

MCHB/DCAFH

The Importance of Teamwork: A State Example and a New Opportunity

April 29, 2008

DENA GREEN: Good afternoon and welcome to the fourth of a webcast scheduled for our ECCS grantees and federal partners and grantees and federal partners from our state team. Today we have a webcast for you today entitled "The Importance of Teamwork: A State Example and a New Opportunity". We plan to present to you two different presentations. The first being one of our ECCS grantees from Alaska, her name is Shirley Pittz. After Shirley finishes her presentation we'll take questions. As you know, you can send questions in at any time but we won't answer the questions until each presentation is completed. After Shirley's presentation, I have the honored privilege of offering to you a first time and an exciting opportunity for you to listen to the staff or the immediate staff from Project LAUNCH, a new initiative out of SAMHSA, the substance abuse and mental health services administration and they'll give you an overview of the program and talk specifically to our state teams about how this can be an excellent opportunity for you to enhance your program.

After they're finished then we'll take questions and I'm sure you'll have many. Think of them and send them in as we go through the webcast. If you have any questions during the webcast at all if it's related to technical information, you are to send a message to the technical staff at that particular time and it will say where you send the message and who you should send it be, whether to me the moderator or to the technical folks. And they will take care of it at that particular time. As I understand in previous webcasts people have had difficulty sometimes downloading the real player so the technical staff will hopefully be able to help you.

I was reminded that Project LAUNCH will do their presentation and they will be utilizing slides that you may not already have. However, Chris did send a copy of the slides through our listserv and they will also be available on the mchcom.com archives once this presentation or webcast is archived so you'll have access to them then. Okay then, our first presenter is Shirley Pittz, our ECCS coordinator from Alaska. Shirley.

SHIRLEY PITTZ: Good morning and I'm happy to report that the sun is shining here in Alaska and our 20 inches of snow we got on Friday is nearly gone. I would also like to thank Chris for inviting me to present this morning. I always find these websites and information from other states helpful and I hope what I'm presenting this morning is helpful to those of you online. We are talking about the importance of teamwork and sort of how that's played out in Alaska in a couple of our projects.

Next slide. What I thought might be helpful for you is if I give you a little background information so you can put some of this in context. And then I would like to talk about who are partners are and some of the work we're doing particularly in early childhood mental health and in the family support areas of our ECCS plan. Next slide. As far as context, I think most of you know Alaska is a very large state. As I found out on the website, there are only 18 sovereign nations that are larger than Alaska so we have lots of territory and at the same time we have a low population. So we have a little under 700,000 citizens in Alaska. We have lots of small communities spread out across our land and about 50% of our population lives in the Anchorage area. So what this means for us is that we have a lot of remote communities that we need to travel to by plane or boat or snow machine. It is challenging to get services out to some of our smaller communities. We do a lot of our work by long distance so most of us have pretty large travel budgets and phone budgets

in order to partner with our local offices. We do have our capital in Juneau. What that means is that our state partners are split between Anchorage and Juneau and so it's not always possible for us to have face-to-face meetings with our team members but we're very good at the conference call and when we do have meetings they tend to be full day meetings when people travel. I also wanted to note that we had an election in the fall of 2006 and so we had a change of administration there. And I guess the way I would talk about the impact because as you know that does impact the time lines that you do your work, I think for us it was sort of neutral. We didn't have significant changes or reorganizations and so that was a plus for us. Another thing that really impacts the work that we do in Alaska is our tribal system. We have a very strong tribal system. We have 13 regional corporations that deliver the majority of our health and mental health services in our rural areas and to our native citizens. Another thing that has an impact that you might want to be thinking about as we talk is our bringing the kids home initiative which has been our task of trying to returning our children from out of state placements in residential and mental health placements back into the state so we have had a big initiative going for the last several years the try to get our kids back in the State of Alaska. We were chosen as a strengthening families pilot site in 2005 and that has tremendously impacted the work we're doing around family support and the other project that has made a difference for us is that we're one of the ABCD states, which is assuring better child development which is about developmental screening and primary practices. So those are some pieces I thought might be of interest to you as we talk about this. Also you should know that when we're looking at children under the age of 8 we have 77,000 children in the State of Alaska. Next slide. This really has to do more with our state structure and I thought it would be helpful again to see where folks are placed because I know that's different in every state. The ECCS grant is in the Office of Children's Services in the Department of Health and social services. In the Office of Children's Services we're located with child

protective services as well as Part C. I think that's an unusual location and for us it's turned out to be a good place to be. But also in the Department of Health and social services commissioner's office is where I bring the kids home initiative is located and we have staff for the Alaska Mental Health Board. We have a children's policy team that is made up of our deputy commissioner and our division directors. And we have an interdepartmental early childhood coordinating council. The structure here is a little deceiving because it includes program managers across the Department of Health and social services as well as the Department of education and early development and labor and commerce. It has representatives from the Alaska mental health trust, the children's trust and the governor's council on disabilities.

In public health we have a children's mental health specialist in behavioral health, an Alaska mental health trust and the Division of public assistance is childcare programs and our head start program is there. The Department of education is not that much larger than health and social services and, of course, what's not represented on there is also labor and commerce which are two other departments that we work with.

Next slide. The mental health pieces in our early childhood comprehensive system plan that I wanted to highlight for you, these are some of the recommendations that were in our plan. The first one has to do with services for kids and making those more accessible and available and funded. So we on our committee have been targeting reimbursement mechanisms and how we pay for services. We've looked at standards of care for young children and we've been looking at financial resources, how they integrate some funding streams to support this and also a goal of ours is to help educate employers about why having insurance and support for families is important.

Next slide. The other target that we had for a mental health piece is working with our workforce like most other states, we have a lack of expertise in early childhood mental health and through our situation because of the remoteness of some of our communities is that we have mental health clinicians but they aren't trained in early childhood issues. And so this has been a key initiative of ours that we've been working on working on professional development statewide as well as really taking a look at how we might implement mental health consultation both for clinical and professional staff as well as for family support workers and early childhood workers.

Next slide. We have a large in-state team of mental health partners and this has really been sort of key for us is to have the sort of partnership and the sort of team developed. We have the bring the kids home manager who again sits in the commissioner's office. We have representatives from behavioral health including the deputy director. We have child protection. Early intervention Part C folks involved, our childcare, title V, disability folks, helped start as well as the ECCS program and this has been an in-state committee that has taken the recommendations that were developed with all of our stakeholders when we did our ECCS plan. And so we've been trying to take those recommendations that I mentioned and move those forward.

Next slide. We also have working relationships with Alaska Mental Health Board. They've been really key in helping us get some funding. That was promoted to the Alaska mental health trust authority. Our newest partner is the behavioral health alliance with the University of Alaska. It's a cross disciplinary group of staff members from across the campuses in Alaska. And as you'll hear later as we work on our mental health credential for young kids these folks are going to be a strong partner for us there.

Next slide, please. So what we've been doing in our mental health work is we started off in the service area, at least, looking at standards of care. And right after our plan was approved, Alaska was revising their standards of care regarding mental health services for children and so those were reviewed for appropriateness for the younger age group. We dug into our service codes and looked at some of the things that we needed to have more appropriate services for young kids so that is everything from family therapy without the client needing to be present. Reimbursement for play therapy, looking at doing more home-based services and developmental testing as well as prevention activities for kids who have a parent with mental health or substance abuse issues and those are service codes that we're in the process of working on now to see the changes that we can implement. We've also talked a lot about eligibility and particularly the need for kids to have an SED designation to get some services and so we're working on how we might make a wider range of services available to that younger age group. We've also looked at the DC03 and are in the process of writing the policy to allow us to use that in the diagnosis for young kids.

Another area of concern for us has been the providers and who can provide services. One of our recent accomplishments is that we now will have licensed psychologists who can do developmental and psychological testing and neural behavioral testing and that's changed for us in our Medicaid system. Part of what we need to accomplish the last bit of changing our regulation for service codes or eligibility is really going to be to develop a cost benefit analysis. To be able to do that we've had to dig into our Medicaid information and luckily we've had a fellow from the CDC who has done some work for us, so we have gone through lots of our Medicaid information and found some interesting things that I'm sure you have found as you've done this. But we really have taken a look at who are these kids, what is their diagnosis, where are they receiving services, how much is it costing and

some of the things that we have found is that number one, age and custody are very high predictors of high cost for kids and particularly our custody children are above -- way above average on the cost of care for those kids. 14.3%, for example, of our custody children are in the top 20% of the individual cost and so they have a higher cost as well as an average number of billings and so our plan is to even drill down into this information a little bit deeper to see if we can't get more historical information on kids to see where the systems have interfaced with them and how we might back that up and intervene more appropriately.

We've looked at diagnosis and just as a matter of interest, the most frequently billed diagnosis has been ADHD. The second most highly billed diagnosis was PTSD. Third was oppositional, fourth was an autism diagnosis and the other was unspecified disturbance of conduct. We have a lot of Medicaid information and our next step is to do the projection about what will happen if we change our service codes, get more service providers and put more of our resources at the front end of the system. We've also done a lot of work around workforce development.

Our Part C program has really -- they're very interested in being able to serve our 0 to 3-year-olds and their mental health needs. We know that a great majority of our kids who have come into that system with other disabilities also experience a delay in social/emotional development so our Part C program has been a very strong partner in our workforce development piece and they're developing a new professional development system with levels of competencies and are working closely with the university around that. Sort of as a short term approach to workforce development in lieu of graduating people with degrees in early childhood mental health, we had chosen to do sort of a short-term strategy so what we did is in the summer of 2007 we provided a training institute and

invited early interventionists and others around the state and we provided scholarship and came in for two days of training on early childhood health and we've connected those providers now with monthly conference calls. We have consultation with Neil horn from Georgetown and they're online each month from that and we're bringing those folks back for additional training. Through the Alaska children's mental health trust were able to get funding through the legislature for an early childhood mental health credential at the university. So we have been working with our behavioral health alliance at the university to start to move that forward. Next slide. In family support and parent education our primary goal was really to increase access to community-based parenting and family support programs. General strategies under that were a suggestion from our stakeholders is that they really needed the clearinghouse for best practice information where they share training and there doesn't seem to be a connection for family support agencies the way that the early childhood community is connected, for example. An integrated service system where there is more one stop shopping, easily accessible information and then family support and employer policies that are more supportive to families and we have worked with -- to support our private partner best beginnings who has done a lot of work with the employee population.

Next slide. What I would like to highlight here is what we've done with our strengthening families program. It has been a primary way of building on this family support goal. We were, as I mentioned earlier, one of the original sites that was selected as a strengthening families pilot state by the Center for social policy. That began in 2005. We have a sort of cross disciplinary leadership team that includes, again, our child protection director in the Office of children's services, childcare title V, head start, university, the SEED project, our professional development for early childhood folks. Our CC R & R network. The prevent child abuse, the children's trust, the association for the education of young children and

parents that make up that leadership team and just yesterday we launched into a revision of our strategic plan so we have new things coming up there.

Next slide. Just a couple of other working relationships and actually these folks are now being invited to join our leadership team at best beginnings which is our private public partnership in the united way of Anchorage and so there are things in each of these systems that can really strengthen the -- embed family support through the strengthening families program and these are vital team members for this initiative.

Next. So what we've done with the strengthening families program is in the beginning after developing our leadership team we selected six pilot sites around the state that represented a diverse collection of early childhood programs to implement strengthening families. Those programs were given many grants of \$10,000 each and really did some fascinating work in terms of family support. We learned a lot through those pilots and since that time we've incorporated some new programs and we provide, again, learning networks which is a way of delivering our technical assistance as well as building and sustainability for these programs to continue family support. We present wherever possible. We always make a point to get at our large conferences like the Alaska association for the education of young children. So that we can get that protective factors information out to as many folks as possible. We did an early childhood partners conference two years ago and this was a cross disciplinary conference which seemed very unique and was kind of interesting to have early intervention in child protection, mental health, family support and early childhood folks at the same conference. We learned a lot through that and we highlighted the strengthening families program at that conference. We have embedded this in university course work, the language around strengthening families and protective factors. We have had our first ever social work

practicums. We are embedding it in our quality reading system. The CAPTA project has brought strengthening families on board there. We have training for a model for facilitated discussion with parents and we did a stronger together cross systems training. A curriculum on family-centered services which is designed for early childhood folks but again we brought in a mix of people from some of those other systems and it was very powerful. It was quite amazing training, as a matter of fact. We also have applied, we've partnered with united way of Alaska and were chosen to be one of the strengthening families united grantees so we've now launched or will be launching that project that is a connection between united way or strengthening families program and our CC R & R.

Next slide. I wanted to just give you a visual of some of the cross systems work that we're doing on the local level particularly if you look at the circles that have the red print, those are three partners that we brought together as part of our CAPTA project and so we have three pilots around the state and where they have strengthening families programs they were invited to join these pilots and so we have local triangles, teams working on how they can implement the CAPTA piece and serve the 0 to 3 age group better and if you look at all the players on that chart, those were some of the folks we had represented at our stronger together training and so now as they go back to their communities they have a support system built in and can do some co-training and partnerships around family supports.

Next slide. These are some things that we have coming up or things that are sort of right in front of us here. One of the things that I'm hearing in almost every meeting I've been in, I think, for the last couple of weeks is really looking more at taking a public health approach to our work and really looking at the continuum of services that we have and examining more closely how many of our resources are at the top of the pyramid in

intervention and how can we be in to bring some of those resources down toward the prevention and early intervention and promotion areas? We're taking a hard look at that with our child protection services. And our interdepartmental group is looking at that across all of our programs. We have an early childhood mental health conference coming up this summer and it is pretty focused on using the DC03 and other kinds of diagnostic measures as well as doing interventions and again, this is going to be a cross disciplinary conference. Hopefully bringing in a variety of professionals who ought to be on the team when you're working with young kids with mental health issues. Our Alaska Children's Trust is launching into a strategic planning process and developing a prevention plan which will be rolled out this fall and summer and we're looking to see how we build in our early childhood mental health work as well as our strengthening families into that process. And last, but not least, one of the things I wanted to share with you is that we've also applied to be part of the prevent maltreatment institute and the partners for that are the alliance for children's trust, and the ECCS strengthening families program. If we're chosen to participate in that we want to take the strengthening families work and framework and do work around how to make that more culturally appropriate particularly for our native villages and so we're looking forward to that this fall.

Next slide. Lastly I just wanted to share some, I guess, lessons learned for us in terms of partnerships and how they're helping us reach tipping point with some of these efforts. I find it's really important to use the plan that has been developed and I call that working the plan. Our little executive summary has gotten a lot of mileage and it is really helped to keep people focused and very clear about some of the things we can do to benefit our youngest children. I've also found that if you set the table, folks will come to dinner. That mostly people are very interested in supporting this work. It is a matter of somebody taking the time to call the meeting, to set the agenda, to organize the facility and people are more

than happy to join in the work if you can do that for them. Meeting everyone's needs I think is very important. Finding out what their issues are and what efforts they're making and things that they're trying to move so that you can incorporate that in your work. I think it's also very important that we give credit where credit is due. I'm sure you know that is really important this kind of work. It doesn't happen with one person. It happens with teams that are connected in many places. Going where there is movements is also I think the lessons we've learned. If you find some interest, passion or open door you head in that direction because things happen more quickly that way. Repetition. I think we've -- several of us here have some mantras about the importance of early intervention and working with young children and the impact on brain development and can probably do that in our sleep. Then the other thing I think that has really been very important is the patience piece. We have at least in Alaska that systems change does not happen quickly. It takes a lot of again repetition and a lot of going back and back and back and the patience eventually pays off for us. So I will pause there. I have probably taken too much time. I would be happy to answer any questions.

>> Thank you very much, Shirley. One of the things that I wanted to add to your presentation is that comment you made if you set the table they will come to dinner that one of the things that we endeavored to do when we set up the webcast was try to provide some follow-up through the partnership meetings -- follow-up to the partnership meeting we had in March. I would like to say that we chose Alaska for this particular presentation because we thought you had a very strong state team and that you were a good example that some of our other ECCS grantees could look at and learn from. I would also suggest that folks go to the ECCS website and take a look at your plan because that would be a good working document for people to look at and to ask questions. I have one question thus far. And the question is what are examples of employee policies that have changed?

>> Okay. Let me say that we have -- I can't articulate that I guess is the best way the answer that question. And that has not been the top priority for us. It is one of the goals that we have and it is something that we plan to work on in the future, at least with mental health services. We want to do some work through the insurance piece but we haven't focused our attention there yet. I do think on the early childhood side, early childhood education and care and learning side we've seen more of that. We had our large corporations get involved with the whole pre-K movement. How do we build a stronger early childhood education system and as a result of that we've had some employers who have started employer-sponsored childcare, have really done some work with the legislature and so I would say the work around that with the mental health piece has not really begun yet. It's in our long range plan.

>> Okay. The second question, Shirley, is we want you to give your contact information.

>> Okay. My phone number is 907-269-8923. And my email is Shirley.Pittz @ Alaska.gov. Phyllis, I did want to comment on the partner's meeting because I think that was really important. I think it validated the importance of this cross systems work for us and I think beyond the team that came, it validated that for commissioners and for other department people to see that the feds are very supportive of this and that we really do cross over in multiple ways. I think it was helpful for us to have team members who heard from national presenters, so I would really just like to thank you for that opportunity. I think that made a difference for our teamwork.

>> Thank you, Shirley. Next question. How many mini grants actually were used in the pilot sites?

>> We had six pilot sites and each of those got \$10,000 mini grants. The funding for those came through the Alaska Children's Trust as well as our Title V program and a minimum amount from our ECCS project. Having the \$10,000 was -- I think it was a huge factor in the innovation that programs used. Their commitment to the project and their willingness to sustain the effort. It was a big leap forward for those programs.

>> Thank you. Next question, do you have childcare health consultants and if so, how do they collaborate with these activities?

>> We have sort of a mixed approach to that. We do have our CC R & Rs who do low level -- what I call low level health consultations so it's not so much the illness stuff but the more sanitation and health issues. We have a sprinkling of public health nurses that were trained some time ago in childcare consulting and still do that. They're pretty proactive but we're in the process of having more meetings. We just had a visit from our national T.A. people to meet with public health nursing and that's the approach we have in Alaska through public health nursing. We've had a shift in their focus and they're refocusing their missions but after 9/11 bioterrorism became very important. As that whole thing gets reframed and reconfigured we're hoping that we can expand on that.

>> The next question are you doing a systems level evaluation for your ECCS initiative and if so, what is your basic strategy to evaluate this level of improvement?

>> With the early interdepartment/early childhood coordinating council which is a big mouthful. What this group has decided to do at our last meeting is pull from all of the programs that we have across our departments, the work that is being done around early

childhood, to see what sort of goals, benchmarks and data is collected and can be cross walked. So we plan on doing the crosswalk and developing a state report card and that's what we'll use to sort of evaluate those population-based issues. Individually programs crunch it down and have more performance targets but we're in the process of revising the benchmarks that are going to help us evaluate that.

>> Thank you. This is a follow-up to the mini grants question. What did the pilot sites actually do with the funds?

>> That was very interesting because as you know with strengthening families there is a lot of flexibility around the protective factors and how you might build them for families. One of our sites, a large center connected with a faith-based organization developed what they call their four-point connect system. They developed systems for proactively connecting with parents and making sure that not only are things going well in the childcare program but they have family support. That was the site that was also located in one of our army bases who had lots of families -- family members deployed so they increased the activities there. We had sites who used their funding to increase mental health consultation for their programs and found it was not only good for children and families but good for staff retention because staff felt more support. We had programs who started dinners for families so once a week families could come for dinner at something like \$3 a head and started having 140 folks show up for dinner. We had programs that started Yahoo groups and had some incredible stories about being able to help families through that process. We did cultural nights. We had programs who purchased computers for families to use to write resumes and do whatever they needed to do on the Internet. We had families who created parents' base where none existent. They would put in attractive things that brought families in. We had some programs starting from scratch that

started minimally learning parents' names. So that they could start to build more close relationships with parents. So we had some really creative stuff and it was different for every program.

>> Okay. This last question, I'm not sure if it's for you or for the universe in general but maybe you could answer based on what you know and going on in your state. The question is how can one get training in early childhood mental health? Is there a degree or certification programs?

>> There are universities and programs around the country. You know, Wisconsin, gosh, I know Oregon has some stuff going on. Several states are offering something through the university system. And there are long distance programs that folks can get training at. We have sort of a mix of that so we do have some people taking long distance training. We're building capacity with our universities because they have recognized that they do not have faculty capacity to do this work. While we're training practitioners through some of these institutes and learning networks, our university folks are launching into a process where they are going to learn more about early childhood mental health so they'll have the capacity to teach the classes in Alaska. So it's out there. You have to look for it. If it is not in your state.

>> Thank you very much. Shirley. At this time this is the end of this particular part of the presentation. I don't have any other questions. If people want to follow up as I said, you can go to the ECCS website and review Alaska's plan and Shirley has also given us her contact information if you have more questions. Before we move to our next speaker I want to mention, I want to give Shirley time to get off the phone and our technical people to readjust. I forgot to say or Chris just reminded me that archives are available on the

website so all you have to do is go to the mchcom.com and there is a button that says download slides now so you can have access to the slides. We'll wait a second before the next presentation. While we're doing this change over. Joe has a comment he would like to offer.

>> To the grantees please start writing your continuation application. Use last year's guidance until we get further instruction but there won't be that much of a change and you really need the time to get the head start on it. Joe and I will be looking for you because I know you'll have a lot of questions throughout that. I hope everybody has had an opportunity in this short time to download the slides. Again, we're talking about strengthening our state teams and have two speakers here will give us an excellent example of how state teams work together. We have David DeVoursney and Marie D'Amico from SAMHSA and they'll talk about Project LAUNCH. I'll take questions after the presentation.

DAVID DEVOURSNEY: Thank you for the lovely introduction. I'll talk into the microphone. What I'm saying is hopefully more interesting than looking at me, okay? We'll talk about Project LAUNCH and it is a program focusing on early childhood specifically through ages 0-8. Before I get into the substantive matters I would like to thank David, Phyllis and everybody at MCH at the Maternal and Child Health for their hospitality and give a special thank you for Dena Green and Chris Botsko because they have been so hospitable in letting us be in the webcast and they include us in everything they do. With that out of the way I'll get to the heart of the matter and talk a little bit about Project LAUNCH. So you can flip to the next page if you have the notes in front of you. The most important part that I'm sure everybody is wondering about is the number and size of the cooperative agreements we'll be funding. In fiscal year 2008 SAMHSA anticipates funding six Project LAUNCH

cooperative agreements for a maximum of \$916,000 per award per year. And the planned grant period is five years and that depends on the availability of future funds. I have to make that disclaimer. Five years is what we state at this time. You can flip to your next page.

The program will serve children 0 to 8 and their families. Targeting this age range allows us to bring together the traditionally disconnected systems that serves families with young children with primary care, daycare and other early childhood programs. It allows us to support a coordinated transition from the pre-school years to elementary school allowing for knowledge and cooperation with elementary educators. Another reason we've chosen that age is early childhood populations have shown the greatest benefits for the cost of programs. We hope these programs supported by Project LAUNCH will generate future cost savings for the sustainability of the program. You can flip to your next page. The purpose of Project LAUNCH is to promote the wellness of young children birth to 8 years of age. They define wellness as a positive State of social, emotional and behavioral health. It includes mental health and positive development free from substance abuse and other negative behaviors. Children with a solid foundation in early childhood are more likely to succeed socially. Participate and thrive in school and avoid substance abuse and other negative behaviors. This positive change will lead not only to positive individual outcomes but also affect communities norms and lead to general understanding that -- and stronger families. We anticipate that children, families and others that participate in Project LAUNCH will contribute to healthy environments at work and in school. Supportive communities and neighborhoods improve connections with family and friends and reduce levels of drug abuse and crime.

>> You can go to your next slide. SAMHSA as an agency has been moving toward using a public health approach in its various initiatives and our administrator has identified this shift as a priority. It has at its core the public health approach. In the broadest sense the public health approach is concerned with the well-being and health of the population rather than solely that of an individual with current problems. In the evaluation criteria section understatement of need page 25 in the RSA you'll see we say Project LAUNCH defined services broadly to refer to any program, support or service implemented to foster young child wellness. Specifically in the areas of promotion and prevention as opposed to treatment. Here we get into what we mean by wellness prevention and applying a public health approach. Some of you may be familiar with the Institute of Medicine's report that talked about the mental health spectrum of intervention. Interventions that fall on the far left or the prevention end of the continuum are those that are implemented before problems are evident or as they are beginning to surface in a given population. Moving to the right we're getting into the area where diagnosable problems have emerged. Interventions at this stage are what we know as treatment interventions. At the far right end of the spectrum are interventions that recognize a diagnosis has been made, treatment has been provided for a given period of time and the focus is recovery or long-term care.

The arrow in the slide indicates the area on the continuum that launch funds will support and in addition to initiatives that are preventive in focus launch dollars will also be used to support wellness or help promotion activities. You can see by the visual there are three types of strategies, universal, selective and indicated. Go to the next slide. Universal interventions are ones that work to promote healthy development in the general population regardless of current problems of any individual within that population. Or their risk for future problems. Selective interventions are those that target a sub group of the larger

population that due to the presence of a particular risk factor is more likely to develop later problems. Indicated interventions are those that target an even more defined and often smaller sub group of individuals who are already exhibiting some symptoms of a disorder. In terms of promotion this approach is not tied to an illness model. You'll see the first three approaches integrate a consideration of problems or illnesses. Promotion approaches suggest that good health is worth fostering in and of itself. And an element of this approach also suggests that although a population may be void of disease, there is an extra step that's necessary to ensure that the individuals in that population are actually healthy.

Launch applicants should propose programs, supports and services that fall into these three categories. Programs and services that are treatment focused are outside of the scope of this cooperative agreement and therefore should not be proposed. You can go to the next slide. A key component of the public health approach is its focus on risk and protective factors. A risk factor is a characteristic or behavior that is associated with an increased chance that an individual will develop later problems either in the form of risky behaviors as in the case of behavioral health or a physical or mental illness. Protective factor is a characteristic that reduces the chance that an individual will develop later problems again either physical, mental or behavioral. They exist at various levels. Project LAUNCH seeks to improve outcomes at the individual, family and community levels by addressing risk factors which can lead to negative outcomes. Project LAUNCH promotes protective factors that support resilience and healthy development which can protect individuals from later social, emotional, physical and behavioral problems. In their applications applicants should identify risk and protective factors that exist in their state and identified locality that relate specifically to young child wellness. You can go to your next slide.

>> The slides are available on the mchcom.com and you can download those slides now actually. On the next slide you'll see some examples of risk and protective factors that can exist at the various levels. Individual or child, family and community. One thing I should mention about risk and protective factors neither the present nor the absence of particular risk and protective factors predict later problems because the interaction between them is quite complex. Rather, it's the accumulation of risk factors when few protective factors are present that increase the probability of problems occurring later. Of course, what you see is not an exhaustive list of possible factors. Applicants should consider various data sources and some possible sources are listed on page 25 of the RFA. To examine the risk and protective factors that exist in their state and identified locality. Those factors identified by the applicant to them specifically become the starting point for the identification of selective programs, supports and services that are proposed. We can't stress enough that as applicants think through their proposed project and begin to develop your comprehensive strategic plan they should consider the unique constellation of risk and protective factors that exist within their area and identified community because applicants will in essence be matching risk and protective factors that they've identified to their selected evidence-based programs and interventions. They want to make sure they're working from an accurate picture of the problems and needs and resources that exist in their area. And this way the programs are later -- that are later implemented are more likely to have some impact on those risk and protective factors. In the project logic model which should appear in section C of the project narrative in your application is a helpful visual that can help applicants draw a logical connection between the needs and resources in their state and locality to their proposed approach and then to their project outcome. You can go to the next slide. For many years states have been talking about the need for federal agencies to better coordinate their efforts in order to begin to break down

the silos that result locally from the many federal funding streams. Project LAUNCH is a direct response to this call employing partnerships at the federal, state, territorial, tribal and local level. Additionally the initiative requires partnership across various federal programs serving the needs of children 0 to 8 and their families. At the federal level we're convening an advisory committee to guide the future direction of the launch initiative. This committee will build on the interagency group that inform the design of Project LAUNCH and includes representatives from HRSA, from the administration for children and families, from the Center for Disease Control and the Center for mental health services and the Center for substance abuse prevention within SAMHSA. The committee will be made up of senior level federal staff and will govern policy-related decisions for the initiative. At the state territorial and tribal level grantees will be required to mirror the federal interagency partnership by convening a council on young child wellness to be made up of individuals representing health, mental health, child welfare, Medicaid, substance abuse prevention, early childhood and stated indication, this is all in the RFA. You don't have to worry about writing it down. The Title V administering agency, a representative from the office of the governor or chief executive of the state, territory or tribe and representatives from families in the population to be served. Additionally tribal applicants will be required to include on their council's members from the Indian Health Service. The council on young child wellness will oversee the initiative at the state, territorial or tribal level and will work to build system capacity and infrastructure specifically along young child wellness. At the local level grantees will be required to convene a parallel council on young child wellness with representation across these same service systems. The work of the council will be focused on building a coordinated local service system through both infrastructure and program development. There is also significant federal interagency cooperation at the programmatic level. Project LAUNCH grantees will be required to build upon HRSA's grant program, HRSA's Maternal and Child Health Block Grant program. The administration for

children and families home visitation program as applicable in their state, territory or tribe. You can go to the next slide. Here I'll talk a little bit about the role of the states, territories and tribes. Up to 20% of launch funds may remain at the state, territorial and tribal level and will be used to build system capacity around promotion and prevention efforts to foster wellness. Grantees will conduct an environmental scan as a first step in their grant period to map out the state, territorial or tribal level systems and programs including federal and private grants that serve children 0 to 8 and their families. The environmental scan should also include a financial map of funding streams that support existing efforts. States, territories and tribes will create a young child wellness expert position. The individual hired for this position should have expertise in the public health approach and in early childhood development. The position will provide overall coordination across service systems, serving on the state, territory or tribe council on young child wellness, which I described earlier, and will work towards policy and infrastructure improvements focused on promotion and prevention efforts to foster wellness. Additionally the young child wellness expert will provide technical assistance to the local level through regular communications with a local child wellness coordinator.

Grantees also in the early months of their funding period will be required to submit a comprehensive strategic plan which should address the infrastructure, programmatic and fiscal elements planned as part of their cooperative agreement. A specific element that the comprehensive strategic plan should address are on the following slide and they include the training and technical assistance that will be provided to the selected localities, policy developments or modifications, the development or enhancement of the existing prevention promotion focus infrastructure. Development of a cross agency fiscal strategy to promote sustainability and mapping of indicators or measures of young child wellness that are collected across service systems. You can go to the next slide. Here I'll talk a little

bit about the role of the identified localities, applicants must identify a local jurisdiction that will receive the majority of launch funds. They must provide a rationale for the selection of the identified locality linked with local risk and protective factors related to young child wellness spanning across, physical, emotional, social and behavioral domains. The local child wellness coordinator will be the local counterpart of the state, territorial or tribal level young child wellness experts and work in close coordination with him or her. Activities and governing bodies at the state territorial tribal level will be mirrored at the local level with the conduct of a local level environmental scan. Development of a local child wellness coordinator and a local council on young child wellness and an extension of the state, territorial or tribal comprehensive strategic plan which would be implemented at the local level.

Go to the next slide. Working from their environmental scan localities will work to coordinate physical and behavioral health systems and enhance existing efforts by replacing non-evidence-based programs with evidence-based one and integrating uncoordinated efforts that on their own show evidence of promise. The piece about enhancing existing efforts is particularly important for launch grantees because we believe that this is part of the process of breaking down the siloed efforts that serve the same population. The local strategic plan will also address how grantees will create and implement a workforce development strategy to enhance the expertise of primary care, mental health and behavioral healthcare providers, child welfare providers, childcare providers, early childhood educators and primary graded indicators specifically related to young child wellness, prevention and promotion. Applicants are expected to implement a range of evidence-based programs and -- promotion and prevention programs at the local level including but not limited to mental health consultation, developmental assessments across a range of settings including primary care, integration of behavioral health

programs into primary care, family strengthening and parenting skills training and home visitation. Go to the next slide. And here are some elements of the state, territorial or tribal and local relationships that we wanted to underscore. Each cooperative agreement will provide funds to states, territories and tribes which will then pass on the majority of those funds to a locality named in the application. The relationship ensures intergovernmental coordination as well as the existence of state, territorial and tribal infrastructure that is supportive of promotion and prevention efforts at the local level.

The young child wellness expert and local young child wellness coordinator work in close coordination with each other to coordinate the efforts of their respective councils and to ensure the implementation -- and to ensure the implementation of the comprehensive strategic plan. States, territories and tribes will serve in a training and technical assistance capacity to their identified locality and ensure the capacity they're building at their level around promotion and prevention supports the local efforts. And then this last bullet distinguishes between the focus of the efforts that occur at both levels, states, territories and tribes are really concerned with developing infrastructure and system capacity while local alts must also address infrastructure and program development.

>> Thank you, Marie, that was great and I'll continue talking at you about this program.

And then we'll answer some questions. States, territories, tribes and lolts receiving funds from Project LAUNCH with undergo a comprehensive planning process to be completed in the first six months of the grant. Some of the work will be completed as part of your application should you decide to apply it. For example, some of the information you will need for step one which is environmental scanning and needs assessment will be included in the statement of need section of your application should you decide to apply. This scan should map out the systems and programs including federal and private grants

that serve children 0 to 8 and identify the needs of the target population. Step 2 is resource mobilization in which you mobilize and build capacity too bring together partners and appropriate organizations and resources at the state, territorial, tribal and local levels. Again, a significant portion of this work should already be done preaward as you develop memoranda of agreement with your partners at the state, territorial, tribal and local level for your application. Step three is planning in which you take all that information and you bring it together into a comprehensive strategic plan that includes evidence-based interventions intended to create changes in the risk and protective factors related to the identified state, territorial or tribal or communities problems or needs. And step four is implementation in which you implement the plan with a range of interventions to address the problems you've identified. I like how they can break down implementation and put it down into one bullet point. I think it will a little more complex in the actual running. Step five is evaluation in which you monitor, sustain, improve or replace prevention strategies which will be ongoing throughout the effort and this strategic plan which you'll develop in the first six months of your initiative should be updated throughout the life of the initiative. You can go to the next page. SAMHSA has just finished receiving responses to an RFA we just put out to provide technical assistance to launch grantees. When funded this center will provide technical assistance services across a wide variety of topics at the state, territorial, tribal and local levels addressing both infrastructure and services. It will provide centralized administration of technical assistant services for all grantees and it will provide localized site specific and cross site technical assistance in a variety of formats and medias for all grantees and establish best practices and resource development in sharing across all the grantees. It will also provide technical assistance that demonstrates come pe pen see with respect to types of diversity age, gender and culture and it will create linkages for Project LAUNCH grantees with state mental health directors and state Maternal and Child Health directors and provide communications, technical assistance.

There will be a range of support available through Project LAUNCH grantees after they're funded. Evaluation is also a major component of the Project LAUNCH plan. Grantees must spend at least 10% but no more than 15% of their funds on data collection performance measurement. They're required to conduct a grantee level -- and identified successful programs for sustainability. Grantees must also provide data to our national cross sight evaluation to assess the overall success of the initiative in their performance report to federal staff and data to SAMHSA's transformation accountability system and you'll receive assistance and support in all these tasks should you decide to apply and you get the grant. This next slide applies only to applicants with existing early childhood comprehensive system. Tribal grantees and territorial grants without these are still expected to work with existing early child had efforts in their governments and in their communities and territories and tribes but there are specific requirements around ECCS for those folks who do have ECCS grants. The young child wellness expert who will be hired at the state, territorial or tribal level and serve as the project director for the launch cooperative agreement is required to coordinate activities under the Project LAUNCH grants with the ECCS coordinator and with the ECCS coordinating council. The Project LAUNCH comprehensive strategic plan must build on the existing plan and list all those items in the Project LAUNCH. The oversight council on young child wellness should be integrated with the ECCS coordinated council in whatever way the state or territory applying feels will be most effective in implementing their program.

That brings us to the end of the substantive part of our presentation. I know that you'll probably have questions and some of them may occur to you after this presentation. And so I'll give you my contact information right now. It is also available as part of the RFA that we have on the SAMHSA website. If you don't have a pen look us up online. I'm David

DeVoursney and you can reach me at David.DeVoursney @ SAMHSA.HHS.gov. We'll now entertain your questions if you have any.

>> Oh, yes, David. We have several. The first one I have is saying please clarify treatment options should not be included in the plan in the application. Treatment options should not be included.

>> The focus of this grant is promotion and prevention and so traditional treatment shouldn't be a part of your Project LAUNCH plan. There will be programs included like mental health consultation that may include some individual work but classic kind of treatment modalities shouldn't be used as a part of your Project LAUNCH plan.

>> Yeah. What we're really looking for is that this program provides programs and supports for a full population of young children. So not necessarily those who have identified problems. As David mentioned there is a piece to get that -- those children who are having problems and may need referrals but really the bulk of the program is focused on population-based efforts to promote well-being and to promote health.

>> Okay. Next question within the context of the application, please describe the environmental scan and how it differs from the application requirements and describe the area, systems and challenges, gaps and redundancy.

>> I think I can touch on that. The environmental scan is a more complete version of what you might put together in your application. The material in the application will provide a summary of some of the problems or issues you might face at both the state, territorial, tribal and local level. The environmental scan is much more in depth and include other

pieces like the financial map so the environmental scan should be a much broader set of working problems you've identified and this is something that should be done in collaboration with your partners and with other actors at the state, territorial, tribal and local levels. It is really a more comprehensive look and accounting of all the pieces that will fit into your initiative including current services, current grants you may be receiving. Sources of private funding and also looking at the identified problems and risk and protective factors at the state, territorial, tribal and local level.

>> Thank you. Next question. Please clarify mental health consultation at the local level as this seems to contradict the prevention focus.

>> Mental health consultation I'm going to preface it by saying I'm not an expert in that area but it can be used inside of a variety of settings including early education and primary care, childcare settings, to create a mental health focus and to create sensitive environments that promote healthy development for children generally. In addition, it can address individual children within these settings to identify their needs and make the setting function more appropriately by serving all the children inside of a given setting. And so mental health consultation can have a promotive effect for a general population in addition to focusing on individuals within a given framework.

>> The next question. I would like more information in regards to integration of behavioral health and to primary care. As a primary care provider it seems essential to develop these initiatives in collaboration with pediatric primary care providers, do you agree?

>> I definitely agree.

>> I think the American Academy of pediatrics offers some material specifically on integrating behavioral health and mental health into primary care is the first piece coming to mine. Another piece is offering appropriate developmental care.

>> Next question our procurement processes prohibit us from naming a specific agency prior to issuing an RFP or RFGA. How can we name a specific locality and service delivery agency in the grant and remain within our procurement restrictions?

>> For questions like this that deal with specific laws or regulations within different applicants, I would prefer if you would contact me directly and we can address them on an individual basis.

>> There seems to be conflicting statements in the RFA concerning whether the Title V only can apply or can it be a community-based non-government service based program.

>> It has to be the Title V agency within a state or territory. Tribes are exempt from this because they don't have a Title V agency in their structure. Otherwise it has to be a Title V agency within a state or territory.

>> Do you have a definition of a local selected locality. Could it be a region that covers more than one locality or more than one tribal reservation?

>> The definition we have inside of the RFA is -- I don't have the specific page. There is a definition in there. It says that a locality should be a county or municipality but provides prospective applicants with the option of specifying a different geographic area. If you feel that there is a community or locality you would like to serve through the grant and they don't fit the exact definition of a county or municipality you can describe that within your

application and create a waiver to explain why you chose that locality instead of a county or municipality.

>> Okay.

>> More detailed information on that is on page 10 of the RFA at the bottom.

>> Thank you. Next question, can there be more than one local grantee?

>> No, there has to be one identified locality. It's our hope that that locality will serve as a pilot for the state where they can test interventions that they hope to move to a wider scale but for the purposes of Project LAUNCH support we do anticipate just having one identified locality for each grantee.

>> Next question, can a Title V agency partner with the state agency for mental health so Title V supports the application instead of actually applying?

>> The application I think at this time has to come from the Title V agency. We do support partnership with a mental health agency and mental health is one of the required partners at the state level that you need to have on board should you decide to apply.

>> Next question. Is there a preference about who submits the grant, behavioral health as long as the team is on board?

>> I think the Title V agency at the state or territory level has to be the agency that applies to submit the grant.

>> I may be redundant in some ways.

>> That's fine.

>> What are examples of EDP's for health promotion that are appropriate for this grant.

>> There are a number of model program lists that you can check out. Look at SAMHSA's national registry of effective programs and practices. There is a rand website that focuses on early childhood initiatives and other websites some listed in the application. Rather than go into a laundry list on the phone I would suggest you go there.

>> Next question. A comprehensive environmental scan including risks and protective factors and an extensive scan of fiscal resources was completed less than 12 months ago in our state. Would this be -- would we be required to entirely recommend indicate this effort should a grant be awarded?

>> Absolutely not. That's great. That's a great position to apply for the grant and I would hope you would use all that information in creating an updated version of that document. It sounds like that's exactly what we want to hear.

>> Okay. Are future rounds of grant funding projected?

>> I can't speak to future funding. I hope this project is going to be fruitful and that's about all I can say so thanks.

>> Next question. Can the funds from this grant be used to pay trainers from evidence-based programs through the local community agencies? You want me to repeat that? Can funds from this grant be used to pay trainers from evidence-based programs to the local community agencies

>> Yes, that is what we hope localities would do. Workforce development is an important part of this initiative.

>> Next question, are ECCS grant and state plan has defined early childhood at 0 to 5. Is the expectation include through 8 years of age or could we continue to work up to five years of age?

>> I hope you would keep a strong focus on 0 to 5 but we would like the population focus to be 0 to 8 because we would like to bridge the gap between early childhood systems and elementary school.

>> Next question, can you build on existing entities rather than have to create a new child wellness council. For example a governor's cabinet on early childhood.

>> This is the piece that we really hope that applicants really examine the resources that already exist in their location and build upon that work. So absolutely I would take a group like that and see where it might be enhanced to address some of the additional goals of the launch initiative. But absolutely those are resources that we really want to -- applicants to capitalize on and to attempt to break down these silos, as I've mentioned.

>> There is language in the RFA which asks grantees or applicants to connect and work with their children cabinets at the state level, should any exist.

>> Next question, SAMHSA's evidence-based programs identify for treatment and intervention. How do we reconcile this with the -- [inaudible]

>> There should be programs on there for prevention. A lot of the work that SAMHSA has done with that list have been on promotion and prevention. There are additional lists out there.

>> Right.

>> I would say I work the rest of my life on state schools healthy students program which is another prevention initiative and our number of our grantees use programs off there which are prevention programs.

>> Next question. With the district of Columbia having a state and local function how should we delineate the two roles and functions. Could a ward represent a locality?

>> I think that's another one of those situations where you'll have to contact me individually after this phone call because I don't want to say anything that isn't correct.

>> Next question, when would the funds actually be awarded?

>> We anticipate that the funds will be awarded in late summer or early fall. The federal year ends at the end of September and we have to get it out before then so somewhere in that time frame.

>> Next question. Is it expected that the local project county or municipality expected to be represented by an official governmental agency or can it be a private non-profit agency or other?

>> Can you repeat the question?

>> Is it expected that the local project, county or municipality is expected -- I'm adding words, is expected to be represented by an official government agency or can it be a private non-profit agency or others?

>> Well, I think what we're looking for is the locality to be -- because we have these mirrors at the different levels, the federal, state and local, we're looking for the local area that's identified to sort of be positioned to cooperate and work across agencies. So ideally the locality would be a governmental agency.

>> It could be a governmental agency but I don't think we have specific language about whether or not private organizations are available to serve or the project director or the project manager at the local level would be able to be from a non-profit so that's something that we'd be happy to answer your questions about after the phone call.

>> Now that seems to be the last question. I have a general comment that says best beginnings, a document available from Georgetown has good information about integration of behavioral health and primary care.

>> Thank you very much.

>> You're welcome. Okay. If there are no other questions the last thing I would like to add is that let me know, a lot of people wanted to know when the continuation application is due. We aren't really sure but hope to have it available by mid-March -- mid June. We're already past March. I have one more question that came in here. If you have other questions about the continuation, please contact Joe or myself and we'll follow up on that and we'll have more information for you at the end of this week.

Next question for David and Marie, the range of expected EVPs on page 7 do span from promotion, prevention into treatment and intervention. Would screening rather than or in addition to assessment be an appropriate service in your model?

>> I think the intent is that launch focuses from if you think of a linear model, promotion, prevention, up to early identification. That's still in sort of the preventive range. The hope is that applicants will focus on really that range and not so much on beyond that. So early identification is still within the permissible range.

>> If funds are awarded in late summer, early fall are they to be spent within fiscal year 08?

>> There is a rough time frame laid out inside of the application and you should anticipate that that time frame starts at the award date so whatever the award date is six months on from there is when we expect to have your comprehensive strategic plan in, etc. So I would just move forward from that at the beginning of your project.

>> That was the last question. Thank you all again and as we said this webcast will be archived within a week or after a week after today. The slides as some of you still seem to have problem accessing you needed to go back to the website, look for the particular presentation and click on download slides. The slides are already there but it will be in the whole package in the archives. Thank you so much. We look forward to talking to you again.