Maternal, Infant and Early Childhood Home Visiting (MIECHV) Program Innovation UH4MC30747 Final Report

Table of Contents

I. PROGRAM SUMMARY

Purpose and rationale for grant: The purpose of Indiana's Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Innovation was to strengthen and improve the delivery of MIECHV-funded home visiting programs through the coordination of community resources and early childhood systems such as child health, behavioral health and human services. Through this project, Indiana State Department of Health, Maternal and Child Health Division ISDH/MCH in partnership with Department of Child Services[1] (DCS) has expanded the services provided by the existing MCH MOMS Helpline and implemented the evidence-based model of Help Me Grow, for the purpose of maximizing the continuum of services for women of child-bearing age through families with children. This integration creates a centralized telephone access point for connecting children ages 0-8 and their families to: care coordination services, child health care providers and community outreach services that support early detection and intervention. This innovation supported the creation and pilot of a data collection system and feedback loop for the purpose of informing availability, provision and quality of services.

Program Elements:

Principle Needs and Problems addressed by the project

Fragmentation in early childhood services creates substantial set-backs for specific populations to attain adequate care. As a result, children and families are not screened appropriately and, if there are issues, there are significant delays in getting into appropriate services. The MIECHV population, like the state and national population as a whole, experiences a number of systematic issues that affect child health and development. These issues include:

- Lack of infrastructure supporting child development, including screening, once children are identified with any type of delay
- Not enough people trained to identify, refer, screen and provide services
- Hard to enter systems with few entry points
- Parents have difficulty connecting with services and understanding what services are available or what services parents can access

Priority Area(s) and Updates on Innovation Activities funded by award

Indiana's innovation – the implementation of the evidenced-based Help Me Grow model – supported the 1st objective[2] of this MIECHV competitive funding opportunity. Help Me Grow Indiana is on its way to improve referral outcomes related to appropriate service referrals and receipt of services that support home visiting; including child health, behavioral health and human services. The pilot implementation of Help Me Grow Indiana demonstrated improvement in the "coordination of MIECHV-funded home visiting programs with community resources and

[1] In Indiana, ISDH and DCS serve as co-lead partnering agencies on the MIECHV project to improve health and development outcomes for children and families who are at risk. Together, the agencies have been awarded MIECHV Formula and Competitive awards successfully since 2010.

[2] "Develop and implement innovations that strengthen and improve the delivery of MIECHV-funded coordinated and comprehensive high-quality voluntary early childhood home visiting services to eligible families and that are expected, based on evidence of promise or strong theory, to demonstrate improvement in one or more of the following program priority areas..."

supports, including comprehensive statewide and/or local early childhood systems, such as child health, behavioral health, and human services systems," the program priority area Indiana proposed to address.

During this project period, Indiana provided MIECHV funded home visiting services through the evidence-based models Healthy Families Indiana in Elkhart, Grant, Lake, LaPorte, Marion, Scott, and St. Joseph Counties and Nurse-Family Partnership in Delaware, Madison, and Marion Counties (refer to map on right).

As of September 30, 2019, Indiana had provided direct home visiting services funded by MIECHV dollars to 9,964 families since the inception of MIECHV funding in 2011.

Indiana consistently aims to achieve the following goals through MIECHV:

1) Provide appropriate home visiting services to women who are low-income and high-risk, as well as their infants and families;
2) Develop a system of coordinated services statewide of existing and newly developed home visiting programs in order to provide appropriate, targeted, and unduplicated services and locally coordinated referrals;
3) Coordinate necessary services outside of home visiting programs to address needs of participants, which may include: mental health, primary care, dental health, children with special needs, substance use, childhood injury prevention, child abuse / neglect / maltreatment, school readiness, employment training and adult education programs.

The pilot implementation of Help Me Grow Indiana began with the unique coordination of two federal awards: The Early Childhood Comprehensive Services Impact award, and this MIECHV Innovation award. Indiana overcame challenges resulting from this uncommon funding collaboration and launched the Help Me Grow Indiana pilot implementation within an accelerated timeline. Additionally, Indiana's success has been recognized nationally, and Help Me Grow Indiana will be hosting the Help Me Grow National Forum in May 2020.

ECCS Early Childhood Comprehensive Systems
MIECHV Innovation
collaboration
Help Me Grow National Center

January - June 2017: Indiana embarked on the pilot implementation of Help Me Grow. HMG Indiana is integrated into existing services and aligned with the Indiana ECCS ImpACT Grant. Leveraging two existing federal grants led to the creation of the HMG organizing entity. Leaders from both ISDH and DCS compose the organizing entity. Indiana understood that federal reporting was required and did not want to place that burden on the four core component workgroups that are embedded within the HMG model. Indiana worked with project officers to achieve budget approval, while simultaneously developing relationships with vendors to support the project. Indiana submitted draft Evaluation plan, which required significant revision to

represent realistic expectation of implementation activities occurring within the project period. Indiana began to develop the relationship with HMG National Center.

July-December 2017: Indiana secured contract with the Help Me Grow National Center, working closely via email and monthly phone calls with HMG national office staff to plan the required implementation site visit and launch of the HMG model in Indiana. The HMG model identifies 4 core component workgroups that lead to the success of implementation, they are:

- Centralized Access Point
- Family Community Outreach
- Child Health Care Provider Outreach
- Data Collection and Analysis.

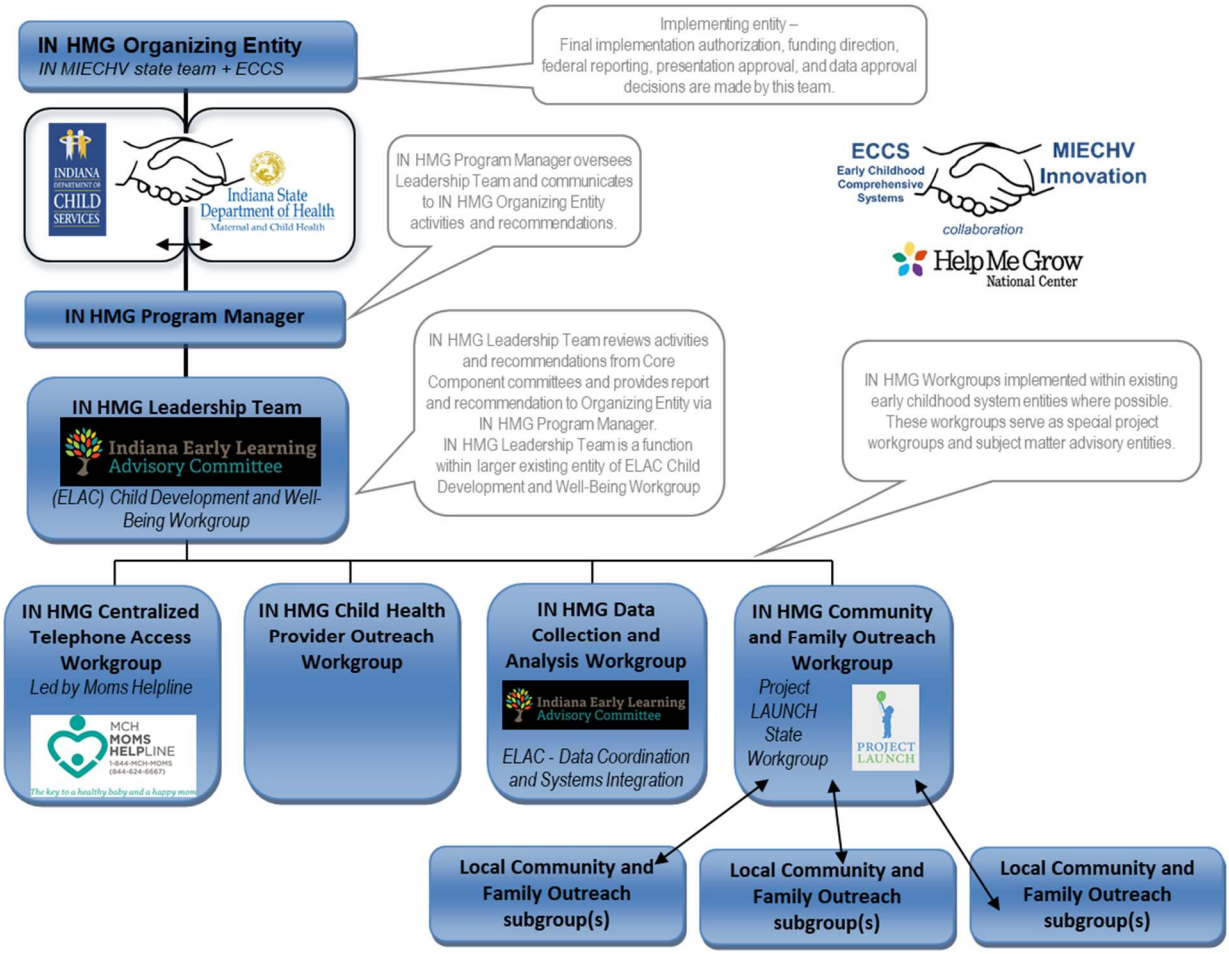
HMG workgroups were identified, through the existing Governor Appointed Early Learning Advisory Committee, (Child Development and Well- Being and Data Workgroup), ECCS place based community workgroup and ISDH internal MOM's Helpline workgroup. This is significant that these groups were formed to just embed HMG within existing work. Having theses existing workgroups helped us prepare for our site visit. Indiana worked with several partners to prepare for the HMG site visit / launch. Indiana contracted with Indiana 211[3] to host MOMS Help Line database and provide technical infrastructure for the HMG database. Indiana began the search for HMG staff. Indiana received approval and began activities for the Help Me Grow Evaluation.

Several descriptions were created to explain entities within the structure of the HMG Indiana pilot implementation.

- The Organizing Entity: Final implementation authorization, funding direction, federal reporting, presentation approval, and data approval decisions are made by this team.
- The Program Manager: oversees Leadership Team and communicates to IN HMG Organizing Entity activities and recommendations.
- Leadership Team: reviews activities and recommendations from Core Component committees and provides report and recommendation to Organizing Entity via IN HMG Program Manager. IN HMG Leadership Team is a function within larger existing entity of ELAC Child Development and Well-Being Workgroup
- Workgroups: serve as special project workgroups and subject matter advisory entities, implemented within existing early childhood system entities where possible.

An Organization Chart was developed to illustrate the HMG Indiana structure to stakeholders and community partners.

[3] https://in211.communityos.org/about-us. Indiana 211 is a free service that connects Hoosiers with help and answers from thousands of health and human service agencies and resources right in their local communities - quickly, easily, and confidentially. Indiana 211 uses statistical data (not personally identifiable information) from calls, texts and web visits to help shed light on the nature of social needs in Indiana for decision-makers and government across the state. Indiana 211 is an independent 501c(3) organization, providing free, unbiased and confidential referrals to the best resources for specific needs. Through data analytics and reporting, Indiana 211 is becoming a leader in monitoring human and health-related trends to help Indiana identify potential problems earlier and reduce threats.



January-June 2018: Indiana hosted a 4-day site visit in January 22-25, 2018 with the Help Me Grow National team. The site visit included: community meetings in central and northern Indiana, with more than 200 stakeholders; several direct interactions with Dr. Dworkin and health care providers to explain role of physicians in the HMG model, including Dr. Dworkin presenting at Indiana Grand Rounds and the HMG model's ability to increase access to services for children; a state leadership meeting including members of Indiana State Department/Division leaders, Early Childhood Comprehensive Systems (ECCS) state committee and Indiana Home Visiting Advisory Board (INHVAB) members; introduction of the HMG Indiana Vision; and launching of HMG workgroups including Leadership Team.

The HMG Coordinator was hired in January 2018.

In April, several members of Indiana's HMG Organizing Entity and HMG Leadership Team members attended the national HMG Forum in Seattle, WA. It was important to have members of HMG workgroups in attendance at the National HMG Forum, as it was an opportunity to meet other affiliates, collaborate and understand HMG. On April 17, 2018, Hederick Partnerships facilitated The Institute for Strengthening Families, which included 2 sessions specific to client engagement. The Family and Community Outreach workgroup worked with IN CDC Learn the Signs, Act Early (LTSAE) Ambassador to incorporate HMG logos and adapted resources to be state/local specific on materials. HMG Organizing Entity members presented HMG Indiana and

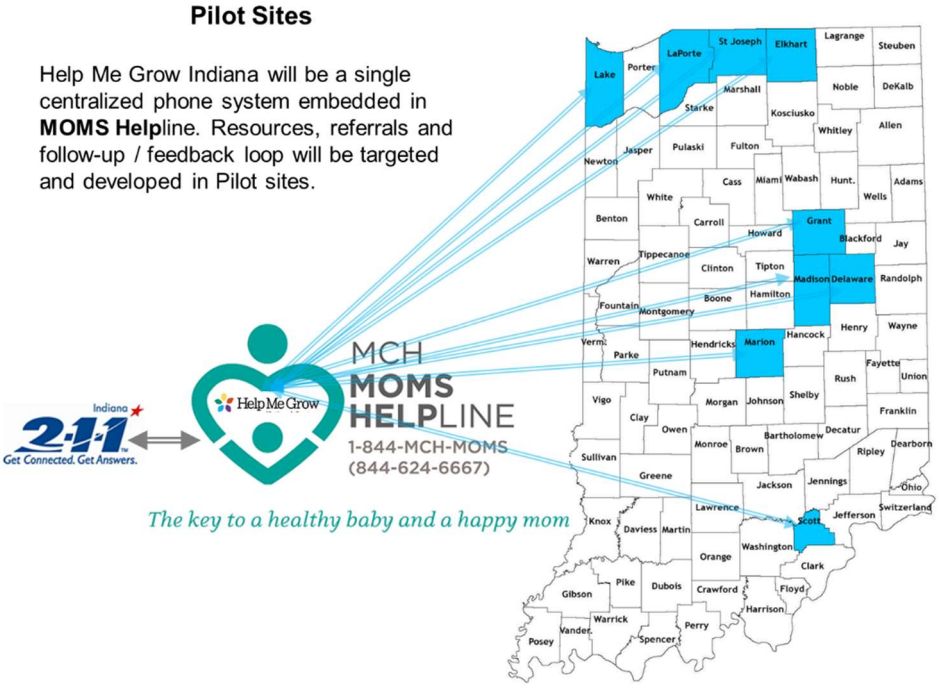
its vision at a variety of community speaking engagements in Allen and Madison counties, for the Indiana Head Start Association, and at the First Steps conference in Bloomington, IN.

Indiana's HMG Organizing Entity worked with MOMS Helpline and Indiana 211 to establish call center infrastructure and protocol for client intake through the follow-up loop to enhance centralized data collection. The HMG Coordinator facilitated advisory conversations with other HMG states across the country to inform the Indiana structure and implementation. HMG Indiana's Organizing Entity received monthly technical assistance from the National HMG office. The HMG National Office provided the Indiana HMG National Site Visit Reflection Report, the Community Capacity for Change Synthesis, as well as monthly technical assistance in the form of 1-hour conference calls. The Indiana HMG Organizing Entity worked with the HMG Leadership Team to disseminate these reports within the 4 workgroups, providing a feedback loop of communication between Organizing Entity, Leadership Team, and implementing workgroups to successfully implement HMG.

The first HMG Care Coordinator was hired June 2018. A training curriculum and schedule are being developed as informed by other HMG implementations, MOMS Helpline staff, and HMG National Office technical assistance.

Evaluation activities included monthly interviews with the HMG Program Manager, focus groups with the HMG Indiana Organizing Entity, and interviews with HMG National Office staff. The leadership team also completed a focus group and surveys. The evaluator ensured the readiness assessments were state specific and results were compiled, then presented to the leadership team.

July-December 2018: The Organizing Entity worked with Indiana 211 to achieve uniform taxonomy attached to home visiting service providers within the Indiana 211 database. Indiana requested No Cost Extension to continue the work of pilot implementation of Help Me Grow Indiana. HMG Organizing Entity members presented HMG Indiana and its vision in each of the pilot communities. HMG Indiana Organizing Entity members presented at the Institute for Strengthening Families in Bloomington, IN September 2018. Help Me Grow staff also had informational tables at several conferences including Medicaid,



WIC, Labor of Love, Institute for Strengthening Families, and IYI Kids Count. The HMG Indiana Call Center launched in October 2018.

Also in October 2018, the HMG Physician Champion presented grand rounds to medical professionals in Indianapolis. The presentation covered HMG and its role for healthcare providers. The PARTNER Tool (www.parnertool.net) was launched as part of the Organizational Network Analysis of the Help Me Grow Network: Indiana report, an implementation requirement of the HMG model. HMG Indiana's Organizing Entity received monthly technical assistance from the National HMG office. A second HMG Care Coordinator was hired, with Spanish speaking and translation skillset. Evaluation activities included monthly interviews with the HMG Program Manager, focus groups with the HMG Indiana Organizing Entity, and interviews with HMG National Office staff. Informational flyers were created to inform families and providers about Help Me Grow Indiana (Figure A).

Figure A – Language from Home Visitor flyer

Help Me Grow Indiana is a service for anyone who influences the life of a young child.

Help Me Grow – Indiana: Information for Home Visitors

- The mission of HMG Indiana is to promote optimal developmental of Indiana's young children.
- HMG Indiana isn't an agency, but a partnership based on a national model for organizing existing agencies with the goal of more efficiently and effectively reaching and helping children.
- Housed at the Indiana State Department of Health, HMG Indiana utilizes the MOMS Helpline's phone system in connection with Indiana 211's resource database.

What's in it for me?

Help Me Grow Indiana can offer numerous benefits to your program:

- **Care Coordination:** HMG Indiana provides free, specialized care coordination for families of young children that you serve. This means that if we have the family's permission, we will share information about the referrals that HMG provides with the providers so we can all be on the same page. Care coordinators will provide referrals to local community resources that support child development. In addition, HMG care coordinators ensure that families successfully connect with those resources.
- **HMG is a resource for you**: HMG will have information on general child development and parenting topics. In addition, do you need assistance with sharing results with families from a recent developmental screening? Do you need a reference for local resources to give to families? HMG can help!

January-June 2019: Indiana worked with the HMG National Center to plan and complete a second site visit to celebrate the launch of HMG Indiana in February 2019. This site visit included a state leadership meeting including members of Indiana State Department/Division leaders, Early Childhood Comprehensive Systems (ECCS) state committee and Indiana Home Visiting Advisory Board (INHVAB), as well as local meetings within Grant County and Marion County with additional local collaborating partners, where the CEO of HMG was able to have in depth conversation with home visitors to help increase the knowledge base of HMG. The Organizational Network Analysis of the Help Me Grow Network: Indiana report was completed. The HMG Organizing Entity began work with Indiana 211 to develop standard reporting and enhance intake design. HMG Indiana's Organizing Entity completed the contractual agreement for monthly technical assistance from the National HMG office. Evaluation activities included monthly interviews with the HMG Program Manager, focus groups with the HMG Indiana Organizing Entity, and interviews with HMG National Office staff. The evaluator assisted in creating summary of the Organizational Network Analysis of the Help Me Grow Network: Indiana. In May, several members of Indiana's HMG Organizing

Entity and HMG Leadership Team members attended the national HMG Forum in Buffalo, NY, at which it was announced that Indiana had been selected to host the 2020 HMG Forum. DCS, ISDH and Diehl presented their evaluation findings and Indiana implementation at the forum. While we did not write it in our report, Indiana was very innovative in evaluating the implementation of HMG, no other state in the network has done this. HMG national and other affiliates have gained knowledge and insight because of this practice. HMG Indiana Organizing Entity members presented at the Institute for Strengthening Families in Indianapolis IN May 2019. HMG also had a table at the Institute to provide home visitors HMG information including resources around LTSAE. Organizing Entity members participated in a 2 part community of practice opportunity with Frameworks around messaging in early childhood.

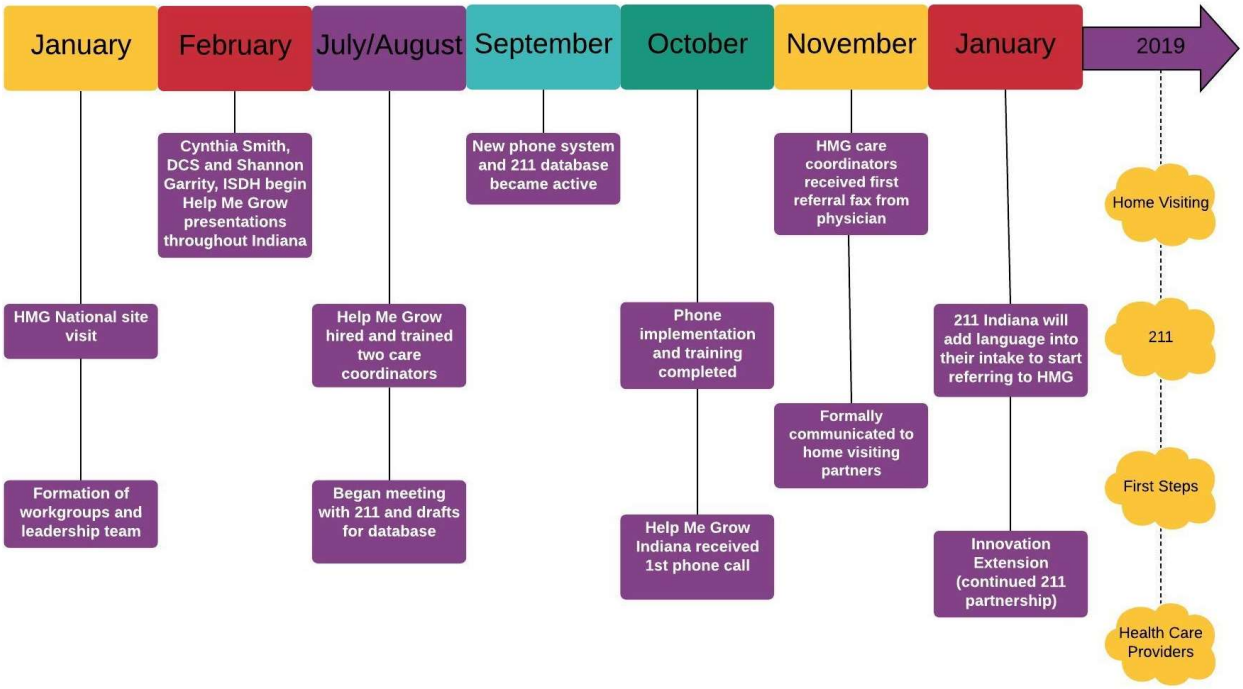
July-September 2019: The HMG Organizing Entity continued work with Indiana 211 to develop standard reporting, building our database out based on the knowledge we gained in our first year of taking calls and enhance intake design. Evaluation activities included monthly interviews with the HMG Program Manager, and focus groups with the HMG Indiana Organizing Entity. HMG Indiana Organizing Entity members presented at the Institute for Strengthening Families in Noblesville, IN September 2019. In July, Organizing Entity members concluded the Community of Practice opportunities with Frameworks around messaging in early childhood. A Family flyer was developed and piloted in communities out of this opportunity. (Figure B). Another significant finding to come out of this CoP was HMG National developing a Universal Statement. Indiana was able to distribute this statement to stakeholders which provided a clearer vision for what HMG was and how it could work within existing structures, including home visitation.

Figure B – Example Family targeted flyer:

Indiana's innovation also supported the 2nd objective[4] of this MIECHV Innovation opportunity through the evaluation of and dissemination of data that will inform other MIECHV grantees of lessons learned and opportunities specific to referral coordination. More about the evaluation of the pilot implementation of Help Me Grow Indiana is in the Evaluation sections of this report.

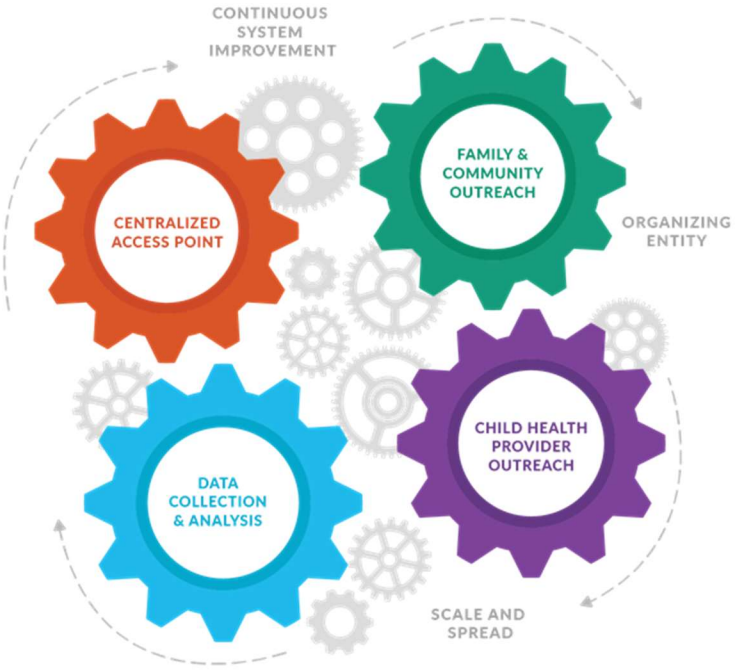
[4] "Contribute to advances in knowledge about the development and implementation of innovations that enable delivery of coordinated and comprehensive high-quality voluntary early childhood home visiting services to eligible families."

Figure C - Help Me Grow January 2018-January 2019 Timeline



Innovations rooted in the evidenced-based or promise of strong theory

Help Me Grow is an efficient and effective model, with a proven track record that assists states in identifying at-risk children, and then helps families find community-based programs and services. Help Me Grow is a system for improving access to existing resources and services. The evidenced-based Help Me Grow (HMG) model is designed to support child well-being by improving the quality of early detection screening and increasing the linkages between families and community resources. These goals are achieved through 1) the creation of a centralized call center, 2) outreach for child healthcare providers, and 3) family and community partner outreach. Locally, participation in the initiative is expected to improve centralized coordination of services and create a feedback loop for coordinating services (through follow up on referrals) for Indiana families, including MIECHV-funded families.



Indiana received a Fidelity Assessment Summary[5] each year from 2017-2019. As of 2019, Indiana HMG has achieved Installation level of Affiliation.

Improvements observed in the delivery of coordinated, comprehensive, high quality, voluntary home visiting services to eligible families

The pilot implementation of Help Me Grow Indiana has created a framework that can organize referrals, receipt of service, and quality of referral information within the early childhood system, which includes home visiting services. The process of implementing Help Me Grow with fidelity to the systems approach has enhanced the collaborative nature and partnerships among the service providers within the local communities and across the state of Indiana. One piece of the implementation process included a network mapping[6] project where HMG partners were surveyed and asked to identify their organization's most important contribution to the HMG system. Each circle in the Help Me Grow Indiana Network Mapping Project 2019 graphic below represents one member and the color represents their most important contribution. The lines show when respondents reported cooperative, coordinated, or integrated working relationships with another partner. A high number of lines indicates that a large number of partners indicated relationships to another partner.

As part of the survey HMG partners were asked to identify the critical goals that were most and least likely to be successful for HMG. The top 3 critical goals that were rated by partners as most likely to be successful were: Advance collaboration among partners, Increase developmental screen rates, and Gain greater clarity around the existing needs of families and child in our community.

[5] The summary of the HMG Fidelity Assessment was created by organizing information provided by the HMG affiliate into a standardized format that demonstrates completion of high-level yet critical activities necessary to fulfill the HMG System Model. Activities are listed according to the core components of the HMG model. Specific criteria that ensure high quality support for families were determined by the HMG National Center and are noted in italics. To categorize sites with respect to their implementation progress, the following scoring method was used:

- Exploration: No indicators within core component
- Installation: At least 1 indicator within core component
- Implementation: All indicators within core component

[6] Organizational Network Analysis of the Help Me Grow Network: Indiana 2019

Figure D - Help Me Grow Indiana Network Mapping Project 2019 - Relationships

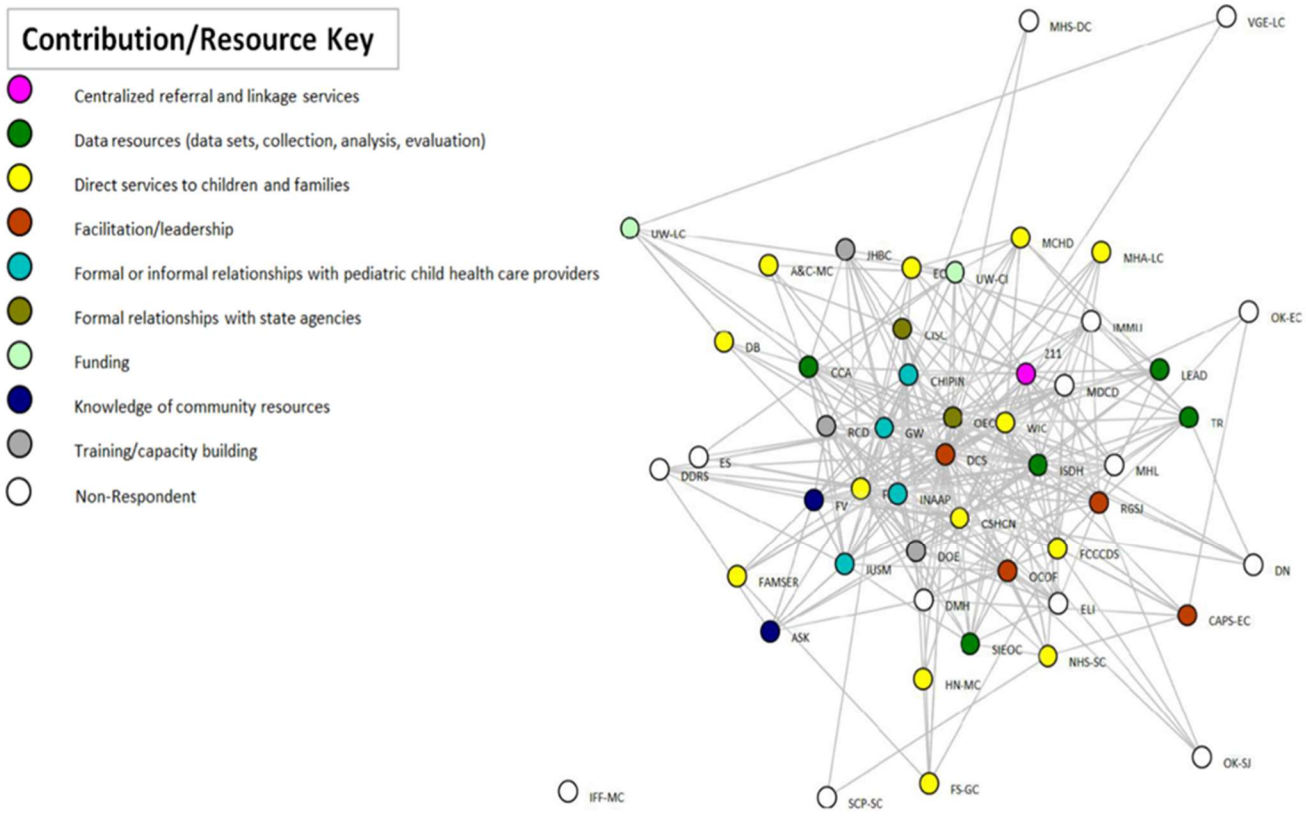
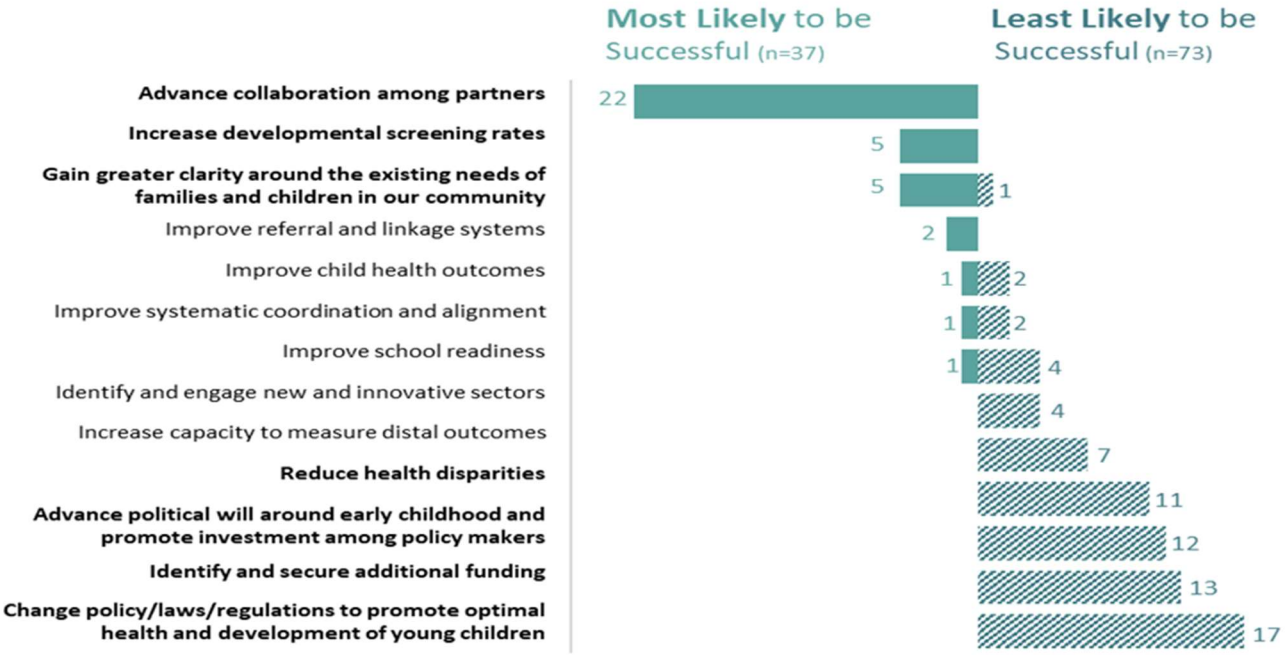


Figure E - Help Me Grow Indiana Network Mapping Project 2019 – Critical Goals Ranking



II. SUMMARY OF OVERALL ACCOMPLISHMENTS

Indiana's MIECHV Innovation strengthened and improved the delivery of MIECHV-funded home visiting services through the following objectives:

1) Enhance home visitors' knowledge of available services and create awareness of Help Me Grow as a resource for service referral by September 2018 (by September 2019 via no cost extension).
    - ✓ The HMG Indiana pilot was introduced to providers serving MIECHV-funded families via webinars, emails, community information meetings, conference sessions, and HMG National Office site visit activities.
2) Improve percent of referrals provided to MIECHV funded home visiting families in which receipt of service can be confirmed by 5% from September 2017 to September 2018 (September 2019 via no cost extension).
    - ✓ As the implementation of Help Me Grow is still in the pilot phase, and some nuances of data collection and reporting are still begin developed, Indiana is unable to contribute receipt of service for referrals provided to MIECHV funded home visiting families as of the end of this project period September 30, 2019. As of September 30, 2019, Help Me Grow Indiana closed the first year with a client base of 97.
    - ✓ Families that were connected to referrals via Help Me Grow Care Coordinators confirmed receipt of service for 138 referrals.
    - ✓ Families that contacted Help Me Grow Indiana indicated that their needs were met for 91 of calls.
3) Contribute to advances in knowledge about the development and implementation of Help Me Grow as a model for service referral coordination by sharing Indiana's experience in public forum by September 2018 (September 2019 via no cost extension).
    - ✓ Help Me Grow Indiana Organizing Entity members provided more than 15 information sessions in pilot communities and as requested to inform local community providers, which included meeting with home visitors in the pilot counties.
    - ✓ Indiana had a poster at the Help Me Grow National Forum 2018 and presented and had a poster at the 2019 Help Me Grow National Forum
    - ✓ Indiana was selected by Help Me Grow National to be the host for the Help Me Grow National Forum in 2020
    - ✓ Indiana presented at the Riley Children's Health Pediatric Conference in May 2019
    - ✓ Indiana presented at the First Steps Conference in 2018 and 2019 with Diehl.
4) Leverage existing partnerships and collaborations to implement HMG Indiana
    - ✓ HMG Indiana Organizing Entity included the pre-existing partnership and collaboration of DCS and ISDH
    - ✓ ISDH and DCS were able to combine various state led meetings into one cohesive state meeting called INVHAB/HMG/ECCS. This reduces workgroup fatigue and serves as a place for other state agencies to come together around all Birth to 5 delivery systems, aligning state work in this area.
    - ✓ HMG Indiana call center was embedded within the existing ISDH MOMS Helpline
    - ✓ MCH MOMS Helpline partnered with Indiana 211 to acquire access to the

VisionLink resource database. This partnership proved to be an integral part of the success for HMG to offer the Care Coordinators access to 20,000+ community resources statewide. Working with Indiana 211 has allowed HMG to dynamically enhance the client intake assessment and adapt to changing data collection requests.

- ✓ As illustrated by the PARTNER survey[7] conducted in October 2018, across 50 organizations, a collective 465 partnerships were reported. The survey was sent to 50 organizations; with an 74% response rate. The average number of partnerships per organization was 9.3 (out of a possible 49).

5) Integrate HMG Indiana into Indiana State Department of Health's MOMS Helpline
   - ✓ The MCH MOMS Helpline upgraded its contact center system to provide better customer service delivery to all Hoosier families. The MOMS Helpline utilizes the Genesys PureConnect contact center system which supports a platform of new technology, such as texting, online access to referrals, resources, and overall enhancements to telephone services. The PureConnect software allows families to connect to HMG by calling the MOMS Helpline toll-free number and selecting option 3 to be connected to a HMG Care Coordinator.
6) Set a foundation for sustainability of HMG Indiana
   - ✓ As further described in the Sustainability section below, by strengthening the partnerships and collaborations among early childhood partners, and by illustrating the successful alignment of disparate funding opportunities, Indiana has set the foundation for sustainability of Help Me Grow Indiana.

III. CHALLENGES AND STRATEGIES

Key Staff turn-over: Since the project application, and during the project period, the MIECHV state team members experienced change in key staff, both within the team, as well as respective agency leadership. As the MIECHV state team also comprised the majority of the Help Me Grow Organizing Entity, this turnover had the potential to compromise the implementation. While these changes did not necessarily have a direct impact on the progression or success of the project, the transitions did impact morale at various points in the project and at times created challenges with balancing transition activities with keeping focus on project goals.

The ISDH MCH team sustained turnover in the following positions:

- ISDH Commissioner: Dr. Jerome Adams departed this position September 5, 2017 to become Surgeon General of the United States, Dr. Kristina Box filled this role October 16, 2017
- Health and Human Services Assistant Commissioner: Art Logsdon left this role in March 2018, replaced by Eldon Whetstone as interim and officially in September 2018.
- Maternal & Child Health Director: Martha Allen resigned April 26, 2019, Shirley Payne served as interim MCH Director until Eden Bezy filled the role in August 2019

[7] In 2018, a Social Network Analysis on the network of organizational partnerships was conducted using the PARTNER Tool (www.partnertool.net). The survey asked respondents to describe themselves and their work in the network, and then to answer questions about their partners. The network used the PARTNER Tool data to address the following questions:

- What organizations are part of the network and how are they working together?
- What activities do members of the network do together? What resources are exchanged?
- What kinds of outcomes have been achieved among organizational partnerships?

- Women, Children and Adolescent Health Programs Director: MaryAnn West departed in June 2017, Sam Lo filled the role in June 2017 and departed in May 2018, Shirley Payne served as the interim director in April 2019, Kate Schedel filled the role in September 2018.
- Home Visiting Coordinator: Cassondra Kinderman departed in June 2017, Shirley Payne served as interim coordinator, Heather Herring filled the role in September 2018.
- Home Visiting Program Manager: Sarah Parks-Reese filled this role in January 2018 and departed March 2018. Cassondra Kinderman returned to the Indiana MIECHV team in this role beginning July 2018.

The DCS MIECHV team members experienced turnover in the following positions:

- DCS Director: Judge Mary Beth Bonaventura resigned December 2017 and was replaced by interim director, Sam Criss. Terry Stigdon was appointed by the Governor DCS Director in January 2018.
- Deputy Director of Child Welfare Services: Sam Criss, departed this position in July 2017 and was replaced by David Reed, in September 2017.
- Prevention Program Coordinator (also known as the HFI Coordinator): Stacy Herald resigned in January 2017 and was replaced by Barbara Gainer in June 2017.
- Cynthia Smith, Prevention Services Manager and Carrie Higgins, contracted DCS MIECHV Grant Coordinator were both consistent during the project period and assisted with continuity of project expectations for newer team members.

The foundation of partnership across ISDH and DCS – specifically, but not limited to, the work related to MIECHV activities – ultimately served as the main mitigator of staff turn-over challenges. By meeting in person regularly, including the entire team on essentially all communication, capitalizing on individual strengths and "Embracing the ambiguity", the team was able to continue through the project with a collective positive attitude and achieve Indiana's proposed innovation – the implementation of the Help Me Grow model.

Innovative Collaboration: In 2016, Indiana proposed implementation of the Help Me Grow evidenced based model in both its Early Childhood Comprehensive Systems (ECCS) Impact application as well as the MIECHV Innovation application. In an unprecedented opportunity, Indiana achieved awards for both grants. One challenge resulting from the unique coordination of the ECCS Impact and MIECHV Innovation projects was a significant delay in budget approval – a full 6 months into the project period. The delay in budget approval impacted the timeline to contract with the HMG National office for technical assistance in implementation (including receipt of materials to guide implementation with model fidelity), in turn impacting the timeline and readiness to establish workgroups and hire HMG Indiana staff. These and other challenges including changes to acquiring a database, partnering with Indiana 211, and updating call center hardware, have been discussed with our project officers and described in more detail in Indiana's MIECHV Innovation Award Progress Report for Project Period: January 1, 2017 – December 31, 2017.

Indiana addressed these challenges and was able to reach a modified end of project solution by November 30, 2018: revised Help Me Grow Evaluation Plan with the assistance of HRSA guided technical assistance, revamped work plan and timeline, and pushed the HMG National team to more quickly move through the HMG model of implementation while maintaining fidelity to the model.

Impact of ELAC - In the fall of 2018, the Early Learning Advisory Committee stopped meeting so the governor could appoint new members to the committee. Changes in the ELAC impacted advisory work for HMG implementation that is described further in the Evaluation sections of this report. Indiana continues to consider Help Me Grow committees as part of the framework of Help Me Grow Indiana.

New State Initiatives impacting implementation and communication: House Enrolled Act 1007 (HEA 1007). On May 8, Governor Holcomb signed House Bill 1007 into law, charging the

Indiana State Department of Health to "establish a perinatal navigator program for the purposes of engaging pregnant women in early prenatal care and providing referrals to pregnant women for wraparound services and home visiting programs in the local community" (IC 16-35-1-11 Sec. 11). The goal is to identify women early in their pregnancy and connect them with an OB navigator – a home visitor who provides personalized guidance and support to a woman during pregnancy and at least the first 6-12 months of baby's life. The focus in the first year will be women who utilize Medicaid for their insurance and who live in one of 20 counties that have been identified as high risk. As an addition to the continuum of services that are available within the early childhood comprehensive system, HEA 1007 will focus on improving infant mortality rates by getting at-risk families into home visiting services early in pregnancy. This includes home visiting services that may be MIECHV funded services. As the focus of HMG Indiana is the connection to services – both into and in addition to or beyond home visiting – some families may enter home visiting via OB Navigation and be directed to additional services – including developmental services – via Help Me Grow Indiana.

IV. LESSONS LEARNED AND BEST PRACTICES

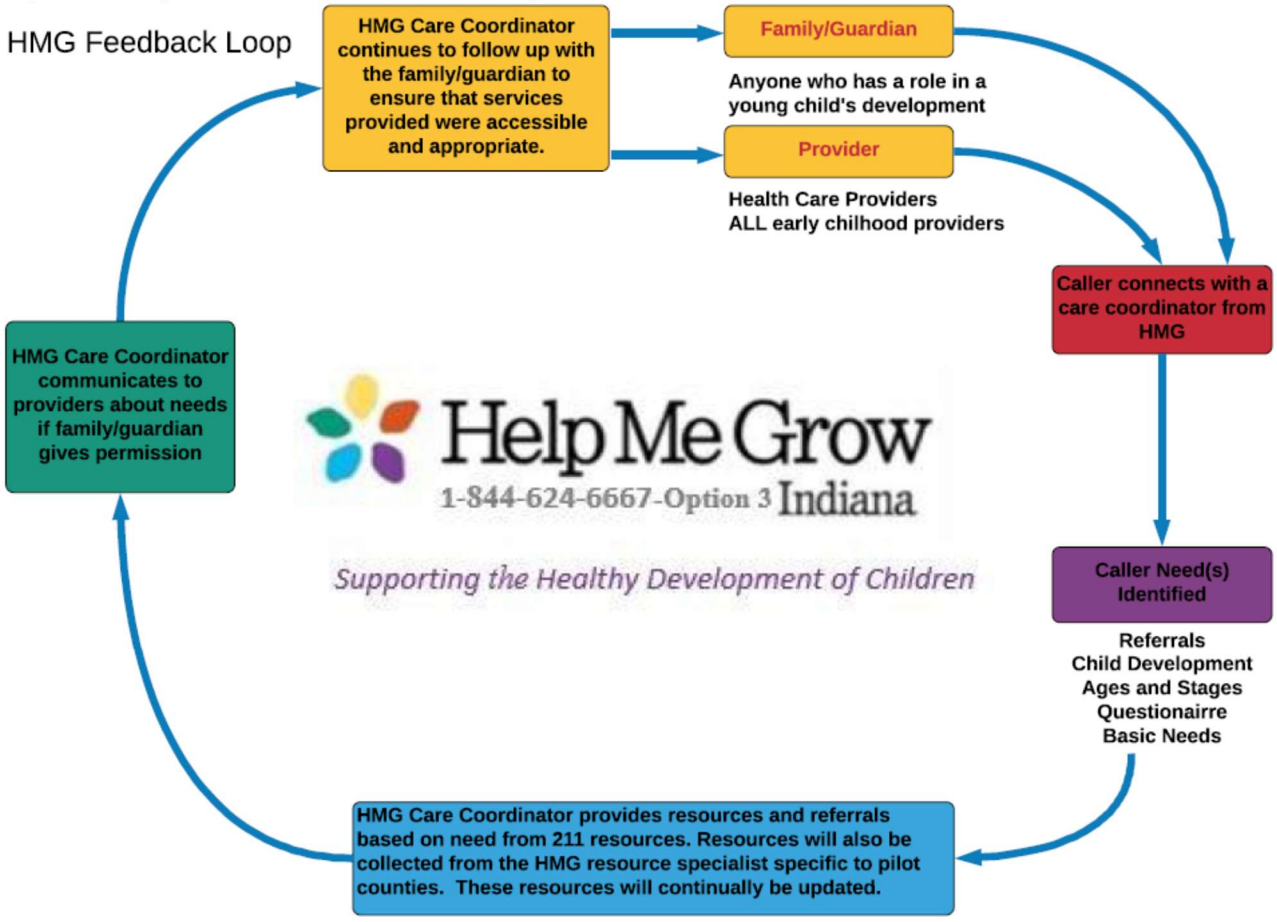
Setting a common agenda/AIM – Indiana aligned goals and practices of the ECCS Impact and MIECHV Innovation awards to successfully implement Help Me Grow Indiana. This alignment resulted in enhancing partnerships and collaborations within the early childhood system within Indiana.

Administrative processes (e.g. contracting) – The MIECHV State Team are members of the Organizing Entity for HMG Indiana. As the state team is comprised of a partnership between ISDH and DCS, existing relationships and resources within each department provided opportunities to accelerate typical contracting processes and mobilize contracted services early in the process. For example, Diehl Consulting was contracted to conduct the evaluation of the HMG implementation, and the relationship with Indiana 211 was secured early on and provided guidance with hardware, software and reporting practices alongside the development of the HMG centralized call center.

Communication and culture – As described further in the Evaluation sections below, the Indiana Innovation project began with a transparent and highly communicative team. Despite a considerable amount of turnover, this established culture of consistent communication and teamwork attitude continued throughout the project period and resulted in successful implementation of Help Me Grow Indiana in an accelerated timeframe. Information Sheets were developed with targeted language for families and providers (Figures A and B):

Help Me Grow Indiana feedback loop (Figure F) illustrates the goal of a non-linear process to enhance a culture of communication that does not stop with a referral, but continues to support the family in the connections of service. Additionally, a communication guide was created (available in English and Spanish) to provide guidance for families and providers to talk about Help Me Grow.

Figure F – Help Me Grow Indiana Feedback Loop



*Pilot counties: Scott, Marion,Madison, Delaware, Grant, Elkhart, St. Joseph, La Porte, Lake

Federal government support – Indiana received support from federal project officers from both the MIECHV Innovation and the ECCS Impact projects. Especially during 2017, programmatic and fiscal project officers were interested and available to assist with the complicated alignment of project budgets. Throughout the project, Indiana team members felt supported by HRSA staff, including the alignment of site visits that created opportunity for project officers to see first-hand the collaboration and interest of early childhood partners.

Pre-award and post innovation award activities – Pre-award activities included the interest from the ELAC group in bringing Help Me Grow Indiana that was an influential factor in proposing the implementation in two federal award applications. Post-award activities include working within partnerships to sustain Help Me Grow Indiana implementation, continue work within pilot communities and prepare to expand Help Me Grow Indiana into additional communities. One of the ways that Indiana accomplished this was by including the local ECCS community meetings in the implementation and launch HMG. Members on this group included, physicians, child care providers, home visitors, first step providers and families.

Strengthening partnerships and stakeholder engagement – Through the implementation process of HMG Indiana, a physician champion emerged that led the Child Health Provider Outreach component. This champion created excitement among healthcare providers, provided the opportunity for Help Me Grow to be presented during physician Grand Rounds on 2 occasions, and was instrumental in developing an appropriate process for physician referral and feedback

within Help Me Grow Indiana. The Physician Champion also marketed HMG to area physicians to build trust and address barriers that dissuade physicians from becoming engaged in HMG.

The relevance of the innovation beyond the awardee's state or territory – Indiana's pilot implementation challenged the typical HMG timeline through an existing network of collaborating early childhood partnerships and an expedited time from introduction to call-center launch. Additionally, Indiana embarked on an evaluation of the implementation process itself. Both the evaluation and the implications of the expedited timeline have practical application and lessons learned for existing and yet to become HMG implementations across the nation. Indiana shared findings from the implementation evaluation during a presentation and poster session at the Help Me Grow National Forum 2019. Help Me Grow Indiana was featured in the HMG National Affiliate newsletter multiple times showcasing site visit successes, implementation, and announcing Indiana as the HMG National Forum 2020 host. Indiana also had the opportunity to present innovation award activities during an Innovation Community of Practice in March 2019 to nationwide MIECHV Innovation awardees.

Innovation awards and integration with MIECHV formula activities – The pilot implementation of Help Me Grow Indiana was built upon a foundation of partnership and collaboration within Indiana's early childhood system. Home visiting – including MIECHV-funded home visiting – is an integral part of the early childhood system that is engaged in provision of service for families with a "no wrong door" goal. The connecting of home visiting families with the services and supports they need is the foundation of Help Me Grow work, making Indiana's Innovation of the pilot implementation a value add to the typical MIECHV formula work. Help Me Grow and home visiting connect through referrals into home visiting programs as well. The Organizing Entity was intentional about assigning a uniform taxonomy attached to home visiting service providers within the Indiana 211 database. Defining the taxonomy has allowed HMG Care Coordinators to more easily search and refer families to home visiting providers, specifically Nurse-Families Partnership and Healthy Families Indiana local implementing agencies.

V. SUSTAINABILITY

The Help Me Grow team continues to partner across state agencies to assure alignment and sustainability. Indiana is a recipient of the Preschool Development Grant in which HMG received dedicated support to expand HMG through communications such as family centered websites as well as learn the Signs Act Early Materials.

The collaboration of DCS/ISDH through MIECHV allows multiple state agencies to work together to ensure adequate resources after the grant period ends. ISDH's MCH Division is a recipient of Title V Federal Block Grant Funds. ISDH is committed to assuring all Title V funded and home visiting services align as well as resource and structural supports like Mom's Helpline and Help Me Grow. Indiana, through ISDH and DCS specifically, continues to contribute to this effort through the ongoing investment of state and federal funds to support HFI and NFP. Additionally, commitment at the national, state, and local level exists to seek expanded support and resources to grow programming, implementation, evaluation, and statewide coordination efforts.

VI. EVALUATION SUMMARY

Evaluation Questions, Study Design, and Target Population:

Pre-evaluation and formative evaluation activities were utilized to examine the integration of HMG within the Indiana early childhood system, while establishing localized measures and processes to document implementation fidelity. Specifically, evaluation activities funded under this grant 1) examined the extent to which key implementation benchmarks were achieved, 2) explored perceptions of the development process, including implementation strategies, potential barriers, and supporting factors, and 3) supported the development of fidelity criteria to inform subsequent evaluations. This approach to evaluation set the stage for future formative and summative evaluation of program outcomes.

Table 1. Summary of research questions, study design, and target population.

A. Research Questions	B. Study Design	C. Target Population
RQ1: To what extent is Help Me Grow being implemented as designed, while being integrated successfully within the Indiana Maternal Infant Early Childhood Home Visiting (MIECHV) system?	The implementation evaluation utilized a mixed-methods approach that incorporated both quantitative and qualitative methodology, including monthly implementation checklists, focus groups, implementation surveys, and document reviews.	HMG Leaders and Advisory Committees: Indiana Program Manager, Organizing Entity, Leadership Team, and Work Groups.
RQ2: What are the essential, localized fidelity criteria associated with each Help Me Grow Core Component?	The design utilized the Expert Opinion and Qualitative methods (Mowbray et al., 2003) for identifying fidelity criteria (Holter et al., 2004 & McGrew et al., 1994), which utilized (a) literature reviews and interviews to identify proposed critical criteria and (b) expert opinions to rate and refine the list of criteria (Mowbray et al., 2003). The process involved three phases: 1) identify fidelity criteria through a review of published materials and interviews; 2) construction of a preliminary list of operationalized critical criteria, and 3) use of experts to rate and validate each criterion, which resulted in a final list of fidelity criteria.	Local and National HMG experts: Organizing Entity, MOMS Helpline staff, members of the Leadership Team, local stakeholders, current HMG affiliates, and HMG National Center staff. HMG National staff recruited for the study included the HMG National Center Executive Director and Program Manager for Research, Innovation and Evaluation. Four HMG affiliates were selected to participate in the study based on recommendations from HMG. These included Vermont, Long Island, Buffalo, and Orange County.

Major findings:

Research Question 1

RQ1a: Is Indiana Making Progress Toward Key HMG Implementation Benchmarks?

Data collected through the implementation study suggested that progress was made toward HMG implementation benchmarks. As of July 2019, 96% (65/68) of all implementation tasks included in Indiana's Roadmap to HMG System Replication toolkit (a list of steps identified by the HMG National Center to guide local implementation) were complete, and the majority of monthly benchmarks were completed before or during the month scheduled.

RQ1b: What Are Key Stakeholders' Perceptions of the Development Process?

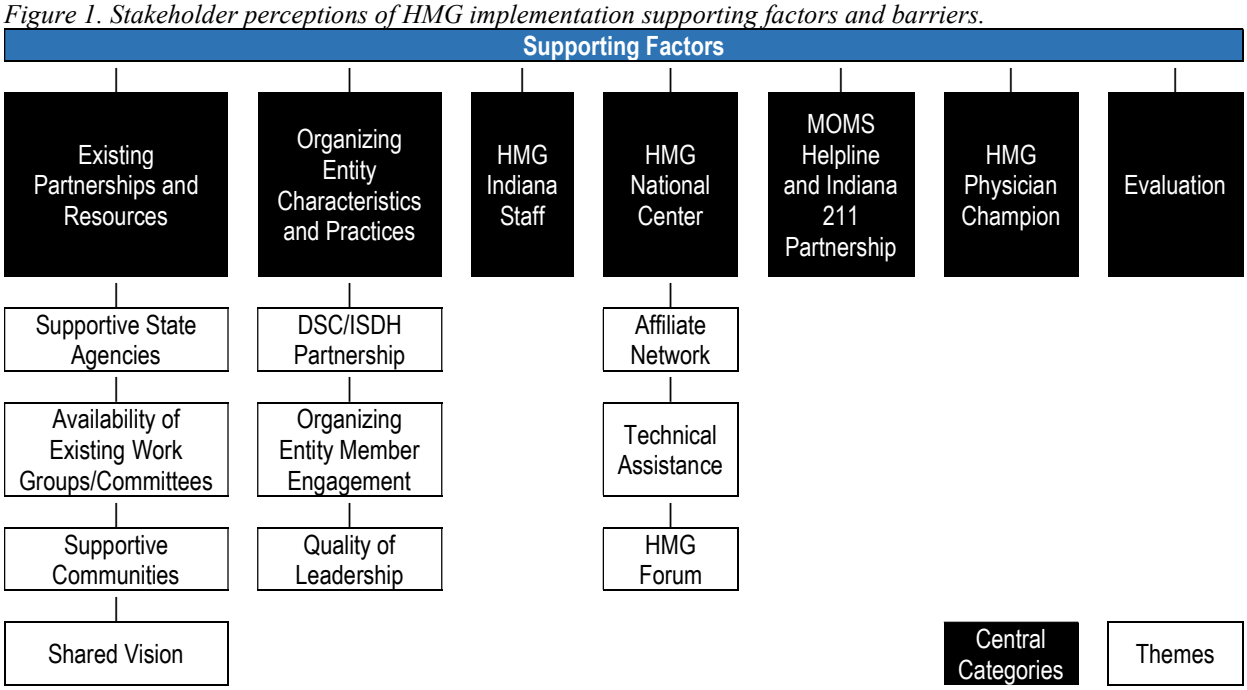
Generally, across participant groups (i.e., Organizing Entity (State DCS/ISDH Team), Leadership Team, and Work Groups), the highest ratings of HMG implementation were observed during the first half of 2018. Key supports identified by participants during this time included 1) collaboration among partners, 2) communication, 3) meeting quality, and 4) HMG National Center support (e.g., site visit, technical assistance). Lower ratings began to emerge in

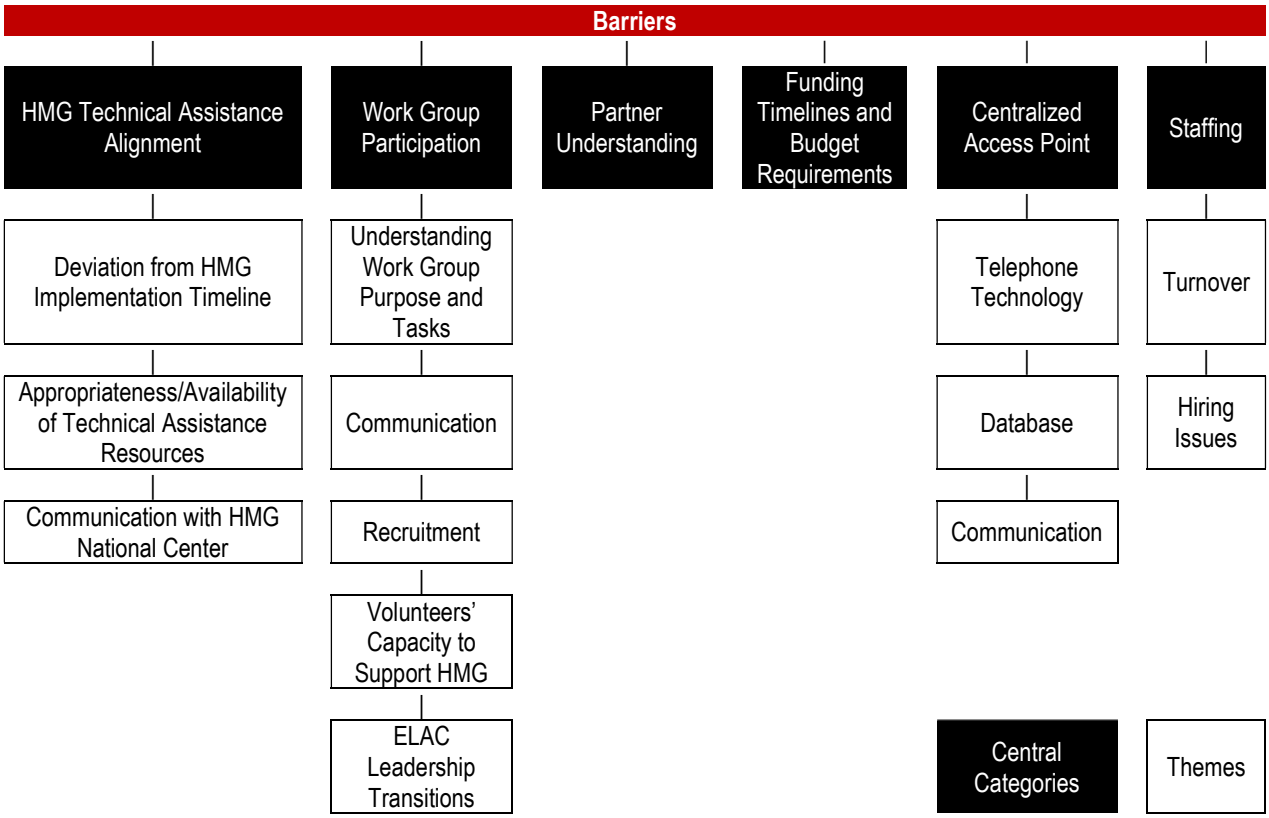
late summer 2018 as the call center rollout approached. For Organizing Entity members, specific barriers during this time included technical and communication challenges related to the call center. In subsequent months, barriers identified by the Organizing Entity included technology issues, communication issues with partners, timeline misalignment, and staff turnover. Responses from the Organizing Entity were generally positive, and supporting factors noted by Organizing Entity members included partnerships/collaboration, HMG Indiana staff, and Organizing Entity team work. For Leadership Team and Work Group members, ratings continued to decrease in subsequent survey administrations. As call center installation neared and commenced, Leadership Team and Work Group members noted a lack of communication and limited clarity around purpose, roles, and responsibilities for their respective groups. Leadership Team and Work Groups generally agreed that their input was valued by their group colleagues, but ratings of their understanding of their roles and responsibilities were typically lower than other items.

RQ1c: What Are the Barriers and Supporting Factors Associated with HMG Model Implementation?

Based on analysis of implementation interviews, open-ended comments from implementation surveys, and focus groups, key HMG implementation barriers and supporting factors were identified.

Figure 1. Stakeholder perceptions of HMG implementation supporting factors and barriers.





RQ1d: What Strategies Are Employed to Complete HMG Implementation Benchmarks?
Based on analysis of implementation interviews, open-ended comments from implementation surveys, and focus groups, key HMG implementation strategies were identified.

- **HMG Outreach.** HMG Indiana conducted outreach using a variety of strategies, including 1) conducting community presentations in pilot counties, 2) developing and sharing marketing materials (e.g., magnets, notepads) with families, community members, providers, and partners, 3) working to ensure that all HMG-related communication was consistent, audience-appropriate, and responsive, and 4) developing communication strategies specifically to promote physicians' HMG usage.
- **Use of Existing Groups.** HMG Indiana relied on existing groups that did relevant work to staff the required HMG Leadership Team and HMG Work Groups.
- **Call Center Partnerships.** Rather than build a stand-alone call center with its own technology, HMG Indiana utilized partnerships to house the Centralized Access Point in the MOMS Helpline and utilize database support from Indiana 211.
- **Organizing Entity Collaborative Practices.** To maximize group effectiveness, the Organizing Entity 1) utilized consistent and transparent communication strategies to encourage participation from all members, promote shared understanding, and build trust, 2) modified their meeting structure and frequency to accommodate project needs, and 3) relied on professionalism to promote honest discussion and collaborative decision-making.
- **Utilization of HMG Technical Assistance.** The Organizing Entity participated in monthly technical assistance with the HMG National Center and used the resources and tools provided to support implementation.

- **HMG Staffing.** The Organizing Entity built a strong HMG staff through targeted recruiting and hiring practices.

Research Question 2

Preliminary Fidelity Criteria

Based on a literature review and HMG expert interviews, the evaluation team compiled a preliminary list of 284 operationalized fidelity criteria grouped by HMG Core Component: 82 Data Collection and Analysis criteria, 110 Centralized Access Point criteria, 52 Family and Community Outreach criteria, and 40 Child Health Provider Outreach criteria.

Final Fidelity Criteria

Survey 1. Ten HMG experts rated the preliminary criteria based on perceived importance to successful implementation. After criteria scoring below the established threshold were removed, 47 Data Collection and Analysis Criteria, 53 Centralized Access Point criteria, 24 Family and Community Outreach criteria, and 16 Child Health Provider criteria were retained.

Survey 2. Ten HMG experts provided ratings of the revised fidelity criteria. Once data were analyzed, criteria identified as "most essential" by at least 50% of experts were retained, and 25 final fidelity criteria were identified: 2 Data Collection and Analysis criteria, 3 Centralized Access Point criteria, 8 Family and Community Outreach criteria, and 11 Child Health Provider Outreach criteria. Data Collection and Analysis criteria identified for Indiana focused on access to the database for call center staff and accurate tracking of referral status, which is essential for closing the feedback loop. Selected Centralized Access Point criteria focused on database competence for HMG staff, training quality, and HMG staff communication efficacy. Family and Community Outreach criteria focused on utilizing existing partners and outreach to build on existing outreach gaps, utilizing communication best practices, and recruiting families and local champions for target populations. Selected Child Health Provider Outreach criteria involved soliciting feedback from the health community (including non-physician staff), identifying local physician champions, closing the feedback loop and providing follow-up to physicians, providing outreach materials, and engaging the American Academy of Pediatrics (AAP).

Limitations:

RQ1. Work Group participation was a noteworthy barrier during implementation, and as a result, several limitations emerged including low response rates, attrition, and small sample sizes. Low response rates were particularly problematic for the Data Collection and Analysis and Child Health Provider Work Group surveys, and small sample sizes prohibited the inclusion of some data in public reports. Due to factors outside of HMG, the Leadership Team and Data Collection and Analysis Work Group (which were drawn from existing groups) ceased meeting in Fall 2018 and were no longer available for evaluation activities. Across all Work Groups, operations varied across the life of the project due to recruiting issues, completion of required duties, and other factors. Given the gaps in data from these groups, special attention was given to ensuring that these groups were not unintentionally silenced by groups that participated more frequently. Responses from these groups were revisited to contextualize themes identified in qualitative

analyses to ensure accurate descriptions. Where applicable, data are disaggregated by Work Group in this report to capture all voices. Moreover, disaggregated reports were provided to the Organizing Entity throughout the project.

RQ2. Misalignments between the evaluation timeline and the HMG implementation timeline created a limitation for the development of fidelity criteria. Because data collection activities preceded HMG Indiana implementation by several months, implementation planning had not been finalized, and it is likely that some local experts were inadequately prepared to rate fidelity criteria. Several modifications from the original implementation plan were made to HMG Indiana immediately following the call center's opening (e.g., referral processes); these adjustments were not captured in responses from local expects. Mowbray et al. (2003) reported that expert opinions may change over the course of program implementation as individuals become more competent in implementation. These factors may have influenced the limited consensus that emerged following the expert survey. To maximize the value of these findings, the evaluation team provided the Organizing Entity with ongoing access to the fidelity criteria as the list was refined to support planning and implementation.

Implications of Evaluation Findings:

Indiana successfully planned and implemented HMG in the nine MIECHV counties, which includes the ECCS community. While timeline modifications were made, HMG was replicated as designed and implemented in accordance with the implementation plan. Through HMG, the pilot communities have access to a fully functioning call center that connects families and providers to personalized resources and ongoing follow up, provides free developmental screening using the Ages and Stages Questionnaire (ASQ), and helps to close the feedback loop with physicians and home visitors through care coordination services.

A review of implementation strategies revealed that Indiana developed the system by leveraging multiple funding sources and collaborations between state agencies and various partners. Indiana conducted targeted outreach to build buy-in, secured existing groups to fulfill HMG Work Group responsibilities, used existing infrastructure to support the call center, and took advantage of technical assistance. Implementation was supported by the availability of existing partnerships and resources, a dedicated Organizing Entity, high quality staff, access to support from the HMG National Center and affiliate network, partnerships with MOMS Helpline and Indiana 211, an engaged physician champion, and evaluation activities. Barriers experienced included technical assistance misalignments due to Indiana's accelerated timeline, struggles recruiting and engaging Work Groups, partners' limited understanding of HMG, call center implementation issues, and difficulties recruiting and retaining staff. Surveys and focus group responses suggested that Organizing Entity overcame the majority of these barriers and maintained positive perceptions of the implementation; however, the findings suggest that some partners would have benefited from defined tasks/responsibilities and clearer communication of group purpose from the Organizing Entity. The results highlight opportunities to refine Work Group purposes and communication as the system is continued and expanded. Overall, the findings demonstrate that Indiana has the infrastructure necessary to secure diverse funding sources and partners to implement a large-scale project successfully.

Through the fidelity component, key implementation practices were identified to support the ongoing implementation of HMG as well as future expansions. Essential criteria aligned very closely to key strategies employed during the implementation and focused on quality data collection to support closing the feedback loop, highly skilled Care Coordinators who receive adequate training, and outreach that utilizes existing resources and champions to engage stakeholders. In addition to the final fidelity criteria, Indiana can utilize best practices identified in earlier iterations for additional implementation guidance.

Lessons Learned:

The evaluation demonstrated that through collaborations among state agencies and partners, Indiana has the infrastructure to successfully implement major initiatives using diverse funding sources. Evaluation findings can provide a model for implementing similar initiatives to make existing systems more effective. At its core, Indiana capitalized on a shared statewide vision, supportive communities, and existing systems to build HMG. This involved engaging state agencies for critical infrastructure, utilizing expertise from existing groups, providing targeted outreach, and recruiting and hiring high quality staff. These practices may be incorporated into developing new programs or supporting ongoing initiatives. Barriers identified in the evaluation provide additional lessons, especially related to interacting with partners and other stakeholders. Finally, through the fidelity component, critical implementation practices were identified that may be incorporated in HMG Indiana procedures. Moreover, earlier iterations of the fidelity criteria provide a repository of best practices.

VII. EVALUATION DESIGN

Entities/organizations collecting and reporting evaluation data:

Diehl Consulting Group (DCG) is an Indiana-based evaluation firm with offices in Evansville and Indianapolis. Dan Diehl and Sam Crecelius were Co-Principal Investigators for the MIECHV Innovation evaluation and were supported by Doug Berry and Jason Chadwell who are senior consultants in the group. In partnership with DCS and ISDH, DCG 1) designed/identified instruments, 2) managed data collection, 3) cleaned and analyzed data, and 4) reported evaluation findings.

Evaluation Rationale:

Pre-evaluation and formative evaluation activities were utilized to examine the integration of HMG within the Indiana early childhood system, while establishing localized measures and processes to document implementation fidelity. Evaluation activities 1) examined the extent to which key implementation benchmarks were achieved, 2) explored perceptions of the development process, including implementation strategies, potential barriers, and supporting factors, and 3) supported the development of fidelity criteria to inform subsequent evaluations. The study utilized the PII Approach to Evaluation (PII-ET, 2013, 2015) and focused on two main goals: examining integration of HMG within the Indiana system and establishing localized criteria document implementation fidelity. This approach to evaluation will set the stage for subsequent formative and summative evaluation of program outcomes. The PII approach is specifically designed to align implementation stages with the appropriate evaluation strategies.

This approach provided feedback to support the development and implementation of a summative evaluation once the model is fully implemented. Monthly implementation checklists were used to track progress toward milestones identified in the HMG Roadmap to Replication. The Roadmap guides efforts from the beginning stages of exploration through full implementation, by supplying HMG Affiliates with the ability to formally develop project plans. The evaluation provided stakeholder feedback related to the implementation and planning of Indiana's HMG system. Through these data, barriers and supporting factors related to successful implementation were identified by program stakeholders, allowing for course corrections. Finally, the development of fidelity criteria identified components of successful implementation and support further model implementation.

Name and Description of Enhancement: Help Me Grow (HMG) Indiana
The HMG system is designed to help states and communities leverage existing resources to ensure that communities identify vulnerable children, link families to community-based services, and empower families to support their children's healthy development through the implementation of four Core Components: Child Health Care Provider Outreach, Community Outreach, Centralized Call Center, and Data Collection and Analysis. The HMG system 1) assists families, primary care providers, and other community-based providers in identifying developmental or behavioral concerns in children, 2) establishes a localized resource inventory, 3) and provides a centralized call center to connect families with programs and services. In Indiana, the Early Childhood Comprehensive Systems (ECCS) grant funding and MIECHV Innovation grant funding were combined to implement the HMG model. The project served one ECCS community and nine MIECHV communities (one of which includes the ECCS community) participating in the HMG pilot. ISDH and DCS recognized the opportunity of combining the goals of ECCS and MIECHV Innovation to pilot a system that could provide centralized coordination of services (or at minimum serve as a centralized referral hub) and in particular be a feedback loop for coordinating services (through follow-up on referrals) for MIECHV-funded families. The Innovation was developed to mitigate a concern observed in state-wide (non-MIECHV) data – families not receiving services following a referral (particularly for the developmental screening and depression/mental health referrals). ISDH and DCS recognize it is insufficient to provide referrals for services without appropriate follow-up; Indiana must ensure that referrals result in services if the family wants the service. The purpose of Indiana's MIECHV Innovation is to strengthen and improve the delivery of MIECHV-funded home visiting programs through the coordination of community resources and early childhood systems such as child health, behavioral health, and human services.

To encourage utilization of the HMG program by staff serving MIECHV-funded families, emails were provided to LIAs that announced the launch of HMG Indiana and the centralized call center. These emails also included fact sheets specifically oriented to families or home visitors respectively and how HMG Indiana was envisioned to be used by home visitors for the benefit of families. Additionally, HMG Indiana presentations in pilot communities included invitations for home visiting program and staff to learn more about how HMG Indiana can connect families to resources in their local communities. The ISDH along with DCS and the HMG National Center worked together to market the call center through media and print to engage Indiana families, including, but not limited to, families served or assessed by MIECHV-funded home visiting.

Through the Child Health Provider Outreach component, the HMG system supports community-based pediatricians by enhancing their effective developmental promotion and early detection activities for all children and families. This support is provided through educating and motivating providers to conduct systematic surveillance and screening of young children, as well as providing community-based pediatricians with access to a centralized access point that can serve as a care coordination arm for busy pediatric primary care practices. In doing so, HMG partners with pediatricians to ensure effective linkage to appropriate programs and services.

The Family and Community Outreach component promotes HMG, facilitates provider networking, and bolsters children's healthy development through families. Family and Community Outreach is key to promoting the use of HMG and providing networking opportunities among families and community-based service providers. HMG Indiana staff work to engage families by participating in community meetings, forums, public events, fairs, and facilitating sessions that help families learn about child development and the role of HMG. These staff also establish and maintain relationships with community-based service providers. A community presence encourages support for and participation in the HMG system and helps to market the service. It also facilitates efforts to gather and update information to include in a local early childhood resource directory. As noted above, outreach was targeted to all Indiana families, including, but not limited to, those served by MIECHV.

In Indiana, the Centralized Access Point core component is a call center, which serves as the hub for family members, child health care providers, and other professionals seeking information, support, and referrals for children. The Centralized Access Point connects children and their families to services they need through the efforts of HMG Care Coordinators. Centralized Access Point staff work to 1) provide education and support to families around specific developmental or behavioral concerns or questions, 2) help families recognize typical developmental milestones, 3) provide referrals to community-based supports, 4) empower families to overcome barriers to services, and 5) follow up with the family to make sure linkages are successful.

The Data Collection and Analysis core component ensures ongoing capacity for continuous quality improvement (CQI), a key structural requirement of HMG. Data are collected throughout all components of the HMG system, including child health provider outreach, family and community outreach, and within the centralized access point. The collection of a set of shared metrics across the HMG National Affiliate Network advances understanding of collective impact, informing the national narrative regarding the impact of HMG on children and families across the country. The collection of locally-sourced metrics enable HMG affiliates to benchmark progress, identify areas of opportunity and systemic gaps, determine potentially advantageous partnerships, and guide strategic quality improvement projects. The HMG data collection process compiles the information necessary to support ongoing formative and summative evaluation, CQI, and HMG affiliate communities of practice.

Use of Prior evaluation findings: This evaluation was the first conducted for HMG Indiana; however, evaluations conducted by the National Center and other affiliates guided the evaluation plan.

Theory of change:

HMG is designed to support child wellbeing by improving the quality of early detection screening and increasing the linkages between families and community resources. These goals are achieved through 1) the creation of a centralized call center, 2) outreach for child health providers, and 3) family and community partner outreach. Locally, participation in the initiative is expected to improve centralized coordination of services and create a feedback loop for coordinating services (through follow up on referrals) for Indiana families, including MIECHV-funded families. The evaluation aligned with the theory of change by examining the implementation of and identifying fidelity criteria for core HMG components, including the Centralized Access Point, Family and Community Outreach, Child Health Provider Outreach, and Data Collection and Analysis.

Table 2. HMG theory of change.

HMG Theory of Change Help Me Grow National Center, 2017				
If we create a specialized centralized access point to community-based resources and supports	➡	Then we expand care coordination capacity to connect children and families to appropriate services	➡	So that we advance developmental promotion, early detection, and linkage to services to support optimal child development and child well-being
If we engage child health providers in developmental screening, surveillance, referral and linkage through HMG	➡	Then we support child health providers in ensuring early detection		
If we connect families and community partners committed to serving families	➡	Then we create a more seamless system of supports for young children and families		

Outcomes:

Table 3. Summary of evaluation outcomes by research question.

Research Question	Outcomes	Data Collection
Research Question 1 To what extent is Help Me Grow being implemented as designed, while being integrated successfully within the Indiana Maternal Infant Early Childhood Home Visiting (MIECHV) system?	Implementation benchmark completion, stakeholder perceptions of implementation, implementation barriers and supporting factors, strategies employed	*Implementation Checklists*; *Implementation Surveys*: Organizing Entity, Leadership Team, & Work Groups; *Implementation Semi-Structured Interviews*: Organizing Entity, Leadership Team, & Work Groups, and *Document Review*
Research Question 2 What are the essential, localized fidelity criteria associated with each Help Me Grow Core Component?	Localized fidelity criteria associated with each HMG component	*Expert Feedback Form, Expert Ratings Surveys, Expert Semi-Structured Interviews*

Target Population:

HMG Program Manager. Monthly implementation checklists were completed by the Program Manager through guided interviews with the principal investigator. The ISDH Children's Program Director served as the HMG Program Manager. The HMG Program Manager was selected to participate in the evaluation because of her knowledge of HMG administration and daily operations.

Organizing Entity. The Organizing Entity provides administrative and fiscal oversight and helps identify and coordinate partners into Work Groups that support HMG. In Indiana, the

Organizing Entity consists of the MIECHV Innovation grantees, and this group provides final oversight for all project activities. As of September 2019, the HMG Indiana Organizing Entity consists of 12 ISDH and DCS representatives, including the MIECHV Grant Coordinator for DCS, DCS Prevention Manager, ISDH Children's Special Health Care Services Director, MCH Programs Director, ISDH Children's Program Director (HMG Program Manager), ISDH Maternal and Child Health Director, ISDH Home Visiting Program Manager, ISDH Home Visiting Program Coordinator, HMG Coordinator, HMG Care Coordinator, and two HMG Resource Specialists. The Organizing Entity was selected to participate in the evaluation because of their knowledge of the HMG administration, finance, and operations.

Leadership Team. The Leadership Team is a group of early childhood experts that exists to support the Organizing Entity in developing and implementing HMG. In Indiana, HMG utilized the Early Learning Advisory Council's (ELAC) Child Development and Well-Being Work Group to serve as the Leadership Team. ELAC is a governor-appointed advisory group that consists of statewide early childhood leaders representing state government, early childhood providers, healthcare, education, community, nonprofit, and faith-based organizations. Additionally, six members of the Organizing Entity participated in this group. The Leadership Team was selected to participate in the evaluation because of its role as partners in the development and implementation of HMG.

Work Group Members. Work Groups were selected for each of the four HMG Core Components to manage its implementation. These groups consist of community members and partners who support the implementation of HMG Core Components.

1) The *Centralized Access Point Work Group* was co-chaired by two local experts from MOMS Helpline and Early Learning Indiana and included call center experts from MOMS Helpline, Indiana 211, DCS, and First Steps.
2) The *Community and Family Outreach Work Group* utilized an existing state work group that was created during Project Launch, a state initiative that ended in March 2018. Five Organizing Entity members and three Leadership Team members served on the Community and Family Outreach Work Group.
3) Chaired by the HMG Physician Champion, the *Child Health Provider Work Group* consisted of three practicing pediatricians and two representatives from the Indiana University School of Medicine.
4) The *Data Collection and Analysis Work Group* was staffed by ELAC's Data Coordination and System Integration Work Group. This group includes representatives from state government, early childhood, healthcare, education, business, and community and nonprofit organizations. Additionally, two members of the Organizing Entity and one member of the Leadership Team participated in this group.

Work Groups were selected to participate in the evaluation because of their role as partners in the development and implementation of HMG.

Local and National HMG Experts: Based on the recommendations from Bond et al., (2000a), experts recruited for the study included individuals who represent multiple perspectives, including the Organizing Entity, MOMS Helpline, current HMG affiliates, and HMG National Center. HMG National staff recruited for the study included the Program Manager for Research, Innovation and Evaluation and HMG National Executive Director. Four affiliates were recruited

to participate in the study based on recommendations from HMG National Center staff. Efforts were made to select affiliates that are similar to Indiana; however, because the number of affiliates fully implementing each core component was limited, an emphasis was placed on selecting affiliates with a record of successful implementation in a particular core component. Affiliates selected for interviews included Help Me Grow Vermont (specific *Centralized Access Point* expertise), Help Me Grow Long Island (specific *Child Health Provider Outreach* expertise), Help Me Grow Western New York (specific *Family and Community Outreach* expertise), and Help Me Grow Orange County (specific *Data Collection and Analysis* expertise).

Evaluation questions:

To address study goals, two research questions were identified.

Table 4. Summary of research questions.

Research Question 1: To what extent is Help Me Grow being implemented as designed, while being integrated successfully within the Indiana Maternal Infant Early Childhood Home Visiting (MIECHV) system?
RQ1a: Is Indiana making progress toward key HMG implementation benchmarks?
RQ1b: What are key stakeholders' perceptions of the development process?
RQ1c: What are the barriers and supporting factors associated with HMG Model implementation?
RQ1d: What strategies are employed to complete HMG implementation benchmarks?
Research Question 2. What are the essential, localized fidelity criteria associated with each Help Me Grow Core Component?

Evaluation design:

Research Question	Design	Aims	Measurement
RQ1	The evaluation team employed a mixed-methods approach that incorporated both quantitative and qualitative methodology to address research question 1 and its associated subquestions. Specifically, monthly implementation checklists, Organizing Entity, Leadership Team, and Work Group focus groups, Organizing Entity, Leadership Team, and Work Group implementation surveys, and document reviews were utilized to examine HMG's integration into the MIECHV system in Indiana.	This research question examined 1) progress toward key HMG implementation benchmarks, 2) key stakeholder perceptions of the development process, 3) barriers and supporting factors associated with HMG model implementation, 4) strategies employed to complete HMG implementation benchmarks.	Seven data sources were utilized to examine research question 1: (1) Implementation Checklists, (2) Organizing Entity focus groups, (3) Organizing Entity surveys, (4) Leadership Team focus groups, (5) Leadership Team surveys, (6) Work Group focus groups, and (7) Work Group surveys.
RQ2	The evaluation team collaborated with state-level HMG leadership teams and other content experts to establish fidelity criteria. Based on the work of Holter et al. (2004) and McGrew et al. (1994), the design utilized the Expert Opinion and Qualitative methods (as defined by Mowbray et al., 2003) for identifying fidelity criteria, which relied on (a) literature reviews (e.g., published research, evaluations, and program materials) and interviews to identify proposed critical criteria and (b) expert opinions to rate and refine the list of criteria (Mowbray et al., 2003). The process involved three phases: 1) identify fidelity criteria through a review of published materials and interviews; 2) construction of a preliminary list of operationalized critical criteria, and 3) use of experts to rate and validate each criterion.	Indiana identified the essential, localized fidelity criteria to support fidelity assessments of core model components.	Potential criteria were identified through a literature review and expert interviews. Final criteria were refined through expert reviews and expert rating surveys.

Rationale for Design:

Research Question 1. Utilizing the PII Approach to Evaluation (PII-ET, 2013, 2015), the evaluation team employed a mixed-methods approach that incorporated both quantitative and qualitative methodology to address research question 1 and its associated subquestions. The PII approach is specifically designed to align implementation stages with the appropriate evaluation strategies. Monthly implementation checklists, focus groups, implementation surveys, and document reviews were utilized to examine HMG's integration into the MIECHV system in Indiana. As such, this approach provided feedback to support the development and implementation of a summative evaluation once the model is fully implemented. Monthly implementation checklists were used to track progress toward milestones identified in the HMG Roadmap. Through these data, barriers and supporting factors related to successful implementation were identified by program stakeholders, allowing for course corrections. Outcome evaluation questions (e.g., 1) *To what extent does participation in HMG influence home visitors' knowledge of available services following implementation?* and 2) *To what extent have rates of successful referrals changed following implementation of HMG?*) were considered, but ultimately not selected due to Indiana's implementation status, the short timeframe available, and uncertainty related to the HMG database and data availability.

Research Question 2. The design utilized the *Expert Opinion* and *Qualitative* methods for identifying fidelity criteria, which relied on literature reviews and interviews to identify a preliminary list of critical criteria and expert judgments to rate, refine, and validate the list of criteria (Mowbray et al., 2003). HMG National Center's development of fidelity criteria has focused on broader HMG affiliate implementation. As such, limited peer-reviewed research and resources to support the identification of fidelity criteria were available. To address these issues, a mixed-methods approach was selected that utilized both the *Expert Opinion* and *Qualitative* methods described by Mowbray et al. (2003). These methods allowed the evaluation team to utilize existing HMG resources (e.g., HMG Handbook, HMG Fidelity Assessment Tool), components of similar initiatives from the literature, and expert options. Moreover, this approach provided access to experts from different backgrounds who represent a variety of perspectives (Bond et al., 2000), including local and national experts. When models are unproven and the research base limited, utilizing expert options is the most appropriate alternative (Mowbray et al., 2003). The creation of fidelity tools and a fidelity study were considered but ultimately not selected due to the Indiana's implementation status and the short timeframe available.

Evaluation Timeline:

Table 6. Evaluation Timeline

Deliverable	2017										2018												2019									
	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
Evaluation Plan Development		■	■	■	■	■	■																									
IRB Submission								■																								
Consultation with HMG							■	■	■	■	■	■	■		■		■		■													
Monthly Evaluation Check-In Calls										■	■	■	■	■	■	■	■	■	■	■												
Quarterly Evaluation Check-In Calls																						■				■				■		
Implementation Checklists (RQ1)										■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■		
Organizing Entity Focus Groups (RQ1)													■			■			■								■			■		
Organizing Entity Survey (RQ1)											■				■			■				■				■			■			
Leadership Team Focus Groups (RQ1)																■			■								■			■		
Leadership Team Survey (RQ1)															■			■				■				■			■			
Work Group Focus Group (RQ1)																		■								■			■			
Work Group Survey (RQ1)																■		■						■			■					
Document Review										■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■		
Literature Review (RQ2)										■	■	■																				
Qualitative Interviews (RQ2)											■	■	■	■	■	■																
Preliminary Criteria Development (RQ2)																■																
Survey Wave 1 (RQ2)																	■															
Survey Wave 2 (RQ2)																		■														
Final Criteria Development (RQ2)																			■	■												
Analysis (RQ2)											■	■	■	■	■	■	■	■	■													
Analysis (RQ1)											■	■	■	■	■	■	■	■	■			■	■	■	■	■	■	■	■	■	■	■	
Final Reporting																									■	■			■	■	■	■

Note: Revised and submitted as part of the MIECHV Innovation No-Cost Extension (NCE) (Summer/Fall 2018).

Instruments:

RQ1 - Implementation Checklists. Implementation checklists were developed for the current project based on the National Center's Roadmap to HMG System Replication toolkit. The Roadmap presents a sequential description of the model including all requisite steps to exploring, planning, and implementing the fundamental activities related to each of the four HMG Core Components. Benchmarks have been assigned to particular months based on Indiana's HMG Scope of Work and initial customized Roadmap. Any activity that was not completed during its designated month was carried forward to the checklist for the subsequent month until completed. The implementation checklists consisted of binary (Yes, No), 5-point Likert Scale (Strongly Disagree to Strongly Agree), and open-ended items. Specially, for each HMG step/activity, the items allowed the HMG Program Manager to describe the completion status (binary), related barriers and supporting factors (open-ended), adequacy of support (Likert Scale), strategies employed to complete (open-ended), resources that would have aided implementation (open-ended), documents developed related to the activity (open-ended), and recommended implementation steps that were not followed (open-ended). Further, additional open-ended items identified by HMG were included for particular steps/activities (e.g., "Which Work Groups coalesce easily/organically, and which experienced challenges?").

RQ1 - Organizing Entity, Leadership Team, and Work Group Implementation Surveys. Six surveys (January 2018, April 2018, August 2018, December 2018, April 2019, August 2019) were administered to the HMG Organizing Entity, three surveys were administrated to the HMG Leadership Team (May 2018, August 2018, December 2018) and depending on how long the group was operational, two or three surveys (June 2018, October 2018, April/July 2019) were administered to the HMG Work Groups to obtain feedback related to the perceptions of HMG implementation and associated barriers, supporting factors, and strategies. The surveys consist of eleven 5-point Likert scale (Strongly Disagree to Strongly Agree) items assessing perceptions of *HMG Development and Implementation* and *Individual Role in HMG* Development. Three open-ended items allowed participants to describe the barriers, supporting factors, and specific strategies being utilized. The Organizing Entity completed a fourth open-ended item that asked participants to identify implementation steps recommended by the HMG National Center that were not followed. The study examined psychometric properties using Scaling Procedures in SPSS (Green & Salkind, 2011) and found no problematic items. Sample sizes were not adequate for factor analyses (Comrey & Lee, 1992; Tabachnick & Fidell, 2001). Moderate to high levels of reliability were observed for the Organizing Entity (*HMG Development and Implementation*: $\alpha = .89$; *Individual Role in HMG*: $\alpha = .84$), Leadership Team (*HMG Development and Implementation*: $\alpha = .86$; *Individual Role in HMG*: $\alpha = .51$), and Work Group (*HMG Development and Implementation*: $\alpha = .93$; *Individual Role in HMG*: $\alpha = .57$).

RQ1 - Organizing Entity, Leadership Team and Work Group semi-structured focus group interview guides. Semi-structured focus group interview guides were developed for the current project. The interview guides provided the interview questions, prompts, and guidance for the interviewer regarding the structure of the focus group (Cherry, 2000; Fowler, 2004; Garvin, Cannuscio, & Branas, 2013; Lindof & Taylor, 2011). Open-ended interview questions were developed to examine participant perceptions of HMG implementation, related barriers and supportive factors, and strategies utilized to accomplish tasks. Interview guides were tailored to each group (i.e., Organizing Entity, Leadership Team, or Work Group) and aligned with the current stage in the implementation process to emphasize the key benchmarks and most recent tasks for each group.

RQ2 - Expert feedback form. A simple form was developed that allowed the expert panel to review and provide feedback related to operationalization of the fidelity criteria. The form was provided via email as a Microsoft Word file consisting of two columns, one for the preliminary criteria and one for feedback. Participants were instructed to provide written feedback related to any criterion that they believe would benefit from modification.

RQ2 - Expert ratings surveys. Based on Holter et al. (2004) and McGrew et al. (1994), frameworks for the expert ratings surveys were developed. Surveys were populated with criteria identified during the literature review and interviews. *HMG Fidelity Criteria Rating Scale 1.* Experts rated the importance of preliminary fidelity criteria identified during the interviews and literature review using a 7-point Likert-type scale (Very Unimportant to Very Important). Following the first survey administration, data were analyzed and non-essential criteria (median scores ≤ 4.5) were flagged and removed from the master list and new suggestions from the experts added. *HMG Fidelity Criteria Rating Scale 2.* Using an approach adapted from Holter et al. (2004), experts were asked to select the fidelity criteria from the revised list that were the most and least essential for program implementation. Specifically, a second survey was administered that asked participants to identify the ten most and least essential criteria from the revised list. Following the second survey, criteria identified as "most essential" by at least 50% of experts were retained (Bond et al., 2000b).

RQ2 - HMG Expert Semi-Structured Interview Guide. A semi-structured interview guide was developed for the MIECHV Innovation evaluation. The interview guide provided the interview questions, prompts, and guidance for the interviewer regarding the structure of the interview (Cherry, 2000; Fowler, 2004; Garvin, Cannuscio, & Branas, 2013; Lindof & Taylor, 2011). Open-ended interview questions were developed to identify fidelity criteria related to the HMG Core Components.

Data Collection:

Table 7. Data collection summary.

Data Collection Activity	Data Collection Instrument(s) Used	Respondents	Frequency of Data Collection
Program Manager Interviews	Implementation Checklist	ISDH Children's Program Director (HMG Program Manager)	Monthly
Implementation Surveys	Organizing Entity Implementation Survey	HMG Organizing Entity	January 2018, April 2018, August 2018, December 2018, April 2019, August 2019
	Leadership Team Implementation Survey	HMG Leadership Team	May 2018, August 2018, December 2018
	Work Group Implementation Survey	HMG Work Groups	June 2018, October 2018, April/July 2019
Implementation Focus Groups	Organizing Entity Implementation Semi-Structured Interview Guide	HMG Organizing Entity	March 2018, June 2018, September 2018, January 2019, May 2019, August 2019
	Leadership Team Semi-Structured Interview Guide	HMG Leadership Team	June 2018, September 2018
	Work Group Semi-Structured Interview Guide	HMG Work Groups	August 2018, April 2019

Data Collection Activity	Data Collection Instrument(s) Used	Respondents	Frequency of Data Collection
Expert Fidelity Interviews	HMG Expert Semi-Structured Interview Guide	13 HMG Experts (6 local, 5 affiliates, 2 HMG National Center)	January 2018 to June 2018
Expert Fidelity Criteria Rating Surveys	Fidelity Criteria Rating Survey 1, Fidelity Criteria Rating Survey 2	10 HMG Experts	July 2018, August 2018

Sampling plan: No sampling was employed.

Statistical Power: Power analyses were not applicable for the analytic methods used for the evaluation.

Analytic methods:

Table 8. Summary of analytic methods.

Research Question	Analytic Methods
RQ1/RQ2	**Descriptive statistics.** Nominal and ordinal data gleaned from implementation checklists, implementation surveys, and expert surveys were examined descriptively. Frequency distributions were primarily used to present information. Data were presented graphically (e.g., line graphs, histograms, bar graphs, etc.) where appropriate. **Content analysis.** Interviews and focus groups were recorded (with participant's permission) and transcribed verbatim for analysis. Analytic methods described in Cherry (2000) and based in grounded theory (Glaser & Strauss, 1967) supported the analysis of data derived from interviews, focus groups, and open-ended survey responses (Cherry, 2000; Larossa, 2005; Lindlof & Taylor, 2011). The multi-step analysis process began with open coding, during which the co-principal investigator assigned indicators (e.g., individual words and phrases) to concepts. As new terms were examined, they were assigned existing concepts, or new concepts were created. Throughout this process, concepts were added and refined (Cherry, 2000; Larossa, 2005). Concepts were assigned into categories, and categories were combined and collapsed as necessary (Cherry, 2000; Larossa, 2005; Lindlof & Taylor, 2011). Axial coding allowed the principal investigator to examine the relationships among categories (Cherry, 2000; Larossa, 2005). Finally, the co-principal investigator isolated the universal narrative present in the data (Larossa, 2005). These analyses were completed by one DCG staff member, the co-principal investigator. Findings were reviewed and vetted by members of the evaluation team throughout the analysis. Emerging findings were shared with the Organizing Entity for validation prior to study completion. **Document Review.** Relevant documents were secured as part of *Program Manager Interviews* and analyzed using procedures identified by the CDC (2018), which included identifying relevant documents, compiling documents, ensuring confidentially, seeking contextual support, determining accuracy, and summarizing information. Document reviews were completed by one staff member.

Evaluation Cost:

Total evaluation costs were $157,000 for a 30-month period. Costs were based on a standard group rate of $100 per hour for consulting staff assigned to the project. The group rate includes employee salaries (commensurate with education and evaluation and analytic experience), employer expenses (fringe benefits, FICA (Social Security and Medicaid) and IN-SUTA), and indirect costs. Group rates align with current market rates for proposed services. DCG committed four senior consultants, three consultants, and one associate consultant to support the project (approximately 50 hours per month).

VIII. EVALUATION RESULTS

Results:

Research Question 1

RQ1a: Is Indiana Making Progress Toward Key HMG Implementation Benchmarks?

Checklists were developed based on the Roadmap to HMG System Replication toolkit, which presents a sequential description of implementation. Progress toward HMG milestones was assessed through monthly interviews with the HMG Program Manager, and document reviews provided context. A detailed summary of each interview was compiled and included in the Appendix.

As of July 2019, 96% (65/68) of implementation tasks schedule for completion by the end of that month had been completed, and 96% (65/68) of all implementation tasks included in the Roadmap to HMG System Replication were complete. Two tasks scheduled for July 2018 (*1. Data Collection & Analysis Work Group identifies and outlines local priorities for outcome measurement and advocacy efforts* and *2. Data Collection & Analysis Work Group conducts environmental scan to identify partners currently collecting aligned priority data*) and one task scheduled for March 2019 (*Early Childhood Mapping - Review report and disseminate to Leadership Team if appropriate)* were not completed. ELAC groups staffed the Leadership Team and the Data Collection and Analysis Work Group for HMG. Due to leadership changes at the state level (see *A. Results. RQ1c - Barriers*), all ELAC groups were placed on hiatus during Fall 2018, and these groups were no longer available to HMG. As a result, tasks assigned to these groups were not completed.

Figure 2 and Table 9 present progress toward implementation tasks completion across the first 20 months of the initiative. Indiana consistently completed implementation tasks on or ahead of schedule, and by July 2018 (month 8), over half (59%) of implementation tasks had been completed. The greatest increases in the percentage of tasks completed occurred from February 2018 (16%) to March 2018 (35%) and October 2018 (68%) to December 2018 (81%), which represented the completion of the first HMG National Center site visit and call center installation, respectively.

Figure 3 and Table 9 present the percentage of benchmarks that were completed before or during the month scheduled. The majority (70%; 47/68) of implementation tasks were completed on time or ahead of schedule. During 70% (14/20) of months, all targeted tasks were completed. The lowest percentages of scheduled tasks were completed during July 2018 (4/9) and October 2018 (2/4). Three tasks scheduled for July 2018 were completed the following month, and as noted above, two Data Collection and Analysis Work Group tasks scheduled for that month were not completed. Two tasks related to the Early Childhood Mapping project (an early childhood social network analysis conducted by HMG National Center) that were scheduled for October 2018 were completed in November. Due to technical issues with the survey that caused it to be flagged as spam, the majority of partners did not receive it as scheduled in October. Members of the Organizing Entity manually administered the survey to partners, and as a result, the survey deadline was extended by two weeks.

Figure 2. From December 2017 to July 2019, Indiana made progress toward implementation tasks identified in the HMG Roadmap to Replication.

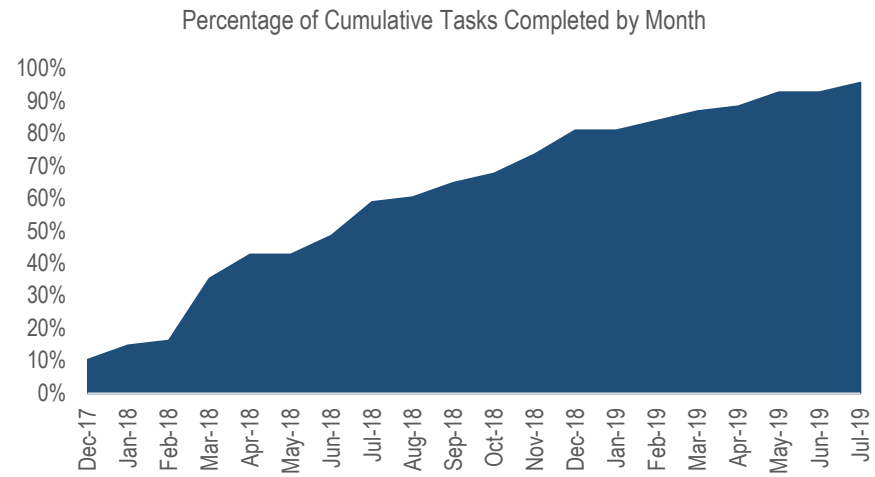


Figure 3. Indiana consistently completed monthly implementation tasks, with all benchmarks completed on time during 70% of months.

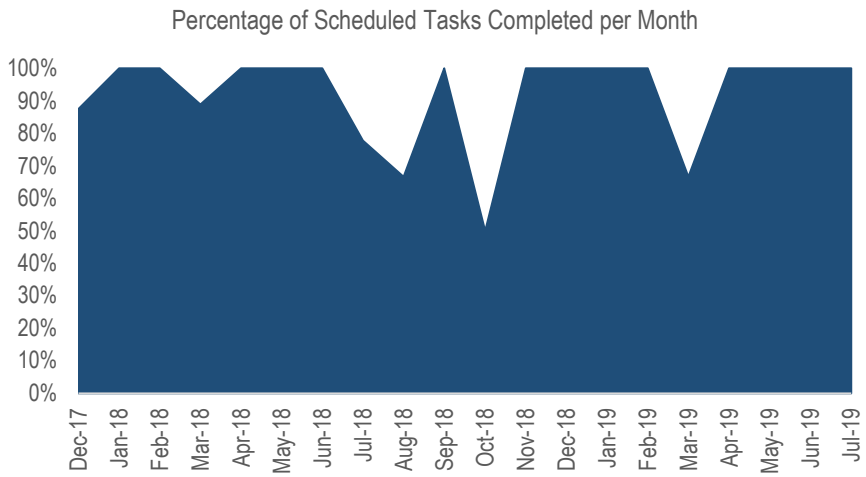


Table 9. Monthly and cumulative implementation task completion.

	2017	2018															2019			
	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul
Monthly Tasks Completed On Time	**88%** 7/8	**100%** 3/3	**100%** 1/1	**89%** 8/9	**100%** 8/8	**100%** 1/1	**100%** 1/1	**44%** 4/9	**67%** 4/6	**100%** 2/2	**50%** 2/4	**100%** 1/1	**100%** 1/1	**100%** 3/3	**100%** 2/2	**67%** 2/3	**100%** 1/1	**100%** 1/1	**100%** 2/2	**100%** 2/2
Cumulative Tasks Completed*	**10%** 7/68	**15%** 10/68	**16%** 11/68	**35%** 24/68	**43%** 29/68	**43%** 29/68	**49%** 33/68	**59%** 40/68	**60%** 41/68	**65%** 44/68	**68%** 46/68	**74%** 50/68	**81%** 55/68	**81%** 55/68	**84%** 57/68	**87%** 59/68	**88%** 60/68	**93%** 63/68	**93%** 63/68	**96%** 65/68

* Includes all tasks completed, including those that were completed after the scheduled month.

RQ1b: What Are Key Stakeholders' Perceptions of the Development Process?
To examine stakeholders' perceptions of HMG development, implementation surveys were administered to members of the Organizing Entity, Leadership Team, and Work Groups. Main findings are synthesized in the following sections, and detailed reports (with frequency distributions) are provided for each group by survey administration in the Appendix.

Generally, across participant groups (i.e., Organizing Entity, Leadership Team, and Work Groups), the most positive ratings of HMG implementation were observed during early 2018. At this time, HMG Indiana stakeholders were engaged in implementation planning, the HMG site visit, Leadership Team formation, community presentations, and Work Group onboarding. Supports identified by participants during this time included collaboration among partners, communication, meeting quality, and HMG National Center support. Lower ratings began to emerge in late summer 2018 as the call center installation approached. For Organizing Entity members, specific barriers during this time included technical and communication issues related to the call center. In subsequent months, barriers identified by the Organizing Entity continued to be technology, communication with partners, timeline misalignment, and staff turnover. Organizing Entity responses were generally positive, and supporting factors noted by Organizing Entity members included partnerships/collaboration, HMG Indiana staff, and Organizing Entity team work. For Leadership Team and Work Group members, ratings continued to decrease in subsequent survey administrations. Once call center installation neared and commenced, Leadership Team and Work Group members noted a lack of communication and limited clarity around purpose, roles, and responsibilities. Leadership Team and Work Groups generally agreed that their input was valued by their group colleagues, but ratings of their understanding of their role and responsibilities were typically lower than other items.

Organizing Entity. Across administrations, the percentage of respondents reporting agreement with *HMG Development and Implementation* items ranged from 61% to 89%, with the highest rates of agreement observed in January 2018 and the lowest in August 2018. The percentage of respondents reporting agreement with *HMG Individual Role* items ranged from 75% to 95%, with the highest rates of agreement observed in January 2018 and the lowest in August 2018 and April 2019. Supporting factors noted by Organizing Entity members in January 2018 included 1) clear and consistent communication, 2) supportive state-level organizations, 3) regular Organizing Entity meetings, and 4) monthly HMG technical assistance. Barriers in August 2018 focused mostly on call center technology and included equipment acquisition, database development, and communication with call center partners. Other barriers in August 2018 included 1) lack of clear next steps, 2) limited partner understanding, 3) Organizing Entity turnover, and 4) misalignment of project timelines (e.g., HMG Indiana, HRSA, HMG National Center). Barriers in April 2019 included 1) fewer meeting opportunities, 2) limited communication with pilot communities, 3) data collection 4) partner understanding, 5) staff turnover, specifically Care Coordinator and HMG Coordinator, 6) discontinued Work Group meetings, and 7) communication with call center partners.

Based on percent agreement across administrations, the highest rated *Development and Implementation* item was "The appropriate people are involved in developing HMG in Indiana" (85%), and the lowest rated was "All members of the Organizing Entity understand the HMG model and how it is being implemented in Indiana" (66%). The highest rated *Individual Role*

item was "I participate regularly in the Organizing Entity" (91%), and the lowest rated was "I am satisfied with the progress made at this stage of implementation" (73%).

Leadership Team. Across administrations, the percentage of respondents reporting agreement with *HMG Development and Implementation* items ranged from 61% to 80%, with the highest rates of agreement observed in May 2018 and the lowest in August 2018. The percentage of respondents reporting agreement with *HMG Individual Role* items ranged from 63% to 79%, with the highest rates of agreement observed in May 2018 and the lowest in August 2018. Supports identified by the Leadership Team in May 2018 included 1) strong collaboration among partners, 2) clear and consistent communication, 3) and informative meetings. Barriers identified in August 2018 included 1) lack of baseline developmental screening rates, 2) unclear Leadership Team goals and tasks, 3) lack of community understanding of HMG, 4) limited sharing time, 5) insufficient information about HMG progress, and 6) limited input on decisions.

Based on percent agreement across administrations, the highest rated *Development and Implementation* item was "Support received was adequate for successful completion of Leadership Team tasks" (87%), and the lowest rated were "The Leadership Team has successfully met its planned objectives at this point in the process" (54%) and "Communication is adequate to support planning and successful implementation" (54%). The highest rated *Individual Role* item was "My input is valued by my colleagues on the Leadership Team" (88%), and the lowest rated was "I clearly understand my role and responsibilities in the project" (57%).

Centralized Access Point (CAP) Work Group. Across administrations, the percentage of respondents reporting agreement with *HMG Development and Implementation* items ranged from 46% to 65%, with the highest rates of agreement observed in June 2018 and the lowest in April 2019. The percentage of respondents reporting agreement with *HMG Individual Role* items ranged from 35% to 63%, with the highest rates of agreement observed in June 2018 and the lowest in April 2019. Supporting factors identified by the CAP Work Group in June 2018 included 1) MOMS Helpline participation, 2) informative meetings, and 3) value of group input. Barriers in April 2019 included 1) lack of communication, 2) unclear Work Group purpose, goals, and tasks, 3) limited Work Group input, 4) member disengagement, and 5) lack of support from Leadership Team due to ELAC hiatus.

Based on percent agreement across administrations, the highest rated *Development and Implementation* item was "The appropriate people are involved in developing HMG in Indiana" (78%), and the lowest rated was "All members of CAP Work Group understand the HMG model and how it is being implemented in Indiana" (37%). The highest rated *Individual Role* items were "I participate regularly in the CAP Work Group" and "My input is valued by my colleagues on the CAP Work Group" (68%). The lowest rated was "I am satisfied with the progress made at this stage of implementation" (38%).

Community and Family Outreach Work Group. Across administrations, the percentage of respondents reporting agreement with *HMG Development and Implementation* items ranged from 44% to 62%, with the highest rates of agreement observed in October 2018 and the lowest in June 2018. The percentage of respondents reporting agreement with *HMG Individual Role* items ranged from 60% to 64%, with the highest rates of agreement observed in June 2018 and the lowest in October 2018. Supportive factors identified by the Community and

Family Outreach Work Group included 1) engaged partners, 2) support from HMG National Center (including the site visit), 3) partner outreach, 4) project management, and 5) HMG Indiana staff. Barriers included 1) short timeline and 2) lack of clarity related to participants' roles and responsibilities.

Based on percent agreement across administrations, the highest rated *Development and Implementation* items were "The appropriate people are involved in developing HMG in Indiana" (68%) and "All members of Community and Family Outreach Work Group understand the HMG model and how it is being implemented in Indiana" (68%). The lowest rated was "Communication was adequate to support planning and successful implementation" (42%). The highest rated *Individual Role* item was "My input is valued by my colleagues on the Community and Family Outreach Work Group" (74%), and the lowest rated was "I clearly understand my role and responsibilities in the project" (48%).

Child Health Provider Work Group. The Data Collection and Analysis Work Group members completed surveys in July 2019; however, due to small sample sizes (n = 2), data are not reported. Open-ended comments were incorporated into qualitative analyses.

Data Collection and Analysis Work Group. Prior to their hiatus, the Data Collection and Analysis Work Group members completed surveys in June 2018 and October 2018; however, due to small sample sizes (n = 3 and n = 1, respectively), data are not reported. Open-ended comments were incorporated into qualitative analyses.

RQ1c: What Are the Barriers and Supporting Factors Associated with HMG Model Implementation?

Based on analysis of implementation interviews, open-ended comments from implementation surveys, and focus groups, key HMG implementation barriers and supporting factors were identified. Document reviews provided context.

Barriers. Six key HMG implementation barriers were identified: 1) HMG technical assistance alignment, 2) Work Group participation, 3) partners' understanding of HMG, 4) funding timelines and budget requirements, 5) Centralized Access Point, and 6) staffing issues. Central categories and associated themes (Cherry, 2000) are described below, and detailed descriptions of specific barriers associated with individual implementation tasks are included in the Appendix.

Table 10. Summary of Barriers

Central Categories	Themes
HMG Technical Assistance Alignment	*Deviation from the HMG implementation timeline.* Indiana's call center was fully operational in less than 12 months; however, the HMG National Center initially recommended 12-18 months for Indiana and often recommends longer timelines for most affiliates. HMG's technical assistance deliverables are designed to be delivered via a specific timeline and sequence: Given Indiana's focus on a Fall 2018 call center rollout, there was a disconnect between the tasks recommended and the products provided by the HMG National Center and Indiana's preferred implementation timeline.
	Appropriateness/availability of technical assistance resources and tools. Due to Indiana's unique funding situation and implementation timeline, many of the resources and technical assistance required modification for Indiana use. While technical assistance activities focus mostly on exploration and planning, Indiana stakeholders felt prepared to complete installation and implementation due to existing

Central Categories	Themes
	infrastructure. Due to the accelerated timeline, some resources were not available when stakeholders felt they were most applicable. Stakeholders reported that HMG National Center calls included a greater focus on reporting progress than traditional technical assistance.
	Miscommunication with HMG National Center. Program stakeholders described miscommunications with the National Center as affecting task completion. A barrier described by stakeholders was a lack of clarity in communication related to specific implementation expectations and that HMG National Center misunderstood the structure across Indiana's multiple pilot sites and funding sources, which affected the appropriateness of the support provided.
Work Group Participation	*Work Group purpose and tasks.* Because the HMG model is intentionally malleable, there was some confusion related to the role of each Work Group. Much of initial decision making was completed by the Organizing Entity to support MIECHV Innovation and ECCS proposal development. Leadership Team and Work Group members voiced some dissatisfaction that major program decisions were made without their involvement. Work Groups were developed to provide advisory support and often did not have concrete tasks assigned to them.
	Insufficient communication. A lack of communication between the Organizing Entity and Work Groups was identified by stakeholders as a barrier that impeded Work Group participation. Some Leadership Team and Work Group members indicated that they were unable to contribute as much as they had hoped due to limited clarity and details, a lack of regular updates, and limited resources (e.g., project timeline, HMG Manual).
	Recruitment barriers. Barriers were noted recruiting members for the Work Groups, especially for the Work Groups that were not built from existing groups. This was a particular struggle when recruiting physicians and nurse practitioners for the Child Health Provider Work Group. Moreover, stakeholders indicated an interest in engaging more parents/caregivers and providers in the Work Groups.
	Limited volunteer capacity. Members noted that schedules and workloads limited the amount of time that they could dedicate to the project. As volunteers, Work Group members were often unable to prioritize HMG-related tasks.
	ELAC leadership transitions. ELAC is a governor-appointed early childhood advisory group that has provided extensive support to HMG. Following the ELAC chairperson stepping down in 2018, the committee – and its associated subgroups – stopped meeting to allow the governor to appoint new members. Because the HMG Leadership Team and Data and Analysis Work Group were staffed by ELAC groups, these HMG Work Groups were placed on hiatus in 2019.
Partners' Understanding of HMG	*Partner understanding.* Because HMG concepts were often vague during planning, stakeholders noted that it was difficult for partners to understand and challenging for leaders to explain. Stakeholders noted that it often takes multiple messages to explain HMG adequately and that messaging was especially challenging prior to the call center's rollout. Finally, a particular barrier was combatting the misconception that HMG would replace existing services.
Funding Timelines and Budget Requirements	*Funding timelines and budget requirements.* Dual funding sources created some logistical and communication barriers for the Organizing Entity. First, the Organizing Entity must work carefully to ensure that all requirements for each grant are met and that all dollars support only funder-approved aspects of the project. Moreover, funding approvals were delayed, which consequently slowed securing a contract with the HMG National Center and subsequent implementation tasks.
Centralized Access Point.	*Telephone technology.* Organizing Entity members identified initial barriers associated with securing the appropriate technology. Once telephones were installed, problems with the interactive voice response (IVR) logic created barriers because incoming calls were routed incorrectly. Building a mechanism to exchange faxes with physicians created some technical issues.
	Database integration. HMG uses an existing database through a partnership with Indiana 211, and stakeholders noted some challenges adapting the data system for HMG. HMG Indiana utilizes data from multiple systems/partners, and the various systems do not share data easily across platforms. Utilizing multiple funding sources requires tracking an increased number of indicators in the system, including some duplicated fields.
	Communication among call center partners. The Organizing Entity noted that required tasks were not always communicated clearly or in a timely fashion to them, which slowed implementation. Further, stakeholders noted that it was essential that the Organizing Entity clearly communicate how HMG fit into

Central Categories	Themes
	the existing network of call centers to enable a transparent partnership and defuse rivalries and competition.
Staffing Issues	*Turnover.* Staff turnover, specifically at ISDH, slowed progress when initially establishing the Organizing Entity, and several ISDH leadership positions transitioned throughout the planning and early implementation periods. Once call center operation commenced, turnover occurred in two critical HMG positions: HMG Coordinator and Bilingual Care Coordinator.
	Hiring. Stakeholders noted barriers hiring new staff members and adding new positions. HMG positions were difficult to fill because they required unique skillsets. The Organizing Entity intentionally waited to hire staff until relevant duties were ready to commence, which was inconsistent with the hiring plan described in the original proposal. HMG staff are contracted employees, so it is difficult to offer competitive benefits when recruiting for these positions.

Supporting Factors. Based on analysis of implementation interviews, open-ended comments from implementation surveys, and focus groups, six key factors supporting implementation were identified: 1) existing partnerships and resources, 2) Organizing Entity characteristics and practices, 3) HMG Indiana staff, 4) HMG National Center, 5) partnership with MOMS Helpline and Indiana 211, 6) HMG physician champion, and 7) evaluation. Central categories and associated themes (Cherry, 2000) are described below, and detailed descriptions of specific supports associated with individual implementation tasks are included in the Appendix.

Table 11. Summary of Supporting Factors

Central Categories	Themes
Existing partnerships and resources	*State agencies.* Stakeholders indicated that partners across state government have supported the initiative since its inception. Specifically, two state agencies (ISDH and DCS) comprised the HMG Organizing Entity and provided the backbone for the system. Divisions with ISDH/DCS and other state agencies supported the Organizing Entity by offering infrastructure and targeted support. Finally, state partners have proposed support through future grants and ongoing collaborations.
	Availability of Existing Work Groups. To fill the required Work Groups, the Organizing Entity identified a strategic set of partners with similar goals and purposes. Utilizing these partnerships, the HMG Work Groups were built from existing state and local groups that were familiar with and supportive of Help Me Grow and had existing buy-in related to the initiative.
	Supportive communities. Stakeholders noted that both the local communities and the state early childhood system were supportive of the initiative. As implementation commenced and understanding grew, communities became more receptive and buy-in increased. The Organizing Entity built on existing community support to engage families, providers, and physicians to use the system, to recruit partners, and to generate interest in HMG.
	Shared state vision. Stakeholders observed that a common vision related to early childhood generally and HMG specifically predated implementation and provided support as the initiative was rolled out. There is a natural alignment between local goals and those of HMG.
Organizing Entity characteristics and practices	*DSC/ISDH partnership.* Staff from DCS and ISHD comprised the Organizing Entity, and the partnership between these agencies facilitated the implementation of HMG. Stakeholders reported that DCS and ISDH have a history of collaboration, as well as the preexisting relationships and trust necessary to implement projects successfully.
	Member engagement. Stakeholders noted that Organizing Entity members were highly engaged in the project and dedicated to its success. These individuals took the steps necessary to ensure that required tasks were completed on time and that the system was implemented on schedule.
	Quality of leadership. Leadership quality was noted by stakeholders as a key implementation support. When describing the Organizing Entity, stakeholders noted consistent leadership across the life of the

Central Categories	Themes
	project, multiple years of experience in their positions, a variety of backgrounds and broad expertise, and transparency when interacting with partners.
HMG Indiana staff	*HMG Indiana staff.* Stakeholders indicated that Indiana utilized a strong HMG staff who supported the implementation. Indiana hired a full-time HMG Coordinator to manage day-to-day operations. Care Coordinators were hired who had extensive call center experience. Resource Specialists with relevant backgrounds and existing contacts were added to the team in spring 2019.
HMG National Center.	*Affiliate network.* As of September 2019, there are 29 HMG affiliates (i.e., states or regions implementing the system), and peer-to-peer support is a key component of HMG implementation. According to stakeholders, Indiana relied heavily on support from other affiliates during the planning and implementation phases.
	Technical assistance. Through their contract with the HMG National Center, Indiana received individual consultation that included monthly technical assistance conference calls, two multi-day site visits, technical assistance resources/reports, implementation guides and toolkits, and communities of practice.
	HMG Forum. The HMG Forum is the annual conference for affiliates and includes a variety of activities including general sessions, panel presentations, keynote addresses, and networking opportunities. Indiana stakeholders attended in 2018 and 2019, and Indiana will host the 2020 HMG Forum. Stakeholders noted that presentations and networking opportunities supported Indiana's implementation.
Partnership with MOMS Helpline and Indiana 211.	*Partnership with MOMS Helpline and Indiana 211.* Rather than build a new call center and a unique database, the HMG Organizing Entity chose to utilize the MOMS Helpline as the Centralized Access Point and to leverage its partnership with Indiana 211 to supply the HMG database. Using these existing partnerships supported the accelerated timeline and provided targeted technical assistance.
HMG Physician Champion.	*HMG Physician Champion.* The Physician Champion has been in place since HMG Indiana's initial planning stages. The Physician Champion was described as an engaged member of the local community served by HMG, a respected member of the physicians' community in Indiana, and a valuable liaison between the Organizing Entity and local physicians. The Physician Champion co-developed the referral processes and feedback loop utilized by physicians and piloted this within her practice.
Evaluation	*Evaluation.* Indiana was the first HMG affiliate to utilize formative evaluation during the planning and implementation phases. Through the formative evaluation, the Organizing Entity was provided a series of reports to support implementation. Secondly, the evaluation identified key components of Indiana's implementation to support future fidelity tools. The required MIECHV evaluation planning process provided early access to the HMG Manual, HMG Roadmap to Replication, and other planning documents. The evaluation team provided additional support to the Organizing Entity including, but not limited to, attending Organizing Entity meetings and calls reviewing HMG National Center data collection tools, synthesizing HMG National Center reports, attending the HMG Forum, and providing/supporting HMG presentations at local, state, and national conferences/meetings.

RQ1d: What strategies are employed to complete HMG implementation benchmarks?
Based on analysis of implementation interviews, open-ended comments from implementation surveys, and focus groups, six key HMG implementation strategies were identified: 1) HMG outreach, 2) use of existing groups, 3) call center partnerships, 4) Organizing Entity collaborative practices 5) utilization of HMG technical assistance, and 6) HMG staffing. Document reviews provided context. Detailed descriptions of the specific strategies employed to complete individual implementation tasks are included in the Appendix.

Table 12. Summary of Strategies

Central Categories	Themes
HMG Outreach	*Community presentations.* In the months leading up to rollout, members of the Organizing Entity provided presentations to community members in pilot counties to raise awareness, build community buy-in, describe HMG, address misconceptions, and recruit partners. Resource Specialists joined early childhood coalitions and regularly attended community events and conferences.

Central Categories	Themes
	Marketing Materials. To secure marketing materials, HMG Indiana utilized a two-pronged approach that included both purchasing materials and collaborating with partners to co-brand existing materials. Materials are provided to families and partners at conferences and family events. Resource Specialists deliver HMG materials to doctors' offices.
	Stakeholder communication. Building strong communication with stakeholders was identified as a critical implementation strategy. This involved planning and coordinating communication strategies, maintaining transparency, providing appropriate follow-up, promoting clear understanding by partners, and securing communication-related technical assistance.
	Physician outreach. Stakeholders identified physician outreach as a critical component of HMG implementation. The Organizing Entity relied on the Physician Champion and Child Health Provider Work Group to support communication with physicians. The Physician Champion has affiliate access to the HMG website and uses it to identify webinars and other resources to share with local physicians. Additionally, members of the Organizing Entity have held ongoing meetings with staff from the local children's hospital. Finally, Resource Specialists deliver HMG materials to doctors' offices and answer questions about HMG.
Use of Existing Groups	*Use of existing groups.* Stakeholders identified the use of existing groups to staff HMG teams and Work Groups as an essential implementation strategy. Formal partners were identified through the funding process and included Healthy Families Indiana (MIECHV) sites, Nurse-Family Partnership (MIECHV) sites, and the John H. Boner Center (ECCS). The use of existing groups was also a strategy for developing HMG implementing groups. *Organizing Entity.* DCS and ISDH used MIECHV and ECCS funding to support HMG implementation. Representatives from these state agencies compose the HMG Organizing Entity. *Leadership Team.* The HMG Organizing Entity secured ELAC's Child Development and Well-Being Work Group to serve as the HMG Leadership Team. In this role, ELAC supported HMG in an advisory capacity. *Work Groups.* The Community and Family Outreach Work Group utilized an existing work group that was created during Project Launch, a state initiative that ended in March 2018. In December 2017, the Organization Entity recruited this group to take on a new role in HMG as Project Launch ended. The Data Collection and Analysis Work Group utilized an existing group created as part of the ELAC initiative.
Call Center Partnerships	*Call center partnerships.* The MOMS Helpline was identified in the MIECHV application as the Centralized Access Point, and Indiana 211 was secured as a partner. At ISDH, the decision was made for MOMS Helpline and HMG to utilize VisionLink (which is used by 211) rather than building a new data system. HMG Indiana has contracted with Indiana 211 to support data system planning, query building, data exports, and ongoing technical support.
Organizing Entity Collaborative Practices	*Open and consistent internal communication.* The Organizing Entity enacted internal communication strategies designed to encourage participation from all members, to create shared understanding, and to build trust. Meetings were structured to provide opportunities for discussion and consensus building, with all members given the opportunity to voice opinions and ask questions. Organizing Entity members utilized emails to maintain consistent communication, and copying the full team on all emails was a group norm to ensure that all members were aware of developments in real-time.
	Adaptive meeting structure. Across the life of the project, the Organizing Entity modified their meeting frequency and structure to accommodate project needs. Meetings increased in frequency as planning and implementation tasks increased. Meetings transitioned from focusing on progress reports to working meetings (i.e., defined tasks and decisions to be addressed), and members were assigned specific tasks to complete between meetings. Finally, meeting agendas were adjusted to ensure that all topics received sufficient time for discussion.
	Professionalism. Organizing Entity members described efforts to maintain professionalism throughout the implementation process to promote honest conversations, foster informed decisions, and minimize disruptions. Members noted leveraging their existing relationships and history of partnership to facilitate challenging decisions, minimize conflict when disagreements occur, and to examine group progress critically.
Utilization of HMG Technical Assistance	*Utilization of HMG technical assistance.* Technical assistance calls were a required part of the contract with the HMG National Center and were held at least once per month. The Organizing Entity met in-person before the calls and participated in conference calls as a group. The Organizing Entity utilized

Central Categories	Themes
	support from the affiliate network to inform and strengthen implementation. HMG Indiana staff and stakeholders participated in the HMG Forum during 2017 and 2018.
HMG Staffing	*HMG staffing.* Using samples from the HMG affiliate website, Care Coordinator and Resource Specialist job descriptions were developed for HMG Indiana. The Organizing Entity placed an emphasis on hiring individuals who were strong fits for the position and could serve the geographic areas targeted by the HMG pilot.

Research Question 2

To support ongoing implementation and future fidelity studies, the evaluation team collaborated with the Organizing Entity, HMG National Center staff, and HMG affiliates to establish fidelity criteria. The process involved three phases: 1) identify fidelity criteria through a review of published materials and interviews; 2) construction of a preliminary list of operationalized critical criteria, and 3) use of experts to rate and validate each criterion, which results in a final list of fidelity criteria.

Preliminary Fidelity Criteria

The evaluation team conducted a review of literature to identify examples of fidelity criteria in published peer-reviewed studies, state and national evaluations, the HMG program manual, and other resources and documents. Expert interviews were employed to complement the literature review. Based on the literature review and interview responses, DCG staff compiled a preliminary list of 284 operationalized fidelity criteria grouped by HMG Core Components. Specifically, 82 criteria were identified for the Data Collection and Analysis core component, 110 Centralized Access Point criteria, 52 Family and Community Outreach criteria, and 40 Child Health Provider Outreach criteria. Preliminary criteria are presented in the Appendix by HMG Core Component.

Final Fidelity Criteria

Survey 1. Ten HMG experts rated the preliminary criteria based on perceived importance for successful implementation. Following the first survey, data were analyzed, and non-essential criteria (median scores ≤ 4.5) were flagged and removed from the master list and new suggestions from the experts were added. Respondents suggested additional criteria be added to the list, including 3 Data Collection and Analysis criteria, 1 Centralized Access Point criterion, and 1 community and family outreach criterion. After criteria scoring below the threshold were removed, 47 Data Collection and Analysis criteria, 53 Centralized Access Point criteria, 24 Family and Community Outreach criteria, and 16 Child Health Provider criteria were retained.

Survey 2. The second survey asked participants to identify the most and least essential criteria from the revised list. Ten HMG experts reviewed the revised fidelity criteria. Once data were analyzed, criteria identified as "most essential" by at least 50% of experts were retained, and 25 final fidelity criteria were identified. These included 2 Data Collection and Analysis criteria, 3 Centralized Access Point criteria, 8 Family and Community Outreach criteria, and 11 Child Health Provider Outreach criteria. Data Collection and Analysis criteria identified for Indiana focused on access to the database for call center staff and accurate tracking of referral status, which is essential for closing the feedback loop. Selected Centralized Access Point criteria focused on database competence for HMG staff, training quality, and HMG staff communication

efficacy. Family and Community Outreach criteria focused on utilizing existing partners and outreach to building on existing outreach gaps, utilizing communication best practices, and recruiting families and local champions for target populations. Finally, selected Child Health Provider Outreach criteria involved soliciting feedback from the health community (including non-physician staff), identifying local physician champions, closing the feedback loop and providing follow up to physicians, providing outreach materials, and engaging the AAP. A list of final criteria is provided in the following table.

Table 13. Final fidelity criteria identified through expert surveys.

Criterion	Percent Identifying As Most Essential
Data Collection and Analysis	
Call center staff have access to the HMG database.	70%
The HMG database accurately tracks referral status for families.	70%
Centralized Access Point	
All care coordinators are comfortable/competent using the database.	70%
Care coordinator onboard training includes an overview of HMG (including all core components).	50%
Care coordinators are skilled communicators.	50%
Family and Community Outreach	
HMG leverages existing community partner and family-friendly forums/fairs to promote awareness (e.g., healthy development, developmental milestones, developmental screening, regional resources, HMG website).	90%
HMG communicates with child health providers, parents, school district superintendents and administrators, early educators, and other services providers about HMG.	70%
All promotional materials adhere to best practices for communicating with target audiences.	60%
Family and community outreach activities are offered in the languages spoken by target populations.	60%
Family and community outreach builds on gaps in existing outreach.	60%
Family and community outreach leverages existing outreach.	60%
Families are represented on HMG Work Groups.	50%
Family and community outreach solicits champions in the target populations (e.g., physicians, providers, families).	50%
Child Health Provider Outreach	
Child health provider outreach activities encourage input and feedback from physicians and the health community.	90%
Child health provider outreach solicits participation from non-physician staff (e.g., front desk, medical assistants, billing).	80%
Physician champions are identified for each county served by HMG.	80%
Child health provider outreach activities communicate the value of HMG for physicians.	70%
Child health provider outreach solicits participation from leaders in the medical community.	70%
Child health providers and practices receive follow-up related to referrals provided to the CAP (if consent provided).	70%
HMG closes the feedback loop with physicians by sharing information about the outcome of a particular child/family at least 75% of the time (if consented by family).	70%
HMG provides outreach materials to physicians to promote developmental screening.	60%
Medical community representatives are included in the planning for all child health provider outreach activities.	60%
Child health provider outreach activities are scheduled at times which are convenient for physicians (e.g., 8:00am or 12:00pm).	50%
Child health provider outreach solicits participation from state and local American Academy of Pediatrics (AAP) leadership.	50%

Sample:

Due to the nature of the study (e.g., ongoing reporting), group size, and relationships among participants, traditional demographics (e.g., race, income) were not included in the approved

evaluation plan nor collected to protect participants' confidentiality; however, other group characteristics were collected and are presented here by research question.

Research Question 1

Work Group and Leadership Team operations varied across the life of the project due to recruiting barriers, completion of required duties, and other factors. After each Work Group started meeting, participation in evaluation activities was mixed, which affected response rates and sample sizes. To address these challenges, the evaluation team worked closely with the Organizing Entity to understand the implementation timeline and stakeholders' readiness to participate in the evaluation, and as necessary, modifications were made. To maximize evaluation participation, existing meeting times and spaces were utilized for focus groups, and the Organizing Entity served as the conduit through which surveys were administered to stakeholders. Then, during fall 2018, state-level leadership changes caused a hiatus for all ELAC groups, which impacted the Data Collection and Analysis Work Group and the HMG Leadership Team. These groups ceased meeting in Fall 2018 and have not yet resumed.

Table 14. Participants by Group and Administration

Implementation Surveys			Focus Groups		
Group	Administration	n	Group	Administration	n
Organizing Entity	January 2018	5	Organizing Entity	March 2018	8
	April 2018	8		June 2018	6
	August 2018	7		September 2018	9
	December 2018	9		January 2019	11
	April 2019	7		May 2019	12
	August 2019	12		August 2019	11
Leadership Team	May 2018	13	Leadership Team	June 2018	11
	August 2018	12		September 2018	11
	December 2018	5			
			Centralized Access	August 2018	5
Centralized Access Point	June 2018	10			
	October 2018	6	Family and Community Outreach	August 2018	8
	April 2019	5			
			Data Collection and Analysis	August 2018	12
Family and Community Outreach	June 2018	9			
	October 2018	5	Child Health Provider	April 2019	3
Data Collection and Analysis	June 2018	3			
	October 2018	1			
Child Health Provider	July 2019	2			

Note: Due to overlap in groups, participants only completed surveys and focus for the most senior group in which they participate: 1. Organizing Entity, 2. Leadership Team and 3. Work Groups. For example, if an individual participates on the Leadership Team and a Work Group, he or she would only complete the Leadership Team surveys.

Organizing Entity. The Organizing Entity provides administrative and fiscal oversight and initially helps identify and coordinate partners into Work Groups that will support the HMG system as it evolves. As of September 2019, the HMG Indiana Organizing Entity consists of 11 ISDH and DCS representatives.

Table 15. Summary of Organizing Entity.

Agency	Position
DCS	MIECHV Grant Coordinator
DCS	Prevention Manager
ISDH	Children's Program Director (HMG Program Manager)
ISDH	Children's Special Health Care Services Director
ISDH	Home Visiting Program Coordinator
ISDH	Home Visiting Program Manager
ISDH	Integrated Community Services Manager (HMG Coordinator)
ISDH	MCH Programs Director
ISDH	HMG Care Coordinator
ISDH	HMG Resource Specialist (2)

Leadership Team. HMG utilized the ELAC's Child Development and Well-Being Work Group to serve as the Leadership Team. This group consists of statewide early childhood leaders representing state government, early childhood providers, healthcare, education, and community, nonprofit, and faith-based organizations. As of September 2019, the group includes 44 individuals; however, the number of individuals attending regular meetings are typically much lower. This group ceased meeting in Fall 2018.

Table 16. Summary of Leadership Team.

Organizations Represented by the HMG Leadership Team	
Ball State University	Imagination Station
Big Goal Collaborative	Indiana Department of Education
Bona Vista Programs, Inc.	Indiana State Department of Health (9)
Brightpoint	Indiana University Health (5)
Children's Ministry of Grace Point Church of the Nazarene	Ivy Tech Community College - North Central Region (2)
Community Action Program of Evansville	Jump IN for Healthy Kids
Department of Child Services	Muncie By 5 (2)
Early Learning Indiana (2)	Notre Dame
Early Learning Indiana/Child Care Answers	SIEOC CCR&R
Family and Social Services Administration (FSSA) (5)	Southeastern Indiana Economic Opportunity Corporation
Family Development Services	St. Mary's Child Center
FSSA Division of Mental Health and Addiction	WFYI
Hamilton Southeastern School District	

Work Group Members. Work Groups were selected for each of the four HMG Core Components to manage its implementation.

The *Centralized Access Point Work Group* was co-chaired by two local experts who represented MOMs Helpline and Early Learning Indiana and consisted of state experts representing existing call centers, including Children's Bureau, United Way, Department of Child Services, and First Steps.

Table 17. Summary of CAP Workgroup.

Organizations Represented by the CAP Work Group	
Children's Bureau (1)	Indiana First Steps (3)
Children's Special Health Care Services, ISDH	MOMS Helpline, ISDH
DCS (3)	United Way of Allen County
Early Learning Indiana (4)	Women, Infants & Children, ISDH
Help Me Grow, ISDH (3)	

The *Community and Family Outreach Work Group* utilized an existing state work group that was created during Project Launch, a state initiative that ended in March 2018. The group included representatives from state agencies and community partners. Five Organizing Entity members

and three Leadership Team members served on the *Community and Family Outreach Work Group*.

Table 18. Summary of Community and Family Outreach Work Group.

Organizations Represented by the Community and Family Outreach Work Group	
Child Care Answers	Indiana University Health
DCS (2)	ISDH (5)
IDOE (2)	John H. Boner Center (2)
FSSA (5)	Riley Child Development Center
FSSA Office of Medicaid Policy and Planning	St. Mary's Child Center
Goodwill of Central & Southern Indiana	Wellborn Baptist Foundation
Indiana Community Action Association	

Chaired by the HMG Physician Champion, the *Child Health Provider Work Group* consisted of three practicing pediatricians and two representatives from the Indiana University School of Medicine. Physicians were not recruited for this group until Spring 2019.

Table 19. Summary of Child Health Provider Work Group.

Organizations Represented by the Child Health Provider Work Group
Community Anderson Pediatrics
HealthLinc
HealthNet People's Health Center and INAAP
IU School of Medicine, Dept. of Pediatrics (2)

The *Data Collection and Analysis Work Group* was staffed by ELAC's Data Coordination and System Integration Work Group. This group includes representatives from state government, early childhood, healthcare, education, business, and community and nonprofit organizations. Two members of the Organizing Entity and one member of the Leadership Team participated in this group. This group ceased meeting in Fall 2018.

Table 20. Summary of Data Collection and Analysis Work Group.

Organizations Represented by the Data Collection and Analysis	
Area Five Agency	Indiana Department of Education (IDOE)
Ball Brothers Foundation	ISDH (3)
Big Goal Collaborative	Indiana Youth Institute
Community Foundation DeKalb County	M.A. Rooney Foundation
Early Learning Indiana	Management Performance Hub
Evansville Vanderburgh School Corporation	Marion Community Schools
Family and Social Services Administration (3)	OECOSL
First Steps	OVO Inc.
Ice Miller	

Research Question 2

Expert interviews

Experts were recruited to participate in interviews designed to identify the critical components of HMG implementation. Participants included HMG National Center staff, HMG affiliates, and local experts (e.g., Organizing Entity, MOMS Helpline).

Table 21. Summary of HMG expert pool.

HMG Core Component(s)	Expert Type	Participant
Centralized Access Point	Local	Children's Special Healthcare Director, Indiana State Department of Health
Centralized Access Point	Local	Care Coordinator, HMG-MOMS Help Line Liaison, HMG Indiana
Centralized Access Point	Affiliate	Vermont 2-1-1
Centralized Access Point, Family and Community Outreach, Child Health Provider Outreach	HMG National	Help Me Grow National Center
Child Health Provider Outreach	Affiliate	Docs for Tots, HMG Long Island
Child Health Provider Outreach	Local	Physician Champion, HMG Indiana
Data Collection and Analysis	Local	Prevention Services Manager, Department of Child Services
Data Collection and Analysis	Local	MIECHV Coordinator, Department of Child Services
Data Collection and Analysis	HMG National	Help Me Grow National Center
Data Collection and Analysis	Affiliate	HMG Orange County
Data Collection and Analysis	Affiliate	Help Me Grow Western New York
Family and Community Outreach	Affiliate	Vermont Department of Health
Family and Community Outreach, Child Health Provider Outreach	Local	HMG Program Manager, Indiana State Department of Health

Note: To protect confidentiality, external experts are not identified by title.

Comparison Group: No comparison group was utilized.

Discussion and Interpretation of Findings:

Research Question 1

The first research question explored the extent to which HMG was implemented as designed, while being successfully integrated within the IN-MIECHV system. Overall, HMG was implemented as designed; however, Indiana deviated significantly from the recommended HMG timeline. Indiana included a Fall 2018 implementation target in their initial proposal, whereas HMG National Center initially recommended 12-18 exploration/planning months for Indiana and often recommends longer timelines for most affiliates. The most substantial differences related to the timing with which partners and Work Groups were identified and recruited and the process for identifying the Centralized Access Point. Prior to contracting the HMG National Center, Indiana had assembled partners and identified existing groups to fulfill HMG Leadership Team and Work Groups, and MOMs Helpline was secured as the Centralized Access Point when the MIECHV Innovation and ECCS grants were written. HMG's technical assistance deliverables are designed to be delivered via a specific timeline and sequence, and while Indiana's timeline was essential for an October 2018 rollout, the accelerated timeline appears to have limited the Organizing Entity's ability to maximize HMG technical assistance and negatively influenced the extent to which Work Groups could contribute to the project.

Data collected through the implementation analysis suggest that while there were considerable deviations from the normal implementation timeline, HMG Indiana was implemented in accordance with the tasks described in the HMG Manual and the HMG Roadmap to Replication. As noted above, 96% (65/68) of implementation tasks included in Indiana Roadmap to HMG Replication were completed as of July 2019. Remaining tasks included specific duties assigned to the Data Collection and Analysis Work Group and the Leadership Team, two ELAC-staffed groups that ceased meeting in December 2018 to allow for the governor to appoint new members

to the state-level ELAC team. As a result, tasks assigned to these groups were not completed. While some minor delays were noted across all tasks, Indiana generally completed assigned tasks during or prior to the month in which those tasks were assigned. The majority (70%; 47/68) of implementation tasks were completed on time or ahead of schedule, and during 70% (14/20) of months, all targeted tasks were completed. The lowest percentages of scheduled tasks were completed during July 2018 (4/9) and October 2018 (2/4). Generally, when tasks were not met during the assigned months, they were completed by the following month. These findings demonstrate that Indiana has successfully replicated an HMG system that serves the pilot counties and incorporates all core HMG components, including a functioning Centralized Access Point staffed by HMG Care Coordinators; Family and Community Outreach administered by HMG Resource Specialists, the Organizing Entity, and other partners; Child Health Provider Outreach through the HMG Physician Champion, Child Health Provider Outreach Work Group, and the Organizing Entity; and Data Collection and Analysis managed by the Organizing Entity and supported by a partnership with Indiana 211.

Perceptions of implementation varied by participant group, with the Organizing Entity and Leadership Team providing mostly positive responses (i.e., percent agreement above 50%) and Work Groups providing mixed responses. Generally, across all groups the most positive ratings were observed in early 2018. Lower ratings began to emerge in late summer 2018 as the call center rollout approached. Following call center rollout, ratings remained mostly positive for Organizing Entity members. For Leadership Team and Work Group members, ratings continued to decrease in subsequent survey administrations. Once call center installation neared and commenced, Leadership Team and Work Group members noted a lack of communication and limited clarity around purpose, roles, and responsibilities. Leadership Team and Work Groups generally agreed that their input was valued by their group colleagues, but ratings of their understanding of their role and responsibilities were typically lower than other items.

Key implementation barriers identified by stakeholders included HMG technical assistance alignment due to Indiana's accelerated timeline, Work Group participation, partners' understanding of HMG, funding timelines and budget requirements, Centralized Access Point barriers, and staffing issues. Due to the deviation from the normal HMG timeline (i.e., 12-18 months of exploration and planning), barriers emerged as technical assistance was modified to meet Indiana's needs, with some resources and tools proving for the Organizing Entity to utilize. Moreover, miscommunications created challenges and confusion during technical assistance, which appears to have created a disconnect between Indiana's needs and the resources/tools provided. As a result, Indiana was unable to maximize the benefits of participation in technical assistance. Secondly, capitalizing on Work Group expertise also proved a barrier due to misunderstandings of Work Group purposes and duties, miscommunications between Work Group members and the Organizing Entity, difficulties recruiting members, limited volunteer time and capacity to support HMG, and ELAC leadership changes that placed the Leadership Team and Data Collection and Analysis Work Group on hiatus beginning in late 2018. Third, because HMG was intentionally designed for local modification, stakeholders often found the model vague and difficult to understand, especially at the community level (e.g., county or city). Fourth, while the dual funding sources allowed Indiana to implement HMG in the pilot communities, it also created issues for those responsible for managing financial aspects. Given the need for increased scrutiny, additional attention was required to ensure that all requirements

were met and all dollars used appropriately. Funding approvals were delayed, which slowed securing a contract with HMG and all subsequent implementation tasks. Fifth, installing the Centralized Access Point created some barriers due to telephone and database technology issues and miscommunication among call center partners. Finally, staffing issues emerged during HMG planning and implementation. Specifically, turnover among ISDH staff on the Organizing Entity and HMG staff (HMG Coordinator, HMG Care Coordinator) created barriers, and hiring issues (e.g., recruiting staff with relevant skills) made filling these vacancies difficult.

Key supporting factors described by stakeholders included existing partnerships and resources, Organizing Entity characteristics and practices, HMG Indiana staff, HMG National Center, call center partnerships, HMG Physician Champion, and evaluation. To facilitate implementation, the Organizing Entity relied on existing partnerships and resources including supportive state agencies for infrastructure and ongoing support, existing early childhood groups to fulfill the duties of required Leadership Team and Work Groups, and shared vision and supportive communities to engage stakeholders and build momentum for implementation. Indiana's early childhood infrastructure and the willingness of preexisting groups to participate in HMG expedited the exploration and planning stages of implementation, which supported HMG's accelerated implementation plan. Secondly, an effective Organizing Entity led the initiative by assembling an engaged group of leaders and building on a history of successful partnerships. Third, Indiana benefited from a strong HMG staff that included an HMG Coordinator to oversee the day-to-day aspects of planning and implementation, Care Coordinators with extensive experience with call center implementation and technology, and Resource Specialists who have relevant backgrounds (e.g., public health and early childhood) and experience networking with stakeholders. Fourth, Indiana benefited from services and resources provided by the HMG National Center, including the affiliate network, technical assistance, and the yearly HMG forum. Fifth, rather than build a new call center and a unique database, the HMG utilized the MOMS Helpline as the Centralized Access Point and Indiana 211 to supply the HMG database. Sixth, a strong HMG Physician Champion was recruited early in the planning stage to support the initiative. The Physician Champion was highly engaged in the process and instrumental in developing the referral process and feedback loop for physicians. Her participation was essential for securing the participation of local physicians who are essential partners in successful HMG implementation. Finally, stakeholders noted that Indiana is the first HMG affiliate to utilize an evaluator during the planning and initial implementation, and through this service, a series of reports were developed to support implementation, key components of Indiana's implementation were identified to support the development of future fidelity tools, and early access to proprietary HMG planning documents was secured. Moreover, the evaluation team attended Organizing Entity meetings and calls (as requested), reviewed HMG National Center data collection tools, synthesized HMG National Center reports, attended the HMG Forum, and provided/supported HMG presentations at conferences/meetings.

Key HMG implementation strategies were identified by stakeholders and included HMG outreach, use of existing groups, call center partnerships, Organizing Entity collaborative practices, utilization of HMG technical assistance, and HMG staffing. First, HMG Indiana utilized a variety of outreach strategies, including conducting community presentations in pilot counties to build awareness and support; developing and sharing marketing materials (e.g., magnets, notepads) with families, community members, providers, and partners; using

consistent, audience-appropriate, and responsive HMG-related communication; and developing communication strategies specifically to promote HMG to physicians. Outreach was essential for engaging families, providers, and physicians to use the system, mitigating misunderstandings, building community buy-in, recruiting potential partners, and sharing information with existing partners. Secondly, HMG Indiana relied on existing groups that did similar work to staff the required HMG Leadership Team and HMG Work Groups. This strategy was utilized to implement Work Groups quickly and to minimize committee fatigue. Third, as noted above, HMG Indiana was intentional in its use of existing groups and resources. Rather than build a stand-alone call center with its own technology, HMG Indiana leveraged partnerships to house the Centralized Access Point in the MOMS Helpline and to utilize database support from Indiana 211. Fourth, to maximize group effectiveness, the Organizing Entity utilized consistent and transparent internal communication strategies to encourage participation from all members, promote shared understanding, and build trust; modified their meeting structure and frequency to accommodate project needs; and relied on professionalism to promote honest discussion and collaborative decision-making. Fifth, the Organizing Entity participated in monthly technical assistance with the HMG National Center and used the resources and tools provided by HMG to support implementation, including monthly conference calls, affiliate network, and the HMG forum. Finally, the Organizing Entity built a strong staff through targeted recruiting and hiring practices that placed an emphasis on hiring individuals who were strong fits for the positions and could serve the geographic areas targeted by the HMG pilot.

Research Question 2

Based on the literature review and interview responses, the evaluation team compiled a preliminary list of 284 operationalized fidelity criteria grouped by HMG Core Components, including 82 Data Collection and Analysis core component, 110 Centralized Access Point, 52 Family and Community Outreach, and 40 Child Health Provider Outreach criteria. Ten HMG experts rated the preliminary criteria based on perceived importance for successful implementation. After criteria scoring below the threshold were removed, 47 Data Collection and Analysis, 53 Centralized Access Point, 24 Family and Community Outreach, and 16 Child Health Provider criteria were retained. In a second survey, ten HMG experts reviewed the revised fidelity list, and criteria identified as “most essential” by at least 50% of experts were retained, and 25 final fidelity criteria were identified. These included 2 Data Collection and Analysis, 3 Centralized Access Point, 8 Family and Community Outreach, and 11 Child Health Provider Outreach. Essential criteria aligned very closely to key strategies employed during the initial implementation and focused on quality data collection to support closing the feedback loop, highly skilled Care Coordinators who have received adequate training, and outreach that utilizes existing resources and champions to engage stakeholders. Data Collection and Analysis criteria identified for Indiana focused on access to the database for call center staff and accurate tracking of referral status, which is essential for closing the feedback loop. Selected Centralized Access Point criteria focused on database competence for HMG staff, training quality, and HMG staff communication efficacy. Family and Community Outreach criteria focused on utilizing existing partners and outreach to building on existing outreach gaps, utilizing communication best practices, and recruiting families and local champions for target populations. Finally, selected Child Health Provider Outreach criteria involved soliciting feedback from the health community (including non-physician staff), identifying local physician champions, closing the

feedback loop and providing follow up to physicians, providing outreach materials, and engaging the AAP.

Unintended Findings

Research Question 1

An interesting – and unintended – finding was that even when less positive perceptions were observed on stakeholder implementation surveys, open-ended responses suggested there was a continued interest in supporting HMG among survey participants. This suggests that the shared vision and supportive early childhood community that made HMG initially possible in Indiana remains intact, and as tangible responsibilities emerge, HMG Work Groups and partners may be reengaged to support ongoing implementation.

Research Question 2

Expert consensus was limited across the four core components, especially for Data Collection and Analysis and Centralized Access Point. Two factors likely influenced this lack of consensus. As noted throughout, HMG is purposely designed to support modifications for local implementation, which was demonstrated by the large number of preliminary criteria identified for these two components. It appears that technical requirements and call center procedures vary significantly based on local context. As a result, it may be inappropriate to expect a consensus to emerge from HMG experts who work in a variety of systems. This places a much greater emphasis on local context and is consistent with the HMG National Center's fidelity work. While the local context was critical for identifying the fidelity criteria, it is possible that the timeline for this study component was inappropriate based on the implementation timeline (see limitations). In collaboration with HRSA and DOHVE technical assistance, modifications were made to the evaluation timeline to maximize local experts' ability to provide valuable responses; however, it is possible that local experts did not have sufficient experience when data were collected. While it is likely that fidelity criteria will be revisited in the future, this study did provide unintended value to the HMG Indiana planning process. Specifically, the literature review and expert interviews provided the Organizing Entity with a repository of implementation strategies that were utilized in states that had successfully implemented the system. The preliminary criteria informed planning conversations and decision making for HMG Indiana.

Limitations:

RQ1. Work Group participation was a noteworthy barrier during the implementation, and as a result, several limitations emerged including low response rates, attrition, and small sample sizes. Low response rates were particularly problematic for the Data Collection and Analysis and Child Health Provider Work Group surveys, and small sample sizes prohibited the inclusion of data in public reports. Moreover, due to factors outside of HMG, the Leadership Team and Data Collection and Analysis Work Group (which were drawn from existing ELAC groups) ceased meeting in Fall 2018 and were no longer available for evaluation activities. Across all Work Groups, operations varied across the life of the project due to recruiting issues, completion of required duties, and other factors. Given the gaps in data from these groups, special attention was given to ensuring that these groups were not unintentionally silenced by groups that participated more frequently. Responses from these groups were utilized to contextualize themes identified by the Organizing Entity to present accurate descriptions. Where applicable, data are

disaggregated by Work Group in this report to capture all voices. Moreover, disaggregated reports were provided to the Organizing Entity throughout the project.

RQ2. Misalignments between the evaluation timeline and the HMG implementation timeline created a limitation for the development of fidelity criteria. Specifically, while initial HMG implementation commenced in October 2018, local experts were interviewed from January 2018 to June 2018 and expert surveys were completed in July and August 2018. Because data collection activities preceded HMG Indiana implementation by between two and ten months, implementation planning had not been finalized, and it is likely that some local experts were inadequately prepared to rate fidelity criteria. Moreover, several modifications from the original implementation plan were made to HMG Indiana in the months immediately following the call center's opening (e.g., referral processes); these adjustments were not captured in responses from local expects. Mowbray et al. (2003) reported that expert opinions may change over the course of program implementation as partners become more competent in implementation. These factors may have influenced the limited consensus that emerged following the expert survey. To maximize the value of these findings, the evaluation team provided the Organizing Entity with ongoing access to the fidelity criteria as the list was refined to support planning and implementation. As noted above, even in their rawest form, these data provided a repository of implementation strategies utilized by established affiliates.

IX. EVALUATION SUCCESSES AND CHALLENGES

Strategies That Facilitated Implementation:

The evaluation was implemented as a partnership between Diehl Consulting Group (DCG) and state-level DCS and ISDH leadership (Organizing Entity), with support from HMG staff, the HMG Indiana Leadership Team and Work Groups, HMG National Center, HMG affiliates, and partners. The evaluation team was heavily engaged in HMG, attending Organizing Entity meetings (as requested), HMG site visit activities, HMG forum, and the MIECHV/ECCS site visit. Locally, DCG provided evaluation progress reports and solicited feedback from key stakeholders through INHVAB/HMG/ECCS meetings. The evaluation team participated in monthly and quarterly technical assistance calls with the HRSA program team and DOVHE team, which allowed Indiana to review the evaluation timeline and provide regular progress reports. As requested, the HRSA and DOVHE teams provided feedback and guidance to support the evaluation.

Successes:

Indiana was the first HMG affiliate to conduct an evaluation during the planning and early implementation phases. Through the formative evaluation, the Organizing Entity was provided a series of reports to support implementation, including 1) Monthly Checkpoint Reports and 2) Organizing Entity, Leadership Team, and Work Group Checkpoints. Secondly, the evaluation identified key components of Indiana's implementation to support future fidelity tools. Moreover, this process established a repository of implementation strategies that were successfully employed by veteran affiliates. The required MIECHV evaluation planning process provided early access to the HMG Manual, HMG Roadmap to Replication, and other proprietary planning documents prior to the HMG contract finalization. Finally, the evaluation team has

supported the Organizing Entity in well-received HMG presentations at the HMG Forum, First Steps Conference, and Institute for Strengthening Families.

Challenges:

Timeline misalignment: Due to implementation delays, timeline misalignments between the approved evaluation plan and HMG implementation created challenges as the evaluation team worked to maximize the usefulness of evaluation products and lessen data collection burdens on HMG staff and stakeholders. This was especially evident during the early planning months of the project as the evaluation team worked to balance the deadlines imposed by the evaluation plan with the need for stakeholders to become better acclimated with HMG to provide valuable responses to surveys and focus groups.

Inconsistent operations of collaborative partners: Work Group and Leadership Team operations varied across the life of the project due to recruiting challenges, completion of required duties, and other factors. State-level leadership changes caused a hiatus for all ELAC groups, which impacted the Data Collection and Analysis Work Group and the HMG Leadership Team.

Varied and small sample sizes: Work Group participation in evaluation activities was mixed, which affected response rates and sample sizes. Ultimately, some Work Group responses could not be reported publicly due to small sample sizes. To address this challenge, the evaluation team worked closely with the Organizing Entity to understand the implementation timeline and stakeholders' readiness to participate in the evaluation, and as necessary, modifications were made to the timeline to accommodate stakeholders. During monthly technical assistance calls, the evaluation team sought guidance from the HRSA program team and DOHVE team, and this feedback was incorporated into modified evaluation timelines. To maximize participation, existing meeting times and spaces were utilized for focus groups. This provided a captive audience and eliminated the need for stakeholders to make dedicated trips to participate. The Organizing Entity served as the conduit through which surveys were administered to stakeholders, which increased buy-in. The Organizing Entity were heavily involved in the evaluation process and met with the evaluation team at least monthly to review methods and planning.

Adherence to Plan / Deviations:

The evaluation was completed in adherence to the approved evaluation plan. No deviations were made to the design, evaluation questions, data collection instruments or procedures, or timeline without approval from HRSA.

X. CONCLUSIONS, IMPLICATION OF FINDINGS, AND RECOMMENDATIONS

Key Findings:

While there were considerable deviations from the normal implementation timeline, HMG Indiana was implemented in accordance with tasks described in the HMG Manual and the HMG Roadmap to Replication. As of July 2019, nearly all implementation tasks included in the Indiana Roadmap to HMG Replication were completed, and while some delays were noted, Indiana generally completed assigned tasks during or prior to the month for which those tasks were assigned. These tasks were accomplished utilizing targeted HMG-specific outreach to engage stakeholders, use of existing groups and resources to fill HMG required positions, leveraging partnerships to implement the call center without creating new systems or technology,

securing strong leadership from an engaged, collaborative Organizing Entity, utilization of HMG technical assistance (including the affiliate network and HMG forum) to identify best practices and implementation support, and intentional HMG recruiting and hiring practices. Perceptions of implementation varied, with the Organizing Entity and Leadership Team providing mostly positive responses, and Work Groups providing mixed responses across survey administrations. Generally, the highest ratings were observed in early 2018, and lower ratings began to emerge as the call center rollout approached. Leadership Team and Work Group ratings continued to decrease in subsequent survey administrations once the call center was implemented. Open-ended responses suggested that less favorable ratings may be associated with unclear goals/tasks and perceptions of decreased agency in the implementation process. Other implementation barriers identified by stakeholders included misalignments between HMG technical assistance offerings and Indiana's needs due to Indiana's accelerated timeline, difficulty recruiting and maintaining participation from Work Group members, limited understanding of HMG among partners, demanding funding timelines and budget requirements, barriers related to the Centralized Access Point, and staff turnover and recruitment struggles.

Through a second study component, 25 final fidelity criteria were identified to support the development of fidelity instruments and a future fidelity study. Final criteria aligned very closely to key strategies employed during the initial implementation and focused on quality data collection to support closing the feedback loop, highly skilled Care Coordinators who have received adequate training, and outreach that utilizes existing resources and champions to engage stakeholders.

Implications:

Through this initiative, Indiana successfully planned and implemented HMG in the nine MIECHV counties and the ECCS community. While modifications were made to the timeline, HMG was replicated as designed and was implemented in accordance with the implementation plan. Through this initiative, those communities have access to a fully functioning call center that connects families and providers to personalized resources and ongoing follow up, provides free developmental screening using the Ages and Stages Questionnaire (ASQ), and closes the feedback loop with physicians, and home visitors through care coordination services.

A review of implementation strategies revealed that Indiana implemented the system by leveraging multiple funding sources and collaborations between state agencies and various partners. Indiana conducted targeted outreach to build buy-in, secured existing groups to fulfill HMG Work Group responsibilities, used existing infrastructure to support the call center, and took advantage of technical assistance. Implementation was supported by the availability of existing partnerships and resources, a dedicated Organizing Entity, high quality staff, access to support for the HMG National Center and affiliate network, partnerships with MOMS Helpline and Indiana 211, an engaged physician champion, and ongoing evaluation activities. Barriers experienced included technical assistance misalignments resulting in Indiana's accelerated timeline, barriers engaging Work Groups, partners' limited understanding of HMG, call center implementation issues, and difficulties recruiting and retaining staff. Surveys and focus group responses suggested that Organizing Entity and Leadership Team overcame the majority of these barriers and generally maintained positive perceptions of the implementation; however, the findings suggest that some partners would have benefited from defined tasks/responsibilities and

clearer communication of group purpose from the Organizing Entity. The results highlight opportunities to refine Work Group purposes and communication as the system is continued and expanded. Overall, the findings demonstrate that Indiana has the infrastructure necessary to secure diverse funding sources and partners to implement a large-scale project successfully.

Through the fidelity component, key implementation practices were identified to support the ongoing implementation of HMG, as well as future expansions. Essential criteria aligned very closely to key strategies employed during the initial implementation and focused on quality data collection to support closing the feedback loop, highly skilled Care Coordinators who have received adequate training, and outreach that utilizes existing resources and champions to engage stakeholders. In addition to the final fidelity criteria, the Organizing Entity and program staff can utilize best practices identified in earlier iterations for additional implementation guidance.

Recommendations:

1. Build on HMG Partnerships to Support Future Initiatives: As noted in this report, the successful implementation can be contributed in part to Indiana's early childhood system and the partnerships among these entities. Given the value of these partnerships, efforts should be considered to maintain and expand these relationships to support the creation of new initiatives. Stakeholders are encouraged to review survey and focus group responses to identify areas in which gaps may have occurred. Where applicable, consideration should be given to increasing partners' voice in programmatic decision making and clearly identifying and communicating group roles and responsibilities.

2. Continue to Support the HMG Affiliate Network: Based on the unique aspects of Indiana's HMG planning and implementation, as well as the evaluation findings available, Indiana has the opportunity to provide valuable support to their peers in the HMG Network. As applicable, Indiana should remain engaged in the affiliate network to share its implementation successes, barriers, and lessons learned.

3. Utilize Fidelity Criteria to Support Refinements: Through the fidelity component, local consensus was achieved for 25 HMG implementation practices. As refinements to the model are made and expansion considered, these practices should be reviewed and incorporated into policies and procedures. Moreover, earlier iterations of the fidelity criteria should be reviewed regularly to identify additional best practices.

4. Reengage HMG Stakeholders to Support HMG Continuation and Expansion: As noted in participant responses, Work Group and Leadership Team members remain supportive of HMG and its vision in spite of barriers that hindered participation. When defined responsibilities or tasks emerge for these groups, the Organizing Entity is encouraged to reengage existing stakeholders for support.

5. Continue and Expand Home Visitor Use of HMG: Organizing Entity members noted that additional work was necessary to engage the home visiting community fully in the HMG system. The Organizing Entity is encouraged to consider successful strategies identified in this evaluation, including targeted outreach, identifying local champions, and utilizing existing systems and resources when engaging with home visitors. Moreover, continued collaborations with affiliates who have succeeded in this area are recommended.

XI. PLAN for DISSEMINATION of EVALUATION FINDINGS and PROGRAM OUTCOMES

The dissemination plan will include opportunities for sharing lessons learned through the development and implementation of HMG to all MIECHV formula recipients and to the home visiting field broadly. The evaluation team and MIECHV innovation assigned staff will participate in an ongoing virtual peer network that convenes no less than quarterly throughout the project period in order to facilitate the exchange of lessons learned, promote strategies for effective development and implementation, and improve the quality of grantee-led evaluation. As part of the dissemination plan, Indiana will contribute to the HMG National Center annual evaluation, including the HMG Fidelity Assessment Tool and National Common and Impact Indicators. This evaluation process is supported by each HMG state affiliate, which submits data that was collected from calls to the state's HMG centralized access point, community outreach efforts, and physician outreach throughout the past calendar year. This report of nationwide aggregated data is expected to demonstrate the impact of HMG, which aids HMG and its affiliates with advocacy and sustainability efforts. Indiana-specific findings will be shared at the HMG annual forum. Additionally, the HMG Replication Report may be shared at the annual national meeting of MIECHV grantees as part of the dissemination plan.

Locally, interim reports will be shared with the early childhood system stakeholders as part of the dissemination process within the state to help identify gaps in services, particularly for these primary needs. Local stakeholders include the Early Learning Advisory Council (ELAC) and all working subgroups, Indiana Home Visiting Advisory Board (INHVAB), and Indiana Early Childhood Comprehensive Systems (ECCS). Sharing opportunities include meetings, conferences, and the ISDH/DCS MIECHV website. Additionally, these reports will be shared with the Federal program staff and technical assistance staff, as the State MIECHV team provides updates on the progress of the grant. Other national stakeholders include the Home Visiting Coalition, the Association of State and Tribal Home Visiting Initiatives (ASTHVI), and the Association of Maternal & Child Health Programs (AMCHP). Finally, conference presentations, including the Institute for Strengthening Families, will be considered during the project.

References

Bond, G. R., Evans, L., Salyers, M. P., Williams, J., & Kim, H. W. (2000a). Measurement of fidelity in psychiatric rehabilitation. *Mental Health Services Research, 2*(2), 75–87.

Bond G., Williams J., Evans L., Saylers, M. Kim, H.W., Sharpe, H., & Leff, H.S. (2000b). *Psychiatric rehabilitation fidelity toolkit*. Cambridge, MA: Human Services Research Institute.

Cherry, A. J. (2000). *A research primer for the helping professions: Methods, statistics, and writing*. Australia: Brooks/Cole.

Comrey, A., & Lee, H. (1992). *A first course in factor analysis.* Hillsdale, NJ:Erlbaum.

Easton, K.L., Fry McComish, J., & Greenberg, R. (2000). Avoiding common pitfalls in qualitative data collection and transcription. *Qualitative Health Research, 10*(5), 703-707.

Foley, G., & Timonen, V. (2015). Using Grounded Theory Method to Capture and Analyze Health Care Experiences. *Health Services Research*, *50*(4), 1195–1210.

Fowler, F. J. (2004). Interview schedule. In M. S. Lewis-Beck, A. Bryman & T. Futing Liao (Eds.), *The SAGE encyclopedia of social science research methods*: Sage.

Garvin, E. C., Cannuscio, C. C., & Branas, C. C. (2013). Greening vacant lots to reduce violent crime: a randomised controlled trial. *Injury Prevention, 19*(3), 198-203.

Giesler, L. J., & Hodge, M. (1998). Case management in behavioral health care. *International Journal of Mental Health*, *27*, 26–40.

Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory: Strategies for qualitative research.* Chicago: Aldine.

Help Me Grow National Center. (2014). *The Help Me Grow manual.* Hartford, CT: Help Me Grow National Center.

Help Me Grow National Center. (2017) Measuring impact. Retrieved from https://helpmegrownational.org/what-we-do/measuring-impact/.

Help Me Grow National Center. (2019) Technical assistance. Retrieved from https://helpmegrownational.org/what-we-do/technical-assistance/.

Holter, M.C., Mowbray, C.T., Bellamy, C.D., MacFarlane, P., & Dukarski, J. (2004). Critical ingredients of consumer run services: Results of a national survey. *Community Health Journal, 40*(1), 47-63.

James Bell Associates (2009). *Evaluation brief: Measuring implementation fidelity*. Arlington, VA.

Kelly, J. A., Heckman, T. G., Stevenson, L. Y., &Williams, P. N. (2000). Transfer of research-based HIV prevention interventions to community service providers: Fidelity and adaptation. *AIDS Education and Prevention*, *12*, 87–98.

Krueger, R.A. (2006a). Is it a focus group? Tips on how to tell. *Journal of Wound, Ostomy and Continence Nursing, 33*(4), 363-366.

Krueger, R.A. (2006b). Analyzing focus group interviews. *Journal of Wound, Ostomy and Continence Nursing, 33*(4), 363-366.

Krueger R. A. & Casey M. A. (2010). Focus group interviewing. In J. Wholey, H. Hatry, & K. Newcomer (Eds.), *Handbook of Practical Program Evaluation* (378-403). San Francisco: Wiley.

Krueger R. A., Casey M. A. (2014). *Focus groups: A practical guide for applied research.* 4th. Los Angeles, CA: Sage.

Kvande, M., Lykkeslet, E., & Storli, S. L. (2017). ICU nurses and physicians dialogue regarding patients clinical status and care options — a focus group study. *International Journal of Qualitative Studies on Health and Well-Being, 12*(1), 1267346.

Larossa, R. (2005). Grounded theory methods and qualitative family research. *Journal of Marriage & Family, 67*(4), 837-857.

Lindof, T. R., & Taylor, B. C. (2011). *Qualitative communication research methods* (3rd ed.). Los Angeles: Sage.

Marty, D., Rapp, C. A., & Carlson, L. (2001). The experts speak: The critical ingredients of strengths case management. *Psychiatric Rehabilitation Journal, 24*(3), 214-221

McGrew, J. H., & Bond, G. R. (1995). Critical ingredients of assertive community treatment: Judgments of the experts. *Journal of Mental Health Administration, 22*, 113-125.

McGrew, J. H., Bond, G. R., Dietzen, L. L., & Salyers, M. P. (1994). Measuring the fidelity of implementation of a mental health program model. *Journal of Consulting and Clinical Psychology, 62,* 670–678.

Mills, S. C., & Ragan, T. J. (2000). A tool for analyzing implementation fidelity of an integrated learning system (ILS). *Educational Technology Research and Development*, *48*, 21–41.

Mowbray, C.T., Holter, M.C., Teague, G.B., & Bybee, D. (2003). Fidelity criteria: Development, measurement, and validation. *American Journal of Evaluation, 24*(3), 315-340.

Permanency Innovations Initiative Evaluation Team (PII-ET). (2015). *The Permanency Innovations Initiative (PII) approach to evaluation.* OPRE Report 2015-86. Washington, DC: US Department of Health and Human Services, Administration for Children and Families, Children's Bureau, and Office of Planning Research, and Evaluation.

Permanency Innovations Initiative Training and Technical Assistance Project & Permanency Innovations Initiative Evaluation Team. (2013). *The PII approach: Building implementation and evaluation capacity in child welfare* (Rev. ed). Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau, and Office of Planning, Research and Evaluation.

Tabachnick, B.G, & Fidell, L.S. (2001). *Using multivariate statistics*. Needham Heights, MA: Allyn & Bacon.