Southcentral Foundation
Indigenous Project LAUNCH

Strategic Plan

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PROJECT LAUNCH

Southcentral Foundation

Table of Content:

The Southcentral Foundation Project LAUNCH Project

In September 2018, Southcentral Foundation (SCF) was awarded an Indigenous Project LAUNCH grant – Linking Actions for Unmet Needs in Children's Health – by the federal Substance Abuse and Mental Health Services Administration (SAMHSA). The purpose of Indigenous Project LAUNCH (IPL) is to promote the wellness of young Alaska Native and American Indian children, from birth to eight years old, by supporting the physical, social, emotional, cognitive, and behavioral aspects of development. The long-term goal of Indigenous Project LAUNCH is to ensure that all children enter school ready to learn and able to succeed.

Indigenous Project LAUNCH also seeks to improve coordination across child-serving systems, building infrastructure and increasing access to high-quality prevention and wellness promotion services for children and their families. To this end, SCF have established working relationships with many programs and services available in the Anchorage area.

During the first year of the grant, SCF Behavioral Services Division completed the needs assessment and focused on expanding the TRAILS program to younger children in the 0-8 age group. Towards the end of the first year, SCF decided that reassigning the grant to SCF Medical Services Division would provide a wider scope of services and opportunities to meet the overall grant objectives. Once this transition occurred, the two divisions partnered to create the comprehensive strategic plan.

Historical Background

The tribal health system is both separate and different from the "system" that serves the general public in Alaska (and most of the U.S.). The tribal health system is more comprehensive in providing a full range of physical and behavioral health services. Even more significant is that it makes all services available to every customer regardless of payer or ability to pay. Finally, it must be recognized that the Alaska Tribal Health system is complex. The overwhelming majority of the population of focus, however, lives within the Municipality of Anchorage and adjacent Matanuska-Susitna Borough. Together they have the highest and fastest growing number of people in general and Native people of any place in Alaska. **Anchorage has the highest proportion of Alaska Native and American Indian people of any major city in the U.S.** The Census Bureau also reports that the Alaska Native population is growing over twice as fast as the general population. The total populations of Anchorage and the Matanuska Susitna Borough are 299,037 and 102,598 respectively - 54% of Alaska's entire population. Of that number 49,330 report being wholly or partially Alaska Native. This is one-third of Alaska's entire Native population. 28% of the Alaska Native population in the area is under the age of 18, 53% of those are male, and 47% female.

The Alaska Native and American Indian population served by SCF is one of the most diverse of any tribal organization in the country. It includes 203 members of the 229 federally recognized tribes in Alaska and 260 members from federally recognized tribes in the contiguous U.S. states.

This is a substantial proportion of all the nearly 600 tribes recognized by the federal government. Culturally, the Alaska Native population served by SCF is also one of the most diverse, while most speak English as a first or second language, SCF as co-manager of the Alaska Native Medical Center in Anchorage has immediate access to interpreters for anyone more comfortable speaking in their Native tongue. Additionally, the employees of SCF more closely resemble the make-up of its customers because of Alaska Native preference allowed under P.L. 93-638 (Indian Self-Determination and Education Assistance Act).

SCF is the Alaska Native owned and governed tribal health organization compacted with the IHS to provide for the health care needs of its beneficiaries in the Anchorage Service Unit and other recognized tribes that have adopted resolutions to have health services for their members provided by SCF. SCF operates 12 HRSA funded Community Health Centers – mostly in rural/remote communities. SCF derives its tribal health authority from Cook Inlet Region Incorporated (one of 13 Alaska Native regional corporations established by the Alaska Native Claims Settlement Act) and by the resolutions passed of the tribal governments of the Iliamna Lake villages, Upper Kuskokwim villages, and St. Paul Island Aleut Community.

SCF's mission is to work together with the Alaska Native Community to achieve wellness through health and related services. The population of focus for Indigenous Project LAUNCH is Alaska Native and American Indian (Native) children birth to eight years of age and their families residing in SCF's Indian Health Service (IHS) recognized service area. The two primary imperatives for focusing on this group are (1) the prevalence of trauma is significantly greater in the Native population than in the general population and (2) the impacts of trauma typically manifest in both psychological and physical conditions that adversely affect population health outcomes. Individuals impacted by trauma are best served when their issues are addressed in a comprehensive system of care that is trauma informed and reduces their trauma symptomology by fostering coping skills and supports at multiple levels and throughout the lifespan.

Differences in Access, Use, Outcomes – Population of Focus vs General Population

Access to the public, non-Tribal mental health system in Alaska is highly dependent on having third party insurance. This stems from a 1992 policy decision to shift funding for the then separate mental health and substance use treatment systems from grants funded by Alaska's General Fund to Medicaid. At the time, the state was feeling the initial effects of declining oil revenues and lawmakers wanted to take advantage of federal matching funds. The grant programs were not eliminated, but the expansion over the previous decade ceased and grants have been slowly whittled away ever since. Community mental health programs were encouraged to maximize Medicaid reimbursement as a means to meet increasing demand for services. No steps were taken to address the needs of the many low and moderate income people in the state who were disenfranchised by this policy change. Alaska Native households comprising the focus population are over-represented in this income group and when seeking

mental health care outside of SCF are likely to receive only bare minimum services and be required to make a co-payment[1].

Three publicly funded community mental health programs serve the area in addition to SCF. None will provide a psychiatric consult to a person without third party coverage. All have service limits and co-pay requirements including one that sets the minimum co-pay at $50/visit.

Another barrier to accessing wellness services for the population of focus is that they must leave the tribal health system to obtain them. While SCF is working with an evidence-based approach, that approach is most suitable for SCF's adult customers. Alaska Native children and adolescents experiencing a lack of coping skills can only receive care from a community mental health center in Anchorage that has developed a program for children. As noted earlier, that organization compensates for losses in state grant funds by requiring co-payments and incentivizing staff to focus on customers with third party payers. Additionally, as a single purpose agency specializing in mental health care, that agency does not have the capacity to deal with the physical health sequelae of trauma. It is fair to say that customers of that organization get only half the treatment they need (mind only not the body). There is no service available for the members of the population of focus who reside in the Matanuska Susitna Borough.

Infant and early childhood physical health in Alaska in many ways mirrors infant and child health at the national level. Below is a description of important prenatal, perinatal, infant and early childhood health data for Alaska and comparison to national data. While overall there are many similarities between state-level Alaska statistics and nationally aggregated statistics, there are important differences. The differences often appear when examining data for Alaska Native and American Indian populations in the state. For example, differences by race appear in child abuse and neglect where Alaska Native children are three times more likely to be reported to child protection than white children. This difference, though should not be assumed to be race based; research has shown that these differences disappear when social determinants of health such as poverty level are controlled for (Sedlak & Broadhurst, 1996; Sedlak, McPherson, & Das, 2010; Fluke, Harden, Jenkins, & Ruehrdanz, 2011). The existence of several poorer health outcomes for Alaska Native children and families makes Southcentral Foundation perfectly situated to maximize impact at the state level.

The mean age of mothers in Alaska was 28.6 years old and the mean for fathers was 31.3 years old, while teenage mothers aged 15-19 years old gave birth to 423 babies in 2018. The 423 births to females aged 15-19 represented 4.2% of the total of 10,090 births in 2018. The youngest mother was 14 years old and the youngest father was 15 years old. The teen birth rate in Alaska decreased from 65.6 births per 1,000 females aged 15-19 years in 1990 to 18.8 in

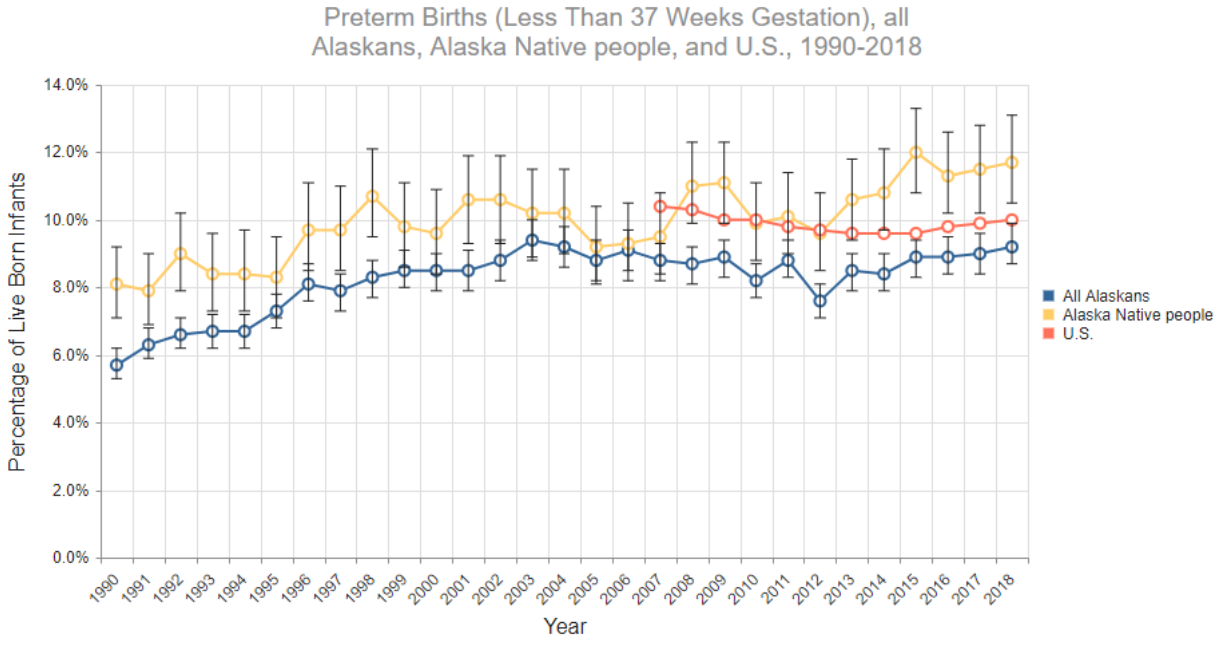
[1] Three publicly funded community mental health programs serve the area in addition to SCF. None will provide a psychiatric consult to a person without third party coverage. All have service limits and co-pay requirements including one that sets the minimum co-pay at $50/visit.

2018, a reduction of 71.3%. In addition to the decline in the rates, the number of teen births has declined from a high of 1,128 in 2008 to 423 in 2018.

Most women in Alaska receive prenatal care in their first trimester at 79% overall and in 2018, 77.95 of mothers received prenatal care in their first trimester of pregnancy compared to 77% in the nation. One in ten mothers in Alaska experience postpartum depression. Low income status is a risk factor for prenatal substance abuse, and they are more likely to have an unplanned pregnancy.

In 2018, there were 94,036 children ages 0-8 in Alaska and Alaska resident mothers gave birth to 10,092 babies. Young children make up 13% of the population. More than half of all young children (0-8) in the state of Alaska live in southcentral Alaska (Anchorage and Mat-Su regions) making the service area for Southcentral Foundation an area that covers over half of all young children in the state. Twenty-four percent of young children in Alaska are Alaska Native or American Indian and 55% of Alaska Native/American Indian young children are living in low income households that fall below the 200% federal poverty level.

Most Alaskan children ages 0-5 live with their parents. Preterm births in Alaska are about the national average at 11% in 2017. Low birth weight babies are below the national average at 6% versus 8% nationally. Breastfeeding initiation is higher than the national average in Alaska with an 86% initiation rate of breastfeeding versus 79% nationally. Preterm births in Alaska accounted for 9.2% of live births in 2018 and is lower than the national average (with statistical significance), although the rate in Alaska is slowly increasing while the national rate remains flat. This is in part due to a significantly higher preterm birth rate of 11.7% of live births for Alaska Natives in 2018. This rate has been trending upward from a low of 8.1% in 1990 to a high of 12% in 2015. These trends can be seen in the chart below.



As a state, Alaska's infant mortality rate in 2017 mirrored that of the United States as a whole, at 5.6 deaths per 1,000 live births in Alaska as compared to 5.8 for the US. Alaska Native populations, though, experienced a rate 50% higher at 8.1 deaths per 1,000 live births. 2018 national data is not yet available, but for the Alaska population the infant mortality rate stayed relatively constant at 5.9, while there was an increase to 10.1 deaths per 1,000 live births in the Alaska Native population (61% higher than the general population). In 2017, Alaska had the highest rate of child mortality of any state in the nation. Child mortality in Alaska is more than double the national rate for children 1-8 years of age. Leading causes of death for young children in Alaska in order of prevalence are unintentional injury, flu and pneumonia, birth defects, acute bronchitis, anemias, cerebrovascular, homicide and malignant neoplasms. The rate of child mistreatment in Alaska is almost double the national average. One third of children in Alaska have an OCS report prior to age 8. Neglect being the most common form of maltreatment in young children in Alaska.

Often young parents lack the knowledge of services available to them leading to other determinants to health. One of Southcentral Foundation's goals for the New Generations Project is to increase awareness of services for children and their families. Several possibilities exist for this type of resource such as an informational website, app, or booklets. Parents and guardians of young children are often overwhelmed by the day-to-day care of small children and need as much assistance as possible to understand and navigate the resources that are available to them but might not be as apparent.

Developmental screening rates are higher than the national average in Alaska at 47% in 2016 and 37% in 2017 as compared to the respective national rates of 30% and 32%. However, children with special needs are less likely to be identified prior to age five as compared to the national average. One of Southcentral Foundations goals with the New Generations Project is to increase efficiency with developmental screenings, interpret results effectively, and refer the families to the appropriate services in a timely manner.

Another barrier for Alaska Native and American Indian children is the successful completion of high school. High school graduation rates continue to be some of the lowest in the country and among other cultural backgrounds. Children entering school from disadvantaged backgrounds and without access to support services struggle in school resulting in an 18.5% rate of Alaska Native children never receiving a high school diploma. Social determinant of health (SDOH) are tied to barriers to care and often lead to reduced access to health services. The SDOH needs of these children can be seen in SCF's medical records where this data is used to assist in balancing provider panels in pediatric clinics.

While there are many aspects of infant, child, and family health that could be addressed by Indigenous Project LAUNCH/New Generations as demonstrated by the data above, an important focus of the project will be screening and referral to services. This is a critical need not only due to the low rates of identification of children with special needs in Alaska (as

compared to the US), but also because of potential downstream impacts that can be achieved. Screening as secondary prevention enables tertiary prevention, or treatment and minimization of physical, mental, and behavioral needs that are identified. Southcentral Foundation is well-suited to these tertiary prevention efforts with a suite of services available in-house (including home visiting, a new developmental/neuropsychological clinic, and our behavioral services division in addition to more standard primary care and pediatric clinics) and existing relationships with partners when care cannot be provided at Southcentral Foundation or on the Alaska Native Medical Center campus.

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Disparities for access to services

The proportion of American Indian and Alaska Native people in the U.S. without any type of health insurance is significantly higher than the general population – 24.6% compared to 16.8%[2]. At the state level, only Texas had a larger proportion of uninsured people than Alaska[3]. For children birth to 18 in Alaska, 12% had no health insurance despite the states federally

[2] Data derived from Adams, PF *et al*. (2013). Summary Health Statistics for the U.S. Population: National Health Survey 2012. National Center for Health Statistics. Vital Health Stats. P.41.
[3] U.S. Census Bureau. (2014). Health Insurance Coverage in the United States: 2014. Table A-1, p.26

sponsored Children's Health Insurance Program (Denali Kid Care) that offers coverage to children in families with incomes up to 203% of the Federal Poverty Level for Alaska. These effects of the 1990's Medicaid Refinancing policy created a huge barrier to access for many Alaska Native families.

A consequence of creating a system based on Medicaid reimbursement is that the quantity, type, and eligibility for services to an individual is determined by the state's Medicaid plan and not the child's need. Medicaid beneficiaries under the age of 21 who do not meet the plan's criteria for Severely Emotionally Disturbed (SED) are restricted to a small service package that does not include many necessary services like home visits, case management and group, individual and family skill building services.

Alaska Native people in the area are at a significant economic disadvantage compared to their neighbors. Per capita income is 36% lower for Alaska Native people in Anchorage and 33% lower in the Matanuska Susitna Borough. A more critical indicator, median household income, shows a similar pattern with Alaska Native households in Anchorage $27,253 (35%) lower than the city's general population ($50,868 vs. $78,121). The discrepancy in the Matanuska-Susitna Borough is also significant ($57,799 vs. $72,249) at 20%. The proportion of Alaska Native people living below the poverty level is another indicator of that economic disparity. 16% of the Alaska Native people in both Anchorage and the Matanuska Susitna Borough are living in poverty compared to 8% and 10% of the total populations of Anchorage and the Matanuska Susitna Borough respectively. These contribute immensely to the adverse conditions experienced by Alaska Native families and children.

Prevalence of mental disorder of children from birth to age eight in the pilot community: The prevalence for the unmet mental, physical and emotional children's health care among Alaska Native people in SCF's service area is likely the product of a number of factors including urbanization, intergenerational (historical) trauma, adverse childhood experiences, child maltreatment, prevalence of family violence in Alaska Native communities, incarceration of family members and increased likelihood of exposure to causal events. While discussed individually below, it is important to understand that the impact of trauma is cumulative, and each traumatic event increases a person's vulnerability and susceptibility to the next event even when positive resilience factors are present.

***Urbanization*:** Huge numbers of Alaska Native people now live in Anchorage where the Alaska Native population has been growing at a rate exceeding the general population for several decades. The transition from an Alaska Native village to the city is life altering. First, Alaska Native people must cope with the change from living with people that are similar to themselves to one where they are the minority in the much larger and diverse community. Since Anchorage has no neighborhoods with strong ethnic identities, Alaska Native people end up being dispersed throughout a metropolitan area larger than the state of Rhode Island and District of Columbia combined. This disbursement combined with significantly reduced exposure to their Alaska Native language and cultural activities makes positive cultural identification extremely

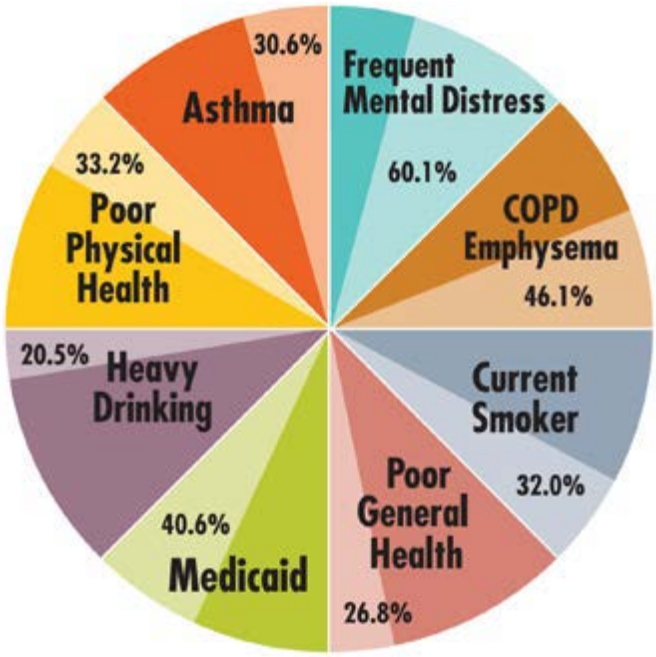
difficult – effectively eliminating an important resiliency factor that increases the likelihood that their move to the city will be a traumatic experience.

***Intergenerational trauma*:** Long before contact with European's, the Native people of the Americas established functioning societies with governance structures, economies that included trade across groups, religions and social norms. These were independent, successful societies. Contact with Europeans totally disrupted this functional order through exposure to diseases for which Alaska Native and American Indian people had no immunity; relocation away from their traditional lands; loss of self-governance to state with increased dependency; forced assimilation with loss of culture, loss of language; and the breaking apart of families by sending children and adolescents to remote boarding schools. Many of these were not only traumatic but had the additional adverse consequence of eroding vital protective factors that may have helped Alaska Native and American Indian people mitigate the impact of these traumatic events. The fact that so many Alaska Native and American Indian people and cultures survived these events is evidence of their tremendous inherent strength and resilience. Unfortunately for many, this intergenerational transmission of historical trauma may be only the first of a series they experienced in their lifetimes. While the mechanism of transmission is not completely understood, certainly having a parent affected by trauma with its concurrent emotional dulling, lack of interest in pleasurable activities, dissociation and emotionally unavailable to others cannot help the child develop a sense of security, autonomy, and affect regulation necessary for healthy development. There is a psychological and physical impact of trauma being transmitted from one generation to the next.

Adverse childhood experiences (ACE): There is also ample evidence to support the view that Alaska Native and American Indian people experience a higher prevalence of traumatic ACE categories than the general public. This contributes to greater health stressors for the Alaska Native population. The graphic below shows the degree to which childhood trauma contributes to poor health in Alaska. The paler areas represent the proportion of each outcome which can be linked back to ACEs."[4] These symptoms are then passed down to the next generation.

[4] Adverse Childhood Experiences Overcoming ACEs in Alaska, The Alaska Division of Public Health, *website: dhss.alaska.gov/abada/ace-ak*

Fig. 1



Child maltreatment: Child maltreatment is a specific trauma passed down. This abuse and neglect are recognized as traumatic by the National Traumatic Child Stress Network[5]. It also accounts for several ACE symptoms from figure 1. Alaska Native children are disproportionately affected by serious maltreatment. The state's child protection agency, Alaska Office of Children's Services (OCS) 2016 Annual Report states: "Alaska Native children (birth to18 years) are the subject of a disproportionate number of child abuse reports, substantiated reports of abuse/neglect and custody/placements into foster care." OCS data reported to U.S. Administration for Children and Families (ACF) provides evidence supporting that statement. In 2015, **57.9% of out-of-home placements for which race is identified was Alaska Native children** even though they account for no more than 20% of all children in the state[6]. Aggravating this significant disparity even further is the fact that Alaska reports the highest incidence of 12-month recurrence of maltreatment (16%) of any state in the country[7].

Violence against mother/witness to interpersonal violence at home: A child witnessing violence, particularly between parents and adults in the household, is another recognized source of trauma. Intimate partner violence against women unfortunately, is much too common. In Anchorage, **46% of women surveyed reported intimate partner violence** (IPV),

[5] http://www.nctsn.org/trauma-types#q7
[6] Downloaded at www.acf.hhs.gov/sites/defaul/files/cb/cfsr_stateperformanceworkbook.pdf.
[7] Downloaded at www.acf.hhs.gov/sites/defaul/files/cb/cfsr_stateperformanceworkbook.pdf.

30% sexual violence (SA), and 50.9% some type of violence (both) in their lifetimes. Past year experiences were 8.2%, 1.4%, and 8.5% respectively[8].

Statistics for the Matanuska Susitna Borough appear even worse at 46% (IPV), 34% (SA) and 52.5% (both)[9]. While these surveys included all women, an earlier study, 10 of 14 years of Anchorage data found that **Alaska Native women were victims of domestic violence at a rate over three times their proportion** in the city during that period of time[10]. Concurrently, Alaska Native men were named as suspects in these incidents at a rate equal to 3 times their proportion in the city. The same Anchorage study found that **children were present in 42% of the domestic violence incidents** from 1999 – 2002. These data provide further evidence that the Native population is disproportionately exposed to traumatic events.

Incarceration of a household member**:** Of over 5,000 people in Alaska's correctional institutions, **36.9% are Native[11]**. This is about double their proportion of the state's population. This disproportionate rate of incarceration of adults impacts Alaska Native children. The proportion of adults in Alaska who experienced the incarceration of a family member is 11.3%, while 21.4% of Alaska Native people experienced the incarceration of a family member[12]. The incarceration of household member can significantly impact children in many ways including parental loss, financial hardship due to loss of household income, inability to foster relationships between parent (or family member) and child, attachment issues, potential trauma leading up to a household member's arrest, and stigma[12].

Mental and behavioral health services utilization: Finally, it should be noted that at 38.5%[13] of all people served, Alaska Native people are represented disproportionately in the public behavioral health programs in Alaska. The proportion of Alaska Native children and adolescents in the mental health system is even greater. More than **44.1%[14] of all children getting mental health services in FY2015 were Alaska Native**. This data clearly indicate that Alaska Native children and adults are disproportionately affected by mental health problems. The fact that many of the stressors thought to underlie the behavioral health problems have high associations with physical health problems makes developing comprehensive approaches to identifying and addressing the issues related to trauma that include both primary care and

[8] UAA Justice Center. (2011). Survey of adult women in Municipality of Anchorage. http://justice.uaa.alaska.edu/avs

[9] UAA Justice Center. (2012). Survey of adult women in Municipality of Anchorage. http://justice.uaa.alaska.edu/avs

[10] Municipality of Anchorage. (2006). Domestic Violence Analyses. Incidents Reported to Police in Anchorage, Alaska. Police Response and Incident Characteristics: Fourteen Year Study 1989-2002.

[11] Alaska Department of Corrections. (2015). Alaska Offender Profile: 2014. http://www.correct.state.ak.us/admin/docs/Final_2014_Profile.pdf

[12] State of Alaska Department of Health and Human Services. (2020). AK-IBIS Report. http://ibis.dhss.alaska.gov/indicator/view/xaceprsn.HA.html

[13] Alaska Interagency Work Group. (2015). Recidivism Reduction Plan Report. http://www.correct.state.ak.us/commish/docs/HB266%20-%20Recidivism%20Reduction%20Plan %20Report%20(2015).pdf

[14] Data source: 2015 MHBG Behavioral Health Report – MHBG Table 11-A & MHBG Table 11-B downloaded at bgas.samhsa.gov . The % given is likely an underestimate since report provides data for single race only with two or more races reported in aggregate. The estimate used in narrative was derived by multiplying the 2 or more race data in the report by the proportion of all people in the state who reported being Native in combination with one or more other races in the U.S. Census American Community Survey 2010 – 2014 5-Year Data.

behavioral health the most promising route for the population of focus. The fact that this can be done within SCF where such a huge proportion of the population of focus is already being served would seem to offer the best opportunity to address this disparity affecting Alaska Native people in the most effective and efficient manner.

Strategic Planning Process

During November 18-19, 2019, 30 people gathered at SCF to discuss project launch including the steering committee, stakeholders and parent partners. Each had the opportunity to present their experience in early childhood health and wellness as well as their passion for the topic and their vision for improvement. The executive sponsors, Dr. Doug Eby, Vice President for Medical Services and April Kyle, Vice President for Behavioral Services, spoke to their vision of how Project Launch could expand and improve early childhood services for SCF's customer-owners and the community. With this context, the group launched a brainstorm session around the various areas of early childhood health and wellness inspired by the 5 Project Launch strategies.

Several small groups held discussion around each topic with the headings of Emotional, Behavioral, Physical, Nutritional and Intellectual needs. The groups were instructed to come up with a list of ideas on expansion, improvement or new programs to fill any perceived gaps. They were asked to think system-wide and about the entire family (moms, dads, caregivers, grandparents, aunts, uncles, etc.).
These ideas were then prioritized thorough an affinity process where each participant was given 12 votes, represented by stickers, to choose their top priorities.
The goals and objectives presented in the strategic plan blow resulted from this prioritization activity.

While this process resulted in a large amount of data, some of the lessons learned includes spending more time in small group discussion prior to large group brainstorming. Everyone was eager to get their thoughts up on the board and may have rushed through the small group conversation that may have deepened the overall process. Further, the large disparate ideas on the topics proved difficult to categorize into buckets. In hindsight, providing some additional

guidance on categories to consider would have made interpreting and operationalizing the data easier

Introduction to Plan

The goal of the strategic planning sessions described above was to encourage stakeholders to share story around their vision for early childhood health and wellness and together strategize creative ways to achieve project launch objectives. The stakeholders were a mix of clinical, non-clinical, parents, community members, behaviorists, and operational managers over early childhood programs. Over 67% of the group is Alaska Native or American Indian and a parent/caregiver of young children. Each small group of individuals discussed several topics and questions, and each offered their perspective on the topics.

Using the lens of relationship-based care and the Alaska Native values upon which SCF is founded, the larger group set about outlining existing programs that support all aspects of family health and how they could be improved: emotional, physical, nutritional and intellectual. The group then brought their expertise and community connections to bear in outlining best practices, tools and strategies to improve the health and wellness of young Alaska Native and American Indian families.

The comprehensive strategic plan that follows will focus on the steps needed to develop a seamless system of care and community connections that surrounds young Alaska Native families and provides optimal opportunities for health and wellness. The goals and objectives are long term, with activities being more short term of a year or less. Each strategy will have its own workgroup to drill down on the activities and outcomes which will feed up to the steering committee to ensure forward progress. The strategic plan follows the SAMHSA template for all Project LAUNCH comprehensive plans.

Vision, Mission, Project Aim & Project Values: (Table 1)

Vision, Mission, & Project Values Statement
Southcentral Foundation Vision Statement
A Native Community that enjoys physical, mental, emotional, and spiritual wellness.
Southcentral Foundation Mission Statement
Working together with the Native Community to achieve wellness through health and related services.
Project Aim Statement
Alaska Native families will increase their physical, mental, emotional and spiritual wellness by optimizing the effectiveness of services that support families in the preparation for and care of new generations by inventorying current work, learning from internal and external best practices, engaging SCF and community stakeholders and creating a coordinated, system approach to be deployed by December 2023.
Project Values (RELATIONSHIPS)
• **R**elationships between the customer-owner, the family, and provider must be fostered and supported • **E**mphasis on wellness of the whole person, family, and community including; physical, mental, emotional, and spiritual wellness • **L**ocations that are convenient for the customer-owner and create minimal stops for the customer-owner • **A**ccess is optimized and waiting times are limited • **T**ogether with the customer-owner as an active partner • **I**ntentional whole system design to maximize coordination and minimize duplication • **O**utcome and process measures to continuously evaluate and improve • **N**ot complicated but simple and easy to use • **S**ervices are financially sustainable and viable • **H**ub of the system is the family • **I**nterests of the customer-owner drive the system to determine what we do and how we do it • **P**opulation-based systems and services • **S**ervices and systems build on the strengths of Alaska Native cultures

Logic Model for LAUNCH (Table 2)

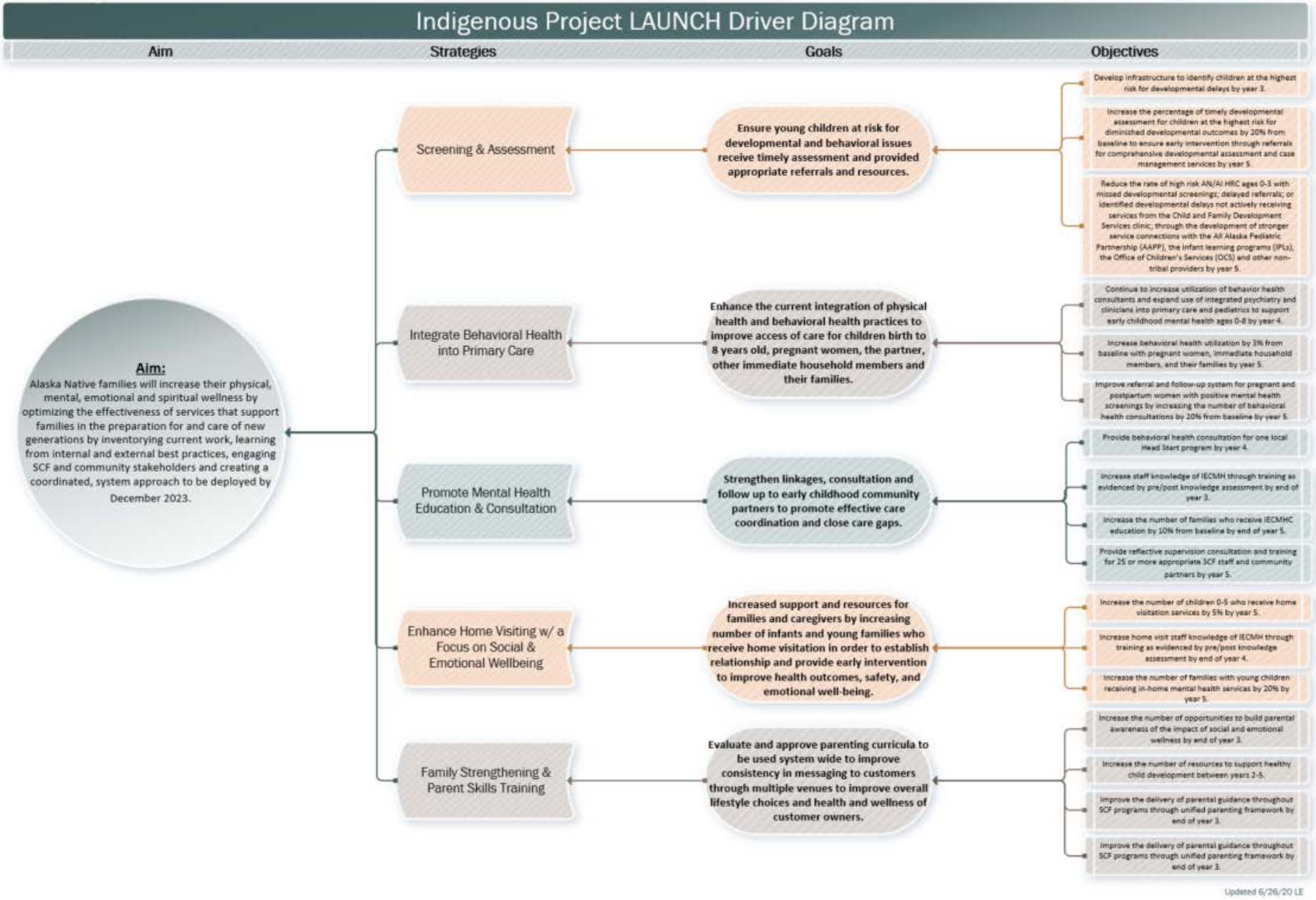
Logic Model for LAUNCH

Program Aim: Alaska Native families will increase their physical, mental, emotional and spiritual wellness by optimizing the effectiveness of services that support families in the preparation for and care of new generations by inventorying current work, learning from internal and external best practices, engaging SCF and community stakeholders and creating a coordinated, system approach to be deployed by December 2023.

Resources/Inputs	Activities/Participation	Impact/Results	Long Term Goals/Outcomes
Overarching IPL Logic Model			
Southcentral Foundation • OB/GYN & midwifery services • Learning circles & parenting services • Pediatric services • Primary care services • Data collection & analysis • Nutaqsiivik program • Home Visiting program • Family Wellness Warriors Initiative • Behavioral Health Division • Health Education Department • Child & family Development Services • Development Center • Elder Program **Community Collaboration** • Cook Inlet Native Head Start • Cook Inlet Tribal Council • Joint Task Force • All Alaska Pediatric Partnership • Best Beginnings • Programs for Infant and Children • Alaska Alliance for Infant Mental Health *see page 25 of strategic plan for additional partnerships.	• Piloting integrated psychiatry in primary care and pediatrics • Increase participation in learning circles • Optimize assessments to identify mental/behavioral health needs in children 0-8 • Increase home visitation services • Create public & community awareness campaign around infant & early childhood mental health competencies • Increase education opportunities for parents & families • Evaluate and align parenting curricula and messaging to customers • Provide behavioral health consultation for one local Head Start program • Provide training for general staff and home visit staff on IECMH • Provide reflective supervision consultation and training for 25 or more staff	• Increased percentage of children with behavioral health consultation & screening • Increased referrals to services based on screenings • Increased parenting knowledge & skills among Customer Owners (CO) • Increased number of families who receive IECMHC education by 10% • Increased knowledge of IECMH through training for general staff and home visit staff • Increased usage of home visiting services meeting parents where they are • Increased percentage of COs aged 0-8 using SCF & local services focused towards childhood physical, mental, & emotional health • Increased integration of behavioral health into medical services • Improved delivery of parental guidance throughout SCF programs through unified parenting framework	• Optimized screening and follow up for children • Fully integrated and supported BHCs in primary care and pediatrics • Expansion of behavioral health services integration into primary care and other child serving settings to impact risk of depression, anxiety, and high-risk lifestyle choices has been explored • Effective care coordination and closure of care gaps through community collaboration • Increased support and resources for families and caregivers • Increasing the capacity of home-based care for children • System-wide parenting information in alignment

Strategies	Goals & Objectives (Table 3)
Screening & Assessment	**Goal 1: Ensure young children at risk for developmental and behavioral issues receive timely assessment and provided appropriate referrals and resources.**
	Objective 1.1: Develop infrastructure to identify children at the highest risk for developmental delays by year 3.
	Objective 1.2: Increase the percentage of timely developmental assessment for children at the highest risk for diminished developmental outcomes by 20% from baseline to ensure early intervention through referrals for comprehensive developmental assessment and case management services by year 5.
	Objective 1.3: Reduce the rate of high risk AN/AI HRC ages 0-3 with missed developmental screenings; delayed referrals; or identified developmental delays not actively receiving services from the Child and Family Developmental Services Clinic; through the development of stronger service connections with the All Alaska Pediatric Partnership (AAPP), the infant learning programs (IPLs), the Office of Children's Services (OCS) and other non-tribal providers by year 5.
Integrate Behavioral Health	**Goal 2: Enhance the current integration of physical health and behavioral health practices to improve access of care for children birth to 8 years old, pregnant women, the partner, other immediate household members and their families.**
	Objective 2.1: Continue to increase utilization of behavioral health consultants and expand use of integrated psychiatry and clinicians into primary care and pediatrics to support early childhood mental health ages 0-8 by year 4.
	Objective 2.2: Increase behavioral health utilization by 3% from baseline with pregnant women, immediate household members, and their families by year 5.
	Objective 2.3: Improve referral and follow-up system for pregnant and postpartum women with positive mental health screenings by increasing the number of behavioral health consultations by 20% from baseline by year 5.
Promote Mental Health Education & Consultation	**Goal 3: Strengthen linkages, consultation and follow up to early childhood community partners to promote effective care coordination and close care gaps.**
	Objective 3.1: Provide behavioral health consultation for one local Head Start program by year 4.
	Objective 3.2: Increase staff knowledge of IECMH through training as evidenced by pre/post knowledge assessment by end of year 3.
	Objective 3.3: Increase the number of families who receive IECMHC education by 10% from baseline by end of year 5.
	Objective 3.4: Provide reflective supervision consultation and training for 25 or more appropriate SCF staff and community partners by year 5.
Enhance home visiting w/ Focus Social/Emotional Well-Being	**Goal 4: Increased support and resources for families and caregivers by increasing number of infants and young families who receive home visitation in order to establish relationship and provide early intervention to improve health outcomes, safety, and emotional well-being.**
	Objective 4.1: Increase the number of children 0-5 who receive home visitation services by 5% by year 5.
	Objective 4.2: Increase home visit staff knowledge of IECMH through training as evidenced by pre/post knowledge assessment by end of year 4.
	Objective 4.3: Increase the number of families with young children receiving in-home mental health services by 20% by year 5.
Family Strengthening & Parent Skills Training	**Goal 5: Evaluate and approve parenting curricula to be used system wide to improve consistency in messaging to customers through multiple venues to improve overall lifestyle choices and health and wellness of customer owners.**
	Objective 5.1: Increase the number of opportunities to build parental awareness of the impact of social and emotional wellness by end of year 3.
	Objective 5.2: Increase the number of resources to support healthy child development between years 2-5.
	Objective 5.3: Improve the delivery of parental guidance throughout SCF programs through unified parenting framework by end of year 3.
	Objective 5.4: Increase parental learning circle participants knowledge of social emotional wellness and healthy child development as evidenced by pre/post knowledge assessment by end of year 4.

Driver Diagram



Implementation Goals and Objectives

(Table 4)

Goal 1: Ensure young children at risk for developmental and behavioral issues receive timely assessment and are provided appropriate referrals and resources.

Objective 1.1: Develop infrastructure to identify children at the highest risk for developmental delays by year 3.

Objective 1.2: Increase the percentage of timely developmental assessment for children at the highest risk for diminished developmental outcomes by 20% from baseline to ensure early intervention through referrals for comprehensive developmental assessment and case management services by year 5.

Objective 1.3: Reduce the rate of high risk AN/AI HRC ages 0-3 with missed developmental screenings; delayed referrals; or identified developmental delays not actively receiving services from the Child and Family Developmental Services Clinic; through the development of stronger service connections with the All Alaska Pediatric Partnership (AAPP), the infant learning programs (IPLs), the Office of Children's Services (OCS) and other non-tribal providers by year 5.

Sustainability strategies:

- Onboarding of new staff for consistency in messaging to caregivers and families about early childhood mental health
- Monitoring of data/utilization/access
- Specialty case management through action lists to monitor and ensure follow up of high-risk children

General Strategy	Activities/Tasks	Stakeholders Responsible	Specific Timeframe
Screening & Assessment	• Optimize in depth evaluation of environmental factors both negative and positive using evidence-based tools as much as possible. o Early inventory of environmental factors/social determinants, ASQ, ASQ-SE, SBIRT, Prime MD etc. • Educate staff and customers on infant and early childhood mental health. • Create action list and dashboard to intensively manage high-risk children and their families. • Connect with community partners to share new process and collaborate ongoing follow up and support for high-risk children and families. • Timely coordination of referrals within SCF to and from behavioral health services.	• Child and Family Development Services Team • Steering Committee • Infant and Early Childhood Work Group • Community Partners	• Objective 1.1 completed by end of year 3. • Objective 1.2 completed by year 5. • Objective 1.3 completed by year 5.

(Table 5)

Goal 2: Enhance the current integration of physical health and behavioral health practices to improve access for children birth to 8 years old, pregnant women, the partner, other immediate household members and their families.

Objective 2.1: Continue to increase utilization of behavior health consultants and expand use of integrated psychiatry and clinicians into primary care and pediatrics to support early childhood mental health ages 0-8 by year 4.

Objective 2.2: Increase behavioral health utilization by 3% from baseline with pregnant women, immediate household members, and their families by year 5.

Objective 2.3: Improve referral and follow-up system for pregnant and postpartum women with positive mental health screenings by increasing the number of behavioral health consultations by 20% from baseline by year 5.

Sustainability strategies:

- Onboarding of new staff for consistency in messaging to caregivers and families
- Monitoring of data/utilization/access

General Strategy	Activities/Tasks	Stakeholders Responsible	Specific Timeframe
Integrated Behavioral Health	• Improve the rates of behavioral health consultation and intervention with infants and families. • Increase the numbers of pregnant women, their partners, children and families receiving behavioral health consultation and intervention by increasing the number of prenatal assessments. • Examine the utilization of integrated psychiatry in Primary Care and Pediatrics. Focus on the perceived gap for mental health and substance abuse issues for families of children 0-5.	• Primary Care and Pediatrics Leadership and Teams • Behavioral Health Leadership and Teams • Steering Committee	• Objective 2.1 completed by end of year 4. • Objective 2.2 completed by year 5. • Objective 2.3 completed by year 5.

(Table 6)

Goal 3: Strengthen linkages, consultation and follow up to early childhood community partners to promote effective care coordination and close care gaps.

Objective 3.1: Provide behavioral health consultation for one local Head Start program by year 4.

Objective 3.2: Increase staff knowledge of IECMH through training as evidenced by pre/post knowledge assessment by end of year 3.

Objective 3.3: Increase the number of families who receive IECMHC education by 10% from baseline by end of year 5.

Objective 3.4: Provide reflective supervision consultation and training for 25 or more appropriate SCF staff and community partners by year 5.

Sustainability strategies:

- Onboarding of new staff for consistency in messaging to caregivers and families
- Campaigning services internally and externally
- Ongoing education for staff annually
- Monitoring of data/utilization/access
- Increase the number of endorsed infant and early childhood behavioral health consultants

General Strategy	Activities/Tasks	Stakeholders Responsible	Specific Timeframe
Promote Mental Health Education & Consultation	• Increase the connections between SCF and community resources for young families specifically addressing IECMHC's and behavioral health consultation. • Provide training and resources on reflective supervision for staff and community partners working with young at-risk families. • Strengthen linkages between tribal community partners and SCF who receive screening and assessment to ensure follow through and appropriate interventions. • Increase the numbers of staff and community members trained and able to receive reflective supervision. • Train behavioral health consultants to be well versed in infant and early child mental health. • Increase the number of behavioral health consultants endorsed in IECMH.	• Steering Committee • Infant and Early Child Mental Health Work Group • Behavioral health Leadership and Teams • Community partners	• Objective 3.1 completed by end of year 4. • Objective 3.2 completed by year 3. • Objective 3.3 completed by year 5. • Objective 3.4 completed by end of year 5.

(Table 7)

Goal 4: Increased support and resources for families and caregivers by increasing number of infants and young families who receive home visitation in order to establish relationship and provide early intervention to improve health outcomes, safety, and emotional well-being.

Objective 4.1: Increase the number of children 0-5 who receive home visitation services by 5% by year 5.

Objective 4.2: Increase home visit staff knowledge of IECMH through training as evidenced by pre/post knowledge assessment by end of year 4.

Objective 4.3: Increase the number of families with young children receiving in-home mental health services by 20% by year 5.

Sustainability strategies:

- Examine resources and services internally and externally
- Monitoring of data/utilization/access
- Financially feasible services

General Strategy	Activities/Tasks	Stakeholders Responsible	Specific Timeframe
Enhance home visiting w/ Focus Social/Emotional Well-Being	• Explore evidence-based programs for home visitation that could expand beyond nurse family partnership model. • Provide training on IECHMHC for staff in outpatient and home visit programs. • Expand home visitation to a greater percentage of customer owners.	• Steering Committee • Community and Home Visit Work Group • Nutaqsiviik Team	• Objective 4.1 completed by end of year 5. • Objective 4.2 completed by year 4. • Objective 4.3 completed by year 5.

(Table 8)

Goal 5: Evaluate and approve parenting curricula to be used system wide to improve consistency in messaging to our customers through multiple venues to improve overall lifestyle choices and health and wellness of customer owners.

Objective 5.1: Increase the number of opportunities to build parental awareness of the impact of social and emotional wellness by end of year 3.

Objective 5.2: Increase the number of resources to support healthy child development between years 2-5.

Objective 5.3: Improve the delivery of parental guidance throughout SCF programs through unified parenting framework by end of year 3.

Objective 5.4: Increase parental learning circle participants knowledge of social emotional wellness and healthy child development as evidenced by pre/post knowledge assessment by end of year 4.

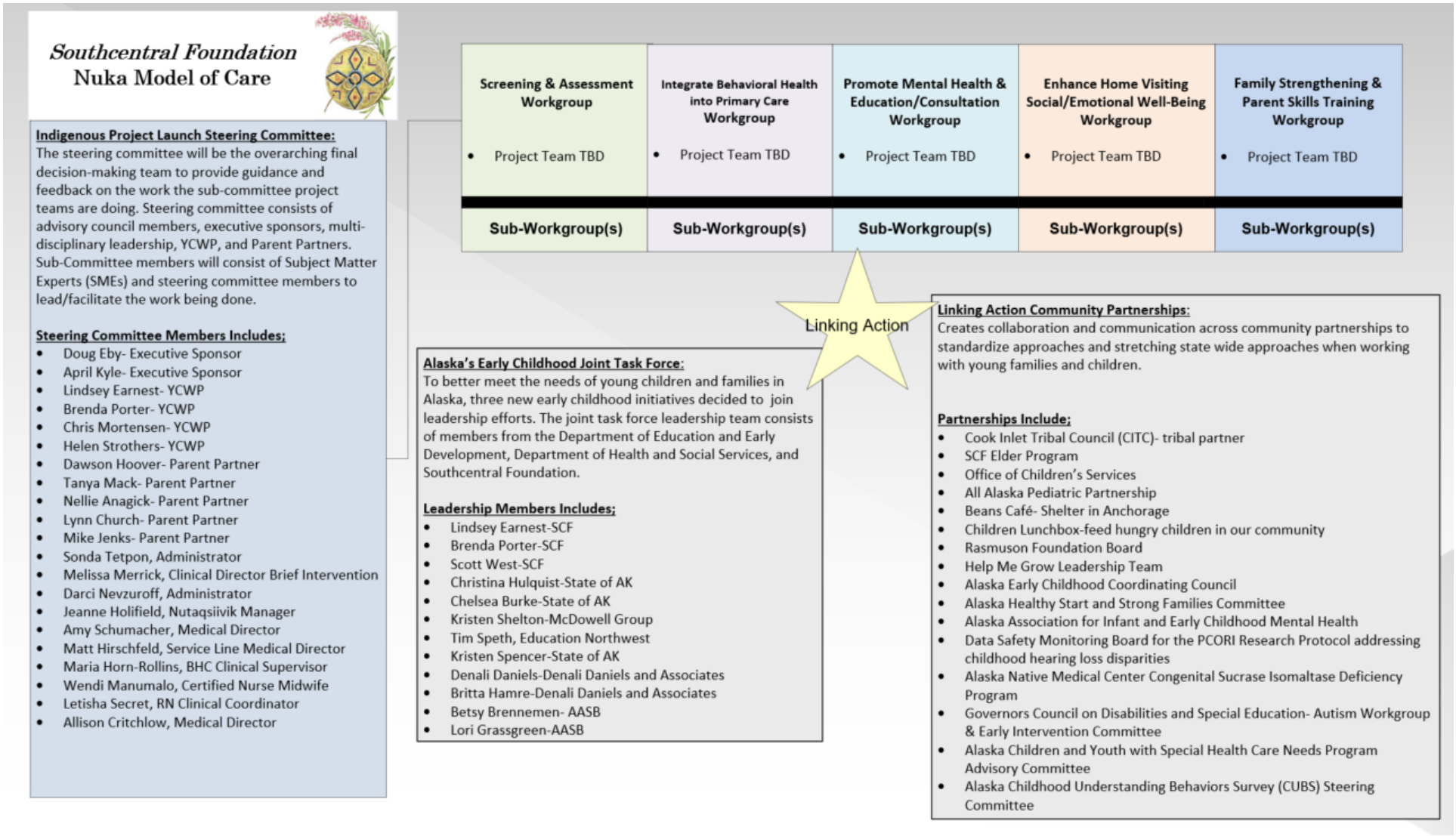
Sustainability strategies:

- Building awareness regarding available services and resources internally and externally
- Monitoring of data/utilization/access
- Develop approval process system wide for programs wanting to deliver parenting curriculum.

General Strategy	Activities/Tasks	Stakeholders Responsible	Specific Timeframe
Family Strengthening & Parent Skills Training	• Create an awareness campaign about existing programs that support young families and infant mental health. • Review and decide on a parenting curriculum consistent with SCF and Alaska Native values. • Build capacity to deliver chosen curricula to staff and customers. • Develop approval process system wide for programs wanting to deliver an alternative parenting curriculum. • Consistent marketing campaign for primary care teams and SCF staff.	• Steering Committee • Parenting Work Group	• Objective 5.1 completed by end of year 3. • Objective 5.2 completed by year 2-5. • Objective 5.3 completed by year 3. • Objective 5.4 completed by end of year 4.

Project Gantt Chart

Committee Structure & Linking Partnership



Disparity Impact Statement

Southcentral Foundation's (SCF) mission is to work together with the Native Community to achieve wellness through health and related services. The population of focus for Indigenous Project LAUNCH is Alaska Native and American Indian (Native) children birth to eight years of age and their families residing in SCF's Indian Health Service (IHS) recognized service area.

1. Proposed number of individuals to be reached by subpopulations in the geographic area.

The projected number of Alaska Native/American Indian children age 0 to 8 in the target community of Anchorage who will receive a direct service (screening, behavioral health anticipatory guidance or other brief intervention, home visiting) to be served in each year of the project is listed in the chart below. Note that these numbers represent unique (unduplicated) individuals and that the decreasing numbers seen in Years 3 – 5 reflect the fact that most children have already received a service through the project and counted in an earlier year.

Services	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Total to be served	N/A.	5000	600	600	600	6800

When looking at the number of children (ages 0-8) empaneled at SCF, there are 7057 children in the Anchorage area, 2138 children in the Matanuska-Susitna Borough area and 333 identified as other, which equates to children residing outside the Anchorage and Mat-Su area. Below is a table which also identifies the number of children by age groups.

Age	0 year	1 year	2 years	3 years	4 years	5 years	6 years	7 years	8 years	Total
Anchorage	696	696	789	743	801	808	808	840	876	7057
Mat-Su	190	202	222	263	222	238	272	247	282	2138
Other	27	26	42	35	36	34	37	45	51	333

These projections reflect only the numbers receiving a direct service and do not include children who may be receiving the service indirectly through the project's early childhood consultation, public education, or family strengthening/parent skill development components.

Two major imperatives support focusing on this group. The first imperative is the prevalence of trauma that is significantly greater in the Native population than in the general population. The prevalence for the unmet mental, physical and emotional children's health care among Native people in SCF's service area is likely the product of several factors including urbanization, intergenerational (historical) trauma, adverse childhood

experiences, child maltreatment, prevalence of family violence in Native communities, incarceration of family members and increased likelihood of exposure to causal events. Since the impacts of trauma typically include both psychological and physical conditions that adversely affect our population of focus' health. The second imperative for our population of focus is that they experience pathological trauma and are best served when their issues are addressed in a comprehensive system of care that reduces their trauma symptomology by skills development that also increases their coping skills. It is important to understand that the impact of trauma is cumulative, and each traumatic event increases a person's vulnerability and susceptibility to the next event even when positive resilience factors are present.

2. Quality Improvement Plan Using SCF Data

SCF's primary care services serve Alaska Native and American Indian families and the GPRA data will be monitored to confirm that services are administered primarily to this population.
SCF will design and implement activities to increase staff and organizational competencies to serve youth ages 0-8 and their families. Activities will be in accordance with the cultural and linguistic needs of individuals in the community. The project team will collaborate with formal partners and community agencies in planning the design and implementation of program activities to ensure cultural and linguistic needs of youth and their families are effectively addressed.

Continuous quality improvement (CQI) will be used to analyze, assess and monitor key performance indicators as a mechanism to ensure high-quality and effective program operations. Program data will be used to monitor and manage program outcomes within a quality improvement process. Programmatic adjustments will be made if indicated by the data. Data collection and reporting processes will be examined to ensure accuracy and usefulness to the project staff. Adjustments to the process will be made by recommendation of the project team. Additionally, the Planning and Grants department will provide independent monitoring of the data as part of their review process. Both CQI and evaluation findings will be incorporated into ongoing program planning and management activities. The project team will meet regularly with data collection and evaluation included on the team meeting agenda.

Outcomes: Once SCF develops the practiced-based care Teens Responsibly Accepting Independent Life Skills (TRAILS) into a culturally relevant curriculum for our target audience, the project team will monitor outcomes for key activities to determine the impact of the project that supports young children and their families to easily transition into the Anchorage School system.

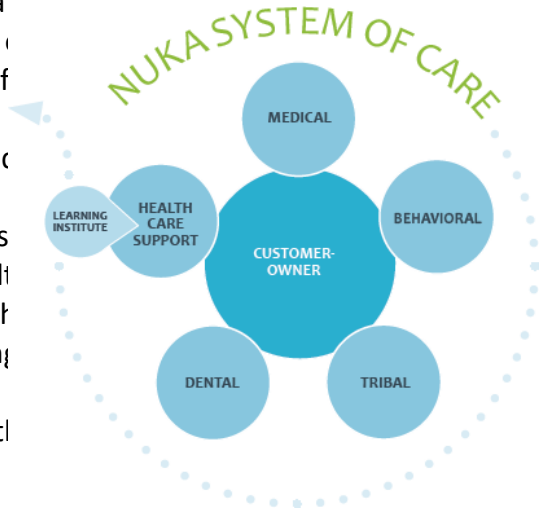
3. Adherence to the CLAS Standards

SCF's quality improvement plan will ensure adherence to the enhanced National Standards

for Culturally and Linguistically Appropriate Services (CLAS Standards) in Health and Health Care. This will include attention to:

a. Diverse cultural health beliefs and practices

The language, beliefs, norms, and values of the area Native population are closely associated with those the regional community. All customer-owners are of Alaska Native or American Indian decent and can represent any of the over 400 tribes currently serve SCF. To more fully accommodate issues of cultural competence, Native customs, traditions, differences and similarities are noted and celebrated. As a result SCF developed the Nuka System of Care, a relationsh based, customer-owned approached to transformin health care, improve outcomes and reducing costs. There are five key work systems that contribute to t Nuka System of Care and the image to the left illustrates how the system is designed to reflect the values and culture of the Native people it serves and offers customer-owners numerous avenues to provide feedback about how well those ideals are being attained.



Cultural translation (project to population) is vital to appropriately understanding the context in which the population of focus is immersed. The population of focus must also understand and
be comfortable with the project. Disabilities are identified and accommodated in all programs and facilities – all SCF facilities meet ADA standards. Consideration for client age, gender, socioeconomic characteristics, literacy, health status, and sexual orientation is accommodated through staff training, awareness, support, and counseling.

b. Preferred languages

All customers served are English speakers and a low percentage of clients either speak or understand some of the Native languages – fluency varies considerably due to exposure and traditional beliefs of families and care givers. Translation services will be provided for customers utilizing services who do not speak English as their primary language.

c. Health literacy and other communication needs of all sub-populations identified in your proposal

SCF will tailor all interventions to include limited English proficient individuals. Project staff will be trained to ensure capacity to provide interventions that are culturally and linguistically appropriate. Program materials being provided to youth and their families will be at an appropriate reading level to improve health literacy.

Appendix A: Strategic Planning Agenda

PROJECT LAUNCH STRATEGIC PLANNING

Location: Address or Room Number

Date: November 18th, 2019 (Day 1)

Time: 10am-12:30pm

Facilitator: Lindsey Earnest, Nellie Anagick

Agenda Items

10:00am – 10:20am	Welcome and Check-in, Background and History Current resources for parenting at SCF History and Vision	April Kyle & Doug Eby
10:20am – 10:50am	Round Robin	All
10:50am – 11am	Break	All
11am – 11:30am	Round Robin Continued	All
11:40am – 11:45am	Boxed Lunch & Break	All
11:45am – 12:15pm	Vision Discussion	April Kyle & Doug Eby
12:15pm – 12:30pm	Closeout	Lindsey Earnest & Nellie Anagick

Additional information

Pre-fill worksheet for Day 2

PROJECT LAUNCH STRATEGIC PLANNING

Location: Address or Room Number

Date: November 19th, 2019 (Day 2)

Time: 11am-12:30pm

Facilitator: Lindsey Earnest, Nellie Anagick

Agenda Items

11:00am – 11:10am	Welcoming & Check-in	April Kyle & Doug Eby
11:10am – 11:20am	Expectations and Structure	Lindsey Earnest & Brenda Porter
11:20am – Noon	Brainstorm Key Strategies- Group Activity	Lindsey Earnest & Brenda Porter
Noon – 12:10pm	Boxed lunch and Break	-
12:10 – 12:30pm	Close out/ Next Steps	Doug Eby

Additional information

Add additional instructions or comments here.

Appendix B: Planning Worksheet

This worksheet was sent to all members prior to the first session taking place. Members were asked to fill out and send back the form back prior to the first session. Everyone's worksheet was shared in a binder and used as talking points in day one.

Indigenous Project Launch Strategic Planning Worksheet

Lindsey Earnest

1. Subject of expertise in connection to parenting:

2. Background and history with your topic: *Please explain your experience with the topic and any background information you feel would be useful for the group.*

3. Best practices and any other curriculum for topic that fits SCF needs and philosophy: *Please list as many best practices you can recall on the topic keeping in mind corporate goals and operational principles.*

4. What are you most passionate about in regards to maternal child health and young child wellness?

Appendix C: Buckets Worksheet

This worksheet was shared in advance to help members prepare for the first session of strategic planning by providing a basic framework of how view and categories different processes, programs, services, etc.

Project Launch – How are we currently engaging w/ young families- what supports, messages & programs do we currently provide? What are the gaps? How could we improve/expand or add to?					
	Preconception	Pregnancy	Birth – 3 Months	3 Months – 2 Years	2 Years- 8 Years
PHYSICAL					
Emotional/ Social/ Behavioral					
Nutritional					
Intellectual					

STRATEGIC PLANNING CHECKLIST

Task	*Progress*
Agenda for Day 1	11/13- Revised Draft ready for review (Doug/Nellie/Brenda)
Agenda for Day 2	11/13- Revised Draft ready for review (Doug/Nellie/Brenda)
Attendees	Confirmation from all – no Tanya Mack
Worksheet sent to attendees	Completed 11/7/19 (Dr. MH)
Follow up on worksheets	In Progress- to be completed 11/13
Brain Storming Activity	In Progress (swim lanes)
Supplies	• Flipchart • Markers • Snacks for table • Binders for each participant (notebook, pen, agenda's, copy of all members worksheets, swim lanes, committee structure proposal/attendee list) • Easel for flip chart
Room Reserved/ Lunch Ordered	Completed 11/7 (reminder set for today and Friday to confirm lunch) *Room set up in a rectangle (6 on each side and 4 at each end)
Communication Plan	Not Started

Close out for Day 1: Attendees will be given activity – preferably to be sent to Lindsey by COB same day to gather data together

Close out for Day 2: Who-What-When-Where-Why details

Appendix E: Project Overview

This document was shared in binders to reorient members participating in strategic planning and was also used a reference material in the process to ensure the work stayed within the bounds of project scope.

Linking Actions for Unmet Needs in Children's Health Grant Program
Short Title: Project LAUNCH

Purpose: promote the wellness of young children, from birth to 8 years of age, by addressing the social, emotional, cognitive, physical and behavioral aspects of their development; provide local communities or tribes the opportunity to disseminate effective and innovative early childhood mental health practices and services, ultimately leading to better outcomes for young children and their families.

Goal: foster the healthy development and wellness of all young children (birth through age 8), preparing them to thrive in school and beyond; build the capacities of caregivers to promote healthy social and emotional development; to prevent mental, emotional and behavioral disorders; and to identify and address behavioral concerns before they develop into serious emotional disturbances (SED).

- Improve outcomes at the individual, family, and community levels by addressing risk factors that can lead to negative outcomes. Promotes protective factors that support resilience and healthy development, which can protect individuals from later problems.

Project LAUNCH's Objectives

- Increase access to screening, assessment, and referral to appropriate services for young children and families.
- Expand use of culturally relevant, evidence-based prevention, and wellness promotion practices in a range of child-serving settings.
- Increase integration of behavioral health into primary care settings.
- Improve coordination and collaboration across disciplines at the local, state, territorial, Tribal, and federal levels.
- Increase workforce knowledge of children's social and emotional development and skills to respond to behavioral health challenges of young children and families.

Project LAUNCH's Five Prevention and Promotion Strategies

- Screening and assessment in a range of child-serving settings
- Integrate behavioral health into primary care
- Promote mental health education and consultation in early care
- Enhance home visiting with a focus on social and emotional well-being
- Family strengthening and parent skills training