Illinois Children's Healthcare Foundation

Children's Mental Health Initiative (CHMI)

Local Evaluation Report – Due May 31, 2015

Project Name	The Children's MOSAIC Project			
County/City Served	Sangamon County/City of Springfield			
Lead Agency (Legal Name)	Mental Health Centers of Central Illinois			
Project Director	Heather Sweet			
Local Evaluator	David Racine			
	Title	Executive Director	**Phone**	(217)206-8417
	Email	draci2@uis.edu		
	Organization (Legal Name)	Center for State Policy & Leadership University of Illinois Springfield		
	Mailing Address	One University Plaza Springfield, Il 62703		

If you have more than one local evaluator please provide the contact information below for each evaluator in the same format as set forth above.

David Racine, Ph.D.
Executive Director
Center for State Policy & Leadership
University of Illinois Springfield
One University Plaza
Springfield, IL 62703

Executive Summary

The Children's MOSAIC project is a collaborative effort in Springfield to change the landscape of children's mental health care by moving it into the community. The main, although not exclusive, elements of MOSAIC's model are screening and embedding mental health clinicians in the settings where screening occurs, so that children who are identified as needing help can be referred to a person able to provide that help. The strategy has been to expand MOSAIC's reach gradually, by starting where the need is greatest. It began in one lower income neighborhood, one elementary school near that neighborhood, and one primary care group practice serving a high percentage of lower income families. MOSAIC now operates through five schools and two of three large primary care practices in Springfield, with plans to continue expanding in coming years, eventually reaching the point of covering the entire community. To date, MOSAIC has conducted 16,000 screens and provided new mental health services to 1,700 children.

MOSAIC's local evaluation has sought answers to three sets of questions:

- What children have challenges to their mental well-being, how do they get connected to the services they need, and do those services make a difference? How supportive of MOSAIC's approach are families with children in need?
- To what extent are the professionals who care for children involved in meeting these needs and how supportive are they of MOSAIC's approach?
- How engaged are MOSAIC's stakeholders and how supportive are they of MOSAIC's approach?

The evaluation has produced the following findings:

- In 2014, the average rate of positive screens indicating social-emotional difficulties for children six and older was 21 percent in the schools and 33 percent in primary care. The rate of positive screens for children under six was 9 percent, which may be low for a higher needs population.
- In primary care in 2014, 40 percent of the children with a positive screen were referred to the MOSAIC mental health clinician, and 40 percent of those children received services. Notably, most referrals to mental health clinicians in primary care occurred without a positive screen. In the schools in 2014, nearly all children with a highly elevated positive screen (95th percentile) were referred for services, and on average 40 percent engaged in services, although there were often delays in receiving services as a result of client cancellations and possibly other factors. Children with an elevated screen (not highly) were referred to various Tier II interventions in the schools.
- School social workers and embedded clinicians reported difficulties engaging families in treatment for their child. Data collected on families of positively screened children indicated that many parents lack the material and social resources that may facilitate engagement.
- There is evidence, in measures of relevant process outcomes, that MOSAIC is beginning to make a positive difference in child well-being. An analysis comparing school-age children in MOSAIC with similar children accessing mental health services in other ways showed that MOSAIC children have been receiving more therapy and have been more likely to cancel appointments rather than just not show up for them.
- A program created with local funding to support parents, MOSAIC Moms, has generated preliminary evidence of positively affecting maternal outlook.
- Primary care physicians participating in MOSAIC have firmly embraced the use of screening and embedded clinicians as valid practice improvements.

- An extensive annual survey has found consistently strong support from community stakeholders of MOSAIC's effectiveness as a collaborative effort.

The findings from the evaluation suggest the following recommendations:

- MOSAIC should stick to its strategy of expanding gradually, since it works and is the best way to manage the complexity this sort of complex, collaborative endeavor entails.
- Now that screening has been in place for more than three years, it may be time to step back and, across both primary care and schools, look carefully at how screening is being implemented to assure consistency.
- MOSAIC should lead an effort to examine family engagement in mental healthcare and how to improve it.
- The strong local coalition MOSAIC has built should not be taken for granted. It now needs to engage in the pursuit of the resources needed to maintain progress and assure that MOSAIC remains the local center of gravity for addressing the mental health of children.

Project Description

The Children's MOSAIC Project is a community collaboration to change the landscape of children's mental healthcare by moving care into the community. The aim is to identify children earlier and quickly engage them in appropriate services and supports in schools, primary care offices, and a target neighborhood. By leveraging trust and relationships, the system being created will be capable of engaging even the most vulnerable children and families, providing services needed to give children the best opportunity to grow up happy and healthy. Families will experience a system of care that is easy to access and responsive to their particular needs. Children and families will also benefit from greater collaboration and communication among those professionals who are providing care.

MOSAIC serves children and adolescents living in the city of Springfield. Approximately 26,000 youth, ages 0-17, live in the city of Springfield, representing about 23% of the total population of 116,250 (American Community Survey, 2014 estimates). There has been a slight decline in total population in the past few years. With an annual enrollment of 15,000 students (pre-K through 12), Springfield Public School District 186 is the largest school district serving the local area. The demographics of its current student body reflect a high level of diversity with 49.1% white, 37.8% black, 8.4% multi-ethnic, 2.4% Hispanic, and 1.9 % Asian. Nearly two-thirds (63%) of students enrolled in Springfield public schools are from low-income households based on participation in free and reduced price school lunch programs.

From the outset, for the MOSAIC Project to be a system of care encompassing all aspects of the community that have an impact on children, critical community partners needed to be at the table. These partners have included the Springfield public schools, large primary care providers, nonprofit service providers, and institutions of higher education. Community partnerships have grown over time, with now over 20 organizations having a seat at the table.

Since the beginning, MOSAIC has worked with the community and its partners in a ground up approach. It has identified target sites demonstrating children and families with the most need to access to mental health care, as well as staff readiness at each site, and it has added news sites each year. At the outset, MOSAIC community partners identified a target neighborhood on Springfield's east side. This neighborhood (as well as areas immediately beyond its boundaries) has a significant number of Springfield's low-income families, with a majority of the children attending school in Springfield public

schools, the city's only public school district. The neighborhood and surrounding area have many risk factors that put its children and their families at risk of experiencing some kind of behavioral health distress.

In the past four years, MOSAIC has grown from the neighborhood, a nearby elementary school, and one primary care practice to fifteen sites: Matheny-Withrow Elementary School, Graham Elementary School, Harvard Park Elementary School, Fairview Elementary School, McClernand Elementary School, St. Patrick Catholic School, Douglas/PREP, Washington Middle School, Southeast High School, Southern Illinois University School of Medicine Center for Family Medicine and Department of Pediatrics, Memorial Physician Services at Koke Mill, and Head Start.

MOSAIC to date has conducted over 31,000 screens and has provided behavioral health services to over 2,800 children. MOSAIC clinicians are currently embedded in eleven sites with a potential reach to 18,000 children.

Evaluation Methodology

The local evaluation of MOSAIC has sought answers to three basic sets of questions:

- What children have challenges to their mental well-being, how do they get connected to the services they need, and do those services make a difference? How supportive of MOSAIC's approach are families with children in need?
- To what extent are the professionals who care for children involved in meeting these needs and how supportive are they of MOSAIC's approach?
- How engaged are MOSAIC's stakeholders and how supportive are they of MOSAIC's approach?

Children Needing and Receiving Services

Participating primary care practices and schools have collected data on their screening of children for developmental and social-emotional problems and, for those children who screen positive, service referrals. For positively screened children whose families have agreed to participate in services and the evaluation, fairly detailed information has been solicited on family well-being, looking at both material welfare and social support. In addition, steps have been taken to gather data from schools on child behavior and basic socio-economic characteristics (e.g., discipline, attendance). An annual survey was instituted last year for social workers and embedded clinicians to offer their perceptions on the level of client engagement in services. The principal measure for assessing child outcomes in the cross-site evaluation is the Child Behavior Checklist (CBCL).[1] There are now 115 baseline CBCLs, and the hope is that during the current calendar year it will be possible to obtain post-baseline measures for some of these children. Since data from CBCLs has been limited, an alternative strategy has been pursued for evaluating the effects of MOSAIC on children. School-aged children receiving services through MOSAIC have been compared to children receiving services outside of MOSAIC, to see whether MOSAIC is better, worse, or the same in terms of relevant process outcomes. The hope had been to extend this

[1] While not ideal, multiple screening scores for children tracked over time could be used to assess the effects of MOSAIC on child well-being. However, because these data have not been available in easily accessed electronic records from primary care sites, and because all participating schools but one are too new to MOSAIC to have conducted more than one screening to date, it is not yet feasible to do an outcome analysis using screening results.

comparative analysis to younger children seen through primary care, but this effort has been held up by data access problems.

In addition to serving children, MOSAIC has developed a component for parents. Parent support activities have been established in the eastside neighborhood that served as MOSAIC's initial focus. And, using local funds, a program called MOSAIC Moms has been instituted to help mothers with their own mental health challenges. MOSAIC Moms has been and will continue to be evaluated using a standardized instrument that tests for depression, adequacy of social support, and service utilization.

Professional Engagement

An annual survey was designed and first implemented in 2015 to obtain feedback from primary care practices on the use of formal screening and embedded behavioral health clinicians, a specific feature of MOSAIC's approach. A version of the same type of survey has been developed and implemented with participating schools in the current year. Later this year, a more complete assessment will be made of the extent to which practitioners in all participating settings have modified their practices in response to MOSAIC.

Stakeholder Engagement

Stakeholders include both professionals providing services, as just discussed, and others in leadership positions with relevant organizations in the community. Every year, for the past five years, including this year, an extensive survey has been conducted of stakeholders on their perceptions of the collaborative value and effects of MOSAIC.

Findings

Children Needing and Receiving Services

The Front End: Screening

One of the key sources of complexity in establishing MOSAIC has occurred at the front-end, in building a predictable capability to screen and refer children. SIU Center for Family Medicine began screening all children during the first year of implementation, but it has not been able to make the results of screening available in an easily extractable form and consistently for evaluation purposes. Koke Mill Medical Associates, which came on roughly a year later, has also been unable to make screening results accessible. An integrated electronic health records system is being implemented in Springfield for most medical providers. The new system may in time have screening results and related data situated in identifiable fields. Meanwhile, the only way to get beyond just the total number of children screened in primary care has been to review medical charts, a time-consuming, labor intensive task, which requires special access to private health information.

It has from the start been more straightforward and easier for the schools to collect screening data and make it available. Schools have been able to set aside time, often at the start of the academic year, to conduct screening of students *en masse*. This has made screening less disruptive to school work flow. By contrast, screening has occurred in primary care on a rolling basis as patients keep appointments. That is, it has had to be more tightly integrated into a typically already congested work flow. Add to that the data rich nature of contemporary medical practice, where physicians and nurses regularly have to

collect data on a wide variety of patient characteristics, and it becomes clear why working something new – social-emotional screening – into the practice equation may be difficult.

Though there have been challenges, and primary care practices and schools have differed in significant ways, it has been possible to construct a meaningful picture of screening levels and rates of positive screens for sites in 2015.

Table 1: Screening, 2015

School	Total Enrollments	Total Screened	Elevated Screen (80th percentile)	Highly Elevated Screen (95th percentile)	Total Positive Screens	Positive Rate 2015	Positive Rate 2014
Matheny-Withrow Elementary	283	281	53	34	87	31%	29%
Graham Elementary	250	250	39	14	53	21%	21%
Harvard Park Elementary	420	420	92	22	114	27%	24%
Washington Middle (No clinician)	591	0	0	0	0	0	18%
Southeast High (Fall 2015 only)	1225	743	97	31	110	15%	19%
Fairview Elementary (New Fall 2015)	297	297	67	29	106	36%	
McClernand Elementary (New Fall 2015)	269	253	43	20	63	25%	
Douglas/PREP (New Fall 2015)	77	77	22	12	34	44%	
Total	3412	2321	413	162	496	28%	

Primary Care Practice	Total Screened	Total* Screened ASQ	Total* Positive ASQ	Positive* Rate ASQ	Total* Screened PSC	Total* Positive PSC	Positive* Rate PSC
SIU Center for Family Medicine	3651	1275	164	13%	1519	402	27%
Koke Mill Medical Associates**	5660						

*SIU was only able to provide screening results for the first two quarters of 2015.

**Koke Mill has not been able to provide screening data in an extractable form. So, the only available data is for the total number of children it has screened.

The rates of positive screens at the schools, which use the Behavioral and Emotional Screening System (BESS), have been fairly consistent. These schools serve high proportions of less advantaged students, who may be more likely to have social-emotional challenges. That shows in their positive screening rates, affecting more than a fourth of their students. Douglas/PREP, with the highest rate, is the alternative middle and high school serving the highest risk youth. Washington Middle School suspended screening in 2015 as a result of not having an available behavioral health clinician to whom to send children with a positive outcome.

SIU Center for Family Medicine also serves a relatively high percentage of less advantaged families. Its positive screen rate for children five and younger, using the Ages and Stages Questionnaire (ASQ), has edged up to 13 percent from 9 percent in 2014, while the rate for older children, using the Pediatric Symptom Checklist (PSC), has dropped some, to 27 percent from 33 percent in the prior year. A question was raised in last year's report about the positive rate for young children being possibly too low given the population SIU serves. The slight increase for 2015 is more on track with prevalence rates indicated by research for behavioral health issues among disadvantaged young children, but still low.

Referrals and Service Use

In primary care at SIU and Koke Mill, a positive screen has generally led the provider to enter an order for services to be provided through MOSAIC, meaning, for the most part, the MOSAIC mental health clinician embedded with that primary care practice. Sometimes, depending on the situation being presented by a patient, the clinician has provided immediate, short-term therapeutic services. Other times, an effort has been made to schedule the child for an appointment with the clinician. Here, as well as in the first situation, a series of appointments may be attempted subsequently as necessary to address the particular needs of the child. A positive screen has not been the only way to access MOSAIC clinician services, however. Even in the absence of a positive screen, a doctor may perceive a need and refer the child to the clinician for help. Indeed, referrals in the absence of screening results have been relatively common in primary care.

The following simple table shows the distribution between referrals to the MOSAIC clinician with and without a positive screen for the first two quarters of 2015 at SIU Family Medicine. Referral data for the last two quarters of the year were not available.

Table 2: Primary Care Referrals

	2015	2014
Referrals with a positive ASQ	20	17
Referrals without a positive ASQ	14	75
Total referrals of children ages 0-5	34	92
Referrals with a positive PSC	20	117
Referrals without a positive PSC	86	244
Total Referrals of children ages 6-18	106	361
Total referrals with a positive screen	40	134
Total referrals without a positive screen	100	319
Total referrals	140	457

Last year's report, covering 2014, showed that the vast majority of referrals occurred without a positive screen. That has changed for younger children for the first half of 2015, with more referrals coming through a positive ASQ than in the absence of one. There has been no change in the proportions referred with or without a positive PSC for older children. It should be noted that in this context referrals come close to being tantamount to treatment, since these are mostly referrals to the behavioral health clinician embedded with SIU Family Medicine.

While the screening process at the schools has worked more seamlessly than in primary care, the referral mechanisms in the schools have been more complex. In the elementary schools, the screening has been completed by teachers, and then the results have been shared with the school social worker. In the middle and high schools, students have completed the screening themselves, with the scoring done by the MOSAIC mental health clinician. If a child has a highly elevated screen, the social worker has usually contacted the family to offer the services of the MOSAIC clinician assigned to the school. These intensive therapeutic services have also been provided by school psychologists. Unsurprisingly, not all families have accepted these services when offered. For a student with an elevated screen, the social worker has consulted with the student's teacher to determine what might work best. The schools have offered various Tier 2 interventions, such as mentoring, problem solving groups, and the like.

Data have been collected from the schools on referrals and participation in services. The table below shows the pathway followed by students in 2015 with highly elevated screening scores. Numbers in parentheses in the far right column indicate the rate of service uptake from a year ago for those schools participating at that time.

Table 3: School Referrals, 2015

School	Number Highly Elevated	Number Referred to MOSAIC Services	Number Using MOSAIC Services	Number Already Receiving Services	Rate of Service Uptake
Matheny-Withrow Elementary	36	30	15	8	64%

Graham Elementary	20	17	9	4	65%
Harvard Park Elementary	22	17	3	3	27%
Fairview Elementary	36	34	25	2	75%
McClernand Elementary	22	14	12	0	55%
Washington Middle	21	4	4	1	24%
Southeast High	33	27	7	5	36%
Douglas PREP	20	18	14	0	70%
Total	210	161	89	23	52%

Service uptake rates have generally improved, in some cases by substantial amounts. Rates in the range of 50-70 percent are a healthy indicator of progress in fulfilling MOSAIC's practical mission – to increase access to services for children in need. (The drop-off in the rate at Washington Middle School stems from the fact that it lost its MOSAIC clinician during the year.) "Uptake," needless to say, does not necessarily mean consistent engagement in services. Appointments are missed, phone numbers wrong or disconnected, and participation can relatively easily fall into a start-stop-start-stop pattern. That said, the data are an encouraging sign that students with significant behavioral health issues are being identified and connected with help.

Last year's report presented preliminary evidence suggesting relatively long intervals between a finding of a highly elevated screen and first contact by a school social worker (18-19 days on average) and first social worker contact and first appointment with a MOSAIC clinician (56 days on average). For 2015, the average screening-first contact interval was 38 days, about twice the 2014 level. This longer period was almost entirely due to schools just beginning their participation in MOSAIC and needing to revise their procedures to accommodate the requirements of the program. Schools involved with MOSAIC longer had much shorter time lapses, by and large, between screening and first contact. The average interval between first contact and first appointment was 26 days, about half the 2014 average.

Family Characteristics

Families whose children screen positive and accept referral for services have been asked to complete a questionnaire on their material and social resources. The questionnaire consists of three validated scales: Family Resource Scale, a 29-item measure of the adequacy of family assets; Interpersonal Support Evaluation List, a 12-item measure of functional social support; and Social Network Index, a scale that measures the extent and closeness of social relationships. In addition, the questionnaire asks parents about their income and education. The intent has been to gain insight into the general ability of families to manage challenges, such as a child with a social-emotional problem.

Since the first year of implementation, 170 parents have completed the questionnaire at baseline, upon the entry of their child into MOSAIC. Response rates thereafter have been low – 38 have completed one follow-up survey and 10 a second follow-up. A paired samples t test, comparing responses to the baseline and first follow-up survey, found no statistically significant differences. The number of responses to the second follow-up have been too low to warrant this comparison. Thus, in what follows, results are reported for all responses combined.

The Family Resource Scale consists of four subscales: basic needs (e.g., money for food), money beyond basic needs (e.g., for entertainment), time for self, and time for family. The choices available range from not at all adequate (=1) to almost always adequate (=5). The mean score for the scale overall (the four subscales combined) has been 3.7, indicating that the average parent in this group perceived her family's material resources to be between sometimes adequate to usually adequate. The highest scores have been given for the adequacy of resources to meet basic needs, where the mean has been 4.5, indicating almost always adequate. The adequacy of time for family also has scored relatively high, with a mean of 4.3. Money for other than basic needs and time for self have been perceived as less adequate, with means of 2.7 and 3.4, respectively. Note that these mean scores are largely consistent with last year's report, except for ratings of money for non-basic needs. This has dropped by more than a full point, suggesting that economic pressures on families may have increased some. Parents reported a median income of less than $20,000/year and a median education level of high school completion. Income reports may not have taken into account participation in public benefit programs such as Medicaid or food stamps.

The Interpersonal Support Evaluation List asks people questions about whether they have persons in their lives who they can turn to when they need or want to do something. The response options include definitely false (=1), probably false (=2), probably true (=3), and definitely true (=4). The list produces three subscales with four items each, for a maximum possible score of 16 for each subscale. The appraisal subscale examines access to help in stressful situations (e.g., I feel there is no one I can share my most private worries and fears with). The belonging subscale focuses on opportunities to engage in activities with other people (e.g., If I wanted to go on a trip for a day, I would have a hard time finding someone to go with me). The tangible subscale poses items about the availability of others to help with particular tasks (e.g., If I were sick, I could easily find someone to help me with my daily chores). MOSAIC parents have scored highest on the appraisal subscale, with a mean of 12.2. The mean score on the belonging subscale has been 11.6, up a point from where it was last year. The tangible subscale mean score has been 11.5. It's worth noting that between 25 percent and 40 percent of parents have scored 10 or below on the three subscales. This is an indicator of difficulties in accessing reliable social support for a substantial portion of the families whose children have been served by MOSAIC.

The Social Network Index asks a person about the different types of relationships she has, how many people there are in each type of relationship, and how frequently she is in contact with them, a measure of closeness.[2] The types of relationships include family, friends, church, student, work, neighbor, and volunteer. The extent and closeness of one's social network has been shown to influence health and well-being. The Index yields three measures: the number of high contact roles a person has, with a maximum of 12, the total number of people in a person's social network, with a maximum of 56, and the number of embedded networks in which a person is active (contact at least every two weeks), with a

[2] The original Social Network Index includes an item asking respondents about their involvement in membership groups, like a trade union or a social club. This item has been excluded from the version of the instrument used in the MOSAIC evaluation, because it would have added significant time to survey completion (individuals are asked to name up to six specific groups) and is not likely to be as relevant to the focal population. Norms for the measures produced by the SNI have been adjusted accordingly.

maximum of 7. The median number of high contact roles for MOSAIC parents has been 6 out of the maximum of 12; last year the median number of high contact roles was 8. High contact has been much more likely in family, friend, and work relationships than other types of relationships. The average number of total people in a parent's social network has been 21. The median number of embedded networks has been 3, up from 2 a year ago. Thus, on average, MOSAIC parents have given evidence of having fairly limited networks, an indicator of social isolation.

Client Engagement

The local evaluation includes a survey of social workers and embedded clinicians on their perceptions of family engagement. Though only seven clinicians have responded, the same number as last year, this is a large enough proportion of the total number of clinical staff working with MOSAIC children for the results to be worth considering as rough indicator of common experience. For this year's survey, a question was added to include contacting clients/families by phone, in addition to the item about using letters and text messages for this purpose. Results for this year are reported in the table below; numbers in parentheses are the previous year's results.

Table 4: Professional Perceptions of Client Engagement, 2016

	Strongly Disagree	Somewhat Disagree	Neither agree nor Disagree	Somewhat Agree	Strongly Agree
Engaging families into mental health treatment is not a challenge.	14.3% (14.29%)	85.7% (71.43%)	0.00% (0.0%)	0.0% (14.29%)	0.00% (0.00%)
Families often don't feel their child has a problem.	14.3% (14.29%)	14.3% (28.57%)	0.0% (57.14%)	57.1% (0.00%)	14.3% (0.00%)
In general, families value mental health counseling.	0.0% (0.00%)	14.3% (42.86%)	28.6% (14.29%)	57.1% (42.86%)	0.0% (0.00%)
Families don't understand the importance of mental health treatment.	0.0% (0.00%)	28.6% (0.00%)	(0.0%) (14.29%)	42.9% (71.43%)	28,6% (14.29%)
Being an embedded clinician decreases the likelihood families will engage with me.	42.9% (28.57%)	28.6% (57.14%)	0.0% (0.00%)	14.3% (14.29%)	14.3% (0.00%)
I have no difficulty engaging the families of vulnerable clients.	14.3% (28.57%)	57.1%) (57.14%)	14.3% (14.29%)	14.3% (0.00%)	14.3% (0.00%)
Clients and families understand what services are available as well as details about the	0.0% (0.00%)	14.3% (14.29%)	28.6% (28.57%)	57.1% (57.14%)	0.0% (0.00%)

	overall treatment process itself.					
	I send reminder letters to families.	14.3% (28.57%)	14.3% (14.29%)	42.9% (14.29%)	28.6% (14.29%)	0.0% (28.57%)
	I remind families of upcoming appointments through text messages.	71.4% (85.71%)	14.3% (0.00%)	14.3% (14.29%)	0.0% (0.00%)	0.0% (0.00%)
	I make direct contact with clients/families through phone calls to remind them of appointments.	0.0%	0.0&	14.3%	42.9%	42.9%

As last year, families engaging in treatment for their child, while not impossible, has been challenging, according to clinicians. This is not surprising. As suggested by the evidence reported above, families have often lacked the material and social resources that could help them navigate the system of care more effectively. This limitation may only be amplified by the reality that problems with social-emotional health cannot be precisely defined and are still often stigmatized. Under the circumstances, engagement may, understandably, be difficult for many.

While care should be taken not to read too much into differences between this and last year's results, given the small number of respondents, there is one slight shift worth noting. There appears to have been modest improvement in social worker/clinician perceptions of how clients value and understand treatment.

Are Children Served Through MOSAIC Better Off?

In 2013, the local evaluation conducted an analysis which compared a small number of elementary school students (30 from one school) served through MOSAIC with similar children otherwise enrolled in treatment with clinicians at the Mental Health Centers of Central Illinois. It found a number of ways in which the experiences of MOSAIC children suggested improvement, such as fewer instances of crisis intervention and more therapy sessions. A similar analysis was conducted in early 2015 of a larger, more diverse group of MOSAIC children and a related group of children who accessed treatment outside of MOSAIC. The MOSAIC sample consisted of 64 children who enrolled in treatment with MOSAIC clinicians at the public schools between August 2013 and April 2015. These children were compared with 847 children who enrolled in treatment during the same period but not through MOSAIC. This analysis, too, had encouraging results along similar lines as the first.

These first two studies were relatively small. To produce a more robust statistical picture of MOSAIC's effect, an analysis using much larger samples was recently completed for inclusion in the current report. It was based on 333 school-aged children who entered care through MOSAIC and a comparison group of 2,298 children who entered care in other ways during the 2012-2016 period. Since MOSAIC is designed, not necessarily to change the content of treatment, but rather, access to and engagement in treatment, the analysis focused on process outcomes. These included: no-shows and cancellations, therapy and counseling sessions, assessment and treatment planning sessions, and case management and community support sessions. What matters is not just the absolute number of these activities, but how

often they occur within a given period of time. For purposes of the analysis, this measure of intensity was defined as the number of activities per 30 days.

The demographic characteristics of the two groups are provided below.

Table 5: Characteristics of Samples, Comparison and MOSAIC, 2012-2016

Characteristic	MOSAIC Group	Comparison group
N	333	2298
% Female*	41.40%	46.70%
% Black*	39.60%	22.30%
% Family Violence indicated*	24.90%	13.40%
Monthly income mean	$1,760	$1,827
Monthly income standard deviation	$1,344	$1,637
Family size mean*	3.85	3.57
Zip code 62702	29.70%	23.10%
Zip code 62703	48.00%	23.10%
Zip code 62704	10.20%	17.40%

*Statistically significant at .05

Compared to the non-MOSAIC group, MOSAIC children were somewhat more likely to be male and substantially more likely to be African American. They also had slightly larger families than comparison children. MOSAIC children and their families were nearly twice as likely to have an indication of family violence in their records. Comparison children were in households with higher monthly income and more variation in income (monthly income standard deviation), though this difference was not statistically significant. Children in MOSAIC were also substantially more likely than comparison children to reside in the less affluent east and north sides of Springfield. More specifically, 80 percent of MOSAIC clients come from the 62702 and 62703 zip codes compared to 46 percent of comparison clients.

In terms of treatment engagement outcomes as measured by session counts, comparison children had more sessions in absolute number but lower intensity as measured by sessions per 30 days. The average comparison group child had 13 months between his/her first and last service session, while that number for the average MOSAIC child was 10 months. Children in the comparison group had more cancellations and no-shows in absolute terms and a greater likelihood of these events per 30 days. MOSAIC clients had a slightly lower number of therapy and counseling sessions on average but a substantially higher prevalence of these sessions per 30 days. They also had slightly higher intensity for assessment/planning and case management/community support sessions than comparison children, though these differences were no statistically significant.

Table 6 : Treatment Engagement Counts, MOSAIC vs. Comparison

Treatment Engagement Outcome	MOSAIC Group	Comparison Group
Mean months between first and last service record (S.D.)	9.9 (11.2)	13.0 (13.2)

Mean of Total cancellations and no shows	3.34*(4.51)	5.75* (5.83)
Cancellations and no shows Per 30 days	.54 (2.07)	.67 (1.36)
Mean of Total therapy and counseling sessions	8.24* (9.29)	8.63* (10.84)
Therapy and counseling sessions Per 30 Days	.92* (.87)	.58*(.53)
Mean of Total assessment and planning sessions	2.98* (2.45)	3.66* (3.21)
Assessment and planning sessions Per 30 Days	.68 (2.11)	.55 (1.74)
Mean of Total case management and community support sessions	1.94 (3.82)	2.38 (5.38)
Case management and community support sessions Per 30 Days	.24 (.60)	.21 (.84)

Ordinary least squares regression analyses were conducted on the four treatment engagement intensity outcomes. In addition to whether a child was in or not in MOSAIC, independent variables included race, gender, family violence, family size above 2, and household income.

MOSAIC involvement was negatively associated with the frequency of cancellations and no-shows, an effecting approaching statistically significance. It corresponded with a 22 percent reduction in cancellations/no-shows for MOSAIC children vs. the comparison group. Higher income was negatively and significantly associated with these events (β=-0.08, p=.006) and being African American was positively associated (β=0.13, p=.047).

MOSAIC involvement was positively associated with the number of counseling and therapy sessions per 30 days. This statistically significant effect (β=0.37, p=.000) corresponded to a 59 percent increase in the intensity of these sessions. Higher income was positively associated with this outcome (β=0.05, p=.000), and being African American had a significant negative association (β=-0.16, p=.000).

Participation in MOSAIC was associated with a 20 percent increase in the frequency of assessment and treatment planning sessions per 30 days, although this effect was not statistically significant. Participation was also positively associated with the frequency of case management and community support sessions per 30 days, but this 23 percent increase, too, did not meet the test for statistical significance. Family violence was positively and significantly associated with the frequency of these sessions (β=0.08, p=.09), and being African American was negatively and significantly associated (β=-0.11, p=.002).

MOSAIC Parents

A key feature of MOSAIC has been to extend its reach gradually toward encompassing the entire geographic area covered by the Springfield school district. This commitment was initially implemented by focusing in the first year on a lower income neighborhood on the eastside of Springfield. The hope

was to establish a neighborhood-based capacity to screen and treat children. Neighborhood outreach workers were hired to develop relationships with local families and to take responsibility for screening.

However, despite their best efforts, the outreach workers encountered substantial barriers to doing screening in people's homes. Work and other responsibilities interfered with parents' availability, and parents were often suspicious. Going door to door could build trusting relationships over time but not in a timely enough way to meet MOSAIC's productivity expectations. Consequently, using the neighborhood as a site for screening was de-emphasized, and outreach workers began looking for ways to connect with parents in group settings. This group method, broadly defined, has become the modus operandi of the neighborhood component of MOSAIC. It is rooted in the recognition that the mental health of children and their parents is often integrally related.

To this end, neighborhood outreach workers have conducted group educational sessions for parents on a variety of topics relevant to the social-emotional well-being of their children. In addition to these activities of the outreach workers, Primed for Life, a local nonprofit youth and family service agency, has provided training for parents on the subject of parental resilience and related subjects. Owing to resource limitations, these activities have not been specifically evaluated.

Since mothers do most of the caring for children, and mothers with limited social supports, which defines much of the MOSAIC population, can have mental health challenges of their own, the Memorial Behavioral Health, with funding from the Women for Women giving circle, a local philanthropy, began in 2014 a program called MOSAIC Moms. The program is a collaboration with the Springfield public schools, M.E.R.C.Y. Communities, a support organization for homeless and at risk individuals, Contact Ministries, and Community Connection Point. It facilitates parent/child groups and support groups for pregnant and post-partum women, provides home-based mental health services, and consults with home visitors and case managers who work with this population of mothers.

MOSAIC Moms has been evaluated using a questionnaire consisting of validated scales that measure feelings of stress, social support, and depression. Parents have been completing the survey when they come for parent/child group and other group sessions. The first surveys were conducted in November of 2014 and the most recent are from March of 2016. A total of 67 mothers have participated, a substantial increase from a year ago when the number mothers who had completed the baseline survey stood at 24.

Table 4 provides the results for the first three iterations of the survey. Although a few mothers have completed the survey as many as six times, not enough have done so to support meaningful comparisons.

Table 7: MOSAIC Moms -- Mothers' Well-Being (mean scale scores), 2014-2016

	Baseline	Time 2	Time 3
Perceived Stress (1=Low, 5=High)	2.79	2.50	2.58
Social Support (1=Low, 4=High)	3.01	2.97	3.31
Depression (1=Low, 4=High)	1.97	1.79	1.79

While the differences across time are not statistically significant, they move in the desired direction for each of the three scales. Both perceived stress and depression decline from the baseline measure, while social support increases. Interestingly, when results are included from the small number of mothers who complete the survey four, five, and six times, all three measures of well-being continue to improve. Though not statistically valid, this pattern suggests that the benefits of MOSAIC Moms may grow the longer a mother participates, thus raising the question of how best to keep mothers involved.

Professional Engagement

As previously pointed out, MOSAIC has attempted to change customary practice in two ways in responding to children with social-emotional challenges. One, and a requirement of participating in the Illinois Children's Healthcare Foundation's Children's Mental Health Initiative, has been to have children screened, ideally on a routine basis, for developmental and mental health issues. Rather than make screening universal out of the gate in 2011, MOSAIC has rolled it out gradually among primary care practices and schools. A second change, directly related to the first, has been to embed a mental health therapist in the places where screening occurs. This way there is a professional skilled in mental health counseling to whom a child with a positive screen or otherwise in need can be referred for help. What MOSAIC did not want to do was to screen large numbers of children and have no appropriate services available for them.

However logical and justifiable in theory routine screening and embedding clinicians may be, they alter work flow and expectations in primary care and schools. Consequently, acceptance of these changes is not guaranteed and, in a sense, must be earned. To learn more about how well the changes have been integrating into primary care, the local evaluation began in Spring 2014 to annually survey physicians and other primary care clinical staff on their reactions to screening and embedded clinicians. This survey was repeated in 2015 and 2016. A similar survey has just been completed with the schools participating in MOSAIC.

Primary Care

Thirty-one individuals (74.2 percent attending physicians, 3.2 percent residents, 22.6 percent nurse practitioners/physician assistants) from SIU Family Medicine and Koke Mill Medical Associates who treat children in primary care completed the survey in 2016. In 2015, 39 people completed the survey, and in 2014 26. Respondents were given thirteen items to rate on a Likert scale ranging from strongly agree to strongly disagree. Three items were new to the 2016 survey, one asking about the indispensability of screening, another about the indispensability of embedding behavioral health clinicians, and the third about the indispensability of the MOSAIC model as a whole. These items were added to provide a more severe test of the value of MOSAIC's two components to primary care practices.

Table 8: Primary Care Engagement in MOSAIC

(1=Strongly disagree, 5=Strongly Agree)

	2016 (n=31)	**2015** (n=39)	**2014** (n=26)
I am identifying more children at risk for mental health issues than I was before MOSAIC.	4.20	4.03	3.96

The screening instruments produce too many false positives.	2.00	2.58	2.92
Results from screening provide useful information that I otherwise would not get.	4.29	4.32	3.81
Screening reduces the amount of time I need to spend discussing children's mental health with patients or parents.	3.23	3.13	3.01
Interpreting and responding to screening results is not a good use of my time.	1.71	2.00	2.50
Use of screening is indispensable to the effectiveness of my practice.	3.90		
Brief interventions by embedded clinicians have reduced the need for referrals for community-based mental health assessment and treatment.	4.52	4.00	3.69
When I want the clinician to meet with a patient on short notice, I can usually find him/her quickly.	4.65	4.38	4.15
Having an embedded clinician increases the likelihood that patients will participate in treatment.	4.80	4.59	4.23
For patients that receive follow-up treatment from the embedded clinician, the clinician does not keep me adequately updated on their progress through notes or other communication.	1.48	1.82	1.96
The MOSAIC clinician has become essential to the effectiveness of my practice.	4.61		
If the MOSAIC model went away, my practice would not be as effective.	4.29		

The comparison across the three years shows a consistent pattern in which primary care staff perceive MOSAIC, in all of its aspects, in an increasingly positive way. The three new items added to the 2016 survey indicate that participating primary care practices regard both screening and embedded clinicians as important to practice effectiveness. This is especially true for embedded clinicians.

Schools

The 2016 schools survey soliciting feedback on the MOAIC model was completed by 138 individuals (2.2 percent principals, 80.3 percent teachers, 3.6 percent school psychologists/social workers, and 13.9 percent other, which included other administrators within schools). The survey contained closed-end items similar to those used in the primary care survey, plus open-ended questions to solicit additional reactions. The table below shows the results of the closes-end items.

Table 9: Schools Engagement in MOSAIC

(1=Strongly disagree, 5=Strongly Agree)

	2016
We are identifying more children at risk for mental health issues than I was before MOSAIC.	3.97
The screening instruments produce too many false positives.	2.86
Results from screening provide useful information that we otherwise would not get.	3.76
Screening reduces the amount of time we need to spend discussing children's mental health with patients or parents.	3.30
Use of screening is indispensable to the effectiveness of our efforts to improve students' mental health.	3.58
Interventions by the MOSAIC clinician have reduced the need for referrals for community-based mental health assessment and treatment.	3.46
When we want the clinician to meet with a patient on short notice, we can usually find him/her quickly.	3.45
Having a MOSAIC clinician increases the likelihood that students will participate in treatment.	3.86
For students who receive follow-up treatment from the MOSAIC clinician, the clinician does not keep me adequately updated on his/her progress through notes or other communication.	3.23

I would recommend to other schools our model for mental health screening and onsite mental health/social-emotional services for students.	3.75
If the MOSAIC model went away, our efforts to serve students with mental health issues would be effective.	2.77

By and large, school evaluations of MOSAIC are positive, albeit not as positive as primary care practices are and have been. Most item scores hover between neutral (3 on the 5-point scale) and a desired response. While it cannot be known for sure, this is most likely due to the limited experience teachers have had with the program, making it difficult for them to judge value. As MOSAIC continues and more teachers have more exposure to it, the expectation is that ratings should improve. Even in the absence of limited involvement with MOSAIC, survey respondents were still inclined to see the program as valuable addition. When asked, in the last item, whether serving students with mental health issues would be effective if MOSAIC did not exist, they disagreed more than they agreed.

Open-ended questions asked respondents about MOSAIC's biggest benefit to their school, biggest problem, and what, if anything, they would change about how MOSAIC is being implemented. Aside from general comments along the lines of "helping children at risk," views of MOSAIC benefits centered on the availability of additional services for meeting mental health needs, and this was, for many, anchored in the availability of the MOSAIC clinician. Screening for social-emotional challenges was mentioned by few. Just as the clinician was viewed as a benefit, needing more clinicians or more access to existing clinicians was identified as among the bigger problems for MOSAIC. Two other problems mentioned most often were students missing classes due to participating in services and resistance from parents to children being involved in mental health treatment. It should be noted that many respondents explicitly indicated they did not perceive any problems, and that others did not know enough about MOSAIC to know if it has problems. As for what school staff think should be changed, responses tended to be consistent with the identification of problems: more access to skilled clinicians, better scheduling to minimize conflict with classes, and more cooperation from parents. In addition, some mentioned a desire for better communication between MOSAIC, including clinicians, and classroom teachers.

Stakeholder Engagement

Integrated or coordinated care initiatives like MOSAIC are complex undertakings involving relatively large numbers of organizations and individuals. It is never easy to coalesce multiple parties in a community around a common agenda in a sustainable way. Every organization has its own interests, which do not necessarily align with the interests of other organizations. Even when alignment is achieved at one point in time, it can be fractured subsequently when interests diverge, perhaps in response to funding increases or decreases or public policy changes. Creating cohesion initially is no mean feat, but retaining it once established is an even greater achievement.

Because of the challenges to sustaining community coalitions and service integration/coordination efforts, the local evaluation from the outset has, on annual basis, surveyed in detail MOSAIC's

stakeholders on their perceptions of how well the collaboration is working. The survey is extensive, consisting of 82 items on key dimensions of collaboration formation and management. All items come from validated scales.

- *Decision making* consists of 8 items on the adequacy of the decision making associated with MOSAIC. Examples include "the decision making process used by the leadership group is open, fair, and clear to all" and "decision making occurs in a politically charged atmosphere."
- *Leadership* consists of 8 items on the qualities and effectiveness of MOSAIC's leadership. Examples include "MOSAIC's leadership is able to get things done" and "MOSAIC's leadership utilizes the skills and talents of many, not just a few."
- *Benefits of participation* consists of 19 items on the different ways in which participating organizations and individuals might be able to benefit from MOSAIC. Examples include "my participation in MOSAIC has enhanced my organization's ability to obtain funding" and "my participation in MOSAIC has improved my connections to others in the community."
- *Problems of participation* consists of 11 items on the different kinds of problems organizations and individuals might encounter as a result of participating in MOSAIC. Examples include "MOSAIC's efforts do not reach my organization's primary constituency" and "MOSAIC is competing with my organization."
- *Conflict management* consists of 9 items on procedures used to manage conflict among those involved in MOSAIC. Examples include "each participating organization gives in a bit and settles on compromise" and "participating organizations tend to withdraw from conflict."
- *Sufficiency of Group Effort* consists of 6 items on the extent of individuals' involvement in MOSAIC. Examples include "all members regularly attend meetings" and "how much time per month have you spent on MOSAIC activities in the past year."
- *Integrative Behavior* consists of 4 items on how seriously participants' input to MOSAIC is considered. Examples include "I am encouraged to critique or provide information that challenges what is being done in MOSAIC" and "the MOSAIC staff are responsive to my concerns."
- *Interagency Collaboration* consists of 17 items on the extent to which a respondent's organization collaborates with other organizations in the community. Examples of the types of collaboration include "sharing facility space" and "sharing responsibility for developing programs or services."

There have now been five annual administrations of the survey, with 19 stakeholders completing it in 2012, 21 in 2013, 16 in 2014, 29 in 2015, and 29 in 2016. The table below shows the overall results, by dimension, for each year of the survey.

Table 10: Evaluation of Collaboration

Collaboration Dimensions	2012	2013	2014	2015	2016
Decision making 1=Weak, 5=Strong	4.0	4.0	4.0	4.0	4.0
Leadership 1=Weak, 5=Strong	4.0	4.1	4.3	4.0	4.0
Benefits 1=Low, 5=High	4.0	4.0	4.1	4.1	4.0
Problems 1=Major problems, 3=No problems	2.9	2.9	2.9	3.0	3.0

Conflict Management 1=Weak, 5=Strong	4.0	4.0	4.0	3.8	4.0
Group Sufficiency 6=Weak, 28=Strong	18.0	18.0	18.0	18.5	18.0
Integrative Behavior 1=Weak, 5=Strong	4.0	4.1	4.2	4.0	4.0
Interagency Collaboration 1=Not at all, 5=Very Much	NA	2.8	3.1	3.2	3.0

As can be seen, there has been very little variation in stakeholder evaluations of the collaboration over time. The remarkable consistency was noted in last year's evaluation, and the past year has been no exception. Ratings have been reliably positive, with only two modest exceptions. One is the sufficiency of group effort, which has held essentially at the same "somewhat positive level" all five years. The other is interagency collaboration, which has varied ever so slightly around the midpoint. Both of these subscales come closer to measuring actual behavior and might be prone, because of that, to more objective judgments than the attitude assessment required by the other subscales.

Interpretation and Discussion

MOSAIC is a highly complex undertaking. Because of the multiple organizations, people, and activities involved, the variables it entails and interactions among those variables defy full comprehension. Consequently, figuring out what's working and what's not, and why – the tasks of evaluation – have to be conditioned by a healthy degree of humility and a willingness to accept that, scientifically speaking, firm conclusions are and will remain beyond reach. The best an evaluation can do is shine a brighter light on things than might otherwise occur. Doing so should pick up details and insights that elude casual observation or the motivated perceptions of those with a direct stake in success.

Viewed from this limiting perspective, the findings described above might best be construed as a set of dualities. For every success or achievement, there is something related that remains unsettled or concerning. That is to be expected in something as ambitious and complex as MOSAIC. These dualities are identified and elaborated below as an appropriate and useful way to synthesize and interpret the evidence.

More children with mental health needs being systematically identified/Low identification of young children with such needs

MOSAIC is succeeding in using screening, and the climate screening creates in primary care settings and schools, to identify more children with possible social-emotional and related challenges. While hard to prove definitively, the available data suggests that MOSAIC has elevated the awareness of a large number of doctors and school personnel of the mental health problems experienced by children. Support for screening existed to some degree at SIU Family Medicine and Koke Mill Medical Associates before MOSAIC, but has evidently deepened since MOSAIC began, and stands a good likelihood of becoming part of routine care. Support for some kind of mental health screening in the schools predates MOSAIC as well, since the Springfield public schools have been operating the Positive Behavioral Interventions & Supports program for a while. Yet, there can be little doubt that MOSAIC's initiative to encourage and support it has gained systematic screening a strong foothold in participating

schools. In both cases, it is unclear whether screening would have taken as strong a hold in the absence of embedded mental health clinicians. Probably not, although there is good reason to think it would have gained some level of greater acceptance just on its own terms as professionals discover the value of knowing more about the children for whom they provide care.

Though screening has moved toward becoming institutionalized in primary care and schools in Springfield, it may be getting implemented somewhat unevenly. Screening at SIU Family Medicine has resulted in low positive rates on the ASQ for children ages 0 to 5. The suggestion that physicians may be taking a "wait and see" approach with young children – probably affecting both screening results and service referrals – could be a reasonable exercise of clinical judgment. Development is so rapid during this early period of life that initial signs of trouble may dissipate. It is also possible that doctors may be wisely reluctant to run the risk of "labeling" children with a social-emotional problem so early in their lives. On the other hand, there is good evidence that catching problems early may be the best way to prevent them from worsening with age. One of the reasons to collect data on screening has been to provide, not just a data point to feed into the evaluation, but a signal to trigger the need for further exploration of issues in clinical practice when warranted.

Referrals for services with and without a positive screen/Variation in the uptake and timing of services

Screening is a somewhat modest accomplishment in the absence of services to respond to the needs that screening flags. The embedding of mental health clinicians in primary care and schools by MOSAIC has added measurably to the local capacity to help children who are experiencing social-emotional difficulties. Positive screens have, in effect, created a sizeable proportion of the demand for the services these clinicians can provide. And for the part of this work that occurs through the schools, there is evidence from measures of process outcomes that children entering the mental healthcare system through MOSAIC may be getting more help. At the same time, the increased awareness of mental health that screening creates and the placement of mental health clinicians in the places where screening happens are likely spurring service demands independent of screening results. Reviewable data on the basis for service referrals in the absence of a positive screen do not exist. Yet, it makes sense that trained professionals –physicians, physician assistants, nurses, social workers, mental health counselors, psychologists, teachers – do not depend on screening alone to identify children having social-emotional problems. A screen may provide useful additional information, but professionals act in an ethically responsible way when they seek to meet the need they know of at the time they know it, with or without a screen.

Although more service capacity has been developed, and it is being used, as a result of MOSAIC, the available data has generated a question about the timeliness of these services, particularly in the schools. As noted in the findings section, the way primary care is designed affords, much of the time, a quick and warm hand-off from the physician who has identified a need through a positive screen and the embedded mental health clinician down the hallway who can respond to that need. This doesn't always happen, and nor do patients always cooperate. But, the possibility of a close nexus between screen and service exists. Schools are different, since they are primarily educational, not clinical, settings, which affects how they do screening.

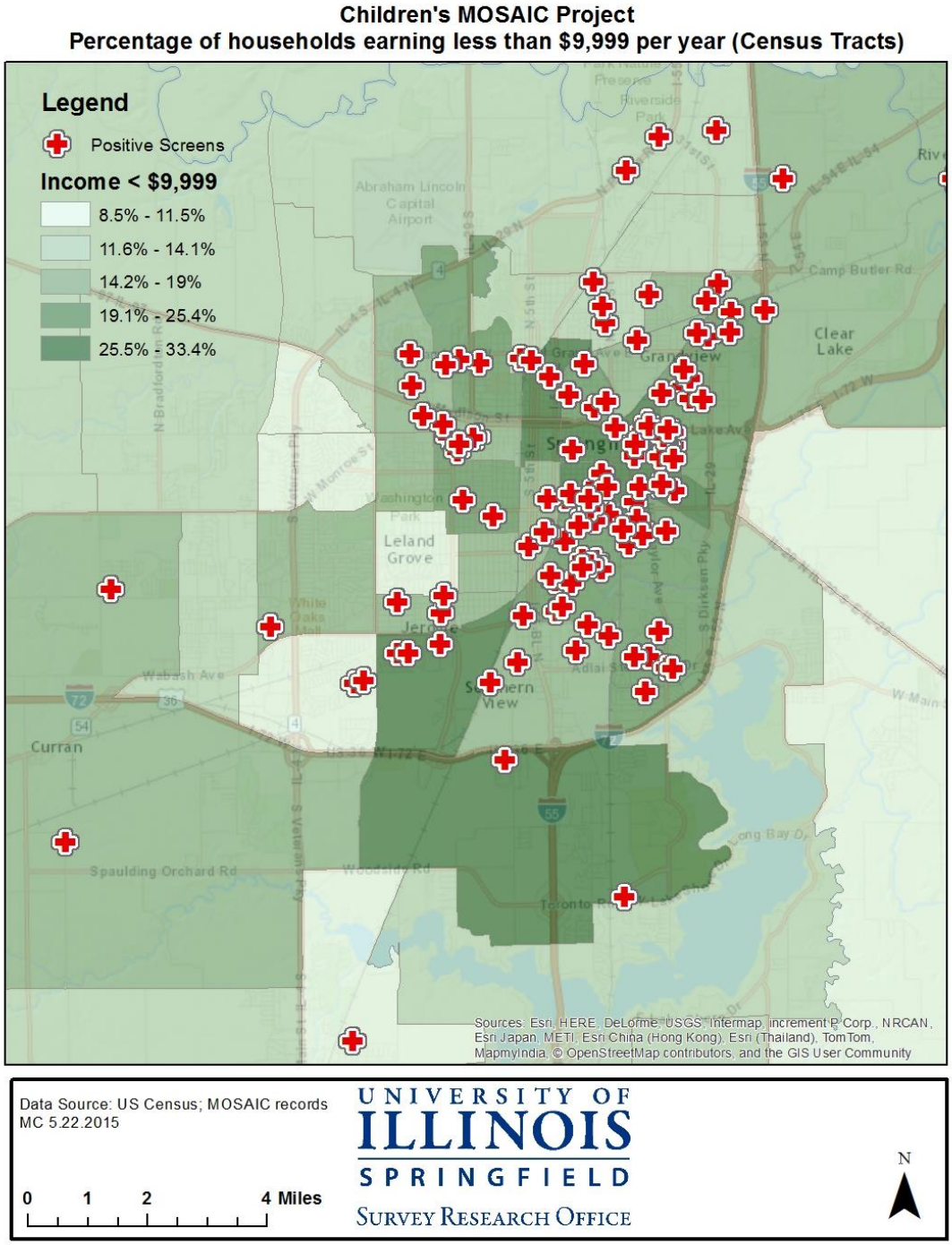
Primary care practices are organized on the basis of service to individuals. Schools are organized around groups, and that ordering of schools creates a preference for carrying out most or many activities, including screening, with groups rather than individuals. When schools screen a large group of students

at one time (e.g., on a given day, during a given week), they also may identify at one time a number of students with social-emotional challenges. This group of students with needs then gets referred, as a group, to the school social worker, who puts them collectively into the queue for the next step in the process, and so on. Moving as a group, rather than individuals spaced out over time, increases the likelihood of bottlenecks. Congestion happens in clinical settings, as well, but the potential for smoothing the work flow is typically greater there than in school settings. At the least, this may help explain the preliminary evidence from MOSAIC schools of time delays in getting highly elevated students into therapy. Looking into this more closely and figuring out if there are ways to reduce those delays will be an important task.

Focusing on families with the greatest needs/Children in families with significant challenges of their own

MOSAIC's strategy was to train its initial efforts on the lower income eastside neighborhood where it was expected that unmet needs for mental health support would be relatively high. While some of the assumptions on which this strategy was based proved incorrect, the underlying premise of building MOSAIC by going first where the needs appear to be greatest has been justified by the experience of the past four years. MOSAIC's intent is to become universal over time, since social-emotional difficulties affect children across the economic spectrum. But, by starting with children in higher need areas of Springfield, MOSAIC has rightly erred in favor of trying to help children, and through them their families, who might otherwise go unidentified precisely because of where they live. Evidence for this comes from the fairly high positive screen rates in the schools and for school-aged children being seen at SIU Family Medicine, and the fact that many of these children have received therapy or other help. (See map below showing the location of children with positive screens at SIU based on household income level.)

When resources are limited, as they are in Illinois for mental healthcare, giving priority to high need children makes sense. Yet, at the same time, focusing on high need children may also increase the challenge of getting them effectively engaged in treatment, given the difficulties their families may face. As shown above in the comparative analysis, the higher a child's household income, the lower the rate of no shows has been. The survey of mental health clinicians and social workers also gave fairly strong indications that they have had difficulty engaging families in services. While data on responding to contact from clinicians, accepting treatment, and complying with appointments has not been compiled across all sites and analyzed, there has been strong anecdotal evidence of problems with phone calls not being returned and people refusing service or making only a tentative commitment. The people who work in mental health know this as not unusual when trying to help under-resourced populations. So, to the extent that MOSAIC has bent the curve, so to speak, and has been able to get at least a significant proportion of children into treatment who might have been missed previously, this is considered a success, and rightly so. But, cracking the engagement code for this population should still be considered among the most important of challenges, given the level of need that exists among these children.



Consistent support among stakeholders for what MOSAIC is trying to do/Question of whether support will hold when ICHCF funding ends

The survey used annually to gauge stakeholder opinion of MOSAIC covers nearly every aspect in which this kind of collaborative effort might matter to the people involved in it. The survey is methodologically sound. It includes a mix of positively and negatively valenced questions to reduce the priming effect that

slanting the questions in only one direction typically has (e.g., questions framed just positively skew responses in a positive direction). Most questions solicit perceptions, but many ask about actual behavior, which are less subject than perceptions to social desirability bias (i.e., giving answers that will be seen favorably by others). In other words, the survey is designed about as well as it can be to assure honest responses. Consistently, under these conditions stakeholders have judged MOSAIC favorably. Not everyone has agreed, and there a few outliers with negative perceptions. But, the vast majority of respondents have given the effort a very positive evaluation from one year to the next, affirming both the importance of the work and the way in which the leadership of MOSAIC has gone about it.

Whether this will continue to hold in the future is unclear. In a way, the purpose of ILCHF's Children's Mental Health Initiative has been to incentivize a shift in direction for long enough to make it stick. There can be little doubt that practice has changed in primary care, and these changes, since they mostly involve activity that can be reimbursed through insurance, have a strong chance of being sustained. The path forward is less obvious for the schools, since the costs of change there are mostly not reimbursable and require hard dollar outlays to be sustained. The stakeholders from these two settings, as well as elsewhere in the community, all appear to believe strongly in the value, even necessity, of the shift in direction MOSAIC represents. And it may be possible to parlay that belief into the support to mobilize the necessary resources. But, there are no guarantees. Indeed, the true test of the strength of community collaboration is its ability to stay the course when the going gets tough.

Recommendations and/or Lessons Learned

- Starting with the highest need areas of the city and building out MOSAIC gradually has proved to be the correct strategy. MOSAIC should stay on this path, and not be overly concerned about covering the entire community within a set period of time. What MOSAIC is attempting to do is very complex, and that complexity cannot be managed effectively if it is pushed to greater scale too quickly.

- Screening children on a regular basis for potential social-emotional problems has been a valuable and necessary addition to the standard repertoire of clinical practice. But, it should not be assumed that every professional administering or scoring screening understands it in the same way. An effort to explore these different understandings and work toward a more common, consistent understanding should be undertaken. It's important that the gateway into mental healthcare for children be uniform, in order to assure that all children are being served fairly.

- Children with social-emotional challenges are receiving therapy and other mental health supports now to a greater extent than before MOSAIC. Yet, engagement in the mental healthcare system remains a problem for too many. This is a difficult nut to crack, but it needs to be attempted, and on a continuing basis. MOSAIC should take on leadership in the community now for making the engagement challenge a topic for discussion and problem solving that will extend beyond the funding from ICHCF.

- Local stakeholders, across the spectrum, have been extraordinarily supportive of MOSAIC. This support is a function of decisions made at the outset, principally through the leadership of the Mental Health Centers of Central Illinois, to create plenty of room for participation by those who wanted or needed to be involved. The resulting coalition now needs to shift into a different gear aimed at sustaining the momentum that has been established. The coalition should have two primary objectives: 1) developing the resources to finance the changes MOSAIC has instituted, and

2) creating a legitimate context for the ongoing and more detailed problem solving that will be necessary to maintain MOSAIC's vitality as a center of gravity for addressing the mental health of children locally.

Appendices

1 – Local Evaluation Plan

2 – Data Collection Instruments

Appendix 1

Local Evaluation Plan

SCREENING	Cross-Site Evaluation	Local Evaluation
#s Screened	1. How many are screened in District 186 each year? How many of these are from the target neighborhood? How many are screened within each zip code of 186?	2. How many are screened within the neighborhood? Within SIU Family Medicine?~~2~~ Within participating 186 schools? Within Koke Mill medical center? Within SIU Pediatrics? Within Head Start?
Positive Screens	3. Of those screened, how many receive a positive screen? What is the incidence of each risk domain from the screen? How frequently and in what patterns do co-occurring risks appear?	4. Within clinical settings, how are screens and corresponding data managed and referred within a given practice, including EHR usage?
ASSESSMENT		
#s Assessed	1. Of those who receive a positive screen, how many receive an assessment? And of those who receive an assessment, how many receive an appropriate assessment? How many receive any kind of assessment within 30 days of referral? How many referring clinicians and families receive completed assessment report(s) within six days of assessment?	2. How many children who are referred for clinician services utilize those services, including all types of one-on-one counseling with or without formal assessment?
Diagnosed Conditions	3. How many assessed children have diagnosable development and mental health problems? What is the incidence of each diagnosis? How frequently and in what patterns do co-occurring diagnoses appear?	
Family Satisfaction/ Engagement	4. How many families report understanding assessment results and treatment needs? Receiving child care if needed? Receiving transportation if needed? Being able to relate their concerns, etc. in their own language?	5. How well do MOSAIC clients engage in counseling services as compared to traditional outpatient clients? Indicators include number of treatment sessions, number of no shows, treatment intensity, and other factors.
Treatment Provider Satisfaction	6. How many treatment providers report being satisfied with the assessment information they received and their access and relationships with others helping the child?	7. What do treatment providers do to engage families? What do residents and attending physicians think about the MOSAIC embedded care model and the associated instruments and processes involved?
Family Characteristics		8. What are the key characteristics of the families of children referred for assessment? -Family resources -Neighborhood conditions -Parental Stress -Family functioning -Family network -Social support -Parent education -Parent employment status
Child Characteristics		9. What are the key characteristics of children referred for assessment? -Race/ethnicity -Income -School attendance -School misbehavior -School achievement

TREATMENT		
#s Treated	1. How many children are referred for treatment? How many children begin receiving appropriate treatment within 30 days after completion of assessment report? How many children within each zip code receive appropriate treatment? How many referrals in child's treatment plan are addressed?	2. How many children with mild positive screens receives special tier 2 interventions in the schools? Does participation in these programs have a measurable impact on children's behavior? How many children who are referred for clinician services utilize those services, including all types of one-on-one counseling with or without formal assessment?
Primary Care Participation	3. How many children have a/their primary care physician participating on their treatment team?	
Treatment Accessibility	4. How many children receive treatment within a one hour commute of their home?	5. How well do MOSAIC clients engage in counseling services as compared to traditional outpatient clients? Indicators include number of treatment sessions, number of no shows, treatment intensity, number of treatment planning sessions, number of total services codes, and number of no shows/cancelations per time period.
Child Improvement	6. How many treated children show improvement in the short-term and long-term?	
Parent/Family Improvement	7. How many parents of treated children show improvement?	
Parenting Education		8. How many individuals participate in parenting programs?
Participation Neighborhood Activities		9. How many neighborhood youth/children participate in supervised neighborhood activities?
Treatment Personnel	10. How many treatment personnel serve District 186?	
Family Expectations of & Satisfaction with Treatment		
MEDICAL HOME		
	1. How many community children are enrolled in a medical home?	
SUSTAINABILITY		
Financial	1. Is the initiative financially sustainable?	
Human Resources	2. Is there a system in place to recruit, select, train, orient, utilize, and, if necessary, reassign professionals needed to implement the initiative?	

Community Support	3. Is there adequate community involvement and commitment to sustain the initiative?	4. How engaged are MOSAIC leaders? How engaged in MOSAIC are other stakeholders in the care of children with mental health needs? What costs and benefits do community leaders perceive from their participation in MOSAIC?
NEIGHBORHOOD		
Staff Time Allocations		1. What efforts are made by the staff assigned to the target neighborhood?
Neighborhood Leadership		

Appendix 2

Data Collection Instruments

MOSAIC Parent Survey (RSSP)

Enter respondent information here:

Parent Name
Child Name
Child Birthdate (MM/DD/YY)

Is this the baseline survey, follow up survey, or is it unclear?

- ❍ Baseline
- ❍ Follow up
- ❍ Unclear

Which of the following best describe your marital status?

- ❍ currently married & living together, or living with someone in marital-like relationship
- ❍ never married & never lived with someone in a marital-like relationship
- ❍ separated
- ❍ divorced or formerly lived with someone in a marital-like relationship
- ❍ widowed

How many children do you have?

- ❍ 0
- ❍ 1
- ❍ 2
- ❍ 3
- ❍ 4
- ❍ 5
- ❍ 6
- ❍ 7
- ❍ 8
- ❍ 9 or more

How many of your children do you see or talk to on the phone at least once every 2 weeks?

- ❍ 0
- ❍ 1
- ❍ 2
- ❍ 3
- ❍ 4
- ❍ 5
- ❍ 6
- ❍ 7
- ❍ 8
- ❍ 9 or more

Are either of your parents living?

- ❍ Neither
- ❍ Mother only
- ❍ Father only
- ❍ Both

Do you see or talk on the phone to either of your parents at least once every 2 weeks?

- ❍ Neither
- ❍ Mother only
- ❍ Father only
- ❍ Both

Are either of your in-laws (or partner's parents) living?

- ❍ Neither
- ❍ Mother only
- ❍ Father only
- ❍ Both
- ❍ Not applicable

Do you see or talk on the phone to either of your partner's parents at least once every 2 weeks?

- ❍ Neither
- ❍ Mother only
- ❍ Father only
- ❍ Both
- ❍ Not applicable

How many other relatives (other than your spouse, parents, & children) do you feel close to?

- ❍ 0
- ❍ 1
- ❍ 2
- ❍ 3
- ❍ 4
- ❍ 5
- ❍ 6
- ❍ 7
- ❍ 8
- ❍ 9 or more

How many of these relatives do you see or talk to on the phone at least once every 2 weeks?

- ❍ 0
- ❍ 1
- ❍ 2
- ❍ 3
- ❍ 4
- ❍ 5
- ❍ 6
- ❍ 7
- ❍ 8
- ❍ 9 or more

How many close friends do you have? (meaning people that you feel at ease with, can talk to about private matters, and can call on for help)

- ❍ 0
- ❍ 1
- ❍ 2
- ❍ 3
- ❍ 4
- ❍ 5
- ❍ 6
- ❍ 7
- ❍ 8
- ❍ 9 or more

How many of these friends do you see or talk to at least once every 2 weeks?

- ❍ 0
- ❍ 1
- ❍ 2
- ❍ 3
- ❍ 4
- ❍ 5
- ❍ 6
- ❍ 7
- ❍ 8
- ❍ 9 or more

Do you belong to a church, temple, or other religious group?

- ❍ Yes
- ❍ No

How many members of your church or religious group do you talk to at least once every 2 weeks?

- ❍ 0
- ❍ 1
- ❍ 2
- ❍ 3
- ❍ 4
- ❍ 5
- ❍ 6
- ❍ 7
- ❍ 8
- ❍ 9 or more

Do you attend any classes (school, university, technical training, or adult education) on a regular basis?

- ❍ Yes
- ❍ No

How many fellow students or teachers do you talk to at least once every 2 weeks?

- ❍ 0
- ❍ 1
- ❍ 2
- ❍ 3
- ❍ 4
- ❍ 5
- ❍ 6
- ❍ 7
- ❍ 8
- ❍ 9 or more

Are you currently employed either full or part-time?

- ❍ Not currently employed
- ❍ Yes, self-employed
- ❍ Yes, employed by others

How many people do you supervise?

- ❍ 0
- ❍ 1
- ❍ 2
- ❍ 3
- ❍ 4
- ❍ 5
- ❍ 6
- ❍ 7
- ❍ 8
- ❍ 9 or more

How many people at work do you talk to at least once every 2 weeks?

- ❍ 0
- ❍ 1
- ❍ 2
- ❍ 3
- ❍ 4
- ❍ 5
- ❍ 6
- ❍ 7
- ❍ 8
- ❍ 9 or more

How many of your neighbors do you visit or talk to at least once every 2 weeks?

- ❍ 0
- ❍ 1
- ❍ 2
- ❍ 3
- ❍ 4
- ❍ 5
- ❍ 6
- ❍ 7
- ❍ 8
- ❍ 9 or more

Are you currently involved in regular volunteer work?

- ❍ Yes
- ❍ No

How many people involved in this volunteer work do you talk to about volunteering-related issues at least once every 2 weeks?

- ❍ 0
- ❍ 1
- ❍ 2
- ❍ 3
- ❍ 4
- ❍ 5
- ❍ 6
- ❍ 7
- ❍ 8
- ❍ 9 or more

Are these resources adequate for you and your family's needs?

	Not at all adequate	Rarely adequate	Sometimes adequate	Usually adequate	Almost always adequate	Does not apply
Food for two meals a day.	❍	❍	❍	❍	❍	❍
Lodging	❍	❍	❍	❍	❍	❍
Money to buy necessities	❍	❍	❍	❍	❍	❍
Enough clothes for your family	❍	❍	❍	❍	❍	❍
Heat for your house or apartment	❍	❍	❍	❍	❍	❍
Indoor plumbing/water	❍	❍	❍	❍	❍	❍
Money to pay monthly bills	❍	❍	❍	❍	❍	❍
Good job for yourself or your partner	❍	❍	❍	❍	❍	❍
Medical care for your family	❍	❍	❍	❍	❍	❍
Public Assistance	❍	❍	❍	❍	❍	❍
Dependable transportation	❍	❍	❍	❍	❍	❍
Time to get enough sleep/rest	❍	❍	❍	❍	❍	❍
Furniture for your home or apartment	❍	❍	❍	❍	❍	❍
Time to be by yourself	❍	❍	❍	❍	❍	❍
Time to be with family together	❍	❍	❍	❍	❍	❍
Time to be with your children	❍	❍	❍	❍	❍	❍
Time to be with spouse/partner	❍	❍	❍	❍	❍	❍
Telephone or access to phone	❍	❍	❍	❍	❍	❍
Babysitting for children	❍	❍	❍	❍	❍	❍
Childcare/daycare for children	❍	❍	❍	❍	❍	❍

Money to buy special equipment or supplies for children	❍	❍	❍	❍	❍	❍
Someone to talk to	❍	❍	❍	❍	❍	❍
Time to socialize	❍	❍	❍	❍	❍	❍
Time to keep in shape and look nice	❍	❍	❍	❍	❍	❍
Toys for your children	❍	❍	❍	❍	❍	❍
Money to buy things for yourself	❍	❍	❍	❍	❍	❍
Money for family entertainment	❍	❍	❍	❍	❍	❍
Money to save	❍	❍	❍	❍	❍	❍
Time and money for travel or vacation	❍	❍	❍	❍	❍	❍

Click to write the question text

	Definitely false	Probably false	Probably True	Definitely True
If I wanted to go on a trip out of town for a day, I would have a hard time finding someone to go with me.	❍	❍	❍	❍
I feel that there is no one I can share my most private worries and fears with.	❍	❍	❍	❍
If I were sick, I could easily find someone to help me with my daily chores.	❍	❍	❍	❍
There is someone I can turn to for advice about handling problems with my family.	❍	❍	❍	❍
If I decide one afternoon that I would like to go to a movie that evening, I could easily find someone to go with me.	❍	❍	❍	❍
When I need suggestions on how to deal with a personal problem , I know someone I can turn to.	❍	❍	❍	❍
I don't often get invited to do things with others.	❍	❍	❍	❍
If I had to go out of town for a few weeks, it would be difficult to find someone who would look after my house or apartment (the plants, pets, garden, etc.).	❍	❍	❍	❍

If I wanted to have lunch with someone, I could easily find someone to join me.	❍	❍	❍	❍
If I was stranded 10 miles from home, there is someone I could call who could come and get me.	❍	❍	❍	❍
If a family crisis arose, it would be difficult to find someone who could give me good advice about how to handle it.	❍	❍	❍	❍
If I needed some help in moving to a new house or apartment, I would have a hard time finding someone to help me.	❍	❍	❍	❍

What was the approximate combined income of all the adults in your household last year?

- ❍ $0-$9,999
- ❍ $10,000-$19,999
- ❍ $20,000-29,999
- ❍ $30,000-39,999
- ❍ $40,000-49,999
- ❍ $50,000-59,999
- ❍ $60,000 or more
- ❍ I don't know

What is the highest level of education you have completed so far?

- ❍ Less than high school
- ❍ High school diploma/GED
- ❍ Some college
- ❍ Associate's degree/certificate
- ❍ Bachelor's degree
- ❍ Advanced degree

If you are employed, please describe your job title or role:

MOSAIC Moms Intro

What was the date that they filled this out (MM/DD/YY):

Gender:

- ❍ Male
- ❍ Female
- ❍ Other/Prefer not to say

What year were you born?

Are you Hispanic/Latino(a)?

- ❍ Yes
- ❍ No

What is your race?

- ❍ White
- ❍ African-American/Black
- ❍ Asian/Pacific-Island
- ❍ Native American
- ❍ Non-resident alien
- ❍ Other _____

What is your annual earned income before taxes:

Highest level of education you have completed:

- ❍ Less than high school
- ❍ High school diploma or equivalent
- ❍ Trade or technical school beyond high school
- ❍ Some college
- ❍ 4 year college degree
- ❍ More than 4 year degree

What is your disability status?

- ❍ Do not have a disability
- ❍ Have a disability

What is your marital status?

- ❍ Single
- ❍ Married
- ❍ Domestic partner
- ❍ Divorced
- ❍ Widowed
- ❍ Other _____

Number of children (under the age of 18) living in your household:

Number of children (under the age of 18) in your family:

Address

Street address
City, State Zip code
Phone number

May we contact you by U.S. mail?

- ❍ Yes
- ❍ No

May we contact you by phone?

- ❍ Yes
- ❍ No

What is their Project Identification Number?

Date:

MOSAIC Moms Monthly Survey

Please enter the project identification number for this participant:

What was the date that this was completed?

EXAMPLE: (11/17/2014)

Section 1: Thinking about your experience over the last month, please report whether the following have happened very often, fairly often, sometimes, almost never, or never.

	Never	Almost never	Sometimes	Fairly often	Very often
In the last month, how often have you felt that you were unable to control the important things in your life?	❍	❍	❍	❍	❍
In the last month, how often have you felt confident about your ability to handle your personal problems?	❍	❍	❍	❍	❍
In the last month, how often have you felt that things were going your way?	❍	❍	❍	❍	❍
In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?	❍	❍	❍	❍	❍

Section 2: Thinking about your current relationships (friends, family members, coworkers, community members, etc.). How much do you agree, if at all, with each of the following statements? Do you strongly agree, agree, disagree, or strongly disagree?

	Strongly Disagree	Disagree	Agree	Strongly Agree
There are people I can depend on to help me if I really need it.	❍	❍	❍	❍
There are people who enjoy the same social activities I do.	❍	❍	❍	❍
I feel part of a group of people who share my attitudes and beliefs.	❍	❍	❍	❍
I have close relationships that provide me with a sense of emotional security and well-being.	❍	❍	❍	❍
There is someone I could talk to about important decisions in my life.	❍	❍	❍	❍
I have relationships where my competence and skills are recognized.	❍	❍	❍	❍
There is a trust worthy person I could turn to for advice if I was having problems.	❍	❍	❍	❍
I feel a strong emotional bond with at least one other person.	❍	❍	❍	❍
There are people who admire my talents and abilities.	❍	❍	❍	❍
There are people I can count on in an emergency.	❍	❍	❍	❍

Section 3: Now thinking about the last 2 weeks, please report whether you have been bothered by any of the following nearly every day, more than half of the days, several days, or not at all. Please mark the response that best matches your experience.

	Not at all	Several days	More than half of the days	Nearly every day
Little interest or pleasure in doing things	❍	❍	❍	❍
Feeling down, depressed, or hopeless	❍	❍	❍	❍
Trouble falling or staying asleep, or sleeping too much	❍	❍	❍	❍
Feeling tired or having little energy	❍	❍	❍	❍
Poor appetite or overeating	❍	❍	❍	❍
Feeling bad about yourself- or that you are a failure or have let yourself or your family down	❍	❍	❍	❍
Trouble concentrating on things, such as reading the newspaper or watching television	❍	❍	❍	❍
Moving or speaking so slowly that other people could have noticed. Or the opposite, being so fidgety or restless that you have been moving around a lot more than usual	❍	❍	❍	❍
Thought that you would be better off dead or of hurting yourself in some way	❍	❍	❍	❍

How difficult, if at all, have these problems made it for you to do your work, take care of things at home, or get along with other people? Have the problems made it extremely difficult, very difficult, somewhat difficult, not difficult at all?

- ❍ Extremely difficult
- ❍ Very difficult
- ❍ Somewhat difficult
- ❍ Not difficult at all

End of survey. Press complete to submit form.

MOSAIC Clinician Engagement Survey

The MOSAIC project has aimed to build and streamline a system of care for children's mental health in Springfield through embedding mental health clinicians in primary care settings in order to provide timely response to referrals of children who screened positive for potential mental health issues. As a clinician, this survey is designed to examine and measure how you engage families in this process. Your participation in the survey is completely voluntary, and refusing to participate will not have an adverse impact on you or your organization. Your responses will be combined with other responses from your organization, and results will be reported in aggregate. Your risks for participating in this survey are minimal and your answers are completely confidential. Only the evaluation team at the University of Illinois at Springfield will have access to the survey data. By completing the survey, you acknowledge that you have read this consent and choose to continue as a voluntary participant. If you have any questions about this survey or this consent form, please contact Dr. Ashley Kirzinger, Director of the UIS Survey Research Office, at (217)206-6591. This project has been reviewed by the Human Subjects Review Officer, Dr. James Klein who is available to answer any questions about your rights as a voluntary participant. Dr. Klein may be reached at (217)-206-6883.

Please identify whether you strongly disagree, somewhat disagree, neither agree nor disagree, somewhat agree, or strongly agree with the following statements.

	Strongly Disagree	Somewhat Disagree	Neither agree nor Disagree	Somewhat Agree	Strongly Agree
Engaging families into mental health treatment is not a challenge.	❍	❍	❍	❍	❍
Families often don't feel their child has a problem.	❍	❍	❍	❍	❍
In general, families value mental health counseling.	❍	❍	❍	❍	❍
Families don't understand the importance of mental health treatment.	❍	❍	❍	❍	❍
Being an embedded clinician decreases the likelihood families will engage with me.	❍	❍	❍	❍	❍
I have no difficulty engaging the families of vulnerable clients.	❍	❍	❍	❍	❍
Clients and families understand what services are available as well as details about the overall treatment process itself.	❍	❍	❍	❍	❍
I send reminder letters to families.	❍	❍	❍	❍	❍

I remind families of upcoming appointments through text messages.	❍	❍	❍	❍	❍
I make direct contact with clients or families through phone calls to remind them of appointments.	❍	❍	❍	❍	❍

Is there anything else you would like to share about the process of engaging families in the MOSAIC project? Please use the space provided below.

Thank you very much for participating in the survey! If you have any questions about this survey, please contact Dr. Ashley Kirzinger at (217) 206-6591 or akirz2@uis.edu.

MOSAIC Physician Survey

The MOSAIC project has aimed to build and streamline a system of care for children's mental health in Springfield through embedding mental health clinicians in primary care settings in order to provide timely response to referrals of children who screened positive for potential mental health issues. This survey is designed to measure your satisfaction with the MOSAIC program and its perceived impact. Your participation in the survey is completely voluntary, and refusing to participate will not have an adverse impact on you or your organization. Your responses will be combined with other responses from your organization, and results will be reported in aggregate. Your risks for participating in this survey are minimal and your answers are completely confidential. Only the evaluation team at the University of Illinois at Springfield will have access to the survey data. By returning the survey, you acknowledge that you have read this consent and choose to continue as a voluntary participant. If you have any questions about this survey or this consent form, please contact Dr. Ashley Kirzinger, Director of the UIS Survey Research Office, at (217)206-6591. This project has been reviewed by the Human Subjects Review Officer, Dr. James Klein who is available to answer any questions about your rights as a voluntary participant. Dr. Klein may be reached at (217)-206-6883.

Please identify whether you strongly disagree, somewhat disagree, neither agree nor disagree, somewhat agree, or strongly agree with the following statements.

	Strongly Disagree	Somewhat Disagree	Neither agree nor Disagree	Somewhat Agree	Strongly Agree
I am identifying more children who are at-risk for mental health issues than I was before MOSAIC.	❍	❍	❍	❍	❍
The screening instruments produce too many false positives.	❍	❍	❍	❍	❍
Results from the screening instruments provide useful information that I otherwise would not get.	❍	❍	❍	❍	❍
The screening instruments reduce the amount of time I need to spend discussing children's mental health with patients or parents.	❍	❍	❍	❍	❍
Brief interventions from embedded clinicians have reduced the need for referrals for community based mental health assessment and treatment.	❍	❍	❍	❍	❍
When I want the clinician to meet with a patient on short notice, I can usually find him/her quickly.	❍	❍	❍	❍	❍

Having an embedded mental health clinician increases the likelihood that patients will participate in mental health treatment.	❍	❍	❍	❍	❍
Interpreting and responding to screening instrument results is not a good use of my time.	❍	❍	❍	❍	❍
For patients that receive follow-up treatment form the embedded clinician, the clinician does not keep me adequately updated on their progress through notes or other communication.	❍	❍	❍	❍	❍
I would recommend our model for mental health screening and on-site mental health services for children to other primary care practices.	❍	❍	❍	❍	❍

What is the single greatest benefit, if any, MOSAIC has provided for your practice?

What is the single biggest problem, if any, MOSAIC has created for your practice?

If you could change anything about the current implementation of the MOSAIC model, what would it be?

Is there anything else you would like to tell us about the current implementation of MOSAIC?

The following questions are for analysis purposes only and will not be used to identify you as a participant.

How long have you worked in your current location?

- ❍ 0-1 year
- ❍ 2-4 years
- ❍ 5 years +

Select the option that best describes your primary job role:

- ❍ Nurse practitioner
- ❍ Physician's assistant
- ❍ Primary care attending physician
- ❍ Primary care resident
- ❍ Specialist attending physician or resident
- ❍ Other: _____

Thank you very much for participating in the 2015 MOSAIC Physician Survey! If you have any questions about this survey, please contact Dr. Ashley Kirzinger at (217) 206-6591 or akirz2@uis.edu.

MOSAIC Collaboration Survey

Thank you very much for your continued investment in MOSAIC. This collaboration survey is conducted by the MOSAIC Evaluation Group at the University of Illinois Springfield. For more information about the survey, please contact the Survey Research Office at (217) 206-6591. Thank you very much for your participation in the MOSAIC annual evaluation!

What is your unique Project ID number? If you did not receive one, please leave this blank.

How much do you agree or disagree with EACH of the following statements. Please mark the response that best matches your view.

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Does not apply
MOSAIC's leadership advocates strongly for their own opinions/agenda.	❍	❍	❍	❍	❍	❍
Participation in MOSAIC has developed useful collaborative relationships with other organizations.	❍	❍	❍	❍	❍	❍
A problem between two organizations involved in MOSAIC is referred to another organization for resolution.	❍	❍	❍	❍	❍	❍
Participation in MOSAIC has changed my organization's revenue sources.	❍	❍	❍	❍	❍	❍
Disagreements among participating organizations are ignored.	❍	❍	❍	❍	❍	❍
MOSAIC's leadership makes timely decisions.	❍	❍	❍	❍	❍	❍
Participation in MOSAIC helped my organization be perceived as a leader in the community.	❍	❍	❍	❍	❍	❍
MOSAIC's leadership is ethical.	❍	❍	❍	❍	❍	❍

MOSAIC's leadership gets things done.	❍	❍	❍	❍	❍	❍
All points of view are carefully considered in arriving at the best solution to a problem.	❍	❍	❍	❍	❍	❍
Participation in MOSAIC has helped my organization get support for policy issues we feel strongly about.	❍	❍	❍	❍	❍	❍
Each participating organization gives in a bit and settles on compromise.	❍	❍	❍	❍	❍	❍
MOSAIC's decision makers willingly collaborate and cooperate with each other.	❍	❍	❍	❍	❍	❍
Participation in MOSAIC has helped my organization move toward its goals.	❍	❍	❍	❍	❍	❍
When participating organizations disagree, they ignore the issue, pretending it will "go away."	❍	❍	❍	❍	❍	❍

During your participation in MOSAIC, have any of the following been a major problem, a minor problem, or not a problem at all. Please mark the response that best matches your view.

	A major problem	A minor problem	Not a problem	Does not apply
My organization would be better served if another staff member or volunteer participated in MOSAIC.	❍	❍	❍	❍
Time spent on MOSAIC takes time away from more important work my organization should be doing.	❍	❍	❍	❍
I am often the only voice in MOSAIC representing my point of view.	❍	❍	❍	❍
MOSAIC is not taking any meaningful action.	❍	❍	❍	❍
My organization's opinions are not valued in MOSAIC.	❍	❍	❍	❍
My skills and time are not well used by MOSAIC.	❍	❍	❍	❍
MOSAIC's efforts do not reach my organization's primary constituency.	❍	❍	❍	❍
The burden of participating in MOSAIC activities is high.	❍	❍	❍	❍
My organization doesn't get enough public recognition for our work on MOSAIC.	❍	❍	❍	❍
The action or positions of MOSAIC have been an embarrassment for my organization.	❍	❍	❍	❍

MOSAIC is competing with my organization.	❍	❍	❍	❍

The following set of questions examines the extent, if at all, YOUR ORGANIZATION share with other child-serving organizations in the following areas. Please mark the response that best matches your view.

	Not at all	Little	Somewhat	Considerable	Very much	Does not apply
Funding	❍	❍	❍	❍	❍	❍
Purchasing of services	❍	❍	❍	❍	❍	❍
Facility space	❍	❍	❍	❍	❍	❍
Record keeping and management information systems data	❍	❍	❍	❍	❍	❍
Developing programs or services	❍	❍	❍	❍	❍	❍
Program evaluation	❍	❍	❍	❍	❍	❍
Staff training	❍	❍	❍	❍	❍	❍
Informing the public of available services	❍	❍	❍	❍	❍	❍
Diagnoses and evaluation/assessment	❍	❍	❍	❍	❍	❍
Common intake forms	❍	❍	❍	❍	❍	❍
Child and family service plan development	❍	❍	❍	❍	❍	❍
Participation in standing interagency committees	❍	❍	❍	❍	❍	❍
Information about services	❍	❍	❍	❍	❍	❍
Case conferences or case reviews	❍	❍	❍	❍	❍	❍
Informal agreements	❍	❍	❍	❍	❍	❍
Formal written agreements	❍	❍	❍	❍	❍	❍
Voluntary contractual relationships	❍	❍	❍	❍	❍	❍

Now thinking about your participation in MOSAIC, please answer the following questions by marking the responses that best indicates your experience.

Did you happen to talk at the last MOSAIC meeting you attended?

- ❍ Yes
- ❍ No

How many MOSAIC meetings did you attend in the last 12 months?

- ❍ No meetings
- ❍ One to two meetings
- ❍ Three to five meetings
- ❍ Six or more meetings

On average, how many hours each month have you spent on MOSAIC activities in the last 12 months?

- ❍ Less than one hour/month
- ❍ One to two hours/month
- ❍ Three to five hours/month
- ❍ Six to 10 hours/month
- ❍ More than 10 hours/month

How much do you agree or disagree with EACH of the following statements? Please mark the response that best matches your view.

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	Does not apply
I am kept informed of changes going on in MOSAIC.	❍	❍	❍	❍	❍	❍
MOSAIC's leadership follows standard procedures for making decisions.	❍	❍	❍	❍	❍	❍
I am given opportunities to influence changes going on in MOSAIC.	❍	❍	❍	❍	❍	❍
Participation in MOSAIC has raised the public profile of my organization.	❍	❍	❍	❍	❍	❍
All members of the MOSAIC Steering Committee regularly attend meetings.	❍	❍	❍	❍	❍	❍
All participating organizations will work hard to arrive at the best possible solution.	❍	❍	❍	❍	❍	❍
I am encouraged to critique or provide information that challenges what is being done in MOSAIC.	❍	❍	❍	❍	❍	❍
Participation in MOSAIC has enhanced my organization's ability to recruit employees.	❍	❍	❍	❍	❍	❍

MOSAIC's leadership is able to secure resources.	❍	❍	❍	❍	❍	❍
The leadership has a clear vision for MOSAIC.	❍	❍	❍	❍	❍	❍
Steering committee members are engaged and participate at meetings by offering comments and ideas.	❍	❍	❍	❍	❍	❍
When two organizations involved in MOSAIC disagree, they seek a third organization to help resolve the issue.	❍	❍	❍	❍	❍	❍
MOSAIC's leadership is responsive to my concerns.	❍	❍	❍	❍	❍	❍
Participation in MOSAIC has enhanced my organization's ability to obtain funding.	❍	❍	❍	❍	❍	❍
Participating organizations yield their position on an issue to others to maintain harmony and stability.	❍	❍	❍	❍	❍	❍
The MOSAIC Steering Committee is a highly efficient, work-oriented group.	❍	❍	❍	❍	❍	❍

The decision-making process used by MOSAIC's leadership is open, fair, and clear to all.	❍	❍	❍	❍	❍	❍
Participation in MOSAIC has helped my organization gain access to key policy makers.	❍	❍	❍	❍	❍	❍
Participation in MOSAIC has helped my organization get client referrals from others.	❍	❍	❍	❍	❍	❍
Important decisions are made privately and informally among individual decision makers.	❍	❍	❍	❍	❍	❍
Participation in MOSAIC has made my organization more aware of specific services/programs available in the community.	❍	❍	❍	❍	❍	❍
Participation in MOSAIC has enhanced my professional skills and knowledge.	❍	❍	❍	❍	❍	❍
Participation in MOSAIC has increased my sense that others share my goals and concerns.	❍	❍	❍	❍	❍	❍
MOSAIC's leadership builds consensus on key decisions.	❍	❍	❍	❍	❍	❍

Participation in MOSAIC has enhanced my organization's ability to retain employees.	❍	❍	❍	❍	❍	❍
In both formal and informal discussions, MOSAIC's decision makers say what they mean and mean what they say.	❍	❍	❍	❍	❍	❍
Participation in MOSAIC has improved my connections to others in the community.	❍	❍	❍	❍	❍	❍
Participation in MOSAIC has enhanced my organization's ability to recruit board members.	❍	❍	❍	❍	❍	❍
MOSAIC's leadership utilizes the skills and talents of many, not just a few.	❍	❍	❍	❍	❍	❍
Participating organizations tend to withdraw from conflict.	❍	❍	❍	❍	❍	❍
Decision-making occurs in a politically charged atmosphere.	❍	❍	❍	❍	❍	❍
Participation in MOSAIC has enhanced my organization's ability to recruit volunteers.	❍	❍	❍	❍	❍	❍

MOSAIC's leadership is not effective keeping MOSAIC focused on tasks or objectives.	❍	❍	❍	❍	❍	❍
Participation in MOSAIC has helped my organization get access to populations with whom we've previously had little contact.	❍	❍	❍	❍	❍	❍
The composition MOSAIC's leadership is sufficiently broad to accomplish MOSAIC's objectives.	❍	❍	❍	❍	❍	❍
Participation in MOSAIC has helped my organization get services for our clients.	❍	❍	❍	❍	❍	❍

Thank you for participating in the MOSAIC evaluation!If you have any additional questions, please do not hesitate to contact the SRO Director, Dr. Ashley Kirzinger at 217-206-6591 or sro@uis.edu.