. I mean, it's amazing. I definitely think it's changed over even just the last couple of years."

Some families also talked about wanting more options and more information about what options are available.

> "I'd say that I would like more information. It's just more options. I feel a little bit like my options are limited sometimes when you live in a rural community. I think it's a matter of how do you reach everybody? People who aren't on social media, or maybe people who haven't been in town, people who went [to] the public parks or the public library. How do you reach everybody?"

DISCUSSION

Although the LAUNCH Together initiative is concluding, the Chaffee and Fremont County communities now have stronger, more coordinated systems and infrastructure to support the behavioral health needs and social-emotional development of young children in the region, which has the potential to create impact for years to come. The region has created a strong shared vision for early childhood mental health, established long-term and trusting relationships across key system partners, successfully engaged primary care practices in the community to integrate behavioral health, and increased workforce capacity and knowledge about early childhood mental health among professionals in the field. In final reflection, a stakeholder in the community shared:

> "Our community has done an excellent job recognizing that the lives of babies are complex and that their social-emotional needs are going to impact the rest of their lives, so the opportunity to support children and families in accessing the resources they need, accessing high-quality social-emotional supports and even clinical services has been a priority for many of our community partners. We share that vision and recognition of the importance of early childhood as an opportunity to set the foundation for the rest of these children's lives."

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