Beyond the Grant: LAUNCH Grantees Influence Policy Changes to Advance Child Wellness Goals

Introduction

Funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), Project LAUNCH (Linking Actions for Unmet Needs in Children's Health) addresses the physical, social, emotional, cognitive, and behavioral aspects of children's development ages birth to 8 years. Project LAUNCH communities have a dual focus on improving collaboration across the child-serving system and improving access to and the availability of evidence-based prevention and wellness promotion practices. Specifically, grantees infuse mental health practices into primary care, early care and education (ECE), Home Visiting programs, and family settings. State, territories, and tribes work to sustain and replicate local innovative and effective prevention and promotion practices and influence broader shifts in policy.

About Project LAUNCH

Project LAUNCH grantees improve coordination across child-serving systems, build infrastructure, and increase access to high-quality prevention and wellness promotion services for children and their families.

States, territories, and tribes receiving Project LAUNCH grants select a local pilot community within the larger jurisdiction as a partner and then bring together child-serving organizations to develop policies, financial mechanisms, and other reforms to improve the integration and efficiency of the child-serving system.

This brief highlights many notable and emerging successes of grantees in expanding and sustaining LAUNCH services through policy changes that advance child wellness goals at the state, territory, or tribal level. An analysis of recent successes finds that grantees were most likely to make policy changes focused on expanding screening and assessment, one of the five LAUNCH core strategies, likely because it is simpler and less costly to scale than the other LAUNCH programmatic approaches.

Methodology

This brief is based on a review of grantee reports, publicly available websites, and other materials. In addition, grantee representatives were interviewed to identify instances in which LAUNCH services were sustained and replicated beyond the grant period and where LAUNCH grants influenced changes in policies and systems at the state, territory, tribal, or local level. The examples highlighted in this brief focus specifically on funding and policy changes that have expanded the impact of LAUNCH beyond the grant. Individual and cross-site grantee evaluations have captured other types of sustaining program

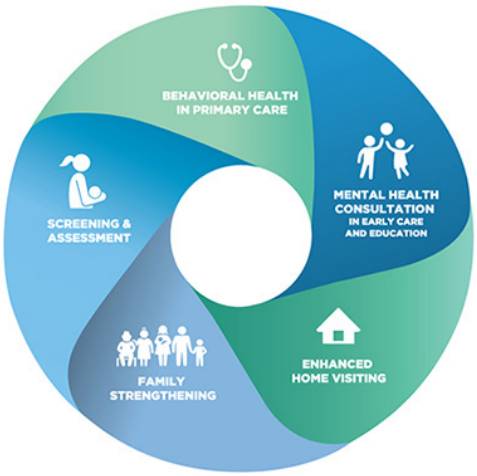
impacts, such as increased organizational capacity and collaboration at the local level or long-term changes in participant knowledge and practice.

Grantees Change Policies to Advance Child Wellness Goals

Beyond efforts to allocate new funding to sustain and scale-up LAUNCH practices, several states, territories, and tribes have changed public policies to advance child wellness goals and better facilitate the practices initiated through LAUNCH. Importantly, these policy changes typically influence practice throughout the state or tribe rather than solely in the original LAUNCH pilot community.

A scan of grantee reports revealed that of the five core Project LAUNCH strategies (Figure 1), LAUNCH grantees have been most successful at embedding screening and assessment activities, such as developmental screening, perinatal depression screening, and social–emotional screening practices into state, territorial, or tribal policies. Some grantees have also influenced policies to strengthen Home Visiting programs and promote the integration of behavioral health into primary care.

Figure 1. Project LAUNCH Framework



Developmental Screening

Several LAUNCH grantees influenced new requirements or created incentives in state policies to promote wider use of standardized developmental screening tools. Most commonly, LAUNCH grantees influenced state Medicaid or other health care policies to advance universal screening in primary health care settings. In some cases, LAUNCH grantees also influenced screening policies and practices in other settings, including child care, early intervention, and child welfare systems.

Health Care Settings

Several LAUNCH grantees sustained and expanded developmental screening practices state-wide through changes in Medicaid or other health policies. For example, Rhode Island's 2008 LAUNCH grant expanded developmental screening practices in the city of Providence and informed several changes in state-wide Medicaid policy. The state's Early Periodic Screening, Diagnosis, and Treatment (EPSDT) policy now mandates the use of a standardized tool to conduct developmental screening for infants and toddlers at ages 9, 18, and 24 months. Primary care providers can also now be reimbursed by Medicaid for an additional five developmental screenings before age 3 years. In addition, Rhode Island LAUNCH developed a system to record developmental screening results electronically and include the results in KIDSNET, the state-wide early childhood data system, which can be accessed by different types of child-serving providers. Through federal Race to the Top-Early Learning Challenge funding, KIDSNET was linked to the state's K–12 data system, allowing the state to track child-level outcomes over time. Informed by efforts through LAUNCH, state leaders have agreed to use developmental screening rates as an accepted outcome measure for an emerging state pediatric medical home initiative; insurers are also closely monitoring this measure. Finally, the state has scaled up a referral mechanism that streamlines referrals to appropriate services for children at risk for poor outcomes, supported in part by the Part C Early Intervention system.

Similarly, Washington State LAUNCH inspired significant state policy efforts to promote developmental screening. The Washington LAUNCH coordinator co-led a state-level Universal Screening System

Partnership that has achieved several accomplishments, including prioritizing developmental screening in the state Early Learning Plan; developing a strategic framework for implementing universal screening; embedding screening in several state initiatives, formally adopting the Help Me Grow model; and piloting the LAUNCH screening initiative in Yakima County, the local LAUNCH site, for possible state-wide expansion. The partnership's work was funded with an Early Childhood Comprehensive Systems grant and other sources after the LAUNCH grant ended, and Washington LAUNCH has had several health policy successes, including the following:

- The Washington State Department of Health developed universal developmental screening as an option for a performance measure for local health jurisdictions receiving Maternal and Child Health Block Grant funds. Two-thirds of localities in the state have selected this performance measure.
- The state Medicaid office included developmental screening as a quality measure in new managed care contracts.
- In 2015, the Washington State legislature passed a bill requiring the Health Care Authority to provide payment for Bright Futures-recommended developmental and autism screening.

The Oregon LAUNCH grant coincided with a significant state health care reform effort, providing a key opportunity for new incentives around developmental screening. Oregon's health reforms included the creation of coordinated care organizations (CCOs), which are networks of local health providers funded to coordinate services and promote positive health outcomes. The LAUNCH Young Child Wellness Council was among the stakeholders that provided recommendations to state policy makers on CCO implementation. The state ultimately adopted a policy aligned with LAUNCH goals—making developmental screening for children ages birth to 36 months an incentive measure for Medicaid payments to CCOs. As a result, the developmental screening rate in Oregon increased from 21% in 2011 to more than 50% in 2015. In addition, Oregon has prioritized developmental screening in ECE settings through metrics of success in its new Early Learning Hubs, which coordinate local early learning efforts.

Other LAUNCH grantees took varied policy approaches to promoting developmental screening. For example, the Bodewadmi Consortium of the Potawatomi was able to sustain LAUNCH screening efforts by requiring the use of screening and assessment tools at well-child visits. Through the LAUNCH grant, the Bodewadmi tribe began using consistent and standardized evidence-based screening and assessment tools as part of well-child visits, including the Ages and Stages Questionnaire®: Social-Emotional and the Pediatric Symptom Checklist. Although the grant period has ended, the tribe instituted these screenings as a required part of well-child checkups, and the data are now built into the tribe's electronic health record system. The Michigan LAUNCH grantee was able to influence the Michigan Primary Care Association to develop procedural changes to expand developmental screening in Federally Qualified Health Centers. In addition, partially supported by LAUNCH funding, the Michigan chapter of the American Academy of Pediatrics has developed a quality improvement process for Maintenance of Certification, which addresses developmental screening and encourages pediatricians—who are required to complete this certification—to adopt a developmental screening project to do so.

Finally, the Massachusetts LAUNCH program influenced policy changes that specifically expanded and implemented postpartum maternal depression screening in pediatric well-child visits. However, these screenings were not covered by Medicaid. Learning from this experience, members of the Massachusetts LAUNCH Young Child Wellness Council successfully advocated for Medicaid to pay for postpartum depression screenings at pediatric and well-child visits state-wide. This policy change went into effect in 2016. As of April 2017, the Edinburgh Postnatal Depression Scale has been added to the

menu of valid tools to be used in mandated behavioral health screening at every well-child visit, under the EPSDT component of Medicaid, with additional reimbursement beyond EPSDT.

Other Settings

While most of the examples highlighted here are focused on health policies and systems, some grantees also influenced developmental screening practices in other settings, including child care, early intervention, and child welfare.

The **Washington** state LAUNCH grantee successfully influenced state child care policy by embedding developmental screening practices in its child care quality initiative. Because of the efforts of the state Universal Screening System Partnership (co-led by the LAUNCH coordinator), developmental screening is now embedded in Early Achievers, the Washington state quality rating and improvement system (QRIS) for ECE programs. Programs currently earn a point toward their QRIS score if they screen the children in their care and refer them to appropriate services. Washington State is currently reviewing the QRIS point system and exploring increasing the number of points awarded for participating in universal developmental screening. In addition, the state's Department of Early Learning is developing a training module focused on developmental screening for licensed child care providers. Through a 2015 LAUNCH expansion grant, the state continues to build child care providers' capacity around developmental screening.

As an example of shifting practices in the early intervention system, the District of Columbia included social–emotional screening practices in its Early Intervention Program. DC's Part C Early Intervention program, known as Early Stages, piloted the use of the Ages and Stages Questionnaire®: Social-Emotional as part of its regular child screenings through LAUNCH. This screening became a valuable part of the standard Early Stages procedures, and its use was sustained beyond the grant.

Finally, Cherokee Nation is an example of a LAUNCH grantee influencing changes in screening practices by a state child welfare system. Based on the success of the tribal grantee, **Cherokee Nation and two state agencies in Oklahoma** adopted the Survey of Well-being of Young Children Screener. A state-wide initiative in Oklahoma, the Oklahoma Trauma Assessment Service Center Collaborative, now uses the Survey of Well-being of Young Children standardized screening tool as part of efforts to better assess and refer children in the child welfare system to mental health services. The LAUNCH team also worked closely with the Tulsa, Oklahoma, Safe Babies Court Team to align efforts related to screening and assessment for infants and toddlers affected by trauma.

Other Policy Examples:

Integrated Primary Care

While most of the policy changes influenced by LAUNCH focused on developmental screening, some grantees also successfully embedded other LAUNCH strategies into state systems. For example, North Carolina LAUNCH developed a family-centered medical home model that brings an early childhood mental health team into pediatric primary care practices. The team consists of an early childhood mental health specialist and a family-centered health navigator, who work together with primary care staff. Their model for integrating behavioral health into primary care has since been expanded state-wide through memoranda of agreement between pediatric primary care and behavioral health providers. A training manual is available to assist pediatric practices that may be interested in developing the model.

Home Visiting

Other grantees have influenced Medicaid policy to expand high-quality voluntary Home Visiting programs. For example, the Iowa LAUNCH grantee sustained their Home Visiting efforts by expanding the Medicaid program to reimburse for home visits to a specific population. Leadership within Iowa's LAUNCH-funded Nurse Family Partnership (NFP) program recognized that new and expectant mothers benefited greatly from nursing home visits. Unfortunately, Medicaid reimbursed only a limited number of visits. To document the need for more visits, the NFP program manager compiled claims data and presented this information (along with evidence supporting nursing home visits) to Medicaid policy specialists. As a result, Medicaid personnel agreed to amend the state policy to increase the number of home visits allowed from 6 visits every 200 days to 10 visits every 200 days. This policy change benefited not only LAUNCH NFP clients but also others across the state who were receiving nursing home visits.

In addition, members of Iowa's LAUNCH State Council, including the state Maternal, Infant, and Early Childhood Home Visiting coordinator, provided information to state policy makers regarding the benefits of investing in evidence-based and promising programs. As a result, state legislation was passed in 2012 that required at least 90% of Home Visiting programs funded with state allocations to be recognized as evidence-based or promising programs by July 1, 2016. This goal has been achieved.

Conclusion

In general, we found that Project LAUNCH grantees were particularly successful in advancing policies and systems to expand developmental screening. Through a variety of approaches and settings, grantees have sustained or expanded screening with a standardized tool state-wide, significantly increasing the number of young children throughout the country who are screened for developmental or social–emotional delays.

Further examination is needed to better understand why grantees have success in sustaining and expanding certain components of LAUNCH and experience challenges in other areas. The initial focus on developmental screening in state policy, however, most likely reflects that expanding screening may be relatively less difficult to implement and could require fewer resources than other LAUNCH strategies. Moreover, in better identifying children's needs, developmental screening may serve as a foundation for additional policy shifts and investments to meet the needs of children who are at risk.

Although there is tremendous variability in efforts to sustain LAUNCH services, this brief shows the promise of LAUNCH grants in catalyzing long-term support for young children's wellness.

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