Maternal, Infant and Early Childhood Home Visiting (MIECHV) Program

Formula Grant X10MC32190 Final Report

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I. PROGRAM SUMMARY

Indiana MIECHV is co-led by the Indiana State Department of Health (ISDH) and the Indiana Department of Child Services (DCS). Indiana's MIECHV vision is to improve health and development outcomes for children and families who are at risk through achievement of the following goals: 1) Provide appropriate home visiting services to women, their infants and families who are low-income and high-risk; 2) Develop a system of statewide coordinated home visiting services that provide appropriate, targeted, and unduplicated services and locally coordinated referrals; 3) Coordinate necessary services outside of home visiting programs to address needs of participants.

Indiana successfully implemented MIECHV Formula-funded services in the communities outlined in this final report. As of September 30, 2020, Indiana has served 10,915 families through 260,733 home visits with MIECHV funding since its inception.

Project Description:

The purpose of Indiana MIECHV is to support the delivery of coordinated and comprehensive high-quality voluntary early childhood home visiting services to eligible families. The project aimed to sustain MIECHV-funded services provided by two existing, evidence-based home visiting programs, Healthy Families Indiana (HFI) and Nurse-Family Partnership (NFP). From 10/1/2019 – 9/30/2020, FY18 funds were used to provide home visiting services to 954 new families in the high-risk areas of Indiana as identified in the *Needs Assessment for the Maternal, Infant and Early Childhood Home Visiting Program* dated September 2010 (MIECHV Needs Assessment), *Building Healthy Futures: The Indiana Maternal, Infant & Early Childhood Home Visiting Program Needs Assessment 2017* and the 2012 IN Natality Report. These areas include Elkhart, Lake, LaPorte, Marion, Scott, and St. Joseph Counties[1].

[1] Indiana served MIECHV-funded families in Delaware, Grant and Madison counties during the FY18 project period, however, these families were funded with FY17 MIECHV dollars and not FY18 funding. As indicated in the application for FY18 funding, discontinuation of service to MIECHV-funded families in Grant, Delaware and Madison counties did not result in lack of evidenced-based home visiting in those communities. Alternate funding (state and federal) available in those communities had capacity to serve need for voluntary evidenced-based home visiting in those communities during the FY18 project period. No MIECHV-funded families were terminated from service based on lack of funding.

This FY2018 Formula award contributed to the provision of MIECHV-funded HFI services for 1,468 families and MIECHV-funded NFP services for 607 families. Both HFI and NFP paired families – particularly low-income, single-parent families – with trained professionals who provided parenting information, resources and support during a woman's pregnancy and throughout a child's first few years. These models have been shown to make a real impact on a child's health, development, and ability to learn – such as health care, developmental services for children, early education, parenting skills, child abuse prevention, and nutrition education or assistance. There is strong research evidence that these models can also yield Medicaid savings by reducing preterm births and the need for emergency room visits.

HFI continued the mental health consultation enhancement that was originally conceived through provision of MIECHV Competitive funding and approved by Healthy Families America (HFA).

Goals and Objectives:

The overall vision of Indiana MIECHV is to improve health and developmental outcomes for children and families who are at risk. This vision is accomplished through the following goals and objectives:

1. **Provide appropriate home visiting services to women residing in Indiana (based on needs) who are low-income and high-risk, as well as their infants and families.**
   a. *By 9/30/20, continue program implementation serving at least 1,660 new and continuing families*
   ✓ X10MC32190 funds supported direct home visiting service of 2,075 new and continuing MIECHV-funded families via 28,436 home visits provided during the October 1, 2019 through September 30, 2020 reporting period.
      i. *HFI will serve 1068 MIECHV-funded families in Elkhart, Lake, LaPorte, Marion, Scott, St. Joseph and Vanderburgh[2] counties*
      ✓ HFI served 1468 MIECHV-funded families in Elkhart, Lake, LaPorte, Marion, Scott, and St. Joseph counties.
      ii. *NFP will serve 592 MIECHV-funded families in counties as identified during the Request for Application (RFA) process[3]*
      ✓ NFP served 607 MIECHV-funded families in Elkhart, LaPorte, Marion, and St. Joseph counties.
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 to all children, mothers, and families who are high-risk throughout Indiana.**
   a. *By 9/30/20, inform organizations in Indiana [that currently serve as a referral source for home visiting programs] regarding referral coordination and continuation of services in order to provide appropriate, targeted, and unduplicated services to all children, mothers, and families who are high-risk throughout Indiana.*
      i. *Facilitate meetings of INHVAB with key representatives from state level social service departments.*
      ✓ Indiana Home Visiting Advisory Board (INHVAB): The goal of INHVAB is to

[2] Indiana elected not to implement MIECHV-funded services in Vanderburgh county as alternate funding available in those communities had capacity to serve the need for voluntary evidenced-based home visiting in those communities during the FY18 project period.
[3] Goodwill Industries of Central and Southern Indiana and Goodwill Industries of Michiana were successful in the competitive bid process – as required by Indiana state policy.

coordinate, promote and define Home Visiting efforts in Indiana and to utilize data to assess need, identify service gaps, maximize resources and inform policy to improve health and developmental outcomes for Hoosier families and children. INHVAB membership has included: ISDH, DCS, Department of Workforce Development (DWD), Department of Education (DOE) and multiple divisions of the Family and Social Services Administration (FSSA) – including the Office of Early Childhood and Out of School Learning (OECOSL), First Steps/Bureau of Child Development Services, Indiana Head Start Collaboration, Office of Youth Services/Division of Mental Health and Addiction (DMHA), Policy/Temporary Assistance for Needy Families (TANF), and Office of Medicaid Policy and Planning.

- ✓ In July 2020, Indiana initiated a INHVAB Facilitation contract with Diehl Consulting. This contract includes the coordination of INHVAB meetings and members, as well as the facilitation goals of:
  - Creating an efficient meeting "space" that maximizes the value of time for participants
  - Facilitate discussions to meet advisory needs of general advisory needs Assist with identifying and recruitment potential collaborative partnerships/member
  - Facilitate invigoration and/or repurposing of advisory board – communicate to collaborative partners, potential board members to see work progressing and moving from state to local teams and vice versa
- ✓ A survey of members was created and administered to INHVAB members to collect information about how INHVAB contributes to their daily work, what members can contribute back to the INHVAB, and preferred logistics for communication and meetings.
- ✓ The INHVAB and Early Childhood Comprehensive Systems (ECCS) state advisory council meetings (held jointly since April 2017) illustrate efficient collaboration to provide coordinated services for Hoosier families. Meetings include MIECHV evaluation, CQI and data outcome updates, as well as ECCS efforts, and partner sharing. Indiana continues to view this combined meeting as a success, with typical attendance of more than 20 individuals. The INHVAB/ECCS quarterly meetings supported very successful site visits from HRSA[4] and Help Me Grow National Center during the FY18 project period. As illustrated in Figure A.
- ✓ As part of the implementation process for Help Me Grow Indiana (HMGIN)[5], several community meetings were conducted introducing HMGIN to local community service providers and state partners. In February 2019, a post-launch site visit from Help Me Grow National Center was held in Indiana to celebrate the pilot implementation and continue informing state and local partners around activities related to HMGIN.

[4] Compliance Review Site Visit Report, Indiana State Department of Health, Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB), Division of Home Visiting and Early Childhood System (DHVECS) Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program, Prepared by: DSFederal, Inc. July 2019.

[5] Implementation and pilot activities for HMGIN funded by joint effort of Indiana MIECHV UH4 Innovation funds and ECCS Impact funds.

Figure A- From the MIECHV 2019 Compliance Review Site Visit Report

The INHVAB meets quarterly, at a minimum. Among planning and collaborative projects on the agenda, the INHVAB also receives ECCS and MIECHV updates including information about evaluations, performance measures, CQI, and HMG integration.

Combining the INHVAB brought real value, member commitment, effectiveness, and efficiency to the process. The INHVAB achieves clear, tangible results. For example, one member noted that with the help of the board, their organization was able to receive a grant award where they had previously failed.

The INHVAB routinely explores opportunities for systems strengthening. For example, the INHVAB is currently exploring the consequences of social determinants (including poverty) on child and adolescent health and well-being. Members will explore the role each member organization agency plays to address social determinants and then look for systems improvement opportunities.

The board not only provides considerable strength to IN home visiting, but it also strengthens other early childhood organizations and the state system overall. While on site, the MIECHV compliance review team attended the INHVAB meeting. Comments shared during the meeting about this collaboration demonstrate this:

> "Indiana has worked hard at getting out of silos and working together. This board is a perfect example of that, and programs from almost every state agency are here. We go back to our offices and share what we learned. Working smarter not harder, not duplicating services, trying to be the best. It is consoling to see the same people in this room for the past five years as well."
>
> "The real value looking around the room is seeing so many familiar faces and the level of trust, not just relationship building. All in the room have a holistic goal of helping children and families and not duplicating services."
>
> "By having this network of early childhood professionals where everyone comes with a different lens, we've been able to make connections outside of this world, leverage this relationship and connection through early childhood into other projects. The consistency in the people and the willingness that someone is here to represent the agency and bring the information back, fosters relationship, and synergy around a common goal."
>
> "Collecting data about all of our initiatives and projects brings value. We started with no data. It is good how we are all collecting measurements, using technology, have evaluators in the room, provide graphs, quantitative data, and qualitative data to show our results – the good and bad and being able to make decisions using that data. It's important that real-time data is part of the process."

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, housing, employment training and adult education programs.**
    - Help Me Grow Indiana (HMGIN) launched in October 2018. During the FY18 project period, the implementation of HMGIN was still considered to be in the pilot phase. Data collection and reporting, as well as alignment and integration with similar initiatives, were still being developed.
    - When creating specific activities to meet the Indiana goal of coordinating services to address needs of participants for the FY18 project, HMGIN was still completing implementation tasks and had not yet begun the pilot to assist families in navigating resources. Indiana's MIECHV activities related to this goal assumed the pilot implementation of HMGIN would achieve the data connections necessary to report on families referred and served via API connectivity. As of the end of this project period, API is not in place to affirm which families are referred from home visitors or which HMGIN families are also participating in home visiting services.

- ➢ In early 2020, HMGIN data were merged with an existing database platform that is a HIPPA protected environment. While this change created efficiency in resources and placed the data in a HIPPA protected environment, HMGIN data from the 2018 and 2019 time periods were lost during the merge.

a. *Referral coordination will be provided by Help Me Grow Indiana for MIECHV-funded families in Indiana with children who screen positive for concern for developmental delay by 9/30/2019.*
   - ✓ During the 10/1/2018 – 9/30/2019 reporting period:
     - 2022 developmental screens were conducted on MIECHV-funded index children
     - 130 screens were positive for concern for developmental delay for 108 distinct MIECHV-funded index children
   - ✓ Counts that were kept outside the data system indicate that from October 2018 – September 2019 indicate that 138 families were connected to referrals through HMGIN and of these clients 91 indicated that their needs were met.

b. *Referral coordination will be provided by Help Me Grow Indiana for MIECHV-funded families in Indiana who require additional services beyond home visiting by 9/30/2020.*
   - ✓ From January 1, 2020- September 30, 2020:
   - ✓ HMGIN indicates there were 296 client interactions. Specifically, counties where MIECHV-funded families are served[6]:
     - Marion Co: 195
     - Lake: 11
     - Elkhart: 5
     - St. Joseph: 11
     - Laporte: 2
     - Scott: 0

Indiana's goals and objectives were determined in alignment with the overall goals and objectives of the entire federal MIECHV project. Both projects (Indiana MIECHV and MIECHV overall) aim to strengthen and improve the programs and activities carried out under Title V of the Social Security Act, improve coordination of services for at risk communities, and identify and provide statewide comprehensive services to improve outcomes such as: improved maternal and child health; prevention of child injuries, child abuse, or maltreatment, and reduction of emergency department visits; improvement in school readiness and achievement; reduction in crime or domestic violence; improvements in family economic self-sufficiency; and improvements in the coordination and referrals for other community resources and supports for eligible families through implementation of evidence-based, voluntary, home visiting models.

Funded Activities:

Infrastructure Building

Indiana began this project with the infrastructure in place to support home visiting services described and the enhancement of HFI mental health consultation. As noted in Key Changes and in Challenges and Strategies sections below, some changes in infrastructure did occur during the project period. Indiana ultimately views these changes as positive for Indiana MIECHV activities.

Home Visiting Program Services

X10MC32190 funding supported home visiting services to MIECHV-funded families in Elkhart, Lake, LaPorte, Marion, Scott and St. Joseph counties during the FY20 reporting period.

[6] This report does not include HMGIN client interactions for counties where MIECHV-funded families are not served. The total client interactions these counties will not equal 296. 41 client interactions did not include county information.

- High risk clients were identified by HFI assessment staff utilizing an Eight Item Screen that measures risks. Additionally, potential HFI clients must score above 40 on the Parent Survey Process. If families score 25 or above and have additional risk factors– they may have also been offered services.
- High-risk NFP clients were identified by referral through community agencies such as schools, clinics, and grassroots neighborhood organizations. NFP in Indiana completes extensive community networking in order to educate referral partners on the program eligibility (first time mom, enrollment at or prior to 28 weeks gestation) as well as the program's goals to reach high-risk and low-income clients.

During the 2019-2020 reporting period, Indiana served 1,654 low income households, 228 pregnant women who had not attained age 21, 529 households with a history of child abuse or neglect or having had interactions with child welfare services, 233 families with history of substance abuse or need for substance abuse treatment, 237 families who identified users of tobacco products in the home, 171 families with children identified with low student achievement, 100 families with children with developmental delays or disabilities, and 25 families who currently serve or have served in the armed forces.

The ISDH MIECHV Coordinator and the DCS MIECHV Grant Coordinator reviewed Quality Assurance (QA) activities for MIECHV LIAs within their respective agencies. The coordinators monitored data collection practices and reporting requirements for assurances that performance measurement constructs and evaluations were measured appropriately. At least quarterly, the coordinators reviewed all performance measurement data along with monitoring program utilization, process measures and data collection compliance to address concerns identified through technical assistance to LIAs. Fidelity to model was monitored by program as described below and reported back to the coordinators.

HFI is accredited by HFA as a state-wide multi-site system, which allows DCS to Centrally Administer the Healthy Families Program. As such, DCS and HFI are subject to exceptionally strict guidelines for model fidelity and has an extensive state-wide QA mechanism. The QA team monitored each of the MIECHV funded sites, in the same manner as all HFI sites, which has been shown to be a highly effective process in attaining successful model fidelity and child abuse prevention. Activities involved in HFI QA:

- Review of adherence to HFI (statewide) policies–including administration of home visiting services, data collection, and reporting requirements.
- Monitor adherence to HFA accreditation standards, including review of local self-study responding to all standards.
- Assist with HFA accreditation activities–including Central Administration review.
- Monitor supervision–HFI sites are required to provide weekly face-to-face supervision to all frontline staff by a qualified supervisor, for a minimum of 2 hours. Supervision has specific components that encompass case review, skill development and staff support. HFA outlines the areas to be covered in accreditation standards.
- HFI sites are required to provide monthly face-to-face supervision of all supervisors which include all of the above categories as well as agency and management issues. Most sites choose to do this at least twice per month.
- Monitor training–All HFI supervisors receive CORE supervisors training as well as meeting all the same requirements as staff.

- Managers are trained by a certified HFA trainer. This training includes extensive mentoring in providing accountability, clinical supervision and emotional support to all levels of staff.
- Provide technical assistance and training related to quality assurance. All HFI sites have access to extensive TA which can include staffing cases and mentoring of supervisors and managers.

The ISDH maintained a contract with the NFP National Service Office (NSO) for support in NFP service implementation. This included program development, nurse consultation, and program quality support. Quality data reports and answers for NFP-related inquiries on a were available on a continual basis. A component of the reporting includes the model fidelity report. In 2012, the NSO instituted a quarterly program fidelity report to track team and agency fidelity to the 18 NFP model elements. The fidelity reports are reviewed quarterly by ISDH to ensure LIA compliance with NFP model elements. During implementation update monitoring meetings, ISDH reviews fidelity reports with NFP LIAs. NFP LIAs are also contractually required to submit monthly information on capacity, which is tracked over the reporting period. Additionally, an annual site visit is conducted by the Home Visiting Program Manager and ISDH MIECHV Coordinator to review program operations.

Figure B – From the MIECHV 2019 Compliance Review Site Visit Report

HFI LIAs maintain appropriate supervision and staff support. Home visitors receive a minimum of two hours of weekly supervision through case review, coaching, guidance, training, and reflection. Programs maintain appropriate supervisor-to-staff ratios. HFI LIAs are reviewed annually by the QA TA contractor, and the state of IN is also reviewed by the HFA national office to review supervision practices and compliance with model fidelity. Fidelity is also reviewed during the quarterly data meetings as needed (further described in the Summary of the *Programmatic Requirement: Data Collection and Reporting*). The IN-MIECHV team supports LIAs through ongoing training on reflective supervision, initial HFA supervisor training, ongoing training at the ISF, and one-on-one training assistance through the QA TA team.

NFP LIAs support home visitors through reflective supervision and case conferences. Nurse home visitors and supervisors receive education and professional development related to reflective supervision, online training, face-to-face education, and webinars. Nurse supervisors provide biweekly reflective supervision and biweekly case conferences. The NFP National Service Office (NSO) generates quarterly reports that include the frequency of supervision and case conferences. The NFP State Nurse Consultant (SNC) and the ISDH home visiting coordinator monitor the data and collaborate with the LIA to implement quality improvement processes as needed.

Meeting Legislatively Mandated Reporting: Performance Measurement - As detailed in Indiana's 2019 MIECHV Performance Measurement, Data Collection, and Data Analysis Plan, client specific data were collected and entered by assessment workers, home visitors, data coordinators, and supervisors. QA staff and data coordinators assured data were entered correctly and timely into respective data systems. Data system providers reviewed collected data for errors. State level and contracted data analysis staff also reviewed data specific to de-identified families. Site specific and community level data were collected monthly to quarterly; state level data, collaborative indicators, and full demographic analysis were completed annually. Data collection occurred via pencil forms, tools and interview notes, online surveys, data transfer as well as electronic data collection and transfer.

Indiana's X10MC32190 funds contributed to these Performance Indicator outcomes:

- Among mothers who enrolled in home visiting prenatally before 37 weeks, 12.4% of infants were born preterm. This is an improvement from FY18 and FY19 performance reporting;

- 91% of primary caregivers were screened for depression within 3 months of enrollment or within 3 months of delivery (for those enrolled prenatally);
- 42.8% of mothers enrolled in home visiting prenatally or within 30 days after delivery received postpartum visit with healthcare provider within 8 weeks of delivery;
- 61.9% of infants were always placed to sleep on their backs, without bed-sharing or soft bedding;
- 89.03% of children had a family member that read, told stories, and/or sang songs daily during a typical week;
- Caregivers were asked if they had any concerns regarding their child's development, behavior, or learning on 97.79% of the home visits;
- 89.86% of children enrolled with positive screens for developmental delays received services in a timely manner.

Indiana focused on data quality during the 2019-2020 reporting period and achieved a reduction in missing data for the performance measures:

- Form 1 –
    - Table A.1 Gender –
        - Adults – 0 missing data points! or 0.0% (down from 15 missing data points or 0.61% in FY19)
        - Index Children – 16 missing data points or 0.87% (down from 24 missing data points or 1.3% in FY19)
    - Table A.4 Adult Age – 22 missing data points or 1% (down from 31 missing data points or 1.3% in FY19)
    - Table A.8 Marital Status – 40 missing data points or 1.8% (down from 69 missing data points or 2.8% in FY19)
    - Table A.10 Employment – 124 missing data points or 5.7% (down from 191 missing data points or 7.8% in FY19)
    - Table A.11 Housing – 47 missing data points of 2.2% (down from 104 missing data points or 4.2%)
    - Table A.12 Language – 1 missing data point! or 0.05% (down from 5 missing data points or 0.27% in FY190
    - Table A.14 Priority Populations
        - Household contains an enrollee who is pregnant and under age 21 – 1 missing data point! or 0.05% missing data (down from11 missing data points or 0.5% in FY19)
        - Household has a history of substance abuse or needs substance abuse treatment – 60 missing data points or 2.9% (down from 1,763 missing data points or 75.7% in FY19)
        - Someone on the household uses tobacco products in the home – 83 missing data points or 4% (down from 1,025 missing data points or 44% in FY19)
        - Household includes individuals who are serving or formerly served in the US armed forces – 55 missing data points or 2.7% (down from 106 missing data points or 4.6% in FY19)
- Form 2 –
    - PM 1 Preterm Birth – 6.94% missing (down from 8.35% missing in FY19
    - PM 6 Tobacco Cessation Referrals – 18.26% (down from 42.33% missing in

FY19)

- PM 7 Safe Sleep – 5.56% (down from 8.56% missing in FY19)
- PM 8 Child Injury – 0.92% (down from 14.54% missing in FY19)
- PM 11 Early Learning Language and Literacy Activities – 6.9% (down from 10.26% in FY19)
- PM 13 Behavioral Concerns – 0.41% (down from 0.6% in FY19)
- PM 18 Completed Developmental Referrals – 11.79% (down from 58.39% in FY19)

Needs Assessment

As required by the Bipartisan Budget Act of 2018, Indiana conducted an update to the statewide needs assessment to ensure home visiting resources are targeted to at-risk communities using FY18 funds. The Indiana MIECHV Statewide Needs Assessment 2020 Update (2020 Update) was submitted October 1, 2020 and is still under review. Highlights from the submitted, but not final approved document follow.

Indiana selected the HRSA simplified method with modifications for identifying communities with concentrations of risk. The utilization of additional data to reflect Indiana context, as provided for in the HRSA guidance, incorporated two additional domains and six additional indicators. Specifically, Indiana expanded the Adverse Perinatal Outcomes domain by adding infant mortality rates and created two additional domains to capture domestic violence and maternal health indicators. While domestic violence was excluded from the HRSA-provided data and considered a limitation due to lack of national sources of county-level data, Indiana was able to include state-sourced indicators of victims and fatalities. Data for infant mortality, domestic violence, and maternal health were included in previous Indiana needs assessments, and represent indicators that focus on populations receiving home visiting services and align with the Indiana culture of reducing infant mortality. In total, Indiana analyzed seven domains consisting of 19 indicators.

Table A - Indiana Domains and Indicators

Socioeconomic Status	Adverse Perinatal Outcomes	Substance Use Disorder	Crime	Child Maltreatment	Maternal Health*	Domestic Violence*
• Poverty • Unemployment • High School Dropout • Income Inequality	• Preterm Birth • Infant Mortality Rate* • Low Birth Weight	• Alcohol • Marijuana • Illicit Drugs • Pain Relievers	• Crime Reports • Juvenile Arrests	• Child Maltreatment	• Smoking During Pregnancy* • Not Breastfeeding* • No Early Prenatal Care*	• Victims* • Fatalities *

While HRSA's simplified method focused on prioritizing counties *most* at-risk within the state, national benchmarks show that many more counties in Indiana that should not be discounted as "not at-risk". When compared to the national benchmark for each indicator (for which a national data point was available), there are four indicators for which more than 65% of Indiana counties sit above the national benchmark. (See Table B.) These four indicators are within the domains of Adverse Perinatal Outcomes and Maternal Health, added by Indiana as part of the modified simplified method to represent priority focus areas for the Hoosier state. In his 2018 State of the State address, Governor Holcomb set a goal for Indiana to have the lowest infant mortality rate in the Midwest by 2024. The death of an infant is not only devastating for families, but infant mortality is also an important indicator of a geographical area's community health status, poverty

and socioeconomic levels, and availability and quality of healthcare services[7]. In addition to adding the IMR indicator, smoking during pregnancy and no early prenatal care are also included as infant mortality risk factors[8]. The child maltreatment indicator was added not only because it is a state priority, but also due to the potential impact home visiting can have on child maltreatment reduction and prevention[9].

Within these indicators, even counties ranking as better performing in Indiana, are in need of improvement. Less than ten Indiana counties are performing better than the national benchmark in rate of child maltreatment, percentage of women smoking during pregnancy, and percentage of women who received no early prenatal care.

Table B - Indiana Priority Indicators and National Benchmarks

Indiana Priority Indicator	Indicator Definition	National Benchmark	Indiana Counties Above the National Benchmark
Infant Mortality[10]	Infant deaths per 1,000 live births	5.7	63
Child Maltreatment[11]	Rate of maltreatment victims ages <1-17 per 1,000 child residents under 18	9.1	87
Smoking During Pregnancy[12]	Percentage of women who smoked during the last 3 months of pregnancy[13]	8.1	83
No Early Prenatal Care[14]	Percentage of women who did not receive prenatal care during the first trimester	13.1	91

Every single county has at least one at-risk indicator as defined by HRSA or one indicator that is worse than the national benchmarks. Specifically, please note the following for counties where MIECHV-funded families receive home visiting services (See Table C.):

Table C

County where MIECHV-funded families are served	Number of At-risk Domains[15]	Number of At-risk Indicators	Number of IN Priority Indicators Above National Benchmark (Out of 4)
Elkhart	1	1	4
Lake	2	3	4
LaPorte	1	3	3
Marion	3	5	4
Scott	3	7	4
St. Joseph	2	4	4

All Indiana counties rank above the national benchmark for priority areas or have at least one at-risk indicator as defined by HRSA. Therefore, Indiana recognizes all 92 counties to be at risk. A state-wide Home Visiting Program Survey was offered to home visiting programs across the state to gather data on the quality, capacity, and resources in their community. A Community Survey was offered to MIECHV partners and other organizations that would be familiar with the needs of MIECHV priority populations and interests of the community at-large. The COVID-19 pandemic and resulting impact on business practices and service provision disrupted plans to convene stakeholders to review and contextualize survey results as well as the results of relevant needs assessments from other state agencies and initiatives.

[7] http://www.amchp.org/programsandtopics/data-assessment/InfantMortalityToolkit/Documents/Why%20Focus%20on%20IM.pdf
[8] https://www.cdc.gov/reproductivehealth/maternalinfanthealth/infantmortality.htm
[9] https://journals.sagepub.com/doi/full/10.1177/1077559517701230
[10] 2018 CDC NCHS data
[11] Children's Bureau Child Maltreatment 2016 Report (ACF)
[12] 2017 PRAMS data
[13] This definition is different from the data from Indiana counties which included pregnant women who smoked at any point during their pregnancy.
[14] 2017 PRAMS data
[15] Elkhart – Crime, Lake – Socioeconomic Status, Crime, LaPorte – Crime, Marion – Socioeconomic Status, Adverse Perinatal Outcomes, Crime, Scott – Child Maltreatment, Maternal Health, St. Joseph – Socioeconomic Status, Crime

The 2020 Update is rich with qualitative and quantitative data that can assist in informing Indiana MIECHV implementation moving forward. Responses from 38 home visiting programs and 444 community stakeholders provide valuable perspective from those providing services to the community.

- Home visiting services are available in every county in Indiana.
- A variety of home visiting programs exist throughout the state.
- 73% of counties have more than one home visiting program model available to serve families.
- Home visiting models are both publicly and privately funded and administered.
- Indiana hosts several collaborative initiatives and advisory boards that are specific to or support home visiting.
- Home visiting programs felt they are generally well equipped to meet the needs of families in their community. However, many families are in need of additional services that home visiting programs do not provide. Families have additional needs for services beyond home visiting.

Figure C

Number of Known Home Visiting Programs in Indiana

Home visiting programs are available in every Indiana county

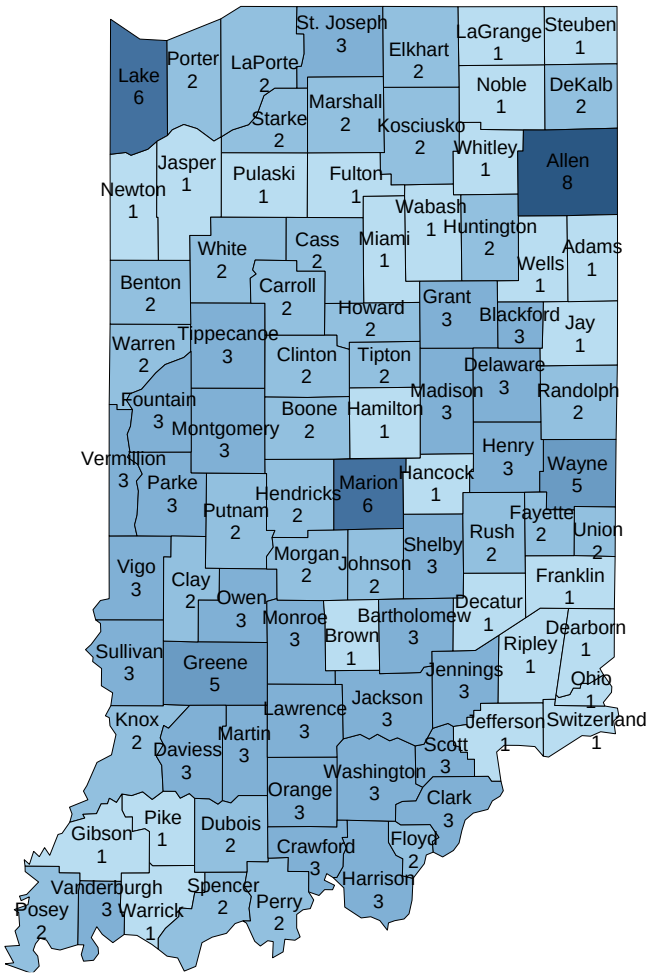


Figure D

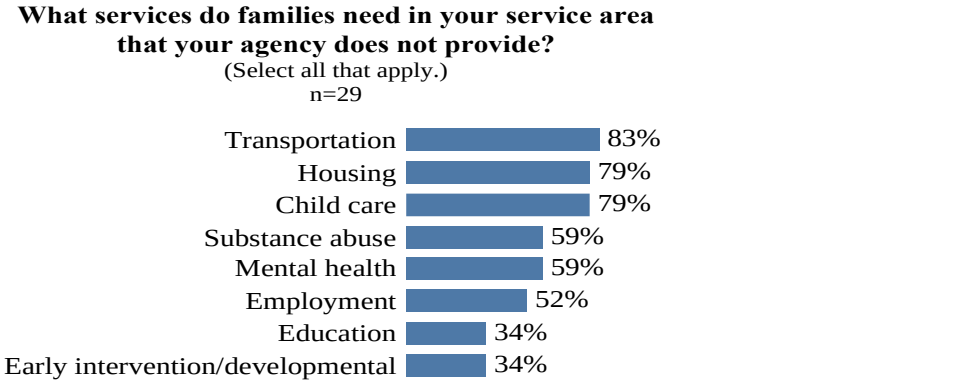
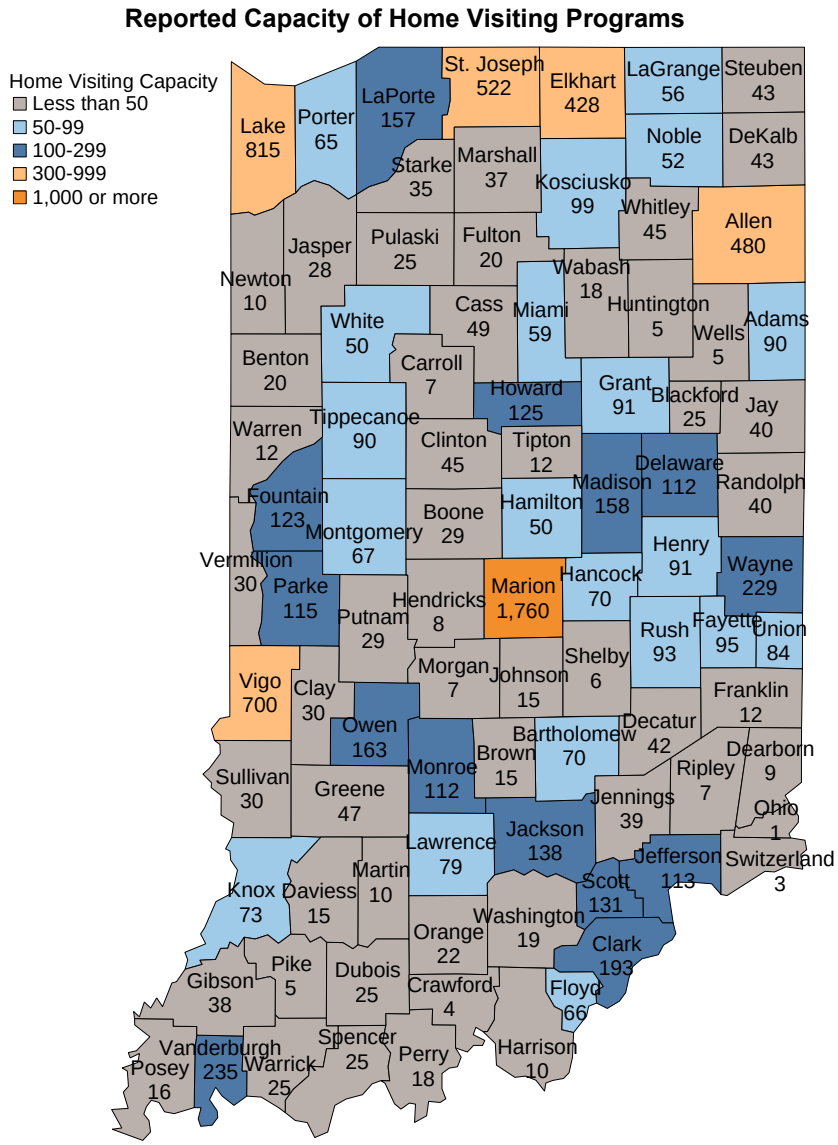


Figure E



To address the needs of clients, home visiting programs indicated partnering with many other local service providers. Many organizations share data with these partners, and often share multiple types of data. Three quarters of organizations share referral data, and two thirds share enrollment information, such as capacity and waitlist numbers. Less than half of organizations share data on Home visiting program survey respondents reported a capacity to serve 9,454 clients[16]. Thirty-four organizations answered whether they operate with a waitlist, and the vast majority do not.

Other Activities

Mental Health Consultation: HFI sites that serve MIECHV-funded families continued to provide a mental health consultation enhancement approved and supported by HFA. Mental health clinicians were embedded within LIAs to provide a minimum of monthly Reflective Practice and consultation to each home visitor serving MIECHV-funded families. Value of the mental health consultation enhancement is supported by several evaluations:

- Indiana's FY2015 Evaluation suggested that the mental health consultation model supports and builds capacity of home visitors
- The FY2016 Evaluation found home visitors receiving mental health consultation reported receiving significantly greater frequency of supervisor guidance related to family stress and mental health and healthy adult relationships compared to home visitors not receiving mental health consultation; were more likely to have access to support from professionals other than their HFI supervisor in the areas of family substance use, stress and mental health, healthy adult relationships, and parenting to support child development compared to home visitors not receiving mental health consultation; were

[16] Capacity was defined for survey takers as "the maximum number of families/clients your program can serve with current resources including funding and staffing in a typical month".

significantly more likely to actually utilize support from professionals other than their HFI supervisor for family substance use, stress and mental health, and healthy adult relationships compared to home visitors not receiving mental health consultation.

- Results and full explanation of the FY2018 Evaluation can be found in the evaluation sections of this report.

Key Changes that occurred during the period of availability for this FY18 project:

- February 2019 - HFI database change. More information about the impacts of this change are included in the Challenges and Strategies section.
- May 2019- Additional NFP LIA selected as a result of ISDH's Request for Application process.

Progress Towards Meeting Needs of Each Community Served with FY18 MIECHV Funds:

FY19 (10/1/2018-9/30/2019) – Home visiting services for 2018-2019 were funded by FY17 funds and reported in the FY17 Final Report.

FY20 (10/1/2019-9/30/2020) – Table D below illustrates entities providing services, evidence-based model(s), enhancements, families served, maximum caseload as of the end of the reporting period, and if the caseload goal was met.

Table D

All MIECHV Formula families served during the FY18 reporting period										
MIECHV Site / Local Implementing Agency (LIA)	At-risk Community / County	EBHV Model(s) / Promising Approach	Model Enhancement (if applicable)	New MIECHV Families Served FY19	New MIECHV Families Served FY20	New MIECHV Families Served during FY18 project period	Continuing MIECHV Families Served (10/1/2018-9/30/2019 enrolled prior to 10/1/2018)	Continuing MIECHV Families Served (10/1/2019-9/30/2020 enrolled prior to 10/1/2019)	Maximum MIECHV-funded Caseload (Family Slots) Capacity as of 9/30/2020	% Caseload Capacity If caseload target was not met provide reason.
Goodwill of Central & Southern Indiana	Delaware County	NFP		0	0	0	3	0	0	n/a*
Goodwill of Michiana	Elkhart County	NFP		0	25	25	0	0	50	no**
Child And Parent Services		HFI	Mental Health Consultation	67	62	129	114	114	115	yes
Family Service Society	Grant County	HFI	Mental Health Consultation	1	0	1	15	0	0	n/a*
Mental Health America	Lake County	HFI	Mental Health Consultation	171	147	318	209	176	231	yes
Goodwill of Michiana	LaPorte County	NFP		0	21	21	0	0	25	no**
Dunebrook		HFI	Mental Health Consultation	57	47	104	59	71	71	yes
Goodwill of Central & Southern Indiana	Madison County	NFP		0	0	0	10	0	0	n/a*
Goodwill of Central & Southern Indiana	Marion County	NFP		304	143	447	347	350	400	yes
Healthnet		HFI	Mental Health Consultation	126	98	224	213	151	208	yes
Health and Hospital		HFI	Mental Health Consultation	158	189	347	234	164	207	yes
New Hope Services	Scott County	HFI	Mental Health Consultation	30	15	45	20	25	28	yes
Goodwill of Michiana	St. Joseph County	NFP		0	68	68	0	0	75	yes
Family & Children's Center		HFI	Mental Health Consultation	93	139	232	98	70	131	yes
				1007	**954**	**1961**	**1322**	**1121**	**1541**	

*These sites no longer serve MIECHV funded families as of 10/1/2019

**Less than 85% capacity

Indiana notes that while Goodwill of Michiana in Elkhart County and LaPorte County did not meet the HRSA expectation of 85%, and appear to be at 50% and 84% respectively. Goodwill of Michiana is a new Nurse Family Partnership implementation (no home visiting services provided prior to October 2019) as well as a new MIECHV-funded LIA. As a new implementation, experienced nurse home visitors capable of taking on full caseloads were not available. Fidelity to the NFP Model Element 12, allows new nurse home visitors build up caseloads of 25 over the first 9-12 months after receiving Unit 2 training.

II. OVERALL ACCOMPLISHMENTS

Improved Recruitment / Retention of Staff:

Turnover at the state-level did not inhibit Indiana's progress toward originally outlined goals of this FY18 Formula project. Indiana's service providers subcontracted to assist this project in areas of data collection and analysis, quality assurance, and program management did experience turnover that is addressed further in the Challenges and Strategies section. While these changes created challenges, the change in these service providers also provided opportunity for fresh perspective and invigoration to the project.

HFI sites serving MIECHV-funded families with this grant are adept at maintaining quality and consistent service despite regular turnover at home visitor and supervisor staff levels. New staff worked with experienced staff balancing fresh perspective with well-founded best practices. During 2020, 2 HFI sites serving MIECHV Formula families experienced change in the Program Manager position. In one site, a program manager with decades of service retired. On another site, an experienced program manager was promoted in agency leadership. In both instances, promotion of an experienced supervisor – familiar with MIECHV-funded services and data – resulted in minimal impact to the organizations overall and did not impact the services to families.

HFI sites were reviewed annually by the QA contractor to ensure compliance with model standards, which include a weekly minimum of 2 hour documented supervision time for each home visiting staff member. Supervisors provided oversight for home visitors - engaging in a variety of techniques such as coaching, shadowing, reviewing family progress, providing reflection, and guidance on curricula, tools and approaches.

While the newer NFP MIECHV LIA experienced some initial hiring challenges, the site's nurse supervisor found success through self-recruitment strategies by contacting peer networks and universities. This new site has retained the staff hired during the initial process. NFP generally maintains high staff retention. This may be attributed to things such as offering ongoing educational opportunities to internal and external staff, allowing nurses at least 1 hour of weekly reflective supervision with nurse supervisor, monthly regional nurse supervisor call to provide guidance, commitment of a Community Advisory Board, support of flexible maternity leave and continuing lactation in the workplace, emphasis on autonomy of nurses, involvement of nurses in a variety of special projects and CQI initiatives, and advancement opportunities within LIA.

The NFP Model Element 14 states "Nurse Supervisors provide nurse home visitors clinical supervision with reflection, demonstrate integration of the theories, and facilitate professional development essential to the nurse home visitor role through specific supervisory activities including one-to-one clinical supervision, case conferences, team meetings and field supervision." These activities ensure that nurse home visitors are clinically competent and supported. Indiana consistently meets this expectation as reported in the NFP Fidelity Reports.

Improved Recruitment / Retention of Families:

HFI implementing sites regularly engaged with other community resources in their efforts to recruit at-risk families and provide referrals for additional services appropriate for engaged families. Local healthcare facilities, physician's offices, mental health centers, educational institutions, career centers, religious institutions, food banks, shelters, daycare centers, Head Start programs, organizations with low-wage employees, and community-based businesses were all resources for educating communities to the availability and services provided by HFI. LIAs often have informal agreements and communicate regularly with these types of organizations for referrals.

Retention efforts for HFI sites included appropriate home visitor assignment, transition planning for changing home visitors, and creative outreach. HFI places a family on creative outreach when the family has not fully engaged in services or has disengaged in services but not refused services or moved out of the service area. Creative outreach included attempts by home visitor to re-engage family for a minimum of 3 months. Based on characteristics of community and family, home visitors may have attempted to re-engage families by cards, letters, drop-by visits with books or activities for family, etc. HFI implementing agencies make best efforts to prevent families from falling into creative outreach efforts by strengthening staff retention and addressing barriers that lead families into disengaging from home visiting.

HFI sites serving MIECHV funded families note that families who are choosing to engage in these voluntary services are at very high risk of child abuse and neglect and are dealing with multiple risk-factors, scoring very high on the Parent Survey. As HFI sites only engage families who score 40[17] or above on the Parent Survey it is important to note that these higher risk families are inherently more difficult to engage and retain in a voluntary program.

Primary referral sources for NFP include local hospitals, clinics, community organization, schools, and WIC. In some counties, NFP and local WIC agencies share an MOU to receive referrals for all eligible women who present at WIC clinics. Other clinics and hospital systems refer clients through a website link. There are also data integration agreements in place with two hospital systems, which provides access to electronic medical records, as well as the ability to message providers when necessary. NFP sites have worked to establish further partnerships with a variety of other providers through outreach efforts.

NFP LIAs continuously build their referral system with community partners through ongoing outreach and networking. Throughout the reporting period, NFP LIAs conducted over 100 outreach events combined, including radio interviews, resource fairs, meetings with organizations, and numerous presentations. Outreach to local organizations and attendance at community events has led to a significant portion of referrals that are self-referrals. Nurses attend weekly obstetric registration days to enroll clients. Prior to COVID, outreach advocates, nurse supervisors, and/or nurse home visitors also visit key healthcare partners monthly to ensure appropriate, eligible clients were referred to NFP.

A summary of attrition rates that culminated in Indiana's Form 4 reporting are illustrated in Table E:

[17] Note: If families score 25 or above on the Parent Survey and have specific additional risk factors– they may also be offered services.

Table E

Attrition Rates		Form 4 2018-2019 reporting period				Form 4 2019-2020 reporting period			
LIA	*Model*	*1st Qtr*	*2nd Qtr*	*3rd Qtr*	*4th Qtr*	*1st Qtr*	*2nd Qtr*	*3rd Qtr*	*4th Qtr*
Goodwill Industries - Delaware	NFP	0.00%	0.00%	0.00%	0.00%	did not provide services			
Goodwill Michiana Elkhart	NFP	did not provide services				0.00%	7.14%	5.00%	0.00%
CAPS	HFI	7.94%	6.78%	1.52%	5.43%	7.41%	14.18%	14.29%	2.70%
Family Service Society	HFI	11.76%	7.14%	0.00%	0.00%	did not provide services			
MHA - Lake Co	HFI	8.29%	9.82%	8.40%	5.73%	12.75%	9.52%	9.09%	0.82%
Goodwill Michiana LaPorte	NFP	did not provide services				0.00%	0.00%	13.33%	0.00%
Dunebrook	HFI	10.00%	11.11%	8.99%	7.50%	5.88%	21.59%	8.75%	5.00%
Goodwill Industries - Madison	NFP	0.00%	0.00%	0.00%	25.00%	did not provide services			
Goodwill Industries - Marion	NFP	6.62%	8.32%	14.16%	9.66%	5.62%	8.90%	2.64%	4.36%
Healthnet	HFI	20.35%	10.14%	5.73%	10.78%	11.17%	12.77%	6.74%	2.40%
Marion Co. Health Dept	HFI	18.12%	20.76%	9.63%	13.78%	18.67%	15.06%	11.02%	2.35%
New Hope Services	HFI	10.34%	3.33%	6.45%	6.25%	7.69%	9.68%	3.57%	0.00%
Goodwill Michiana St. Joseph	NFP	did not provide services				0.00%	2.38%	8.51%	4.84%
Family & Children's Center	HFI	20.19%	21.18%	13.13%	20.34%	40.54%	23.68%	8.62%	2.50%
Indiana overall		***12.32%***	***11.42%***	***9.49%***	***10.10%***	***12.41%***	***12.51%***	***7.58%***	***2.81%***

Improvements in Home Visiting Infrastructure:

Referral/service networks supporting home visiting and families served in at-risk communities

HFI policies require local sites to hold advisory committee meetings at least quarterly. These committees include professionals from the local community, advice on activities of planning, implementation, and/or assessment of program services, and provide LIAs community feedback and guidance on referrals to the program. HFI has a state memorandum of understanding (MOU) with the ISDH WIC program, which ensures that those WIC participants interested in HFI have their information transferred to the appropriate HFI site.

NFP maintains key relationships among hospital systems, community agencies, and schools in order to develop home visiting referrals and service networks for the high-risk communities in Marion, Elkhart, LaPorte, and St. Joseph counties. MOUs have been signed by leaders with organizations such as WIC, Early Learning Indiana providing childcare assistance and employment/education for clients, Community Action of Greater Indianapolis offering housing assistance to clients, Eskenazi Health providing employment opportunities to clients, and Community Resurrection Partnership supporting referrals and assistance from the faith community. Other partnerships include The Bowen Center for clients with mental health diagnoses, Community Advocates of Northern Indiana for doula services, several organizations for housing assistance, and breastfeeding coalitions for additional client lactation support.

Goodwill supportive services offer opportunities for educational resources for both NFP LIAs such as the Indy Metropolitan High School (Marion county) and The Excel Centers. Workforce Development and placement services are offered through Goodwill Talent Source. Re-entry and expungement services are available through Goodwill New Beginnings.

A new significant referral network partner during the X10MC32190 project period for both HFI and NFP is My Healthy Baby, formerly known as OB Navigator. My Healthy Baby is a collaboration between the Indiana State Department of Health (ISDH), the Indiana Family and Social Services Administration (FSSA) and the Indiana Department of Child Services (DCS). This initiative is building a network of services and support to wrap around moms and babies to

create healthier outcomes for both. It was established by House Enrolled Act 1007, which was signed into law by Governor Eric Holcomb in 2019. The vision is for every pregnant woman in Indiana to be supported, the efforts began in 2020 connecting pregnant women who are covered by Medicaid in Indiana's highest risk areas to home visiting services in their communities.

Work with national model developer(s)/description of technical assistance/secured curriculum

HFI is accredited by HFA which serves as a resource for model specific questions. Indiana achieved successful 2018 accreditation status in early 2019. Indiana regularly had representation at the national HFA and Prevent Child Abuse America conferences. Additionally, many HFI sites had staff members who served as peer reviewers for other states/HFA sites outside of Indiana seeking accreditation. HFI's contribution to the national model included HFA panel representatives, piloting online training and data tracking systems and participation in national HFA committees.

Indiana worked closely with the NFP NSO and their technical support team as necessary. The ISDH held a contract with the NFP NSO to receive ongoing state program support including assistance with program development and implementation, nurse consultation, quality support such as quarterly data support in order to report on the legislatively mandated benchmarks. The NFP NSO was available to answer any data or program related questions on a continual basis and remains under contract to continue their relationship with ISDH in this manner.

Each program (NFP, HFI) had specific curricula provided and/or recommended by its respective model developer. Indiana's models began this MIECHV Formula Project with curricula in place.

Training and Professional Development Activities

MIECHV team members in Indiana were provided opportunities for professional development, such as: (1) personal development opportunities; (2) conferences concerning home visiting, life course education, and maternal and child health, including annual conferences hosted by co-lead or other state agencies relevant to MIECHV activities as well as other federal, national, and statewide conferences; and (3) education opportunities offered by listservs and access to national journals and peer-reviewed articles. MIECHV staff also had access to HFI and NFP model developer information and training opportunities. ISDH's MIECHV Coordinator and MCH Epidemiologist attended NFP NSO's Administrator Orientation in March 2019 and the ISDH NFP Administrator attended in August 2020[18]. The purpose of this training was to ensure that the necessary critical factors for successful implementation are understood, provide tools and techniques to support quality implementation with fidelity to the model, and to develop a forum to connect with other administrators and NFP NSO staff to share success practices to sustain and improve implementation.

Nationally, MIECHV team members attended Home Visiting Summits, Association of Maternal and Child Health Programs (AMCHP) conferences and Association of State and Tribal Home Visiting Initiatives (ASTHVI) meetings in 2018, 2019 and 2020, MIECHV All Grantee meeting in 2018, 2019 and 2020, HFA national conferences, Help Me Grow National Center conferences

[18] As Indiana continues to support the expansion of NFP, MCH developed the NFP Administrator position. The NFP Administrator is responsible for coordinating implementation, on-going monitoring and support of NFP providers for ISDH MCH. The NFP Administrator is responsible for ensuring that all ISDH funded NFP programs are implemented in a manner that meets all guidelines for model fidelity as well as all related Federal and State requirements. In addition, the NFP Administrator works closely with state and local partners to ensure programs operate in a coordinated and cooperative manner with other similar programs available in Indiana. The NFP Administrator works under the direct supervision of the Home Visiting Program Manager. This position was filled in June 2020.

in 2019 and 2020, and online educational opportunities as provided through this grant and other resources presenting relative topics to grant activities. Due to the pandemic, most 2020 conferences attended by MIECHV team members were entirely virtual.

Locally, ISDH hosted the annual Labor of Love Infant Mortality Summit focused on reducing infant mortality with an emphasis on disparities and the importance of partnerships in 2018 and 2019. Members of the MIECHV state team and local communities participated in these conferences that provided access to national experts and tools to use in the community. http://www.infantmortalitysummit-indiana.org/. DCS hosted the biannual Institute for Strengthening Families in 2018, 2019, and 2020. Other local conferences and educational opportunities regarding mental health, safe sleep and other topics related to families with children 0-3 were attended by various team members throughout the reporting period.
HFI sites serving MIECHV-funded families followed the same training requirements and activities as the state-wide HFI system. The HFI Training Committee reviews annual site surveys and prioritizes what trainings will be provided based on the needs of staff and families. Trainings are offered regionally and locally throughout the state via conference setting, classroom instruction and on-line access. HFI embraces the HFA critical elements that requires and provides the following training for all staff on an ongoing basis:

- Orientation prior to working with families and entering homes;
- CORE (model training) provided by contracted certified HFA trainer;
- Additional training provided by the contracted Quality Assurance (QA) team: Infant Mental Health, Individual Family Support Plan (IFSP), Home Visit Narrative, Interpersonal Violence, Documentation, Edinburgh Postnatal Depression Scale (EPDS), Advanced Supervisor, Child Protective Indicators (CPI), Ages and Stages Questionnaire (ASQ), Depression, Schizophrenia, Bi-Polar, Difficult Relationships, Suicide, Introducing Consents/Evaluations, Difficult Conversations, Home Visit Planning;
- Twice each year, *The Institute for Strengthening Families* (Institute), hosted by DCS through contracted services, provided sessions developed to assist home visitors and site staff to meet ongoing training needs.
- Training and support from contracted providers for data collection and QA;
- Annual National HFA conference;
- Annual training for cultural competency, based on the families served by each program;
- Additional training provided by each individual site beyond what is provided by the model or provided by the HFI contracted training staff.

NFP Training: The NFP NSO develops and delivers initial education for nurse home visitors and nurse supervisors. Nurse home visitors directly provide service to clients with support from nurse supervisors and nurse consultants. Initial education is required as part of model fidelity as outlined in agency contracts.

All new, expansion, and replacement nurse home visitors and nurse supervisors are required to attend Nurse-Family Partnership Nurse Supervisor Units 1, 2 and 3. Units 1 and 2 need to be completed before enrolling and independently visiting clients. Unit 3 is completed about 6 months after units 1 and 2. Nurse supervisors are additionally required to attend Supervisor Unit 4 after completing Units 1 through 3.Core education for nurse home visitors and supervisor consists of two distance education components and two face-to-face education units, though these moved to a virtual format beginning in April 2020 due to the pandemic.

All NFP staff received Unit training and continued to participate in Consultative Coaching, as

prescribed by the national model. Required model trainings received by nurses included Ages and Stages Questionnaire (ASQ) training, Dyadic Assessment of Naturalistic Caregiver-child Experiences (DANCE), Strengths and Risks Framework (STAR), HOME Inventory training, and the NFP Goal Mama app.

In addition to the required NFP NSO training, NFP staff attended training on the following subjects: child abuse reporting, health and racial equity, mental health (maternal mental health, stigma, maternal suicide, and mental health first aid), DMCN use, reducing Indiana infant mortality, security awareness, adverse childhood experiences, leadership, maternal mortality, implicit bias, smoking cessation, CPR, active shooter, substance use, breastfeeding, safe sleep, HIPAA, telehealth, client financial wellness, basic Spanish, and more.

Finally, CQI training has been available as described in the Continuous Quality Improvement Initiatives section.

Partnerships and Collaborations:

***Local activities to coordinate services**:* Families that participate in home visiting services often have needs that are better addressed through additional or alternative community resources. Education regarding available resources requires an ongoing commitment to regular communication with local communities. Home visitors referred families to outside services as needs were identified through home visit activities. These referrals were tracked in the model respective data system and follow-up occurred as part of the home visiting process. Statewide, Indiana continues to work with home visitors to be more complete in the data collection during the follow-up process. Sites are encouraged to work with other local agencies to reciprocate staff training, to serve on local committees that facilitate information sharing and service awareness, and to maintain relationships with other local service providers. Help Me Grow Indiana (HMGIN) was developed with home visitors in mind regarding support for home visitors and families with identification, follow-up, access, and feedback specific to referrals to resources beyond home visiting

HFI local agencies continue to coordinate locally by operating advisory committees quarterly. These committees allow for local agencies to meet and discuss planning, implementation, and/or program assessment. The Healthy Families Central Administration team also collaborates on specific projects with other state agencies which include: DCS, ISDH, and FSSA.

NFP Model Element 18 requires NFP LIAs to convene a long-term Community Advisory Board of committed individuals/organizations, which reflects the community composition, whose expertise can advise, support and sustain the program, and meets at least quarterly to implement a community support system for the program promoting program quality. Collaboration with community partners representing critical services such as housing, child care, transportation and health care are demonstrated in contractual agreements, memorandums of understanding, and routine visits of NFP staff.

Additional Partnerships and Collaborations are described in more detail in the following Coordination with other Early Childhood Systems section.

Coordination with other Early Childhood Systems:

In addition to locally focused partnerships and collaborations described in the previous section, state-level initiatives contribute to the provision of appropriate services that support home visiting families and early childhood systems. Indiana illustrates many examples of meaningful

support and collaboration vital for the proposed activities within Indiana's FY18 Formula project as described below in Table F:

Table F- Coordination with Early Childhood Systems

Indiana Home Visiting Advisory Board (INHVAB): The goal of INHVAB is to coordinate, promote and define Home Visiting efforts in Indiana and to utilize data to assess need, identify service gaps, maximize resources and inform policy to improve health and developmental outcomes for Hoosier families and children. As indicated in the goals section above, many collaborating agencies are part of this advisory group, which is currently aligned with the ECCS state advisory board.
Early Childhood Comprehensive System (ECCS): Since 2003, Indiana's ECCS grant has been awarded to ISDH/MCH and provided impetus for much needed collaboration of statewide early childhood organizations. In 2016, ISDH/MCH was awarded an ECCS Impact competitive award. The Impact award supports the enhancement of early childhood systems building and demonstration of improved outcomes in population-based children's developmental health and family well-being indicators through a Collaborative Innovation and Improvement Network (CoIIN) approach. Indiana partners with the IndyEast Promise Zone, which is also a community receiving MIECHV funding, to 1) develop collective impact expertise, implement and sustain efforts at the state, county and community levels; 2) increase by 25%, -- from baseline in age – appropriate developmental skills among 3 year old children; 3) increase access to child developmental & maternal depression screenings as well as improved coordination of Indiana Early Childhood Systems. In February 2019, the Placed-base-Community (PBC) – which includes representation from HFI and NFP implementations that serve MIECHV-funded families – launched an ASQ cohort. The cohort launched was trained in March 2018 and will be receiving TA from an inclusion specialist. In May 2018, the providers received trainings from Indiana's CDC Learn the Signs Act Early Ambassador on how to incorporate LTSAE materials with the ASQ. In early 2020, all early childhood librarians were trained on developmental screening, milestones, and development, including distributing LTSAE materials and HMGIN marketing materials. Parent Café trainings began October 2018 and cafes are held on a monthly basis in the evenings at the PBC. Parent Cafes spread to another community center within the PBC. A three-day training was offered for many community partners and families attended in June 2019. This training certifies that the participants can host parent cafes in the communities. A partner café was held in the local community to engage other partners to this model. The Parent Café model was developed by Be Strong Families. They are a national organization that promotes the empowered engagement of vulnerable parents, youth, children, and extended family members in ways that nurture the spirit of the family and promote well-being, healing and peace.
Early Learning Advisory Committee (ELAC)*:* ELAC was established in 2013 by the Indiana General Assembly to assess availability, affordability, and quality of early childhood programs statewide and to make best practice recommendations for interventions to improve and expand early childhood education. ELAC is working to ensure children ages birth to 8 years and their families have access to affordable, high quality early education programs that keep children healthy, safe and learning. Members of the MIECHV team actively participate in the various workgroups of ELAC. Since 2017, the child development and well-being work group serves as the leadership team for the implementation of Help Me Grow. The data workgroup serves as a guiding team for Help Me Grow as well, understanding what data needs to be collected the Help Me Grow National, MIECHV Innovations and ECCS.
Project LAUNCH (Linking Actions for Unmet Needs in Children's Health)*:* In 2012, ISDH MCH with co-lead DMHA, was awarded Project LAUNCH bringing together key stakeholders including State and Local child-serving agencies and parents to create the State Young Child Wellness Council (YCWC). The YCWC developed a vision that states: Indiana Project LAUNCH envisions a State where all individuals responsible for the care and development of children before birth to age 8 years are supported to promote optimal social and emotional wellness in all children leading to healthier families and safer communities. Indiana Project LAUNCH is tasked with piloting initiatives that focus on family strengthening and parent skills training, screening and assessment, integration of behavioral health into primary care settings, mental health consultation, and enhancing home visiting. Home visiting programs are being enhanced through building competency of those providing home visiting services. Trainings in Motivational Interviewing, Trauma-Informed Care Approaches, Mental Health First Aid, and the Georgetown Model of Mental Health Consultation have been provided to a variety of home visitors in the Southeastern region including HFI, First Steps, and Head Start. A mental health consultation initiative (distinct from the model used within MIECHV) will serve as a support to home visitors, children and their families. In 2016, Parent Cafes (an evidence based parenting model from Be Strong Families out of Illinois) began statewide expansion to increase parent skills and promote family strengthening. Families are welcome to attend and learn about the 5 protective factors while having a safe space to talk about their family and needs. Parent Café training was offered to Home Visitors through existing training structures.

Help Me Grow Indiana (HMGIN): Help Me Grow[19] is not a stand-alone program, but rather a system model that utilizes and builds on existing resources in order to develop and enhance a comprehensive approach to early childhood system-building in any given community. Successful implementation of the Help Me Grow model requires communities to identify existing resources, think creatively about how to make the most of existing opportunities, and build a coalition to work collaboratively toward a shared agenda. The system model of HMG reflects a set of best practices for designing and implementing a system that can optimally meet the needs of young children and families. Initial HMG implementation in Indiana was a unique collaboration across federal funding for MIECHV Innovations and the ECCS Impact Grant. Through HMGIN, ISDH continues the system approach to designing a comprehensive, integrated process for ensuring developmental promotion, early identification, referral, and linkage to early childhood resources and services. During the coming year, plans to expand HMG to additional counties and systems.
Indiana Commission on Improving the Status of Children (CISC): CISC was established under a law signed by Governor Pence on April 30, 2013. This 18-member Commission consists of leadership from all three branches of government including the Director of DCS and ISDH Commissioner. CISC is charged with studying and evaluating services for vulnerable youth, promoting information sharing and best practices, and reviewing and making recommendations concerning pending legislation. This broad-based state commission studies and evaluates state agency policy and practice as well as proposes legislation that affects the well-being and best interests of children in Indiana. The enhancement and expansion of our statewide home visiting programs aligns well with this multi-tiered, action-oriented, outcome-expected approach.
Indiana Children's Mental Health Initiative (CMHI): The CMHI is collaboration between DCS and DMHA and local Community Mental Health Centers (CMHCs) and other providers who serve as access sites to ensure children are served in the most appropriate system to meet their needs. The purpose of the children's mental health initiative (CMHI) is to allow families access to needed services so that children do not enter the child welfare system or probation system for the sole purpose of accessing services, to ensure that children are receiving services in the most appropriate system, and to build community collaborations. The children's mental health initiative is intended to reach children and youth with significant mental and behavioral health issues, those families that are having difficulty accessing services generally due to the extensive costs of high need mental health resources, and those families who are best served in the mental and behavioral health arena as opposed to the child welfare system or probation system. The CMHI serves children and youth who do not have funding for intensive services and those who have intensive mental and behavioral health needs. The CMHI creates a process that is easy to access, multiagency, and strength based. The CMHI ensures families and children are served in the best system for consistency and continued care, do not have to tell their story over and over to service providers, ensures financial burdens and insurance capabilities are not in the way of help and support, and removes barriers for a simple access to services approach.
DFR, TANF and Supplemental Nutrition Assistance Program (SNAP): DFR is responsible for establishing eligibility for Medicaid, SNAP, and TANF to support families by emphasizing self-sufficiency and personal responsibility. TANF provides a number of services to low income families. In addition, DCS and ISDH have MOUs with DFR to utilize a portion of the state's TANF allotment for the provision of HFI and NFP services. This further demonstrating the state's collaborative approach to supporting home visiting efforts.
Indiana Head Start State Collaboration Office (IHSSCO): IHSSCO partners with Early Childhood stakeholders to provide coordination across early childhood programs. Representatives from ISDH MCH and DCS Prevention Programs are members of the Multi-Agency Advisory Council. The mission of this council is to build early childhood systems to enhance access to comprehensive services and support for children throughout the state. The IHSSCO provided annual financial support to DCS Prevention Programs for the bi-annual Institute for Strengthening Families conferences which provides high quality training opportunities at a low cost to providers serving families across the state. The financial support from the Collaboration Office allows for significant attendance from Head Start and Early Head Start Program staff and further demonstrates the state's priority to support the development of all high-quality home visiting programs available to Indiana families.
Healthy Start: The Indianapolis Healthy Start Program offers education, referral and support services to pregnant women and their families in an effort to eliminate the disparities in birth outcomes and improve infant mortality. In January 2016, the new ISDH/MCH Director and Director of Women, Children and Adolescent Health programs began meeting with the Indianapolis Healthy Start Program Director to enhance collaboration efforts moving forward. The MIECHV State team has subsequently been invited to join the Indianapolis Healthy Babies Consortium which is led by Healthy Start.
Indiana Perinatal Quality Improvement Collaborative (IPQIC): The mission of IPQIC is to improve maternal and perinatal outcomes in Indiana through a collaborative effort with the use of evidence-based methods. The Governing Council of IPQIC is co-chaired by the ISDH Commissioner and the President of the Indiana Hospital Association, and is comprised of members across various hospital, medical, state and community health departments and social services organizations from both the

[19] https://helpmegrownational.org/hmg-system-model/

state and community levels including key members of State MIECHV Team. The IPQIC serves as an advisory board to the ISDH with the primary goal of improving the health of women and children throughout Indiana.
Early Intervention Program, Part C of the Individuals with Disabilities Education Act (IDEA): At the state level, FSSA's Bureau of Child Developmental Services administers First Steps, a family-centered, locally-based, coordinated system that provides early intervention services to infants and young children with disabilities or who are developmentally vulnerable. At the state level, First Steps is advised by the Interagency Coordinating Council (ICC), a federally mandated group that assists and advises the state's program of early intervention services for infants and toddlers with disabilities and their families. It is a Governor-appointed council that includes membership of all pertinent state agencies/departments, service providers, and family consumers and includes the DCS Prevention Program Manager (CBCAP Lead). Many First Steps providers regularly participate in training opportunities available through The Institute for Strengthening Families. Referral coordination occurs at the state level through a data exchange between DCS for child welfare clients and First Steps. At the local level, many HFI and NFP providers have developed reciprocal referral relationships with their local First Steps offices as part of outreach efforts to support families of children with disabilities.
Think Tank: *A* broadly based group of representatives who advise direction in the planning and coordination of HFI services and system wide activities. The facilitator of this advisory group provides annual report utilizing program monitoring, evaluation and technical assistance data as well as principles from the field of implementation science to inform recommendations for improvement. As part of the strategic plan, the HFI mission statement is reviewed and a thorough review of current operations, current committee structure, and strategic goals is conducted. Many representatives on the Think Tank are from agencies that coordinate early childhood services with HFI implementing agencies.
The Institute for Strengthening Families: The Institute for Strengthening Families is administered by DCS Prevention Team and offers a unique opportunity to bring together a wide array of providers serving families and parents across multiple systems for high quality, affordable training and promotion of the vast array of services available to assist in all of our efforts to improve the lives of children and families in Indiana. Many members of the Institute Planning Committee represent collaborative partners listed in this report.
Health Insurance Outreach and Enrollment: ISDHs MOMS Helpline focuses on ensuring all mothers and families in Indiana have accurate information readily available to them to ensure they have access to appropriate healthcare and related services, when they need it. Helpline team members are is trained to inform and assist families with obtaining the most appropriate health insurance available to them including Indiana's Healthy Indiana Plan (HIP 2.0), Indiana Medicaid and CSHCS. In addition, several Helpline staff are trained navigators for the Federal Health Insurance Marketplace. Promotional materials for the MOMS Helpline are regularly shared with HFI and Goodwill NFP LIA's, MOMS Helpline staff also support informational tables and session presentations at The Institute for Strengthening Families to ensure home visitors from both programs are aware of this state-wide resource.
My Healthy Baby Advisory Committee: *(formerly OB Navigator)* The OB Navigator Advisory Committee is created for the purpose of advising the OB Navigator Program on matters related to perinatal home visiting in Indiana, thus enabling the Program to make decisions that are informed by the perspectives and experience of those who provide home visiting services in Indiana communities. The OB Navigator Program will seek to consult with the Committee on topics such as: OB Navigator standards; OB Navigator policies; Perinatal home visiting education and training; Performance management and improvement; and perinatal home visiting capacity and expansion. Representation includes a cross-section of home visiting programs in Indiana, as well as state staff from the Indiana Department of Health, Department of Child Services, and from the Family and Social Services Agency.
Safety PIN: Protecting Indiana's Newborns (PIN) – State-appropriated funding to provide competitive grant funding to health departments, hospitals, other health care related entities, or nonprofit organizations. The goal is to develop and implement services focused on reducing infant mortality throughout Indiana. The 2018 awards provided the state the ability to support a Safety PIN program in each of the Indiana hospital districts. This funding also supported the creation of a state pregnancy mobile app with a focus on reducing infant mortality. The app launched in November 2017 including statewide resources to improve health and is promoted amongst home visiting programs.

Continuous Quality Improvement Initiatives:

Indiana's FY 2020 Maternal, Infant, and Early Childhood Home Visiting Program Continuous Quality Improvement Plan Update received final approval April 7, 2020. Each Local Implementing Agency (LIA) has at least one CQI team that selects and conducts Plan-Do-Study-Act (PDSA) cycles to improve home visiting services within a local culture of quality where continuous quality improvement is a part of everyday practice. Local outcomes are reviewed and analyzed through the lenses of model fidelity, data collection, staff retention, family engagement and

home visiting best practices. In developing the entire culture of quality, some local CQI teams identified appropriate improvement efforts beyond MIECHV specific outcomes, but all improvement efforts addressed overall MIECHV goals.

Indiana utilized FY18 funding to contract with CQI provider Michigan Public Health (MPHI) to provide coaching and specific coordination to LIAs and the State MIECHV team with regard to organizing, conducting, and documenting improvement efforts. Support from MPHI includes an annual half-day support visit in the fall/ early winter, monthly coaching calls with each LIA regarding current CQI efforts, "just-in-time" support/coaching upon request, monthly check-in calls with the Indiana state team providing overview of improvement efforts and activities, consulting with Indiana state team around prioritization of training/learning opportunities for LIAs and development of training/learning opportunities to meet LIA needs.

CQI Training/Learning Opportunities have included:

- 2-day Beginning CQI workshop: *"The two-day quality improvement (QI) workshop is designed to train participants on the basics of quality improvement, the Plan-Do-Study-Act (PDSA) model, and key quality improvement tools. The workshop will use hands-on activities to provide participants with the opportunity to immediately apply the training content, and will be designed to support participants in working through several steps of the Plan stage of the PDSA cycle. Participants will leave the workshop with the knowledge, tools, and skills needed to conduct and participate in QI efforts within their program/organization."*
  This workshop is typically offered in-person on an annual basis. Due to the COVID-19 pandemic, this workshop could not be offered in-person in 2020. To ensure this important workshop was still offered, the content was transitioned to a virtual format that was delivered over the course of five three-hour training sessions. Training sessions included all training content traditionally delivered in-person along with activities to practice and experience the hands-on application. Additional tools were developed to support hands-on application and various engagement tools, such as Mentimeter and shared documents on a SharePoint Partner Portal, we used to recreate hands-on activities.
  - ✓ May 2019 – at the Institute for Strengthening Families, Indianapolis, Indiana
  - ✓ September 2020 – virtual training via Zoom
- Tools, Tools, and More Tools! Applications of QI Tools in Improvement Efforts and Beyond: *"Many home visiting and early childhood professionals begin their Quality Improvement (QI) journey with a handful of standard/commonly used tools to support their improvement efforts. This workshop will explore commonly used QI tools, suggest new ways to use the same tools to support daily work, and expand participant toolboxes to include new, possibly less familiar tools that can be used in improvement efforts and beyond. Workshop participants will engage in hands-on practice of a variety of QI tools during the session to support comfort in applying and using the tools in their day-to-day work."*
  - ✓ May 2019 – at the Institute for Strengthening Families, Indianapolis, Indiana.
- Getting from A to B: Understanding your Current Process to Support Improvement and Beyond: *"Many processes and procedures in your day to day work are undocumented and ever evolving. As home visiting and early childhood professionals embark on formal Quality Improvement efforts to improve processes, it's vital for the team engaged in the improvement effort to gain a clear understanding of the current process before working toward improving the process. This hands-on workshop will provide attendees with the knowledge they need to engage in creating a process map, writing a standard operating procedure (SOP), and provide time for attendees to work through using at least one tool on a process of their choosing. Attendees will leave with the knowledge and skills needed to replicate use of these tools in formal improvement efforts they are*

engaged in and their day to day work."
  - ✓ May 2019 – at the Institute for Strengthening Families, Indianapolis, Indiana.
- Tools, Tools, and More Tools! Using QI Tools to Move from Problem-solving to Identifying Potential Solutions: *"Early childhood professionals encounter daily challenges. Some of these challenges require a specific solution, while others need concerted problem-solving linked with a solutions brainstorm. This workshop will provide participants with QI knowledge and tools necessary to effectively move from exploring root cause to brainstorming potential solutions. Workshop participants will engage in hands-on practice to increase comfort in applying/using the tools in their everyday work."*
  - ✓ August 2019 – at the Institute for Strengthening Families, Noblesville, Indiana.
- Making your Data Count! Using Data for Quality Improvement and Beyond: *"This workshop will provide participants with the opportunity to build skills around using data for improvement. Participants will further their learning on identifying and developing measures, collecting and compiling data, and presenting and interpreting data through the sharing of content, hands-on exercises, and discussion. Participants will leave the session with knowledge and skills to support improvement efforts at their organization and beyond."*
  - ✓ August 2019 – at the Institute for Strengthening Families, Noblesville, Indiana.
- Tips for Developing Data Charts and Graphs in Microsoft Excel: *"This session will provide participants with the opportunity to explore various ways to display data in Microsoft Excel to support improvement efforts. Participants will gain an understanding of how to chart/ graph data in Microsoft Excel and various features of Excel to utilize when displaying data. Participants will leave the session with the knowledge and necessary skills for charting simple datasets in Excel."*
  - ✓ August 2020 – at virtual Institute for Strengthening Families
- Virtual Learning Opportunities: As needs arise throughout the year, short, focused virtual learning opportunities are offered to support LIAs in gaining knowledge and skills. The following opportunities were offered:
  - ✓ April 2019 – Fostering and Nurturing a Culture of Quality in Home Visiting
  - ✓ September 2019 – Tools, Tools, and More Tools! Using Tools for Root Cause Analysis
  - ✓ October 2019 – Tools. Tools, and More Tools! Tools for Identifying Potential Solutions
  - ✓ October 2019 – Selecting a Topic for Quality Improvement and Running Short, Rapid PDSA Cycles
  - ✓ March 2020 – Data and QI: Beyond your Program's Data System
  - ✓ July 2020 – Acting on and Sustaining Improvement Efforts
- Quality Improvement Community of Learning (CoL) Gatherings: These gatherings provide a mechanism for peer-to-peer sharing and learning among LIAs to enhance Indiana MIECHV improvement efforts. Gatherings occur about once per quarter and each has of a topic of focus. Gatherings are primarily discussion based and occurred on the following dates:
  - ✓ December 3, 2019 - Successes and Challenges with QI Efforts in the Past Year
  - ✓ January 7, 2020 - Facilitating QI Efforts – Successes, Challenges, and Tips
  - ✓ April 22, 2020 – Engaging in QI in the Virtual Setting
  - ✓ June 30, 2020 – Building Excitement and Engagement in QI
  - ✓ August 12, 2020 – Acting on and Sustaining Successful Changes

Indiana has received positive feedback for all workshops, trainings, and learning opportunities listed above and continues to develop additional opportunities addressing participant requests and LIA needs.

Indiana did plan to offer a one-day facilitation workshop in April 2019 to address needs LIAs have expressed when it comes to facilitating improvement efforts. The decision was made to postpone this workshop until it could be offered in-person recognizing the importance of some of the hands-on practice and application the workshop was set to offer. However, with the uncertainty of when it will be safe to gather in-person in the future, the decision has been made to transform this workshop into a virtual one that will be held in March of 2021. Indiana is excited about this opportunity and looks forward to sharing more about it in the future.

Table G - Summary of CQI teams/projects

Local Implementing Agency	SMART Aim Statement	Improvement Theory (to Adopt, Adapt, or Abandon)	Reached Aim? (Yes/No)	How Team Acted on Cycle
Child and Parent Services (CAPS) Healthy Families Indiana (HFI)	By December 2018, the HF Elkhart County will increase home visit completion rates by 5%.	If we come up with a way to reward our families in the ECHF program, then we hope to see an increase in families keeping visits and being served.	No	Adopt
	By October 2019, the Healthy Families Elkhart County FRS staff member will decrease the number of pre-enrollment terminations from 2 to 1 per month.	If the FRS calls the family and talks to them about who their home visitor will be and give them their contact information, then there will be a decrease in the number of pre-enrollment terminations from 2 to 1 per month.	No	Adopt
	By April 2020, Healthy Families Elkhart County will decrease the percent of incomplete paperwork from 5.2% to 2%.	If supervisors track the number of returned documents per staff and report that number to staff at the end of each month, then Healthy Families will decrease the percentage of incomplete paperwork from 5.2% to 2%.	Yes	Adopt
Dunebrook (LaPorte County) HFI	By May 31, 2019, Healthy Families LaPorte County will increase the percent of enrolled Hispanic Families in the Healthy Families Program by 5%.	If HFLC's Spanish speaking FSS visits our local ESL classes monthly with Spanish Healthy Families fliers, HFLC will increase enrolled Hispanic families in the Healthy Families Program.	Yes	Adopt
	Healthy Families LaPorte County will increase the number of home visitors who feel prepared for MIEC Supervision from to four to ten by September 30, 2019.	If HFLC's home visitors' email MIEC Clinician 3 days before supervision with 3-4 families to discuss, home visitors will feel more prepared for MIEC supervision meetings.	No	Adapt
	By May 2020, HFLC home visitors will increase the percentage of Mother of Baby (MOB) post-partum visits that are documented in the health log from 30% to 50%.	If the team updates the client tracking form to include a place for the post-partum care visit date and inform staff of the change, then there will be an increase in the percent of MOB post-partum visits that are documented in the health log.	Yes	Adopt
	By September 2020, Healthy Families La Porte County home visitors will increase the percent of breastfeeding data entered by 10%.	If HF staff is trained on when and where to enter breastfeeding data in the database and how to use a "cheat sheet" created with breastfeeding tracking data, then there will be a decrease in the number of missing data for breastfeeding.	Yes	Adopt
Family and Children's Center HFI	By March 1, 2019, HFJSC will increase the average number of families who receive referrals to local library services from .05% to .1%.	If all home visitors give a calendar of local library events each month, this will increase library referrals from .05% to .1%.	Yes	Adopt
	By May 2019, HFSCJ will increase the percent of families who report reading to their	If home visitors provide a nursery rhyme resource to families weekly, The Families served by HFSJC will report reading to	No	Adopt

Local Implementing Agency	SMART Aim Statement	Improvement Theory (to Adopt, Adapt, or Abandon)	Reached Aim? (Yes/No)	How Team Acted on Cycle
	children on a regular basis from 85% to 90%.	their children on a regular basis.		
	By November 4, 2019, HFSJC will increase the percent of families who meet with the assessment worker on the 1st scheduled appointment from 58% to 63% (a 5% increase).	If HFSJC assessment workers offer more incentives ($5.00 gift card), then the number of families who meet on the initially scheduled visit will increase.	Yes	Adopt
	By January 1, 2020, HFA St. Joseph County will increase the parent attendance in Parenting Group from 8 families attending to 10 families attending.	If HFSJC staff hand out Parenting Group flyers at the beginning of each month during staff meetings and encourage staff to have their clients/families attend, then the number of clients who attend Parenting Group will increase.	Yes	Adopt
Family Services Society, Inc.[20] HFI	By April 2019, each Family Support Specialist (FSS) will increase documenting efforts of challenging issues ongoing in 8 out of 10 of their family's home visits.	If FSS's properly document challenging issues in the correct section of HV narrative ongoing, then documentation efforts for challenging issues will improve, therefore meeting the standard 7-4B.	Yes	Adopt
Goodwill of Central and Southern Indiana Nurse Family Partnership (NFP)	By December 31, 2018 team 2 nurses will increase their infancy retention by 1-2%.	If all nurses incorporate "best practices" into infants visits our overall retention rate will increase.	Yes	Adopt
	By June 1, 2019, Goodwill NFP nurses will increase the CLC/CLS exam passing percentage rate from 80% to 95%. By June 1, 2019, Goodwill NFP nurses will increase their breastfeeding knowledge and confidence.	If nurses are educated early and continually on breastfeeding topics, then nurses will be more knowledgeable and confident when the take the CLC/CLS exam and support their clients.	Yes	Adopt
	By April 16, 2019, at least 90% of Marion County NHVs will report an increase in competency related to safe sleep knowledge.	If we provide safe sleep education to NHVs then we will increase nurse home visitor competency related to safe sleep knowledge.	Yes	Adapt
	By March 15, 2020 Goodwill NFP Subsequent Pregnancy Committee will increase the NHV's knowledge they need to provide clients with accurate and consistent family planning education from 52% to 75%.	Cycle 1: If we provide a Family Planning education for nurses and review of our current Subsequent Pregnancy data then we will increase the knowledge of our nurses as well as provide them with standardization of family planning education. Cycle 2: If we provide family planning education for nurses in smaller groups and focus specifically on the demonstration of our new birth control box and community resources for low-income family planning services then they will be able to provide more clear information to the clients.	Yes	Cycle 1: Adapt Cycle 2: Adopt
	By May 1, 2020, Goodwill/NFP nurses will improve their knowledge, comfort, and	If nurses are educated on how to utilize breastfeeding boxes with their clients and have their own boxes to use when	Delayed due to COVID	Delayed due to COVID

[20] Family Services Society, Inc. only received MIECHV funding from October 1, 2018 to September 30. 2019 of this grant period.

Local Implementing Agency	SMART Aim Statement	Improvement Theory (to Adopt, Adapt, or Abandon)	Reached Aim? (Yes/No)	How Team Acted on Cycle
	confidence in using their BF boxes by 10% for breastfeeding education with their clients.	needed nurses will improve their knowledge in using their BF boxes.		
	By July 1, 2020, increase the knowledge among nursing staff about available mental health resources; including NSO facilitators, mental health tool kit on the HUB, and NFP resource map.	If MH committee members (mental health reps) share information about the mental health facilitators, the NFP resource map, and the mental health toolkit on the HUB twice monthly during their team meetings, then the NHVs will report an increase in knowledge, comfort, and confidence in using mental health facilitators, the NFP resource map, and the mental health toolkit on the HUB.	Yes	Adapt
HealthNet HFI	By January 1, 2019, Healthnet Healthy Families program will increase the home visit acceptance rate from 57% to 60%.	If we are aware of staff skill sets then Families will be assigned to the FSS who can best meet their needs which will increase the HV acceptance rate by 3%.	No	Abandoned
	By November 2019, Healthnet Healthy Families program will increase staff knowledge and confidence in breastfeeding support from pre to posttest assessment.	IF we provide staff training, THEN staff will feel confident having conversations and providing resources to support families struggling with breastfeeding up to 2 months of age.	Yes	Adapt
	By July 2020, HealthNet Healthy Families program will increase their Home Visit Acceptance Rate by 3%, from 53% to 56%.	If FSS' utilize virtual business card for initial outreach with UE assigned families, then home visit acceptance rates will increase by 3%.	No	Adapt
Marion County Public Health Department HFI	By October 31, 2018, Healthy Families Marion County Public Health Department will increase staff confidence in educating families on birth spacing and family planning from 25% to 50%.	If Staff have specifically targeted training, a fact sheet to share with clients, and the option to use the birth control kits ordered by the program to address birth spacing and family planning with participants, then they will feel more confident about educating families on this topic.	Yes	Adopt
	By December 15, 2018 the survey response rate will increase from 30% to 40%.	If supervisors are entering the survey data, then the response rates will increase.	Yes	Adopt
	Marion County Public Health Department Healthy Families home visitors and assessment workers will increase confidence and competence in administration of the safety plan by 5% by 6/1/19.	If we develop a new, uniform safety plan form, then home visitors and assessment workers will increase confidence and competence in administration by 5% by 6/1/19.	Yes	Adopt
	Marion County Public Health Department Healthy Families Supervisors will increase completion of Staff Development Notes from 87% to 92% by 11/15/2019.	If Supervisors have clearer, more detailed guidance on what should be written on the Staff Development Note, then Supervisors will increase completion of Staff Development Notes to a rate of 92% by 11/15/19.	Yes	Adopt
	The home visitors on the MCPHD Healthy Families CQI team will increase the collection and data entry of the 6-week postpartum checkup date by 30%, from 35% to 65%, by 5/27/2020.	If home visitors on the CQI team receive a mini-training on the purpose, timeline, and data entry requirements of the 6-week postpartum checkup, then the home visitors on the CQI team will increase the collection and data entry of the 6-week postpartum checkup date by	Yes	Adopt

Local Implementing Agency	SMART Aim Statement	Improvement Theory (to Adopt, Adapt, or Abandon)	Reached Aim? (Yes/No)	How Team Acted on Cycle
		30%, from 35% to 65%, by 6/1/2020.		
Mental Health America of Northwest Indiana HFI	Healthy Families Lake County will increase 3-month family retention from 53% to 65% by August 2019.	If we focus visit activities (scrapbook and/or values exercises) on moms during the first 3 visits, then more families will be retained at three months.	Yes	Adopt
	By July 2019, The CHEERS Team Leaders will increase the completion of the CCI tool from 0% to 25%.	If we update the Tool Tracker to reflect when the 4-month CCI tool is due and implement the updated tool tracker, then we will see a 25% increase in CCI tool completion.	Yes	Adopt
	By July 2020, MHANWI will decrease the percent of families who report co-sleeping from 45% to 30%.	If MHANWI retrains and provides home visitors with ISDH resources around safe sleep and the home visitors uses resources with families, Then the percent of families who report co-sleeping will decrease.	Yes	Adopt
	By September 2020, MHANWI will increase the number of FRS staff who enter secondary information in consistently (monthly) from 3 to 5.	If FRS documents the secondary activities into Enlite within 7 days of the contact/attempt, THEN there will be an increase in the number of FRS staff who enter secondary information consistently (monthly).	No	Adopt
New Hope Services HFI	By 10/1/18 the New Hope Services HFA program will increase staff retention for staff hired by July 1, 2018 from 50% to 60%.	If supervisors train according to a strict plan, then staff will not be overwhelmed by the volume of training material. If staff are not overwhelmed, then staff retention will increase.	Yes	Adopt
	Program will increase referrals sent to Bartholomew, Jackson, Jennings, Floyd, Scott, Jefferson, and Clark Counties by 25% in the identified counties by April 30, 2019.	If we educate our partners in the community, then they will refer to our program.	No	Adopt
	New Hope Services acceptance rate will increase in Bartholomew County by five percent, from 38% to 43% by April 30, 2020.	If the Family Resource Specialist provides a warm hand off to the Family Support Specialist, then more families will accept home visiting services.	Yes	Adapt
	By June 1, 2020, New Hope Services will maintain or increase Parent Survey completed by the program as compared to pre-pandemic levels.	If we offer intake services virtually, then more families will accept Parent Surveys.	Yes	Adopt

III. CHALLENGES and STRATEGIES

***Data*:**

- Overall data: Aggregating data across two distinct models with established yet disparate data collection systems was a sizable challenge.
  - ✓ Indiana utilized its third-party evaluator to objectively aggregate data for state level reporting. Quarterly data reviews were used to identify and address challenges with data prior to federal reporting. and improve issues around missing data.
- Change in data system: In February 2019, Healthy Families Indiana experienced a planned change in data systems and data system providers. HFI data was migrated from FamilyWise (provided by Datatude) to EnLite (administered by Brite Systems). This transition proved to be a significant undertaking for a system that serves more than

10,000 families each year. The biggest impact on MIECHV performance data was the lack of monitoring reports and several issues related to legacy data during the project period.

- ✓ Indiana began addressing identified issues during 2nd quarter data reviews in July 2019. The frequency of the MIECHV data reviews highlighted several overshadowed issues that – when addressed to meet MIECHV data needs – resulted in system-wide improvements.
- ✓ Specifically during the 2019-2020 reporting period, key staff from the data analysis provider (PCG), HFI quality assurance/technical assistance provider (Straight Path Consulting, HFI database provider (Brite Systems) and the MIECHV state team met on several occasions to address specific MIECHV data elements and inform the HFI database committee and the development of monitoring reports..

- ➢ Excessive Missing Data: Indiana has experienced minimal missing data issues in previous reporting periods. During the 2018-2019 reporting period, Indiana experienced missing data in excess of 50% in several performance measures. Indiana attributed the majority of those issues to the database transition within HFI that may have been exacerbated by abrupt turnover in 3rd party evaluator staff late in the 2019 reporting period. Indiana acknowledged that excess of missing data may mask programmatic issues impacting data quality.
  - ✓ Several efforts were conducted during the project period to address missing data, including typical quarterly data reviews, revision to missing data reports, more detailed data analysis plans for Forms 1, 2, and 4. In addition, the Indiana state MIECHV team established a state-level CQI team to address data quality. Team members include representatives from LIAs, state MIECHV team, database representatives, MIECHV data analysis team members and subject matter experts (in program, data analysis, and quality improvement).

***Staff Turnover*:**

- ➢ Indiana State Team staff: During YEAR 8[21], the ISDH team experienced turnover for the MCH Division Director . Martha Allen left the role in 2019 and Shirley Payne, Director of the Children's Special Health Care Services (CSHCS) Division served as interim director until Eden Bezy filled the role in August 2019. During Year 9[22], Cynthia Smith left the role of DCS Prevention Services Manager. Hannah Robinson replaced Cynthia Smith in this role in October 2019. .
  - ✓ The foundation of partnership across ISDH and DCS – specifically, but not limited to, the work related to MIECHV activities since 2012 – 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 sustaining common practices, new staff have assimilated into the team with minimal disruption to practice.
- ➢ LIA staff:
  - o Local implementing agency staff: Locally, direct staff turnover was a challenge many home visiting sites experienced.
    - ✓ Throughout the project period, LIA leadership addressed challenges through practical staff recruitment, additional training and collaborative

[21] Year 8=10/1/2018-9/30/2019
[22] Year 9=10/1/2019-9/30/2020

communication with other sites experiencing similar barriers to staff retention. LIA leadership have successfully rebuilt staff as needs arise to meet service capacities and the needs of families served.

- Contracted providers:
  - During the period of availability for the FY18 Formula project, a new HFI data system – EnLite – was implemented. Some features – such as monitoring reports – have taken longer than anticipated to realize. Issues related to legacy data have also been a more formidable challenge than expected.
    - ✓ The MIECHV Grant Coordinator actively participated in many committees and advised on system changes with regard to impact on MIECHV data. Specific attention was provided to MIECHV data challenges that resulted in overall system improvement. DCS and the database provider have committed resources to continue the work towards mitigating MIECHV data challenges resulting from HFI database specific limitations.
  - Indiana's performance measurement vendor experienced staff turnover during the project period. On September 11, 2019, Indiana was informed with very little notice of a full team turnover to occur prior to October reporting activities, with one data analyst leaving in 2 days, the other data analyst and project manager leaving prior to October analysis. Prior to October analysis, while a new data analyst from the September transition remained, the project management staff assigned to the Indiana contract again completely turned.
    - ✓ The 2019 transition was detrimental to both the morale of the Indiana team, as well as the ability to minimize the impact of the HFI database transition on MIECHV data. Much energy was directed toward getting new team members up to speed on both MIECHV reporting requirements and Indiana specific challenges and data plans. Strategies to address these challenges included several phone calls and emails focused on itemized questions and clarifications. The resulting PCG team that conducted the final analysis spent focused energy on reading Indiana documentation and crafting informed questions and assistance to complete required reporting. Additionally, the PCG team committed to continue work with Indiana to improve the data review process and to minimize similar challenges in 2020 reporting. Examples of this effort include improved code that simplified the presentation process for LIAs, and improved reports to address missing data and minimize errors in missing data efforts.
  - During the period of availability for the FY18 Formula project, a new contract was put in place for a facilitator of the INHVAB. This vendor facilitates quarterly meetings, assists with agendas and communication to advisory members, and coordinates activities specific to the Advisory Board.

COVID-19:

The Year 2020 and the impact of COVID-19 was an unanticipated and unprecedented experience for all involved with Indiana MIECHV. In March of 2020, Indiana's Governor issued the first stay-at-home order which impacted the ability for home visitors to travel to and be in the homes of MIECHV-funded, evidenced-based- home visiting participants. State-level, contracted vendor(s) and LIA staff were all required to pivot very quickly to avoid disruption

in services. This required rapidly learning new software, adapting to a virtual vs. in-person meeting paradigm, creating office / work space within a family home, and in many cases creating alternative work schedules to accommodate child-care, K-12 education and/or other family members working in the home.

At the State level, state MIECHV team members made the change from fully supplied office and meeting spaces and typical in-person meetings to home work spaces and a new virtual platform in about three business days. It was a challenge to change the mindset of typical in-person meetings to the virtual meeting space. One large component that was immediately missing was the pre- and post-meeting conversations that are natural in an in-person environment. Typically, it is the "in-between" where relationships are developed and brief updates occur without resource requirements of a formal meeting. The pandemic having disposed of that paradigm in 2020 meant that team members had to adapt to a need for more meeting time that included some relationship building and an increase in communication. For the state team, implementing the Microsoft Teams working environment resulting in central document storage across state agencies, real-time collaborative report and document creation as well as consistency in meeting platforms for connecting with other partners. Meeting time was dedicated to making sure contracted vendors, LIAs and other stakeholders had access and support as needed.

The state team gathered updates from LIAs each quarter (as an expanded request during Form 4 data collection) regarding family service, challenges and celebrations. In general, family services did not experience much interruption. In some cases, families became more engaged, and new families were more interested in service with the virtual platform. Despite the stress of overcoming the major changes and challenges of COVID-19, many LIAs reported praise of their home visiting staff:

- *"My team is incredible! They have pivoted so quickly, maintained a positive attitude, and been creative to continue serving families. I am truly humbled and full of gratitude for them right now."*
- *"We are hanging in there and adapting to virtual visits. Most all of our families have been receptive to virtual visits and they have been going well!"*
- *"The nurses have adapted well to this change and continue to safely drop supplies off to families in need. We are continually evaluating the needs of our clients and nurses and supporting them in any way we can."*

LIAs received general and specific support from contracted technical assistance providers and model developers. In some cases, staff at all levels reported "technical assistance" or "COVID" overload, as resources were coming rapid fire from federal, national, model, professional association, program and funder levels. Strategies to address this fatigue included focusing on LIA or local specific need as necessary, and not creating expectation that all staff would be expert in all technical assistance.

Indiana was already dealing with a major database change in the HFI system when the pandemic began. However, this challenge was not exacerbated by COVID. In Indiana, model-specific databases were already situated to receive and export data appropriate for MIECHV reporting. In fact, data quality improvements continued even after pandemic response work environment consequences occurred.

Continuous quality improvement efforts were not overly hampered by COVID-19 restrictions. While some LIAs required adjustments to current projects at the time of initial stay-at-home

restrictions, all LIAs were receptive to technical assistance and continued to meet quality improvement expectations during 2020. Indiana is particularly proud of the efforts by LIAs in this area, as local culture of quality is championed and encouraged, but not systematically required.

IV. LESSONS LEARNED AND INNOVATIONS

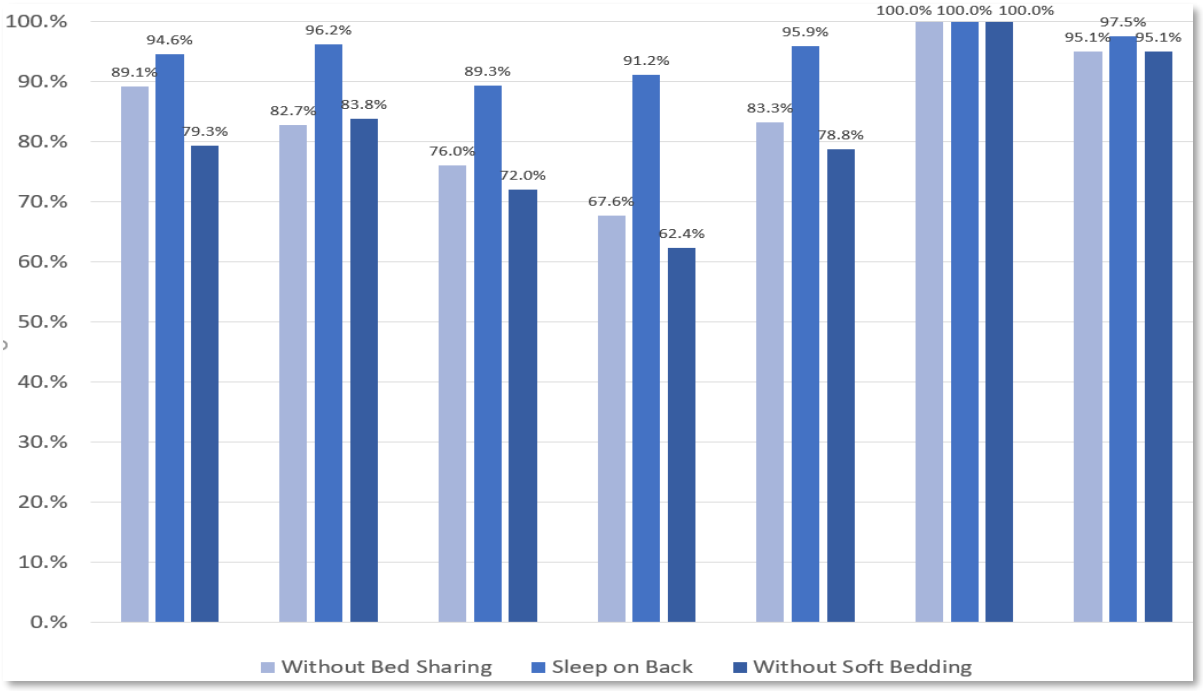
Lessons Learned:

Quarterly data reviews: – Indiana continues to view quarterly data reviews as a necessary practice that improves data quality and the timely programmatic use of data for state and local understanding of home visiting practice and impact as learned over time.

- Safe Sleep Practices: In reviewing more detailed safe sleep analysis than required for HRSA reporting, Indiana data typically reflects higher % of "back to sleep" practices, but lower % of non-bed-sharing or non-soft-bedding practices. During 2019-2020 reporting, Indiana noted the following ranges of safe sleep practices:
    - "Always on Back" – 88% - 100%
    - "No soft-bedding" – 57% - 100%
    - "No bed-sharing" – 49% - 100%

Figure F is an example of a slide used to share data with LIAs regarding Safe Sleep during quarterly data reviews.

Figure F



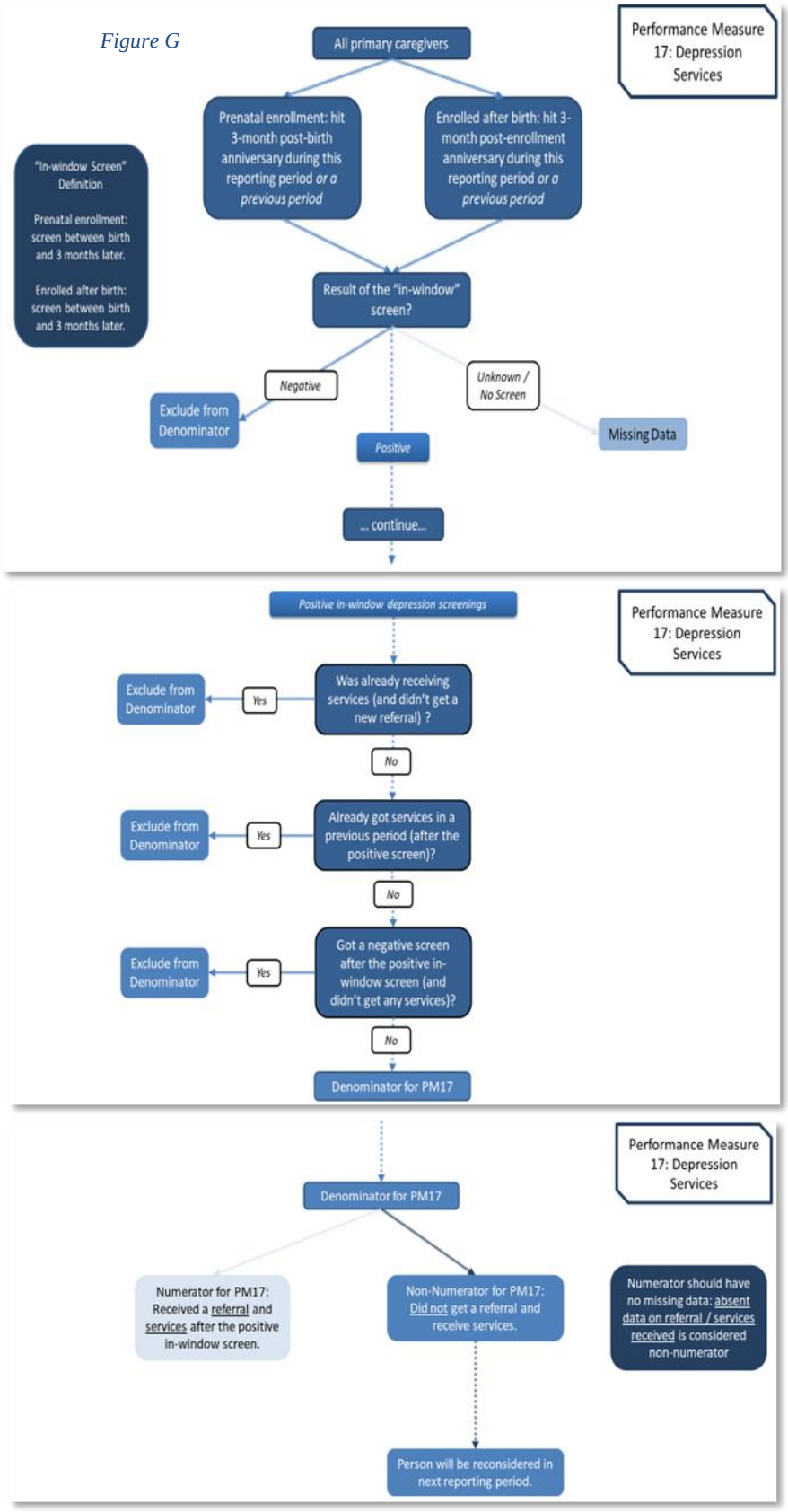
Indiana finds these typical outcomes to reflect higher % of safe sleep practice than indicated in a recent HRSA press release[23]. Nonetheless, LIAs have been focused on not only continuing the "back to sleep" messaging, but addressing concerns around bed-

[23] "Study Finds Safe Infant Sleep Practices Need Improvement", HRSA Press Release Monday October 21, 2019, https://www.hrsa.gov/about/news/press-releases/safe-infant-sleep-practices-need-improvement

sharing and soft-bedding use. At least 2 LIAs focused on safe-sleep related CQI projects during the FY18 period of availability.

- Completed Referrals: Indiana reviews depression and developmental referral data using both outcomes (percentage and number) and process map visualization (see Figure G) to better understand each step of the analysis (screen, referral, receipt of service) and what factors impact families falling out of the numerator along the way (screening after defined time period, subsequent negative screen, lack of referral, termination, and receipt of service opportunity after program completion).
- Missing Data reports: Indiana determined that too much time was spent by looking for the same missing data on multiple occasions and/or attempting

Figure G



to correct missing data for terminated families. As a result, missing data reports have been revised to distinguish between families that have terminated from those engaged in services at the time of report. Missing data reports indicate if data was actually missing (null or blank vs. unknown or other response that indicates home visitor attempted data collection) Additionally, in direct response to LIA feedback, missing data reports will now include both performance outcome specific missing data lists, and family specific data lists – in theory minimizing the time investigating family records with multiple missing data points.

Detailed data plans: During the period of availability for the FY18 formula project, Indiana identified that more robust communication was needed around the data plan for analyzing MIECHV performance outcomes. During quarterly data reviews, Indiana recognized that some topics were addressed repeatedly, with insufficient documentation to alleviate revisiting time and time again. Staff turnover exacerbated this problem, leaving sustained team members without appropriate documentation to verify previous determinations as to details within analysis code.

During 2019, Indiana developed detailed analysis plans for Form 1 and Form 2 performance measure reports. These detailed analysis plans specifically tie data collection field names and forms with analysis code and includes programmatic reference to accommodate a higher level of clarity among Indiana's data analysis, database, model-specific quality assurance, and state team members with regard to a) what data is included in the analysis, b) where data is pulled from within respecting databases, and c) exactly how data is determined to be in or out of each measure.

Innovations:

Quarterly Data Reviews: Indiana began utilizing quarterly benchmark analysis in early 2013 to reduce potential data challenges around DGIS reporting. Expanding to include review of Form 1 (demographic data) in 2017, this innovation enabled Indiana to foresee data issues prior to the required DGIS submission and prepare solutions and explanation as appropriate for the federal report, particularly around "missing" data. State level stakeholders and LIAs were invited to a formal presentation of quarterly outcomes for performance measures, including Form 1 demographics, Form 2 benchmarks and related data. CQI technical assistance staff and evaluation staff also participate in the review so as to keep apprised of data collection and reporting that may inform their practice.

LIAs received quarterly reports that included their individual performance for each benchmark construct following the formal presentation, which were reviewed individually with a MIECHV coordinator upon request or if specific concerns were evident. LIAs received quarterly missing data reports, that allowed LIAs to address missing data in a more timely manner (within 1-4 months of data entry vs. up to 13 months post data entry). Quarterly benchmark analysis not only served as practice analysis for annual reporting, it created the opportunity to inform LIAs of local outcomes of benchmarks, and has become the forum for investigating more meaningful analysis of home visiting data.

Indiana utilizes performance measure specific PowerPoint slides, data visualization and sub-analyses that is LIA-informed to provide on-going state-level monitoring and locally focused reporting. LIA representatives often discuss impacts on data collection or family outcomes from the local community perspective.

Indiana views the "deeper dive" into MIECHV performance measure data as described under

lessons learned as innovative practice, as this is not widely discussed among other LIAs. Specifically the visualization for safe-sleep and receipt of service outcomes.

Indiana is particularly excited about the lessons learned from the more detailed analysis plans described above – which have not only become instrumental in addressing database migration challenges, but have clarified and improved the quality of data Indiana reports to stakeholders. One example is that crisis mental health practice within NFP home visiting had previously been excluded from being reported as successful receipt of service for depression as the data for crisis mental health service is entered in a separate field from typical depression screening and referral. The detailed analysis plan helped to bring this oversight to the attention of state MIECHV team, and created the opportunity to revise the data plan. Indiana communicated this revision during quarterly data review to acknowledge and celebrate the work being done by local direct service staff.

Indiana identifies the quarterly benchmark analysis as a true success in achieving quality data collection and reporting.

Use of advisory groups: Combining the INHVAB and ECCS state advisory council into the same quarterly meeting has been a successful venture in collaboration across state agencies and programs. Prior to combining these entities, the INHVAB struggled with attendance, direction, and engagement. As these meetings combined, INHVAB members began to better understand the importance of home visiting within the early childhood system, and more importantly, how the services represented by the INHVAB members contribute to home visiting and a successful early childhood system. The combined INHVAB/ECCS meetings are well attended. Individual representatives appreciate the efficiency of a combined meeting and actively participate in discussions regarding collaboration that benefit Hoosier families. The INHVAB/ECCS quarterly meetings have increased individual knowledge of programs within other state agencies and inspired conversation – both in and out of the quarterly meetings – around creating efficiencies and improved services for families. As of July 2020, a contracted facilitator – Diehl Consulting – is providing objective support and facilitation for this advisory group.

***WIC Referrals*:** In response to challenges prior to the project period, an MOU was executed between DCS HFI and ISDH WIC outlining agreements to electronically share appropriate referral information on a weekly basis, assisting families in getting connected to both HFI and WIC and establishing those connections in a timely manner. Indiana continues to view this collaboration as a success in both referral and systems building.

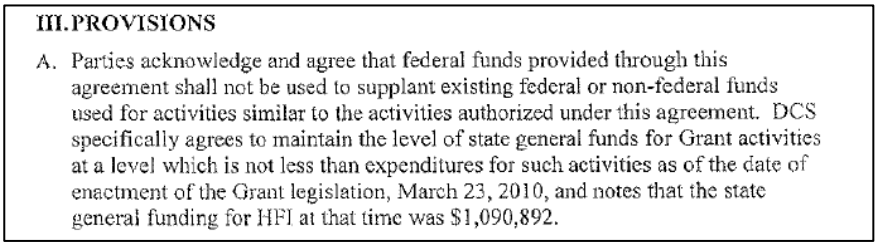
External CQI Technical Assistance and Training Provider: Indiana engaged MPHI in late 2017 to provide regular intensive technical assistance and coordination of CQI efforts. MPHI team members provide a minimum of monthly coaching sessions with each LIA serving MIECHV-funded families. MPHI conducts formal training for both beginning and experienced CQI team members via conference and virtual learning settings. MPHI meets monthly with Indiana state MIECHV team members to review LIA progress in quality improvement efforts, identify alignment with state and MIECHV priorities, review and plan to address training opportunities, and support state team members with quality improvement efforts. Indiana views this contract as innovative because it created opportunity for Indiana quality improvement practice to move beyond simply establishing culture of quality within LIAs. Indiana's CQI teams have begun to seek advanced training, engaged more team members in the quality improvement process and have expressed interest in using a variety of tools to tackle improvement opportunities. In addition to moving MIECHV quality improvement efforts

forward in an efficient and foundational manner, the MPHI team helped Indiana MIECHV to create opportunities to engage home visiting and early childhood partners beyond MIECHV in the quality improvement conversation through learning opportunities focused on topics relevant to a larger audience. Attendance at learning opportunities at the Institute for Strengthening Families has been strong, with the most recent virtual opportunity exceeding 50 participants.

V. MAINTENANCE OF EFFORT

Two Fiscal Years Prior– Actual (Corresponds to State FY 2018)	Fiscal Year Prior – Actual (Corresponds to State FY 2019)	Most Recently Completed Fiscal Year–Actual (Corresponds to State FY 2020)
Actual two years prior state FY non-federal (State General Funds) expended for the proposed project by the **recipient entity administering the MIECHV formula grant,** for the evidence-based home visiting services, in response to the most recently completed statewide needs assessment. **Include prior state general funds expended only by the recipient entity administering the MIECHV grant and not by other state agencies.** This number should equal the reported expenditures entered in the "FY Prior to Application (Actual)" column submitted as Attachment 4 in response to HRSA-20-101. (Nonprofit recipients must agree to take all steps reasonably available for this purpose and must provide appropriate documentation from the state supporting its accomplishment of the maintenance of effort/non-supplantation requirement.) **Amount: $ 1,656,688.88**	Actual prior state FY non-federal (State General Funds) expended for the proposed project by **the recipient entity administering the MIECHV formula grant,** for the evidence-based home visiting services, in response to the most recently completed statewide needs assessment. I**nclude prior state general funds expended only by the recipient entity administering the MIECHV grant and not by other state agencies.** This number should equal the reported expenditures entered in the "FY Prior to Application (Actual)" column submitted as Attachment 4 in response to HRSA-20-101. (Nonprofit recipients must agree to take all steps reasonably available for this purpose and must provide appropriate documentation from the state supporting its accomplishment of the maintenance of effort/non-supplantation requirement.) **Amount: $ 3,071,492**	Actual prior state FY non-federal (State General Funds) expended for the proposed project by the **recipient entity administering the MIECHV formula grant,** for the evidence-based home visiting services, in response to the most recently completed statewide needs assessment. **Include prior state general funds expended only by the recipient entity administering the MIECHV grant and not by other state agencies.** (Nonprofit recipients must agree to take all steps reasonably available for this purpose and must provide appropriate documentation from the state supporting its accomplishment of the maintenance of effort/non-supplantation requirement.) **Amount: $ 4,829,923.21**

The State Fiscal Year 2020 (Actual) MOE of $4,829,923.25 is different than the MOE reported to HRSA in past applications and reports prior to 2017. This is due to revised instruction and clarification as provided by HRSA that no longer includes Indiana funded home visiting services – specifically the evidenced-based program Healthy Families Indiana – administered by the Indiana Department of Child Services (DCS). While Indiana is no longer counting funding from Healthy Families Indiana in the MOE, it is listed as a provision in interagency Memorandum of Understanding (MOU) between the Indiana State Department of Health (ISDH) and DCS that DCS would provide the MOE for the MIECHV grant.



III. PROVISIONS

A. Parties acknowledge and agree that federal funds provided through this agreement shall not be used to supplant existing federal or non-federal funds used for activities similar to the activities authorized under this agreement. DCS specifically agrees to maintain the level of state general funds for Grant activities at a level which is not less than expenditures for such activities as of the date of enactment of the Grant legislation, March 23, 2010, and notes that the state general funding for HFI at that time was $1,090,892.

The State Fiscal Year 2018, 2019, and 2020 MOE is comprised of Indiana funded home visiting services – specifically the evidenced-based program Nurse-Family Partnership – administered by the ISDH. Indiana state funding for Nurse-Family Partnership is new funding as of State Fiscal Year 2018.

VI. EVALUATION SUMMARY

A. & B. Evaluation Questions, Study Design, and Target Population

The FY2018 evaluation was designed to 1) identify the supporting factors and barriers associated with implementing MHC with fidelity at the site level, 2) examine the effects of perceived MHC fidelity on staff perceptions of quality/relevance/usefulness of resources, self-efficacy, secondary trauma, compassion satisfaction, and burnout, and 3) explore the effects of MHC services on parenting and family functioning/support using a dose-response framework (i.e., increased fidelity is an increased dose).

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

A1. Research Questions	A2. Study Design	B. Target Population
RQ1. What are the supporting factors and barriers associated with implementing Mental Health Consultation with fidelity to the Mental Health Consultation model?	An implementation-focused evaluation (CFIR, 2019; Stetler et al., 2006) utilizing a qualitative design and semi-structured interviews was employed.	Interview responses were drawn from the full population of 1) HFI Program Managers and 2) Mental Health Consultants.
RQ2. To what extent are home visitor perceptions of Mental Health Consultation fidelity associated with ratings of perceived quality/relevance/usefulness of resources, self-efficacy, secondary trauma, compassion satisfaction, and burnout?	An exploratory, correlational design examined the relationship between home visitors' ratings of MHC fidelity and ratings of perceived quality/relevance/usefulness of resources, self-efficacy, secondary trauma, compassion satisfaction, and burnout.	Responses were drawn from the full population of home visitors who received MHC at HFI sites serving MIECHV-funded families (using the MIECHV MHC model).
RQ3. What is the effect of Mental Health Consultation on parenting and family functioning/support outcomes as measured by the depression, personal care, and mobilizing resources subscales of the Healthy Families Parenting Inventory (HFPI) and the emotional and verbal responsivity of primary caregiver, organization of physical and temporal environment, and parent involvement with child subscales from the Home Observation for Measurement of the Environment Inventory (HOME)? (i.e., 1) Among the families with Mental Health Consultation, do those with higher fidelity to the MHC model have better outcomes; and 2) Do families receiving MHC have better outcomes than families not receiving the enhancement?)	The evaluation team 1) determined the objective and subjective measures of fidelity that were related to family outcomes, 2) created a summary measure of fidelity for each family drawn from measures of fidelity shown to be predictive of outcomes, and 3) examined whether the fidelity score predicts family outcomes within the MHC treatment group. In a second step, an exploratory quasi-experimental matched comparison groups design was employed. MIECHV-funded families served by home visitors receiving the MHC enhancement were divided into low and high fidelity treatment groups, and each was compared to a separate matched group of non-MIECHV-funded families served by home visitors not receiving the MHC enhancement.	The matched groups were drawn from the full population of families participating in the HFI program from January 1, 2016 to December 30, 2019 (*N* = 19,302 families) for whom outcome data were available (*N* = 7,943 families). This consisted of 1,692 MIECHV-funded families receiving the MHC enhancement and 6,251 non-MIECHV-funded families. Families who enrolled in HFI prior to implementation of the Localized MHC model were excluded from the sample. Non-MIECHV-funded families (not receiving MHC) in sites serving MIECHV-funded families (receiving MHC) were excluded from the comparison groups. Decatur County and the HFI site in Marion County that does not serve MIECHV-funded families were excluded because they implemented a different model of MHC.

C. Major Findings

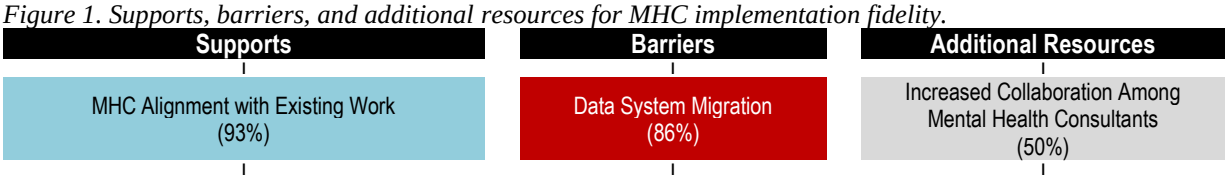
Research Question 1

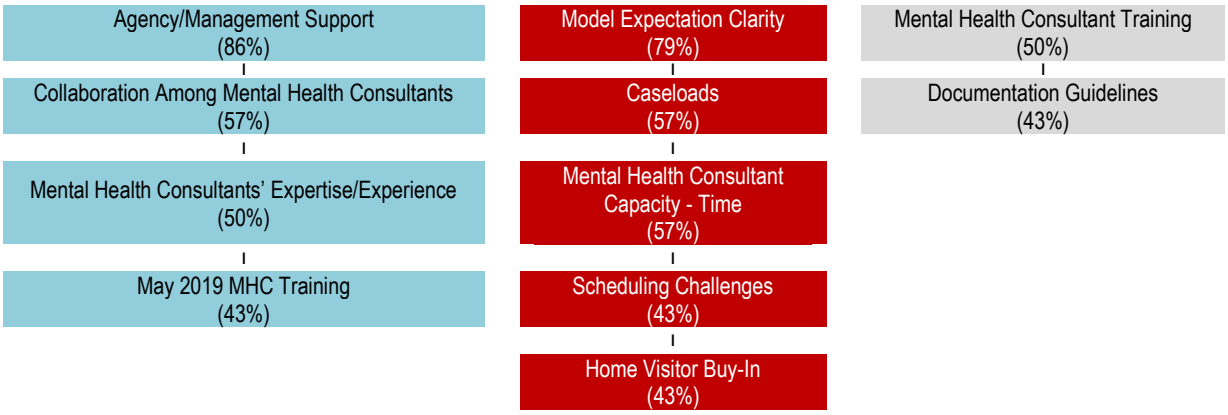
During August/September 2019, Diehl Consulting Group (DCG) completed semi-structured interviews with mental health consultants (*n* = 7) and program managers (*n* = 7).

Implementation Discrepancies. Mental health consultants and program managers reported that the majority of model expectations were met; however, most sites experienced challenges meeting documentation expectations, and some sites struggled to complete monthly reviews for all MIECHV-funded families. Most sites noted that monthly reviews were not completed and/or documented in adherence to model expectations prior to May 2019.

Supports, Barriers, and Additional Resources. Key themes described by at least 40% of participants were identified using the framework method.

Figure 1. Supports, barriers, and additional resources for MHC implementation fidelity.





Research Question 2

To examine the relationships between home visitors' ratings of MHC fidelity and ratings of perceived staff outcomes, a partial least squares-path analysis (PLS-PA) was utilized to create a fully linked model that explored the unique relationships between each fidelity measure and staff outcome. The model suggested that the individual aspects of fidelity make different, at least partially unique contributions to outcomes. There was a large, significant relationship between delivery quality and perceived quality of MHC resources. Increased participant responsiveness (i.e., home visitors' confidence completing key aspects of MHC) was associated with greater self-efficacy (a medium-sized effect) and greater compassion satisfaction (a small effect) among the home visitors. An increase in adherence to the structural aspects of fidelity (e.g., model adherence and exposure) was associated with an increase in burnout (a small effect).

Research Question 3

RQ3a. Fidelity to the MHC treatment model predicted family outcomes within the MHC treatment group for the HOME outcomes but not for HFPI outcomes. For the HOME subscales (Responsivity, Organization, and Involvement), there were effects of total fidelity score on the slopes of the outcome measures, which indicated greater improvement as fidelity increased. Effects were very small, with fidelity accounting for 1% of the variance in the change in the HOME outcomes over time. For the HFPI subscales (Mobilizing Resources, Personal Care, Depression), no effects of fidelity on the change in these subscales were observed. Supplemental analyses confirmed the findings from the primary analyses (see full report). Results suggest an effect of MHC fidelity on HOME outcomes, albeit a small one.

RQ3b. For High Fidelity MHC families, no differences in improvement were observed when compared to their matched comparison group. For Low Fidelity MHC families, significant differences were observed, with Low Fidelity MHC families showing less improvement compared to their matched comparison group. On the HOME subscales (Responsivity, Organization, and Involvement), all groups tended to improve over time except the Low Fidelity MHC treatment group, which either did not improve over time or demonstrated less improvement than other groups. On the HFPI subscales (Mobilizing Resources, Personal Care, Depression), the data suggested no changes over time for all groups except the Low Fidelity treatment group, which actually worsened over time on these subscales. Two possible interpretations have emerged from these results: 1) Because the majority of the total fidelity score was determined by factors occurring at the site level rather than at the family level, it is possible that poor performing sites both have difficulty adhering to the MHC model with fidelity and execute their invention more poorly. 2) Within the dose-response framework used for the evaluation, increased fidelity to the MHC model is interpreted as an increased treatment dose. Therefore, an alternative possibility is that because MIECHV sites are specifically selected due to their location in high-risk counties, Low Fidelity MHC families may represent higher-risk families that essentially did not receive a treatment (based on the theorized dose-response relationship that defines lower fidelity as a lower treatment dose). This may suggest that families from high-risk communities not receiving a treatment, or receiving a low-quality

treatment, may perform more poorly in general than those from lower risk communities. In this case, the fact that the High Fidelity MHC group performed the same as its matched-comparison group may indicate that it is actually performing much better than it otherwise would have without the treatment because it is composed of families from high-risk counties.

D. Limitations

RQ1. Evaluation data were drawn from self-report interviews, which can create a number of limitations including, but not limited to, social desirability bias, attribution issues, and memory errors. Moreover, responses reflected the perceptions of the interviewee and may not be independently verifiable. Finally, responses reflect each participant's understanding of specific MHC model expectations and may have varied across respondents and/or have been inconsistent with the MHC contractual expectations. **RQ2.** Due to the small sample size, the analysis was "rank deficient" (i.e., there were more measurement items (88) than observations (N = 66)). As a result, the overall analysis is not as reliable as a non-rank deficient analysis; therefore, some caution in interpretation is necessary. In particular, one should use caution when interpreting any small effects because small effects in a small sample may not be present or even reverse direction in a larger sample. Large effects may be viewed as preliminary evidence of relationships among variables; however, these findings would benefit from further investigation. **RQ3.** *Propensity Score Matching/Quasi-Experimental Research.* While propensity score matching was used to create comparison groups that were similar to the families participating in MHC, the process cannot control all bias and should not be considered equivalent to a true experimental study. These analyses should be interpreted as only preliminary evidence of impacts. *HFPI.* Overall, the HFPI appeared less sensitive to detecting changes in family outcomes over time. It is unclear if these issues are the result of the outcomes themselves (i.e., HFPI outcomes are particularly resistant to change) or measurement problems (i.e., issues with the scale or how it is administered/scored). Alternatively, emerging findings from Oklahoma's MIECHV program (which showed that home environment mediated other outcomes) may provide additional context these results. *Fidelity.* While fidelity has improved, opportunities for sites to improve the implementation of MHC remain, especially in the areas of documentation and family review. It is important to interpret the findings within the context of fidelity improvement. While families within the High Fidelity MHC treatment group had higher fidelity scores than families in the Low Fidelity MHC group, it is likely that many of the High Fidelity MHC families received services that did not satisfy model requirements. *Home Visitor Fidelity Measures.* Structural fidelity as measured by the home visitor survey was not associated with structural fidelity as measured by secondary activity data. Review of these measures suggested that home visitors may not be the best source of information for some aspects of structural fidelity. While they should have strong insights related to the model expectations in which they are directly involved, accurately recalling other model expectations might be difficult. Finally, psychometric concerns emerged related to the IN MHC Fidelity Scale. The development of new tools to assess staff-perceived fidelity should be considered.

E. Implications of Evaluation Findings

The results suggest that participation in MHC may provide benefits for families, home visitors, and agencies; however, implementing the enhancement with fidelity is essential for improving outcomes for stakeholders. For families in particular (RQ3), the evaluation found that increased fidelity to the treatment model was associated with improved outcomes in the areas of *emotional/verbal responsivity* ("the communicative and affective interactions between the caregiver and the child"), *organization of physical and temporal environment* ("how the child's time is organized outside the family house, [and] what the child's personal space looks like), and *parent involvement* ("how the adult interacts physically with the child") (Totsika & Sylva, 2004, p. 26). Matched-comparison analyses may suggest that when implemented with higher levels of fidelity, MHC could provide some mitigation for negative parenting outcomes experienced by families in high-risk communities. The evaluation also provided preliminary evidence to identify the model components that appear to have the strongest relationships with family outcomes when implemented with fidelity: family reviews, reflective practice, clinical consultation, clinical risk assignment, and MHC training. Moreover, there appears to be a link between longer family

participation in MHC and improved outcomes. It is important to note that given the small effect sizes observed for all family outcomes, the magnitude of family improvements may be very limited when fidelity is improved. For home visitors (RQ2), the study identified how individual dimensions of MHC fidelity contribute to better outcomes. Specifically, the quality of MHC delivery was positively associated with perceived *quality of resources*. Increased home visitor responsiveness (i.e., confidence completing key aspects of MHC) was associated with greater *self-efficacy* (i.e., confidence providing support in the areas of drugs/alcohol, mental health, partner violence, behavior management, and child development) and greater *compassion satisfaction* (i.e., job satisfaction related to helping others). While the effect size was small, there was some evidence to suggest that when MHC is implemented with higher levels of structural fidelity (i.e., model adherence and exposure), there was greater *burnout* among home visitors, and this finding is important as adaptations to the model are considered. At the program level (RQ1), qualitative interview responses indicated that while improvements to implementation fidelity have occurred, some sites continue to struggle with documentation and monthly reviews for all MIECHV-funded families. At the time of the interviews, strategies to maximize fidelity were still in the early stages. Mental health consultants and HFI program managers identified a variety of factors currently in place that support implementation, as well as barriers that hinder fidelity. Finally, respondents provided recommendations for improving the quality of implementation. In summary, findings examining family and home visitor outcomes (RQ3 and RQ2, respectively) provide preliminary support for continuation of the model, especially with strategies in place to improve the fidelity of implementation. Interview responses (RQ1) provide valuable insight to understanding deficiencies in current implementation, identifying strengths and gaps, and developing strategies to strengthen the model and its implementation. These data have and will continue to inform program-level decision-making in Indiana.

F. Lessons Learned

The FY2018 evaluation reinforces the importance of fidelity as a necessary ingredient for improving outcomes for MHC families and home visitators. The FY2018 evaluation results have established clear links between increased fidelity and improved outcomes for both families and home visitors; however, some effects were very small. Along with promoting fidelity generally, the results also demonstrate the unique contributions of individual fidelity dimensions, which supports the development of robust strategies to improve implementation that would include a focus on delivery quality, participant responsiveness, exposure, and adherence (James Bell Associates, 2009). Moreover, resources may be maximized by prioritizing model components that are positively associated with improved stakeholder outcomes. Potential effects on home visitor burnout should be considered as strategies are developed. Mental health consultant and program manager interview responses identify existing supports and barriers, as well as additional resources that could support implementation. In summary, results provide data necessary to identify strengths and gaps in implementation, isolate critical model components to maximize resources, and develop practical strategies for improving fidelity. Preliminary findings from the FY2018 evaluation were presented to DCS Prevention Staff during spring 2020, and these data were used to guide the development of Indiana's FY2020 MIECHV application, particularly through strategies to improve MHC and increase fidelity across sites via a variety of new supports and resources. Moving forward, the data suggest that by increasing MHC fidelity across participating sites, Indiana may experience improved outcomes for families participating in the program; however, because of the small effect sizes observed, the magnitude of family improvements may be limited as fidelity is improved.

VII. EVALUATION DESIGN

A. Entities/Organizations Responsible for Collection and Reporting Evaluation Data

Diehl Consulting Group (DCG) is an Indiana-based evaluation firm with offices in Evansville and Indianapolis. Dr. Dan Diehl and Sam Crecelius were Co-Principal Investigators for the FY2018 evaluation and were supported by Dr. Kelly Goedert, field consultant, and Amanda Vote and Jennifer Bellville who are consultants in the group. In partnership with Indiana Department of Child Services

(DCS), DCG 1) designed/identified survey instruments, 2) managed data collection, 3) cleaned and analyzed data, and 4) reported evaluation findings and recommendations.

B. Evaluation Rationale

The FY2018 evaluation was designed to 1) identify the supporting factors and barriers associated with implementing MHC with fidelity at the site level, 2) examine the effects of perceived MHC fidelity on staff perceived outcomes, and 3) explore effects of MHC on parenting and family functioning/support using a dose-response framework that considered increased fidelity as an increased dose.

RQ1. The evaluation examined supporting factors and barriers associated with implementing MHC with fidelity. While not an evidence-based model, specific model expectations have been developed and are governed by contractual obligations agreed to by sites. Concerns related to implementation fidelity emerged during the FY2016 evaluation, and program sites varied in the extent to which they offered the enhancement with fidelity. Based on these findings and supported by the implementation-focused evaluation approach (Stetler et al., 2006) and the CFIR framework, the FY2018 evaluation identified 1) discrepancies that existed between model expectations and implementation, 2) resources to support improved Mental Health Consultation implementation fidelity, and 3) actionable barriers associated with implementing MHC with fidelity. The FY2018 evaluation incorporated a qualitative study to examine supporting factors and barriers to implementing MHC with fidelity, as reported by site-level staff.

RQ2. The study examined the extent to which home visitors' perceptions of MHC fidelity were associated with ratings of quality/relevance/usefulness of resources, self-efficacy, secondary trauma, compassion satisfaction, and burnout. The current study draws from recent studies of reflective practice and focused more intentionally on staff outcomes that are aligned with MHC. Specifically, staff outcomes selected for the FY2018 evaluation emerged from FY2016 evaluation findings.

RQ3. The study examined the relationship between participation in MHC and family outcomes using a dose-response framework that considered increased fidelity to the treatment model as an increased dose. Implementation fidelity was identified as a concern during the FY2016 evaluation. The FY2018 evaluation incorporated fidelity into the examination of family outcomes via exploratory analyses designed to 1) determine which fidelity measures were related to better family outcomes, 2) examine whether overall fidelity score predicted family outcomes, and 3) compare the outcome trajectory of high fidelity and low fidelity MHC participants to propensity matched non-MHC families. The selection of family outcomes was focused solely on domains that are theorized to be influenced by the MHC model.

C. Description of Adaptation/Enhancement

HFI MHC services are currently provided to all MIECHV-funded families receiving HFI services. This enhancement was originally conceived as a centralized provision of service through a single contractor. In January 2016, MHC transitioned to a localized provision of service with the intention of increasing availability of the consultant to direct program staff and the cultural responsiveness of the consultant to the local needs. Services are provided by licensed mental health clinicians who are located within the local agency. In each site, a locally-based, licensed clinician is hired or contracted as the mental health consultant and is available to support home visitors between two and five days per week. Core responsibilities include: (a) monitoring all MIECHV-funded family records (newly enrolled and on-going families) to assess risk and identify families with greater need; (b) one hour per month of reflective practice with home visitors serving MIECHV-funded families; (c) reviewing cases with home visitors and assisting home visitors in developing strategies to address client mental health; and (d) monitoring and identifying overall trends related to mental health concerns in program sites and conducting trainings.

Table 2. Comparison of model components.

Original Model	Revised Model (2016)
Single licensed clinician provided oversight for three Advanced Family Support Specialists (AFSS).	No "oversight" of mental health consultants as a group beyond contract requirements. Reflective supervision group available for clinical support.
Licensed clinicians did not meet directly with home visitors.	Licensed clinician(s) meets directly with home visitor.
AFSS met with home visitors.	AFSS role eliminated; services provided directly by licensed clinician(s).

Three AFSS served nine sites in seven counties.	Localized licensed clinician(s) serving each site.
AFSS may not be from or familiar with local community.	Licensed clinician(s) from local community.
AFSS reviewed family record.	Licensed clinician(s) reviews family record.
AFSS provided MHC.	Licensed clinician(s) provides MHC.
AFSS provided reflective supervision as part of the HFI model.	Licensed clinician(s) provides reflective practice in addition to HFI model supervision.
Reflective supervision counted as standard HFI model supervision.	Reflective practice and consultation beyond standard HFI model supervision.
HFI model supervisor was not present for consultation or reflective supervision.	HFI model supervisor is usually present for consultation and reflective practice ensuring continuity of guidance for home visitor.
AFSS were based at centralized locations, not at site.	Licensed clinician(s) based at local site.
AFSS provided training upon request.	Licensed clinician(s) required to provide staff training at a minimum of once every other month.

D. Use of Prior Evaluation Findings

While not a continuing evaluation, prior evaluations were incorporated into planning (see full report).

E. Theory of Change and Evaluation Framework

Theory of Change. MHC was designed to support home visitors, strengthen home visitors' skills, and increase home visitors' ability to help at-risk families. As recommended by Segal et al. (2012), the MHC enhancement is theory-driven and incorporates a defined theory of change. MHC is based on the theory that change occurs within the context of the relationships that consultants build with home visitors. Specifically, MHC is theorized to improve service quality by providing individualized resources and guidance, modeling reflective practice, and supporting staff whose work is emotionally challenging (Hunter, Davis, Perry, & Jones, 2016; Watson, Bailey, & Storm, 2016). The consultant establishes a climate of mutuality, reciprocity, and collaboration through which he or she moves beyond solely providing one-way instruction to promoting exploration, modeling relationships, and potentially altering the home visitor's internal experience (Johnston & Brinamen, 2012). Through parallel process, home visitors replicate these relationships in their work with families using reflective practice. Moreover, reflective practice provides support for practitioners working in emotionally-charged, stressful situations (Johnston & Brinamen, 2012; Watson, et al., 2016). Positive shifts in the family-home visitor relationship; improved self-efficacy, and capacity for reflection; and the additional resources provided by the mental health consultant are theorized to improve the quality of home visiting services (Hunter et al., 2016; Johnston & Brinamen, 2012; Watson et al., 2016).

Evaluation Framework. The FY2018 evaluation utilized a mixed-methods approach to answer the research questions and incorporated several evaluation approaches. It incorporated formative approaches (process and implementation evaluation) to address RQ1 and summative approaches (outcome-based evaluation) to examine RQ2 and RQ3 (Church & Rogers, 2006; Trochim, 2000). These approaches provided the most effective vehicles through which evaluation questions could be answered. The formative evaluation utilized for RQ1 was supported by the implementation-focused evaluation approach (Stetler et al., 2006), which includes a focus on "resolving actionable barriers, identifying levers of change, and refining components of the implementation" (CFIR, 2019, np). The evaluation incorporated principles of the utilization-focused evaluation approach to engage stakeholders in evaluation activities.

F. Outcomes

Table 3. Summary of evaluation outcomes by research question.

Research Question	Outcomes	Data Collection	Analysis
RQ1. What are the supporting factors and barriers associated with implementing MHC with fidelity to the MHC model?	1) Perceptions of MHC model implementation (e.g., feasibility, supporting factors, barriers)	Program Manager Interviews: *Program Manager Semi-Structured Interview Guide* Mental Health Consultant Interviews: *Mental Health Consultant Semi-Structured Interview Guide*	Framework Analysis

RQ2. To what extent are home visitor perceptions of MHC fidelity associated with ratings of perceived quality/relevance/usefulness of resources, self-efficacy, secondary trauma, compassion satisfaction, and burnout?	Short-term Outcomes: 1) Home visitor self-efficacy, 2) quality/relevance/usefulness of resources, 3) home visitor burnout, 4) home visitor compassion satisfaction, and 5) home visitor secondary trauma	Home Visitor Surveys: (1) *Professional Quality of Life Scale*, (2) *IN MIECHV Survey for HFI Home Visitors,* (3) *IN MHC Resources Scale*	Partial-Least-Squares Path Analysis
RQ3. What is the effect of MHC on parenting and family functioning/support outcomes?	Intermediate Outcomes: 1) depression, 2) personal care, 3) mobilizing resources, 4) emotional and verbal responsivity of primary caregiver, 5) organization of physical and temporal environment, and 6) parent involvement with child	Family Outcome Data: (1) *Healthy Families Parenting Inventory* (HFPI) and (2) *Home Observation for Measurement of the Environment Inventory* (HOME)	Mixed Linear Modeling

G. Target Populations

Table 4. Target population.

Research Question	Target Population
RQ1	The target population consisted of all program managers and mental health consultants employed by HFI sites serving MIECHV-funded families using the MHC model. The interviews focused only on current consultants and managers. Consultants and managers providing the enhancement for fewer than three months were excluded from the sample. HFI program managers and mental health consultants were selected because of their firsthand experience with the implementation of MHC model components.
RQ2	Responses were drawn from the full population of home visitors who received MHC at HFI sites serving MIECHV-funded families using the MHC model. Home visitors were selected because of their firsthand experience with the staff outcomes explored by this research question.
RQ3	The matched comparison groups were drawn from the full population of families participating in the HFI program from January 1, 2016 to December 30, 2019 (N = 19,302 families) for whom outcome data were available (N = 7,943 families). This consisted of 1,692 MIECHV-funded families receiving MHC and 6,251 non-MIECHV-funded families. Families who enrolled in HFI prior to implementation of the Localized MHC model (i.e., before January 2016) were excluded from the sample. To limit contamination, non-MIECHV-funded families (not receiving MHC) in sites serving MIECHV-funded families (receiving MHC) were excluded from the comparison groups. Families in Decatur County were excluded from the comparison group because they implement a different model of MHC through a separate funding source. The HFI site in Marion County that does not serve MIECHV-funded families was excluded because they implemented a prior model of MHC.

H. Evaluation Questions

To address study goals, three research questions were identified.

Table 5. Summary of research questions.

Research Question 1. What are the supporting factors and barriers associated with implementing Mental Health Consultation with fidelity to the Mental Health Consultation model?

- **RQ1a.** What discrepancies exist between the model expectations and implementation at the site level?
- **RQ1b.** What resources would support improved Mental Health Consultation implementation?
- **RQ1c.** What actionable barriers impede Mental Health Consultation implementation?

Research Question 2. To what extent are home visitor perceptions of Mental Health Consultation fidelity (as measured by the *IN MHC Fidelity Scale*, *Reflective Supervision Rating Scale*, and *Reflective Supervision Self-Efficacy Scale*) associated with ratings of perceived quality/relevance/usefulness of resources, self-efficacy, secondary trauma, compassion satisfaction, and burnout as measured by the *IN MIECHV Survey for HFI Home Visitors, IN MHC Resources Scale*, and the *Professional Quality of Life Scale*?

Research Question 3. What is the effect of Home Visitor Mental Health Consultation on parenting and family functioning/support outcomes as measured by the depression, personal care, and mobilizing resources subscales of the *Healthy Families Parenting Inventory* (HFPI) and the emotional and verbal responsivity of primary caregiver, organization of physical and temporal environment, and parent involvement with child subscales from the *Home Observation for Measurement of the Environment Inventory* (HOME)? *(i.e., 1) Among the families with Mental Health Consultation, do those with higher fidelity to the MHC model have better outcomes; and 2) Do families receiving MHC have better outcomes than families not receiving the enhancement?)*

- **RQ3a.** Does fidelity to the MHC treatment model predict family outcomes within the MHC treatment group?
- **RQ3b.** Do high and low fidelity MHC treatment groups have better family outcomes than non-MHC comparison groups?

I. Evaluation Design

Table 6. Summary of evaluation design.

Research Question	Design	Aims	Measurement
RQ1	An implementation-focused evaluation (CFIR, 2019; Stetler et al., 2006)	The study explored staff perceptions of model implementation. Interview responses were drawn	Responses were collected through semi-structured interviews using interview guides.

	utilizing a qualitative design and semi-structured interviews was employed.	from the full population of 1) HFI Program Managers and 2) Mental Health Consultants.	
RQ2	An exploratory, correlational design was employed.	The study examined the relationship between home visitors' ratings of MHC fidelity and ratings of perceived quality/relevance/usefulness of resources, self-efficacy, secondary trauma, compassion satisfaction, and burnout.	Ratings were drawn from survey responses provided by home visitors participating in the enhancement.
RQ3	An exploratory mixed methods design was employed that utilized dose-response correlational and matched-groups designs.	The FY2018 evaluation incorporated fidelity into the examination of family outcomes via exploratory analyses designed to 1) determine which fidelity measures were related to better family outcomes, 2) examine whether overall fidelity score predicts family outcomes, and 3) compare the outcome trajectory of high fidelity and low fidelity MHC participants to propensity matched non-MHC families.	**Family outcomes** were measured using the Healthy Families Parenting Inventory (HFPI) and Home Observation for Measurement of the Environment Inventory (HOME). **Fidelity measures** included the IN MHC Fidelity Scale, Reflective Supervision Rating Scale, Reflective Supervision Rating Scale – Adapted for Mental Health Consultant, Reflective Supervision Self Efficacy Scale, and Secondary Activity Reports.

J. Rationale for Design

RQ1. A qualitative design using semi-structured interviews was selected because interviews allowed the interviewer to examine specific pre-determined concepts, while providing the flexibility to explore particular themes or concepts in greater detail. The use of structured interviews with an interview protocol (rather than an interview guide) was considered, but due to exploratory nature of the study, final questions were open-ended and included prompts to encourage new ideas.

RQ2. The FY2016 evaluation suggested that MHC fidelity varied in terms of model adherence, exposure, quality, and participant responsiveness across sites. Based on this, a correlational design was selected to explore the association between consultation fidelity and staff outcomes. Due to the nature of the intervention, it was not feasible nor appropriate to manipulate MHC fidelity (e.g., ethical considerations, inability to randomize subjects/ locations) (Harris et al., 2006). Given the exploratory nature of the research question, the current design provided the opportunity to examine the variables of interest in their natural setting and support future research.

RQ3. The study used a multi-pronged approach to examine the relationship between participation in MHC and outcomes for families, while examining the role of implementation fidelity. The study explored both the dose-response relationship between treatment and family outcomes (with increased fidelity equaling increased dose) and compared outcomes between treatment (high fidelity and low fidelity) and matched non-treatment groups. Along with responding to fidelity concerns identified in the FY2016 evaluation, RQ3 was designed to address evaluation technical assistance recommendations provided in 2017. Several analytic revisions, including MLM, were made to increase study rigor. Moreover, the selection of family outcomes was guided by HomVee guidelines (Avellar and Paulsell, 2011) and focused solely on domains that were theorized to be influenced by the MHC model.

K. Evaluation Timeline

Table 7. Evaluation Timeline

Deliverable Task	2018			2019												2020									
	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
Initial Evaluation Planning	■	■	■	■																					
Ongoing Evaluation Planning and Communication					■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Submit Initial Evaluation Plan				■																					

Table 7. Evaluation Timeline																											
Deliverable Task	2018			2019												2020											
	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		
DOHVE, HRSA OPRE Review				■	■	■	■	■																			
Evaluation Plan Revisions						■																					
IRB Submission								■																			
Family Data Collection (RQ3)*	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■												
Secondary Activity Data (RQ3)*	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■												
Initial Propensity Score Model											■	■															
Initial Family Data Export/Exploration (RQ3)									■	■																	
Staff Survey (RQ2/RQ3)									■	■	■	■															
Mental Health Consultant Survey									■	■	■	■															
Semi-Structured Staff Interviews (RQ1)												■	■	■	■	■											
Final Propensity Score Model													■	■													
Final Family Data Export (RQ3)													■	■													
Preliminary Analyses															■	■	■										
Preliminary Report																		■	■	■							
Final Analyses																		■	■	■	■	■	■	■	■	■	
Final Report																									■	■	
*Note: Administrative data collected as part of normal service delivery and independent of the FY2016 evaluation.																											

L. Instruments

Table 8. Instruments.

Research Question	Instrument	Details
RQ1	Semi-Structured Interview Guide	The interview guides provided interview questions, prompts, and guidance for the interviewer regarding interview structure (Cherry, 2000; Fowler, 2004; Garvin, Cannuscio, & Branas, 2013; Lindof & Taylor, 2011). Open-ended interview questions were developed to determine the factors influencing successful implementation. Based on FY2016 findings, items included a specific focus on the expectations that were not met, along with a general focus on fidelity. Through the implementation-focused evaluation approach, the evaluation focused on identifying discrepancies that existed between the MHC expectations and implementation, resources to support improved MHC implementation, and actionable barriers.
RQ2	The Professional Quality of Life Scale	The 30-item *Professional Quality of Life Scale* (ProQOL) (Stamm, 2009) was designed to assess compassion satisfaction and compassion fatigue among professionals in the helping professions. Items were scored on a 5-point Likert-type scale (Never to Very Often). In the current study, moderate levels of internal consistency were observed for *Compassion Satisfaction* (α = .91), *Burnout* (α = .77), and *Secondary Traumatic Stress* (α = .76). *Rationale:* MHC is theorized to improve service quality by providing support for practitioners working in emotionally-charged, stressful situations (Johnston & Brinamen, 2012; Watson, et al., 2016). The selection of this outcome was based on the theory of change and logic model.
RQ2	IN MIECHV Survey for HFI Home Visitors	The *IN MIECHV Survey for HFI Home Visitors* utilizes the *Self-Efficacy* subscale (6 items) from the *MIHOPE Home Visitor Survey – Baseline* that was modified for the purposes of this study. Each item was scored on a 7-point Likert scale (Strongly Agree to Strongly Disagree). In the current study, acceptable levels of internal consistency were observed (α =.89). *Rationale:* Through MHC, mental health consultants provide individualized resources and guidance, model reflective practice, and support staff whose work is emotionally challenging. Staff who receive high quality MHC are theorized to have higher self-efficacy.

Research Question	Instrument	Details
RQ2	IN MHC Resources Scale	The 11-item IN MHC Resources scale was developed for the current study. Each item was scored on a 5-point Likert scale (Strongly Agree to Strongly Disagree). The study examined psychometric properties using Scaling Procedures in SPSS (Green & Salkind, 2011) and found no problematic items. A principal components analysis yielded one factor that explained 85% of variance. All items loaded successfully on the first factor, with loadings of .79 or greater. Results were consistent with intentions of the developers. In the current study, high levels of internal consistency were observed (α =.98). *Rationale:* The scale was developed to examine the quality, relevance, and usefulness of resources provided through MHC. Items were informed by FY2016 home visitor survey and mental health consultant interview responses.
RQ2/3	IN MHC Fidelity Scale	The 11-item IN MHC Fidelity Scale was designed for the current study to measure adherence and exposure to the MHC model based on Indiana's specific model expectations. Two subscales were developed: *Model Adherence* (4-items) and *Model Exposure* (7-items). *Model Adherence* was scored on a 4-point Likert-type scale (No Families to All Families), and *Model Exposure* was scored on a 7-point Likert-type scale (Never to More Than Once a Month). A confirmatory principal components analysis of the *Model Adherence* items and *Model Exposure* items did not confirm the structure of the scale as designed. Furthermore, while the *Model Adherence* scale, as originally structured, had adequate reliability (α = .85), the *Model Exposure* scale did not (α = .75). Because of these properties, all items were considered a single factor. *Rationale:* This scale was developed to measure two dimensions of fidelity not addressed adequately by existing scales.
RQ2/3	Reflective Supervision Rating Scale.	The 17-item *Reflective Supervision Rating Scale* (RSRS) (Gallen et al., 2016) was designed to measure reflective supervision fidelity and the quality of reflective sessions. Four subscales comprise the RSRS: *Reflective Process and Skills* (6 items), *Mentoring* (6 items), *Supervision Structure* (3 items), and *Mentalization* (5 items). In the current study, high levels of internal consistency were observed for the full scale (α =.87) and the subscales: *Reflective Process and Skills* (α = .91), *Mentoring* (α = .94), *Mentalization* (α = .89) and *Supervision Structure* (α = .87). *Rationale:* The scale was designed to assess the quality of reflective supervision and was designed specifically to support fidelity measurement.
RQ2/3	Reflective Supervision Self-Efficacy Scale for Supervisees	The 15-item *Reflective Supervision Self-Efficacy Scale for Supervisees* (Shea et al., 2012) was designed to assess supervisees' confidence participating in components of reflective supervision. Each item was scored on a 5-point Likert-type scale (No Confidence to Extremely High Confidence). During the current evaluation, high levels of internal consistency were observed (α = .93). *Rationale:* The scale includes items that are aligned with the style of supervision provided to home visitors through the enhancement. The scale examined the extent to which home visitors were confident in their ability to successfully complete critical components of reflective practice.
RQ2/3	Reflective Supervision Rating Scale – Mental Health Consultant	The scale was adapted for mental health consultants by the evaluation team. Psychometric properties were examined using Scaling Procedures in SPSS (Green & Salkind, 2011) and found no problematic items. In the current study, acceptable levels of internal consistency were observed for the full scale (α =.81). Due to the small sample size (*N* = 8), diagnostics were limited. *Rationale:* The scale was designed to assess the quality of reflective supervision and to support fidelity measurement.
RQ3	Secondary Activity Reports	Data related to program outputs were drawn from Secondary Activity Reports. Secondary activity data were recorded by mental health consultants as part of their normal duties. DCS/HFI requires that mental health consultants provide service documentation using Secondary Activity Reports, which included all contractual obligations. Data were entered into the HFI data system by mental health consultants using procedures established by DCS/HFI and the database provider. *Rationale:* Secondary Activity Reports were utilized because they provided objective documentation of the completion of model expectations.
RQ3	Home Observation for Measurement of the Environment Inventory (HOME)	The 45-item HOME (Caldwell & Bradley, 1984) assesses the presence of emotional support and cognitive stimulation in the home through six subscales. Statements that make up the inventory are scored "Yes" or "No" by a trained assessor following direct observation and a semi-structured interview with the primary caregiver (Totsika & Sylva, 2004). High levels of inter-rater reliability (> .80) have been reported for the HOME; however, some issues with internal consistency have been reported, with Cronbach's α coefficients ranging from .30 to .80 (Bradley, 1993; Totsika & Sylva, 2004). Due to the manner in which data were provided, item-level survey responses were not available for psychometric testing. The FY2018 evaluation focused on three subscales: *Emotional and Verbal Responsivity of Primary Caregiver*, *Organization of Physical and Temporal Environment*, and *Parent Involvement with Child*. *Rationale:* The use of the HOME was informed by the MHC theory of change and supported by prior results.
R3	Healthy Families Parenting Inventory (HFPI)	The 63-item HFPI (LeCroy & Milligan 2004a; LeCroy et al., 2007) was designed to assess change in eight parenting domains. These domains were supported by an exploratory factor analysis, and each subscale had acceptable levels of internal consistency, with α coefficients ranging from .76 to .92 (Krysik & LeCroy, 2012). Due to the manner in which data were provided, item-level survey responses were not available for psychometric testing. The FY2018 evaluation focused on three subscales: *Mobilizing Resources*, *Personal Care*, and *Depression*. *Rationale:* The use of the HPFI was informed by the MHC theory of change and supported by prior results.

M. Design Specific Components

Description of Qualitative Approach. The content analysis approach was employed using the framework method (Ritchie & Spencer, 1994), which can be applied to either deductive or inductive research across various epistemological, philosophical, or theoretical approaches (Gale et al., 2013; Hsieh & Shannon, 2005, Pope et al., 2000; Ritchie & Spencer, 1994). See *X. Analytic Methods*.

Definition and Collection of Fidelity Components. The assessment of fidelity examined four dimensions: Adherence, Exposure, Quality of Delivery, and Participant Responsiveness (James Bell Associates, 2009). Specific tools were informed by model expectations and relevant literature. While not an evidence-based model, specific model expectations have been developed for MHC and are governed by contractual obligations agreed to by sites and staff. These contractual expectations informed measures of Adherence and Exposure, which included administrative data collected by mental health consultants and a new instrument developed specifically for the evaluation. For a more robust examination of fidelity, instruments were identified in the literature that assessed Delivery Quality and Participant Responsiveness within the context of reflective supervision. See *VII. L Instruments*.

Table 9. Instruments by fidelity dimension.

Fidelity Dimension	Instruments
Adherence	*IN MHC Fidelity Scale, Secondary Activity Reports*
Exposure	*IN MHC Fidelity Scale*
Quality of Delivery	*Reflective Supervision Rating Scale* (Gallen, Ash, Smith, Franco, & Wilford, 2016); *Reflective Supervision Rating Scale – Adapted for Clinician* (Gallen, Ash, Smith, Franco, & Wilford, 2016)
Participant Responsiveness	*Reflective Supervision Self-Efficacy Scale* (Shea, Goldberg, & Weatherston, 2012)

VIII. DATA COLLECTION METHODS AND SCHEDULE

A. Data Collection

Table 10. Data collection summary.

Data Collection Activity	Data Collection Instrument(s) Used	Respondents	Frequency of Data Collection
Mental Health Consultant Interviews	Mental Health Consultant Semi-Structured Interview Guide	7 mental health consultants	Fall 2019
Program Manager Interviews	Program Manager Semi-Structured Interview Guide	7 program mangers	Fall 2019
Family Outcomes: Emotional and verbal responsivity of primary caregiver, organization of physical and temporal environment, and parent involvement with child	*Home Observation for Measurement of the Environment Inventory (HOME)*	Low Fidelity: 779 MIECHV-funded enhancement families and 779 non-MIECHV-funded families High Fidelity: 487 MIECHV-funded enhancement families and 487 non-MIECHV-funded families	2-month, 4-month, 12-Month HOME*
Family Outcomes: Depression, personal care, and mobilizing resources	*Healthy Families Parenting Inventory (HFPI)*	Low Fidelity: 779 MIECHV-funded enhancement families and 779 non-MIECHV-funded families High Fidelity: 487 MIECHV-funded enhancement families and 487 non-MIECHV-funded families	3-month, 6-month, 12-Month HFPI*
Fidelity: Home Visitor Surveys	*IN MHC Fidelity Scale, Reflective Supervision Rating Scale, Reflective Supervision Self-Efficacy Scale for Supervisees, Professional Quality of Life Scale, IN MHC Resources Scale, IN MIECHV Survey for HFI Home Visitors*	74 Home Visitors	Summer 2019
Fidelity: Mental Health Consultant Survey	*Reflective Supervision Rating Scale – Adapted for Mental Health Consultant*	8 mental health consultants	Summer 2019
Fidelity: Secondary Activity Data	*Family - Clinical Risk Assignment, Family – Monthly Review by Mental Health Consultant, Home Visitor – Monthly Clinical Consultation, Home Visitor – Monthly Reflective Practice, Home Visitor – Monthly Meetings with Mental Health Consultant, Bi-Monthly Home Visitor Training*	8 mental health consultants	Ongoing*

Note: * Family data and secondary activity data collected outside of the evaluation as part of normal home visiting activities.

B. Design Specific Components

Description of Data Collected at Multiple Time Points. The family outcomes were collected at multiple time points. The *HFPI* was completed by the primary caregiver as early as possible (by 3 months) and at 6 months, 12 months, 24 months, and 36 months from the date of baby's birth. The *HOME* was completed by HFI staff through observation and documentation of the Target Child at 2 months, 4 months, 12 months, and 18 months. For both instruments, the study focused on administrations occurring during the first 12 months.

Description of Consistent Data Collection and Time Points. Family data were drawn from existing sources, which were collected by HFI staff and/or contracted vendors and stored using the HFI data system. All family data collection was completed by staff as part of normal service delivery. Strict guidelines are in place for the collection, entry, and storage of all required family data, and extensive training is provided to all staff. Indiana conducts quarterly data reviews, and unexpected outcomes, missing data, and other questions are identified by an external evaluation team and investigated at the program and/or local level in collaboration with the Indiana MIECHV state team. Ongoing issues are addressed individually with local staff members and are brought to the attention of state MIECHV coordinators. Local Implementing Agency program managers have continuous access to live local data and can run real-time reports. Quarterly data audits are used to identify missing data. These audits occur prior to preparing data for the Indiana quarterly data review. Trends are monitored by site-level and state-level Quality Assurance staff.

IX. SAMPLE SIZE(S) AND SAMPLING PLAN

A. Sampling Plan

No sampling was employed. For sample sizes, see *XI.B. Sample and Comparison Group*.

B. Statistical Power 3

Conditions under which analyses were completed were consistent with assumptions utilized in the *a priori* power analyses.

Table 11. Statistical power.

	Power Analysis Details
RQ2	Because power issues were suspected based on the sample of 47 complete cases and 66 imputed cases, an alternative analytic plan (see approved evaluation plan) was utilized, which had smaller sample size requirements: partial-least-squares (PLS) path analysis (PA). PLS-PA required smaller samples sizes, with simulation studies suggesting that between 48 and 50 respondents were sufficient for achieving a power of .80 for path coefficients as small as .397 (e.g., Chin et al., 2003; Kock & Hadaya, 2018).
RQ3	Across analyses, the evaluation came close to meeting or exceeded the sample sizes proposed in *a priori power* analyses included in the evaluation plan. For the matched comparison groups, the evaluation was just under the target sample size of 500 in each high fidelity group and well over that target sample size for the low fidelity groups. In the overall sample for steps 1, 2, and 3a, the target sample size of 1,000 was exceeded, with a total of 1,692 families. Furthermore, the results of the analyses (some of which were statistically significant for very small effects (e.g., $R^2 < .01$)) suggested more than adequate power to detect even small effects at the family-level (the level-1 variable) in the MLMs. **RQ3a.** Multiple exploratory MLMs were conducted to determine the ability of each of the measures of fidelity to predict family outcomes over the three measurement time points. *A priori* power analyses revealed that at a sample size of $N = 1{,}000$, statistical power associated with each of these MLMs, assuming an alpha of .05, was 1.00. To reduce the chance of Type I errors, the Benjamini-Hochberg (1995) correction was used on the *p*-values to control the false discovery rate. Therefore, *a priori* power goals were achieved. **RQ3b.** An *a priori* power analysis was conducted using PASS 2019. The evaluation team powered for the treatment by time interaction fixed effect (with time as a continuous variable), assuming an alpha of .05, three repeated time-points, and a small difference in the treatment versus comparison group slopes ($d = .20$), in a 3-level MLM. Resultant power varied as a function of the within-family correlation among the repeated measures at level-1, with power increasing from .73 to .76, to .82 with increasing correlations among the level-1 repeated measures (.45, .50, and .60, respectively).

C. Design Specific Components

Strategies to Address the Risk of Contamination. Non-MIECHV-funded families (not receiving MHC) in sites serving MIECHV-funded families (receiving MHC) were excluded from comparison groups. The HFI site in Decatur County and the HFI site in Marion County that does not serve MIECHV-funded families were excluded because they implemented different models of MHC.

Baseline Equivalence. To achieve baseline equivalence, propensity score matching was employed (Rosenbaum & Rubin, 1983). HomVEE guidance for baseline equivalence was incorporated into planning. Equivalence was established on characteristics measured before participants received services, and equivalence was established on the groups used in the final analysis (HomVEE, 2014, 2017). The study also relied on the Sommers et al. (2013) recommendations for controlling bias using propensity scores in observational studies. To control bias, the evaluation team sought to identify comparison groups that contained 1) prescreened individuals with motivation and incentives (or deterrents) to participate that are similar to those of the treatment group, 2) individuals from close geographical proximity to the treatment group (e.g., regional), and 3) those who have similar pretest scores on the outcome of interest compared to the treatment group (Cook et al., 2008; Glazerman et al., 2003). Propensity score matching yielded balanced samples based on the covariates of interest, and multivariate and univariate tests revealed no evidence of imbalance, including on covariates identified by HomVEE (2014) for a moderate study rating (the highest possible for a matched groups design): race/ethnicity, socioeconomic status, and baseline outcomes. See *XI.B Sample and Comparison Group* for details.

X. ANALYTIC METHODS OR ANALYSIS PLAN

A. Analytic Methods

Table 12. Summary of analytic methods.

	Analytic Methods
RQ1	**Content Analysis.** Verbatim transcripts were written from digital interview recordings and used for the analysis. The content analysis process utilized the framework method (Ritchie & Spencer, 1994), which can be applied to either deductive or inductive research across various epistemological, philosophical, or theoretical approaches (Gale, Heath, Cameron, Rashid & Redwood, 2013; Pope, Ziebland, & Mays, 2000; Ritchie & Spencer, 1994). The technique involved five steps: familiarization, identifying a thematic framework, indexing, charting, and mapping and interpretation. During the Familiarization process, the first Co-Principal Investigator identified the key ideas and recurring concepts through immersion into the text (i.e., verbatim home visitor and mental health consultant interview transcripts). Specifically, the researcher thoroughly read and re-read interview transcripts and listened to interview recordings to become familiar with the whole dataset. Next, the researcher developed a Thematic Framework by identifying all key issues, concepts, and themes in the data to create a detailed coding index. This process was informed by a variety of factors including responses and concepts present in the data, as well as by existing theory, research questions, and study objectives. The coding index was reviewed by the second Co-Principal Investigator, with input from DCG senior staff with experience in qualitative research. During the Indexing stage, the first Co-Principal Investigator applied the thematic framework (developed in the prior step) systematically to the entire dataset by annotating the transcripts with codes from the index. Next, through the Charting process, the first Co-Principal Investigator synthesized data by arranging them according to the themes to which they relate using a framework matrix. Specifically, charting allowed data to be arranged and summarized, with each column representing a theme and each row a case. Other evaluation team members were consulted throughout this process. Finally, through the Mapping and Interpretation process, the researcher explored and described the associations between themes generated by the analysis (Gale et al., 2013; Moullin, Sabater-Hernandez, & Berimoj, 2016; Pope et al., 2000; Ritchie & Spencer, 1994). At this stage, the analysis focused on "defining concepts, mapping range and nature of phenomena, creating typologies, finding associations, providing explanations, and developing strategies" (Ritchie and Spencer, 1994, p. 186). The final stage of the analysis was completed by the first Co-Principal Investigator and reviewed by the second Co-Principal Investigator. Throughout the analysis, the full transcripts were regularly consulted to confirm participants' wording and the context of their remarks. Findings were reviewed and vetted by members of the evaluation team throughout the analysis. Emerging findings were shared with the DCS state team for validation prior to study completion.
RQ2	**Partial-Least-Squares (PLS) Path Analysis (PA).** Because power issues were suspected based on the sample size, partial-least-squares (PLS) path analysis (PA) (included in the approved plan) was utilized. PLS-PA estimated the set of direct model links in two steps. In a first step, the fidelity latent construct was constructed from the set of four fidelity indicators. In a second step, the path coefficients between the fidelity construct and each of the outcome measures were estimated. PLS-PA was performed using WarpPLS. For the measurement model (creating factors from items), the evaluation team used factor-based PLS Type PTH2, which created loadings using Djikstra's (Djikstra & Henseler, 2015) consistent PLS method combined with robust path analysis, whereby latent constructs are linear sums of their composite items. The evaluation team modeled linear relations on the direct links among the latent constructs and sampled to obtain standard errors and *p*-values using Kock's (2018) Stable3 resampling method. Constructs were examined for statistical suppression issues using the combined criteria of a path-correlation ratio no greater than 1.3 and a *p*-value for the absolute difference between the path coefficient and correlation not less than .05. None of the directed relationships exceeded the criteria, suggesting no problems with statistical suppression. Missing data were addressed using predictive mean matching.
RQ3	**Mixed Liner Modeling.** Both research questions entailed performing mixed linear modeling (MLM) with the HOME and HFPI as outcome variables. The evaluation team assessed change in the HFPI and HOME outcomes over time during families' first year in

the program using separate MLM analyses on the total scores of each of these outcome variables. For analysis of the HFPI, the team used the assessments performed at 3 months, 6 months, and 12 months. For the HOME, the evaluators used those performed at 2 months, 4 months, and 12 months. In these models, time was treated as a continuous variable. The evaluation team estimated a group-level slope representing families' change over the first year in the program.

The random effects structure of the MLM were explored using restricted maximum likelihood (REML) estimation (Singer & Willett, 2003). Given the structure of the study design, families are nested within HFI sites, with repeated measures of the HFPI and HOME outcome variables over time nested within families. The evaluation team used a model comparison approach for determining the random effects structure that best captures the variability in the data, comparing nested versions and building to the 3-level model that matches the data structure, with time at level 1, family at level 2, and HFI site at level 3. At a minimum, the team retained family-level intercepts, but also tested for family-level variability in slopes over time, and site-level variability in slopes over time. The best-fitting random effects structure was determined using null hypothesis significant testing via likelihood ratio tests (LRT) and the Akaike Information Criterion (AIC). After having determined the best-fitting random effects structure with REML, the evaluation team used that random effects structure in modeling the fixed effects in the MLM models described below using maximum likelihood (ML) estimation (West, Welch, & Galecki, 2007). All MLMs were executed in STATA 16.0 because of its greater flexibility and facility for more complex MLM models, including maximum likelihood estimation procedures, which were better accommodate missing data.

Question 3a. Does fidelity to the MHC treatment model predict family outcomes within the MHC treatment group?

The analysis for research question 3a involved three steps: 1) an initial exploratory analysis to determine which objective fidelity measures were related to better outcomes on the HOME and HFPI measures, 2) creation of a single summary fidelity score for each family, and 3) analyzing whether the fidelity score predicts family outcomes as measured by the HOME and HFPI scales.

Identification of Fidelity Measures Predicting Outcomes. The evaluation team had access to a number of objective measures of fidelity (directly aligned with MHC expectations), including Family – Clinical Risk Assignment, Family – Monthly Review by Mental Health Consultant, Home Visitor – Monthly Clinical Consultation, Home Visitor – Monthly Reflective Practice, Home Visitor – Monthly Meetings with Mental Health Consultant, and Bi-Monthly Home Visitor Training drawn from mental health consultants' Secondary Activity Reports. The team also had access to subjective measures of fidelity, including home visitor surveys (*IN MHC Fidelity Scale*, *Reflective Supervision Rating Scale*, *Reflective Supervision Self Efficacy Scale*) and a mental health consultant survey (*Reflective Supervision Rating Scale – Adapted for Mental Health Consultant*). Because the relationships between fidelity measures and family outcomes were unknown, the evaluation team performed preliminary MLM analyses to identify which of the fidelity measures predict family outcomes.

Creation of Fidelity Scores. A single summary fidelity score was created from a principle components analysis (PCA) of those fidelity measures identified as predictive of family outcomes. By producing a weighted linear combination of the observed fidelity measures, the PCA produced uncorrelated and orthogonal components. Scores on the orthogonal components of the PCA were weighted and summed to create a fidelity score for each family.

Creation of High and Low Fidelity Groups. High and low fidelity treatment groups were determined by a median split on the family-level fidelity scores. The median split was chosen for defining these groups because of the exploratory nature of this analysis, the lack of clear a priori threshold for determining high versus low fidelity scores, and the desire to preserve as much of the sample as possible, thus protecting statistical power to the extent possible.

Inferential Statistics. An MLM examined whether overall fidelity score predicted family outcomes as measured by the HOME and HFPI scales. To the extent that greater fidelity was associated with higher slopes over time on these outcomes, it suggested a causal relationship between receiving the intervention and having better outcomes.

Question 3b. Do high and low fidelity MHC treatment groups have better family outcomes than non-MHC groups?

The analysis for research question 3b involved three steps: 1) the creation of propensity scores based on participant characteristics, 2) matching high and low fidelity treatment groups each with their own comparison group based on the propensity score, and 3) determining differences between HFPI and HOME subscale scores between the matched groups.

Propensity score development. Propensity scores were created using a logistic regression model that incorporated observable covariates or appropriate proxies (Austin, 2011; Caliendo & Kopeinig, 2008; D'Agostino, 1998; Rosenbaum & Rubin, 1983). The selection of covariates was informed by the relevant literature and theory (Austin, 2011; Caliendo & Kopeinig, 2008), institutional selection processes (i.e., the role of initial family risk status/scores in assignment/services) (Blundell, Deardeb, & Sianesi, 2005; Sianesi, 2004), and empirical methods (Caliendo & Kopeinig, 2008). These include demographics associated with MIECHV participation/outcomes (e.g., adult age, child age, education, employment status, income) (MIECHV, 2016), baseline screening instruments (e.g., HFI Eight Item Screen, Parent-Survey/Family Stress Checklist, IPV screens, EPDS), and other variables influencing participation and outcomes. To account for missing data, the missing indicator method was used to model the relationship between the pattern of missing data and propensity to participate in MHC (Rosenbaum & Rubin, 1984).

Covariates included the following: Baseline Edinburgh Postnatal Depression Scale, Baseline HFPI (Total Score), Baseline HOME (Total Score), Intimate Partner Violence Status, Parent Survey/Family Stress Checklist, Urban Influence Codes (USDA, 2013), Child Birth Status, Primary Caregiver's Age, Primary Caregiver's Language, Primary Caregiver's Racial Identification, Primary Caregiver's History of Substance Abuse, Primary Caregiver's History of Mental Illness, Primary Caregiver's History of Criminality, Primary Caregiver's Education Level, Primary Caregiver's Enrollment Status, and Income.

Matching. To balance the treatment and comparison groups, the research team utilized nearest neighbor matching (with caliper) using the R-Essentials SPSS extension (D'Agostino, 1998; Ho, Imai, King, & Stuart, 2007). This process involved matching treatment individuals with the comparison individual with the most similar propensity scores (D'Agostino, 1998; Stuart, 2010). The use of the caliper reduced the number of poor matches (Stuart, 2010). A caliper width of .2 of the standard deviation of the propensity score was used (Austin, 2011; Rosenbaum & Rubin, 1985; Cochran & Rubin). Unmatched cases were excluded.

Inferential Statistics. The evaluation team performed two separate mixed linear models (MLM): one examining the difference between the high fidelity treatment group and its propensity score matched comparison group, and a second examining the difference between the low fidelity treatment group and its propensity matched comparison group. Because the primary research question was the effectiveness of the treatment (i.e., assignment to MHC vs. non-MHC), for both MLMs the team modeled the treatment by time interaction, and component main effects, as fixed effects (i.e., group-level effects) in all the models under consideration. The team was then able to ask whether this change differs for the treatment (MHC) and comparison groups. Secondary, exploratory MLM analyses examined whether change over time within the MHC treatment group varies as a function of the random effect of MHC consultant.

The MLM analytic method and random effects structure employed for both Research Questions 3a and 3b allowed for the examination of site-level effects in both analyses. As part of the random-effect structure, measurement timepoints were nested within family, which were nested within sites. This structure allowed the researchers to 1) assess whether there is significant variability among the sites and 2) to examine the site-level best linear unbiased predictors (BLUPs), which are site-level regression slopes for the outcome measures over the three measurement timepoints. Thus, the evaluation was able to examine the magnitude of the regression coefficient for each individual site.

B. Evaluation Cost

Total evaluation costs were $100,000 for a two-year 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), IN-SUTA), and indirect costs. Group rates align with current market rates for proposed services. DCG committed two senior consultants, one statistical field consultant, and two consultants to support the project (500 hours per contract year).

C. Design Specific Components

Qualitative Data Analysis Techniques. The content analysis process utilized the framework method. Consistent with this method, the identification of themes was informed by responses and concepts present in the data, as well as by existing theory, research questions, and study objectives. In the final step, the analysis focused on "defining concepts, mapping range and nature of phenomena, creating typologies, finding associations, providing explanations, and developing strategies" (Ritchie & Spencer, 1994, p. 186) to identify associations between themes generated by the analysis.

Qualitative Data Processing. Interviews were recorded (with participants' permission) and transcribed verbatim for analysis. Data processing was informed by the framework method, which involved familiarization, identifying a thematic framework, indexing, charting, and mapping and interpretation.

XI. EVALUATION RESULTS

A. Results

Research Question 1

Interviews were completed with seven mental health consultants and seven program managers to explore MHC fidelity. Using the framework method (Richie & Spencer, 1994), key themes were identified (e.g., mentioned by 40% or more of respondents) and are discussed in the following sections. Percentages are provided to present the prevalence of each theme in the responses.

RQ1a. What discrepancies exist between the model expectations and implementation at the site level? Participants reported that they believed most requirements were met consistently; however, responses suggested that most sites experienced challenges meeting documentation expectations, and some sites struggled to complete monthly reviews for all MIECHV-funded families.

Table 13. Program manager and mental health consultant perceptions of model adherence.

Model Expectations	Met	Not Met
All New MIECHV-Funded Families Reviewed	93% (n=13)	7% (n=1)
Family Priority Assigned for All MIECHV-Funded Families	93% (n=13)	7% (n=1)
Monthly Review for All MIECHV-Funded Families	79% (n=11)	21% (n=3)
Monthly Clinical Consultation for All Home Visitors	93% (n=13)	7% (n=1)
Monthly Reflective Practice for all Home Visitors	93% (n=13)	7% (n=1)
Bi-Monthly Training Provided for Home Visitors	93% (n=13)	7% (n=1)
Documentation Completed	43% (n=6)	57% (n=8)

Description of Model Discrepancies
Documentation: Mental health consultants and program mangers noted that the spring 2019 database transition, unclear MHC model expectations, and a lack of experience documenting their responsibilities and/or using the database contributed to difficulties completing documentation in adherence with expectations. Consultants were especially concerned that documentation issues reflected poorly on their job performance because model expectations that they believed that they had met were not accurately captured in the database.
Monthly Review of MIECHV-Funded Families: While the majority (79%) of mental health consultants and program managers reported that all MIECHV-funded families were being reviewed monthly at the time of the interview (August-September 2019), participants noted that in many sites, only high priority families had been reviewed and documented on a monthly basis prior to a May 2019 MHC training that clarified this model expectation. Specifically, 86% (6/7) of mental health consultants noted prior confusion about this expectation and stated that they had incorrectly completed and/or documented family reviews before May 2019. After receiving clarification, some sites (particularly sites with larger caseloads) continued to struggle to review all families each month. As a result, some staff feared that other aspects of the model (e.g., training) may suffer due to the amount of time dedicated to reviewing families. Additionally, some staff were uncertain about what a review should entail and sought additional clarity. Finally, given that all families (regardless of priority) were reviewed monthly, the expectation that mental health consultants prioritize families for MHC was questioned.

RQ1b. What resources would support improved Mental Health Consultation implementation?

Current Supports. Analysis of interview responses revealed a number of current supports, which are described in the following table.

Table 14. Summary of current supports.

Key Themes
Alignment with Existing Work (Overall: 93%; Mental Health Consultants: 100%: Program Mangers: 86%): Sites recognize the role that mental health plays in family success, as well as gaps in mental health expertise among home visitors and supervisors. Respondents noted that MHC was a necessary enhancement to support mental health needs for families and noted that sites leverage MHC to bolster their capacity to address mental health needs and to improve family outcomes. There is generally shared understanding among staff about the role of reflective supervision and how home visitors can use the consultant to improve their work with families, especially as it relates to mental health. From a fidelity perspective, this alignment promoted buy-in among leaders and staff. In particular, the MHC's relevance for home visitors encouraged them to participle in the model through clinical consultation, reflective practice, and training.
Agency/Management Support (Overall: 86%; Mental Health Consultants: 100%; Program Mangers: 71%): Respondents reported that management integrated MHC into all agency activities, communicated the importance of MHC to staff, ensured that time and resources were appropriately allocated for MHC, and involved mental health consultants in meetings and other collaborative work. Management buy-in reinforced expectations to home visitors, which encouraged them to participate in consultation activities, reflective practice, and training.
Collaboration Among Mental Health Consultants (Overall: 57%; Mental Health Consultants: 71%: Program Mangers: 43%): Both one-on-one communication and the monthly reflective supervision to which all mental health consultants had access were identified as beneficial by participants. Respondents noted that they communicate informally with their peers one-on-one or in small groups on an as-needed basis through emails and telephone calls. Additionally, monthly reflective supervision was made available to all mental health consultants by DCS. Through collaboration, the consultants have shared forms for documentation, resources, strategies for supporting home visitors, general information about MHC, and best practices for meeting model expectations.
Mental Health Consultants' Expertise/Experience (Overall: 50%; Mental Health Consultants: 43%: Program Mangers: 57%): Respondents noted that mental health consultants' backgrounds were highly aligned with the duties and tasks necessary to implement MHC model expectations with fidelity. Specifically, consultants relied on their education and clinical experience to review families, provide consultation and reflective supervision, and design and deliver training efficiently and with high quality.
May 2019 MHC Training (Overall: 43%; Mental Health Consultants: 43%; Program Mangers: 43%): DCS Prevention staff reviewed the model expectations and associated documentation, answered questions, and provided resources for reference. Additionally, this training provided an opportunity for consultants to meet in-person and for them to interact with the DCS staff who oversee MHC. All mental health consultants and program managers were invited to participate.

Additional Resources/Support Needed. Along with existing resources, analysis of interview responses revealed three additional supports that respondents believed would improve fidelity if provided.

Table 15. Summary of additional resources/support needed.

Key Themes
Increased Collaboration Among Mental Health Consultants (Overall: 50%; Mental Health Consultants: 86%: Program Mangers: 14%): Respondents were interested in more frequent in-person meetings and continuation of reflective supervision calls. There was some interest in exploring scheduling options for that would increase participation in the existing reflective supervision provided to the consultants.
Dedicated Mental Health Consultant Training (Overall: 50%; Mental Health Consultants: 71%: Program Mangers: 29%): Recommendations included reflective supervision training, funding for continuing education, and yearly sessions specifically for mental health consultants at the Institute for Strengthening Families.
Documentation Guidelines (Overall: 43%; Mental Health Consultants: 43%: Program Mangers: 43%): Recommendations included standardized forms, clarification of and rationale for expectations, documentation reviews/audits, and detailed roles and responsibilities.

RQ1c. What actionable barriers impede Mental Health Consultation implementation? Analysis of interview responses revealed a number of barriers, which are described in the following table.

Table 16. Summary of barriers.

Key Themes
Data System Migration (Overall: 86%; Mental Health Consultants: 86%: Program Mangers: 86%): Specific barriers associated with the migration included lack of access to the new data system (e.g., unavailable login credentials, user privileges not created, inability to edit family records), difficulty learning to use the new system and accessing technical support, limited features to support MHC (e.g., no reports that identify new families, that allow program managers to review mental health consultants' work, or that allow mental health consultants to track their own work or flag records/assessments that have already be reviewed), and poor functionality (e.g., multiple screens/menus to navigate, increased likelihood for missing data). Note: As described in *VII. K Timeline,* interviews occurred approximately six months after the initial database rollout, which may have influenced the frequency with which related barriers were described by participants.
Model Expectation Clarity (Overall: 79%; Mental Health Consultants: 100%: Program Mangers: 57%): Participants sought additional clarity related to family reviews and documentation expectations, which was consistent with the discrepancies identified by mental health consultants and program managers when comparing implementation at their site with model expectations.
Caseloads (Overall: 57%; Mental Health Consultants: 57%: Program Mangers: 57%): Large caseloads made it difficult for sites to meet model expectations, particularly the monthly family review and clinical consultation. In addition, larger caseloads were perceived to negatively affect the quality of MHC delivery because less time could be devoted to each family.
Mental Health Consultant Capacity – Time (Overall: 57%; Mental Health Consultants: 71%: Program Mangers: 43%): In some sites, staff did not believe that the amount of time that mental health consultants were on site was sufficient to address model expectations. Moreover, mental health consultants reported that an inadequate amount of time was dedicated to clinical consultation and reflective practice, which they believed had negative effects on the quality of MHC delivery.
Home Visitor Buy-In (Overall: 43%; Mental Health Consultants: 14%: Program Mangers: 71%): Most program mangers identified issues with home visitor buy-in as a barrier for MHC implementation; however, this was not noted as a concern by mental health consultants (Mental Health Consultants: 14%; Program Mangers: 71%). Specifically, program managers noted that some home visitors see MHC as an extra requirement and fail to see the value in participating in the extra support.
Scheduling Challenges (Overall: 40%; Mental Health Consultants: 29%: Program Mangers: 57%): Participants reported that coordinating schedules among mental health consultants, home visitors, and supervisors created implementation barriers. Due to the nature of their work, home visitors' and supervisors' schedules are often unpredictable, and while participants noted that mental health consultants attempt to adapt to scheduling needs, canceled clinical consultation and reflective practice sessions are often difficult to reschedule.

Research Question 2

RQ2. To what extent are home visitor perceptions of Mental Health Consultation fidelity associated with ratings staff outcomes? To examine the relationships between home visitors' ratings of MHC fidelity and ratings of perceived outcomes, a partial least squares-path analysis (PLS-PA) was utilized. A fully linked model was created that explored the unique relationships between each fidelity measure and each staff outcome.

Missing Data and Imputation. Of the 77 participants starting the survey, 3 participants did not complete any of the survey questions, 47 completed all the survey questions, and 11 participants had more than 5% missing data. Participants with more than 5% missing data were excluded. Missing data were imputed for the cases with less than 5% missing (N = 66) using predictive mean matching. After assuring an adequate imputation by comparing the descriptive statistics for the imputed (N = 66) and complete cases (N = 47), all subsequent analyses were performed on the imputed data. None of the single survey items from the original raw dataset had greater than 5% missing cases, which suggested that no item was systematically omitted by respondents and that the assumption of missing at random appears to hold.

Descriptive Statistics. Descriptive statistics for each scale are provided below for the imputed sample.

Table 17. Descriptive statistics for fidelity and staff outcome scales.

Staff Outcomes				Fidelity Measures			
Measures	***M***	***SD***	***N***	**Measures**	***M***	***SD***	***N***
Resource Quality	4.17	0.89	66	Delivery Quality	4.30	0.52	66
Self-Efficacy	6.03	0.86	66	Participant Responsiveness	3.65	0.68	66
Burnout	2.03	0.59	66	Structural Fidelity	4.85	0.99	66
Compassion Satisfaction	4.20	0.58	66	Delivery Quality	4.30	0.52	66

Path Coefficients and Characteristics of Latent Variable Composites. Table 18 depicts the path coefficients for each of the models and the characteristics of the latent constructs. Across outcomes, adjusted R^2 ranged from .03 to .50, with predictors (i.e., fidelity dimensions) accounting for the greatest amount of variance in resource quality and the least amount of variance in burnout and secondary trauma.

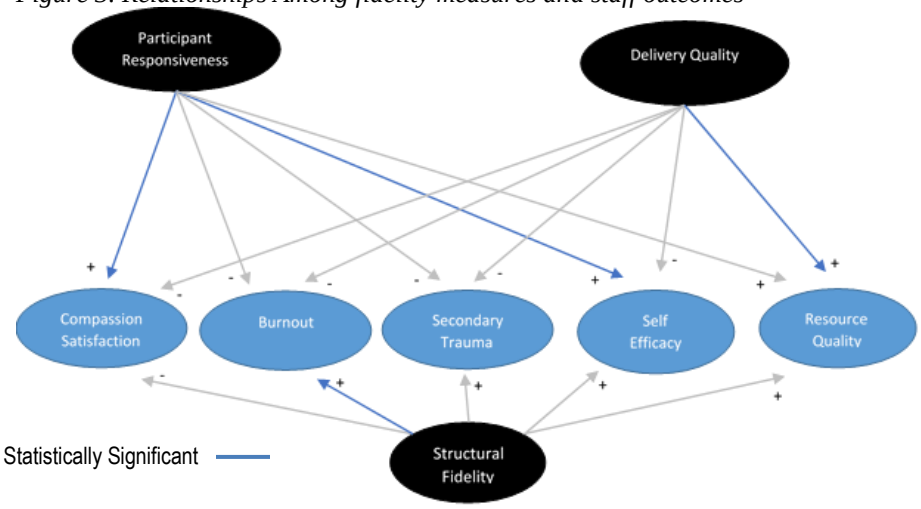
Table 18. Path coefficients for each of models and characteristics of latent variable composites.

	Participant Responsiveness AVE=0.509 REL=0.940	**Delivery Quality** AVE=0.622 REL=0.961	**Structural Fidelity** AVE=0.350 REL=0.853
Resource Quality	β =.170	**β = 0.53***	β = 0.16
Adj R^2 = 0.50	se =0.10	**se = 0.10**	se = 0.12
AVE = 0.832	*p* = 0.15	***p* < 0.002**	p = 0.16
REL = 0.982	ES = 0.07	**ES = 0.36**	ES = 0.09
Self-Efficacy	**β = 0.49***	β = -0.14	β = 0.05
Adj R^2=0.18	**se = 0.10**	se = 0.12	se = 0.12
AVE=0.476	***p* < 0.002**	*p* = 0.23	p = 0.70
REL=0.845	**ES = 0.22**	ES = 0.01	ES = 0.01
Burnout	β = -0.13	β = -0.16	**β = 0.32***
Adj R^2 = 0.03	se = 0.12	se = 0.12	**se = 0.11**
AVE = 0.267	*p* = 0.28	*p* = 0.18	**p = 0.006**
REL = 0.763	ES = 0.01	ES=0.00	**ES = 0.06**
Compassion Satisfaction	**β = 0.22***	β = -0.18	β = -0.11
Adj R^2 = 0.06	**se = 0.11**	se = 0.12	se = 0.12
AVE = 0.519	***p* = 0.004**	*p* = 0.12	p = 0.34
REL = 0.915	**ES = 0.07**	ES = 0.02	ES = 0.01
Secondary Trauma	β = -0.07	β = -0.13	β = 0.05
Adj R^2 = -0.03	se = 0.12	se = 0.12	se = 0.12
AVE = 0.380	*p* = 0.60	*p* = 0.28	*p* = 0.66
REL = 0.856	ES = 0.01	ES = 0.02	ES = 0.00

Notes: AVE = average variance extracted. REL = composite reliability. ES = effect size, .02-.149 = small; .15-.349 = medium; .35 and higher = strong. * *p* < .05; Statistically significant findings are shown in **bold**.

Interpretation of Path Coefficients. The fully linked model suggests that the different aspects of fidelity make different, at least partially unique contributions to home visitor outcomes. There was a large, significant relationship between delivery quality and perceived quality of the resources. Increased participant responsiveness (i.e., home visitors' perceived efficacy participating in MHC) was associated with greater self-efficacy (a medium-sized effect) and greater compassion satisfaction (a small effect). Finally, an increase in adherence to the structural aspects of the fidelity model was associated with an increase in burnout (a small effect). This latter relationship suggests that home visitors may find maintaining fidelity to the delivery model to be demanding and burdensome. Because this is a small effect, these results suggest a need for additional exploration to understand how participation in MHC (when model adherence and exposure is greater) creates obstacles for home visitors.

Figure 3. Relationships Among fidelity measures and staff outcomes



Research Question 3

RQ3. What is the effect of Home Visitor Mental Health Consultation on parenting and family functioning/support outcomes?

To address research question 3, the evaluation team employed the multistep process described below.

Step 1	The evaluation team determined the objective (secondary activity reports) and subjective (home visitor and clinician surveys) measures of fidelity that were related to family outcomes.
Step 2	The evaluation team created a summary measure of fidelity for each family drawn from measures of fidelity shown to be predictive of outcomes.

Step 3a	The evaluation team examined if the fidelity score predicts family outcomes (as measured by the HOME and HFPI) within the MHC treatment group.
Step 3b	An exploratory quasi-experimental matched comparison groups design was conducted. MIECHV-funded families served by home visitors receiving the MHC enhancement were divided into low and high-fidelity treatment groups, and each group was compared to a separate matched group of non-MIECHV-funded families served by home visitors not receiving the MHC enhancement.

Research Question 3 – Steps 1 and 2

Step 1. The evaluation assessed the performance of both site-level fidelity criteria and family-level fidelity criteria. A total of nine fidelity criteria emerged as reliable predictors of at least a subset of the outcomes. Seven of these were site-level items (of a possible total of 10 site-level items) and two of these were family-level items (of a possible total of 3 family-level items). Fidelity criteria that reliably predicted outcomes appear in Table 19. Detailed analyses are presented in the full report, with complete results of all analyses provided in Appendix A.

Table 19. Fidelity criteria that reliably predicted outcomes.

Fidelity Criteria	Associated Family Outcomes
Site Level Indicators	
Mean Participant Responsiveness [A]	Organization [C], Involvement [C], Responsivity [C], Mobilizing Resources [D]
Percent of families reviewed for clinical risk [B]	Organization [C], Involvement [C]
Percent of families reviewed all months [B]	Organization [C], Involvement [C], Responsivity [C]
Percent of home visitors receiving reflective practice all months [B]	Organization [C], Involvement [C], Responsivity [C]
Percent of home visitors receiving consultation all months [B]	Organization [C], Involvement [C], Responsivity [C]
Average number of total meetings per home visitor [B]	Organization [C], Involvement [C], Responsivity [C]
Total number of trainings offered [B]	Organization [C], Involvement [C], Responsivity [C]
Family Level Indicators	
Number of weeks served by MHC [B]	Personal Care [D], Mobilizing Resources [D]
Number of months reviewed by MHC [B]	Depression [D], Personal Care [D], Mobilizing Resources [D]

Data Sources: [A] Home Visitor Reflective Supervision Self-Efficacy Scale, [B] Secondary Activity Logs, [C] HOME, [D] HFPI

Step 2. To create a single fidelity total score, the evaluation team submitted the nine fidelity criteria to a principal components analysis. Exploratory parallel analysis indicated a three-factor solution would best account for the variance in the items. The evaluation team then ran a confirmatory principal components analysis with three factors and a Varimax rotation. This analysis showed that the three-component solution cumulatively explained 79% of the variance among the fidelity criteria, with the first, second and third components explaining 35%, 27%, and 16% of the variance, respectively. To create component scores, the evaluation team assigned the items to the component on which they loaded most heavily (see Table 20). Test-retest reliability indices for each of the components appears in Table 21.

Table 20. Principal components analysis of fidelity items.

Component	Fidelity Criteria	Component Loadings		
		Component 1	Component 2	Component 3
	Site Level Indicators			
(1)	Percent of home visitors receiving reflective practice all months	.96	-.13	<.10
(1)	Percent of home visitors receiving consultation all months	.93	<.10	<.10
(1)	Average number of total meetings per home visitor	.69	.50	.19
(1)	Total number of trainings offered	.87	.30	<.10
(2)	Mean Participant Responsiveness	-.16	.80	-.15
(2)	Percent of families reviewed for clinical risk	.23	.76	.17
(2)	Percent of families reviewed all months	.23	.84	<.10
	Family Level Indicators			
(3)	Number of weeks served by MHC	<.10	-.17	.85
(3)	Number of months reviewed by MHC	<.10	-.31	.82

Table 21. Reliability for the three fidelity components.

Component	Component Name	Cronbach's Alpha	Guttman's Lambda 6
Component 1	Site Level Number of MHC Meetings & Trainings (4 items)	0.53	0.90
Component 2	Site Level Family Review (3 items)	0.20	0.68
Component 3	Family Level Service (2 items)	0.25	0.51

Creation of Single Total Fidelity Score per Family. The evaluation team first created family scores on each component by standardizing the family's score on a given criterion and then multiplying it by its respective component loading and then summing the resulting values for all the items on a given component. From the three component scores, the evaluation team created a single fidelity score by multiplying each component score by the amount of variance that component explained in the overall set of items. That is, the total fidelity score = 0.35*Component1 score + 0.268*Component2 score + 0.167*Component3 score.

Table 22. Summary statistics on family total fidelity scores, by county.

Site	Mean	SD	Median	Min	Max
Site 1	1.71	0.31	1.71	1.22	2.39
Site 2	1.56	0.22	1.47	1.30	2.24
Site 3	0.30	0.32	0.23	-0.08	1.42
Site 4	-0.05	0.21	-0.09	-0.38	0.72
Site 5	-0.25	0.20	-0.30	-0.49	0.22
Site 6	-0.79	0.24	-0.88	-1.16	-0.14
Site 7	-2.26	0.18	-2.29	-2.53	-1.72
Site 8	-2.38	0.15	-2.40	-2.59	-1.95

RQ3a. Does MHC fidelity predict family outcomes within the MHC treatment group?

Step 3a. To determine whether fidelity to the treatment model predicted outcomes of families in the treatment group, the evaluation team performed separate MLMs on each of the three HOME and three HFPI subscales. The dependent measure was the standardized family-level slope across month on the respective subscale. The evaluation sought to determine if increased fidelity to the model (i.e., total fidelity score) was associated with greater improvement in family outcomes. The sample size for this analysis was N = 1,692 families and N = 8 sites. Table 23 depicts descriptive statistics for family-level slopes on each of the six subscales, as well as the intraclass correlation coefficient (ICC) for site on that subscale. The ICC indicates the amount of overall variability in the data that was accounted for by differences between the sites before the analysis begins to take account of other variables of interest. Inspection of the site-level ICC suggested little variability attributable to the site-level. Typically, random effects are not modeled when the ICC is below 0.10. Therefore, the evaluation team inspected both the MLM with site as a random effect (as proposed) and the ordinary least squares (OLS) regression with no random effects, as a supplemental analysis (see full report).

Table 23. Descriptives on family-level slopes across month for measurement subscales and ICC for random effect of site.

Measure	Mean	SD	Min	Max	ICC
HOME subscales					
Responsivity	-0.030	0.164	-0.647	0.493	0.026
Organization	-0.014	0.078	-0.285	0.238	0.015
Involvement	-0.013	0.092	-0.361	0.262	0.029
HFPI subscales					
Depression	-0.006	1.179	-4.491	4.723	0.001
Mobilizing Resources	-0.005	0.764	-3.098	3.188	0.000
Personal Care	-0.003	0.612	-2.572	2.665	0.000

Tables 24 and 25 depict the analyses on the HOME and HFPI subscales, respectively. In the scatterplots, each dot represents one family's score, and the line represents how the slope of the outcome variable changed with changes in total fidelity scores. For each scale, the family-level total fidelity score resulting from steps 1 and 2 was used as the sole predictor of the standardized family-level slope across month for that subscale.

HOME Subscales. For the HOME subscales, there were effects of total fidelity score on the slopes of the outcome measures, indicating greater improvement in the outcomes as fidelity increased. These effects were statistically significant in the OLS regression for all of the HOME measures (all p-values < .001), but not always so when the random effect of site was also included in the model (see MLM results in Table 24). Regardless, in both cases, these effects were very small, with all R^2 = 0.01, indicating that fidelity accounted for 1% of the variance in the change in the outcome measures over time.

HFPI Subscales. For the HFPI subscales (Table 25), the results of the MLM and OLS regressions were equivalent. There were no effects of fidelity on the change in these subscales. All slopes on these measures were at zero (see flat regression lines in last row of Table 25).

Table 24. Analyses using total fidelity score to predict HOME subscales among MHC-treated families.

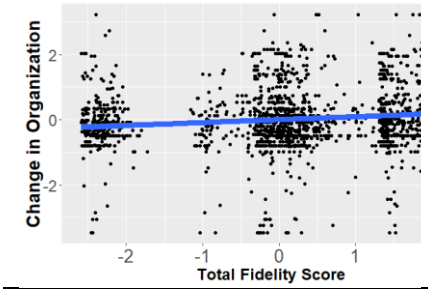
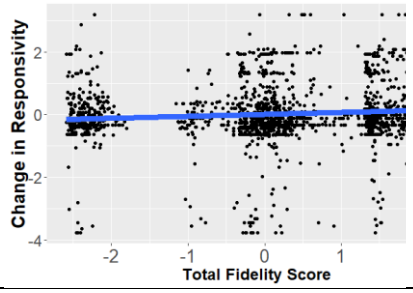
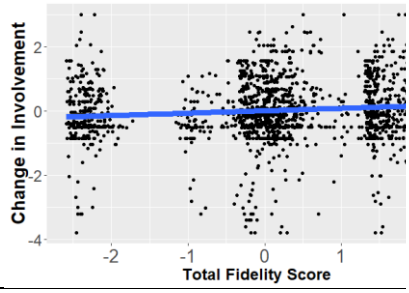
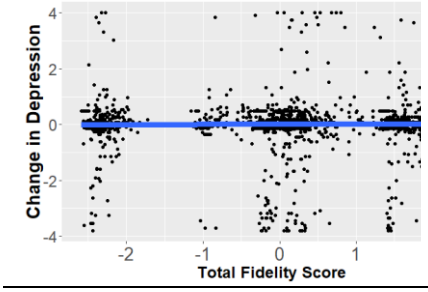
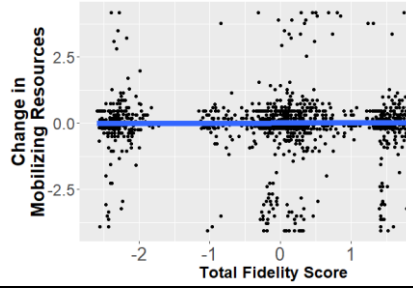
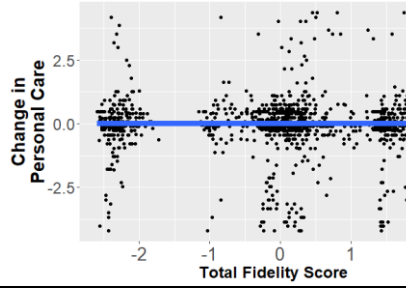
Organization Subscale	Responsivity Subscale	Involvement Subscale
MLM *b* = 0.06, *SE* = 0.03, *β* = 0.08, *p* = .066, fixed effect R^2 = 0.01, fixed + random R^2 = 0.02	***MLM*** *b* = 0.06, *SE* = 0.02, *β* = 0.08, *p* = .014, fixed effect R^2 = 0.01, fixed + random R^2 = 0.01	***MLM*** *b* = 0.05, *SE* = 0.04, *β* = 0.08, *p* = .170, fixed effect R^2 = 0.01, fixed + random R^2 = 0.02
		

Table 25. Analyses using total fidelity score to predict HFPI subscales among MHC-treated families.

Depression Subscale	Mobilizing Resources Subscale	Personal Care Subscale
MLM *b* = 0.01, *SE* = 0.02, *β* = 0.01, *p* = .685, fixed effect R^2 < 0.001, fixed + random R^2 = 0.002	***MLM*** *b* = 0.01, *SE* = 0.02, *β* = 0.01, *p* = .599, fixed effect R^2 < 0.001,fixed + random R^2 < 0.001	***MLM*** *b* < .001, *SE* = 0.02, *β* < .001, *p* = .980, fixed effect R^2 < 0.001, fixed + random R^2 < 0.001
		

RQ3b. Do high and low fidelity MHC treatment groups have better family outcomes than non-MHC treatment groups?

Step 3b. Evaluation Step 3b uses propensity-matched non-treatment comparison groups that were created in Step 2 for the high and low fidelity treatment groups based on the median split of total fidelity score. Separate sets of six 3-level MLMs (one for each of the subscales) were conducted for the high fidelity treatment group (High Fidelity MHC) and its propensity-matched non-treatment comparison group (High Fidelity Comparison), and separately for the low fidelity treatment group (Low Fidelity MHC) and its propensity-matched non-treatment comparison (Low Fidelity Comparison). Site was the level-3 variable, family the level-2 variable, and month the level-1 variable. Each MLM modeled the group (treatment, non-treatment) by month factorial as fixed effects and the intercepts for site and family as random effects. The dependent measure is the standardized score on that outcome at that point in time (rather than standardized change in the outcome across months as in 3a).

High Fidelity Treated Families vs. Propensity-Matched Non-Treatment Comparison Families and Low Fidelity Treated Families vs. Propensity-Matched Non-Treatment Comparison Families.

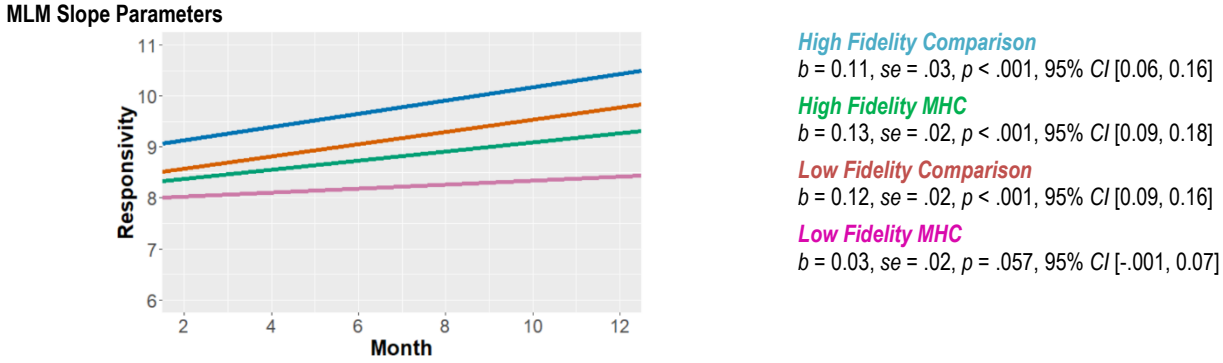
HOME Subscales. Results of the analysis of the HOME subscales appear in Table 26 and Figures 4, 5, and 6. For the High Fidelity MHC group versus the High Fidelity Comparison, across the three subscales, none of the group by month interactions reach significance, which suggests no difference in the performance improvement of the two groups over the months. For the Low Fidelity MHC group versus Low Fidelity Comparison, the group by month interaction reached statistical significance for all three subscales. The pseudo-R^2 for the fixed effects components of all of the models depicted in Table 26 were less than 0.01. The fixed effects in each model improves its ability to capture the data by less than 1%.

Table 26. Results of MLM analyses for HOME subscales for MHC treatment groups and propensity matched comparison groups.

Responsivity Subscale									
Effects		***High Fidelity MHC vs. Matched Comparison***				***Low Fidelity MHC vs. Matched Comparison***			
Fixed		***b***	***SE***	***p***	**95% *CI***	***b***	***SE***	***p***	**95% *CI***
	group	-0.35	0.45	.440	-1.23, 0.53	0.06	0.49	.910	-0.90, 1.01
	month	0.13	0.02	< .001	0.09, 0.18	0.03	0.02	.057	-0.00, 0.07
	group X month	-0.28	0.03	.404	-0.09, 0.04	0.09	0.03	.001	0.04, 0.14
Random		**Var Est**	***SE***		**95% *CI***	**Var Est**	***SE***		**95% *CI***
	site	0.79	0.40		0.29, 2.23	0.88	0.31		0.44, 1.74
	family	2.90	0.36		2.27, 3.69	3.42	0.29		0.04, 0.14
Organization Subscale									
Effects		***High Fidelity MHC vs. Matched Comparison***				***Low Fidelity MHC vs. Matched Comparison***			
Fixed		***b***	***SE***	***p***	**95% *CI***	***b***	***SE***	***p***	**95% *CI***
	group	-0.73	0.26	.006	-1.25, -0.21	0.10	0.24	.678	-0.38, 0.58
	month	0.07	0.12	<.001	0.047, 0.09	0.02	0.01	.019	0.00, 0.04
	group X month	-0.012	0.02	.483	-0.05, 0.02	0.04	0.01	.002	0.02, 0.07
Random		**Var Est**	***SE***		**95% *CI***	**Var Est**	***SE***		**95% *CI***
	site	0.33	0.18		0.11, 0.96	0.21	0.07		0.10, 0.42
	family	0.92	0.11		0.72, 1.16	1.06	0.09		0.90, 1.25
Involvement Subscale									
Effects		***High Fidelity MHC vs. Matched Comparison***				***Low Fidelity MHC vs. Matched Comparison***			
Fixed		***b***	***SE***	***p***	**95% *CI***	***b***	***SE***	***p***	**95% *CI***
	group	-0.14	0.26	.582	-0.66, 0.37	0.10	0.26	.699	-0.41, 0.61
	month	0.09	0.01	<.001	0.07, 0.12	0.05	0.01	<.001	0.03, 0.07
	group X month	-0.02	0.02	.408	-0.06, 0.02	0.04	0.01	.008	0.01, 0.07
Random		**Var Est**	***SE***		**95% *CI***	**Var Est**	***SE***		**95% *CI***
	site	0.26	0.14		0.09, 0.73	0.24	0.09		1.16, 1.55
	family	1.17	0.12		0.95, 1.43	1.34	0.10		1.16, 1.55

HOME – Responsivity. All groups showed significant improvement in responsivity over time, with the exception of the Low Fidelity MHC group. The High Fidelity MHC group (blue line) and the High Fidelity Comparison group (green line) had very similar slopes of 0.13 and 0.11, respectively. The lack of a significant group by month interaction for responsivity in Table 26 indicates this small slope difference was not significant. The Low Fidelity Comparison group (orange line) also performed similarly, with a slope of 0.12. The Low Fidelity MHC group (pink line), however, had a slope of only 0.03, which did differ significant from zero. Given, the significant month by group interaction shown in Table 26, the Low Fidelity MHC group showed less improvement compared to the Low Fidelity Comparison group.

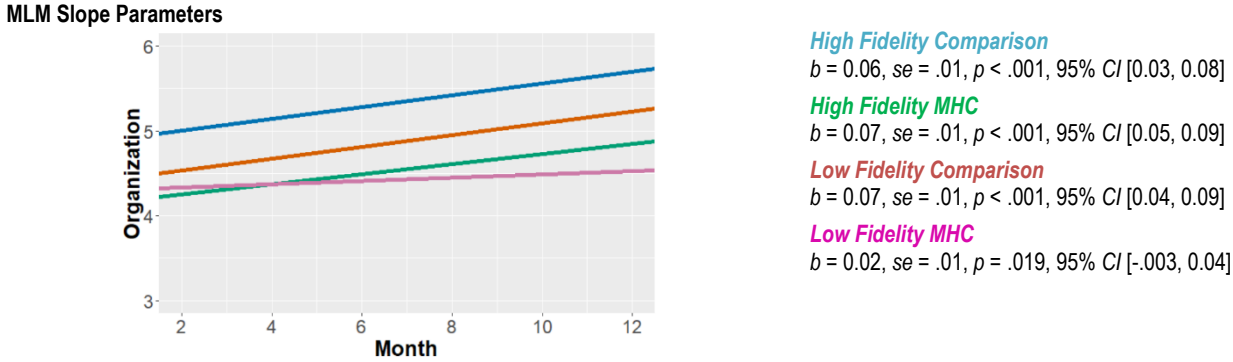
Figure 4. Responsivity subscale – MLM Slope Parameters and Raw Data Descriptives



HOME – Organization. As with responsivity, the High Fidelity MHC group, the High Fidelity Comparison group, and the Low Fidelity Comparison group all performed similarly, showing slopes in the 0.06 to 0.07 range that were significantly different from zero. The Low Fidelity MHC group, however, while also having a slope that was significantly greater than zero, demonstrated much less

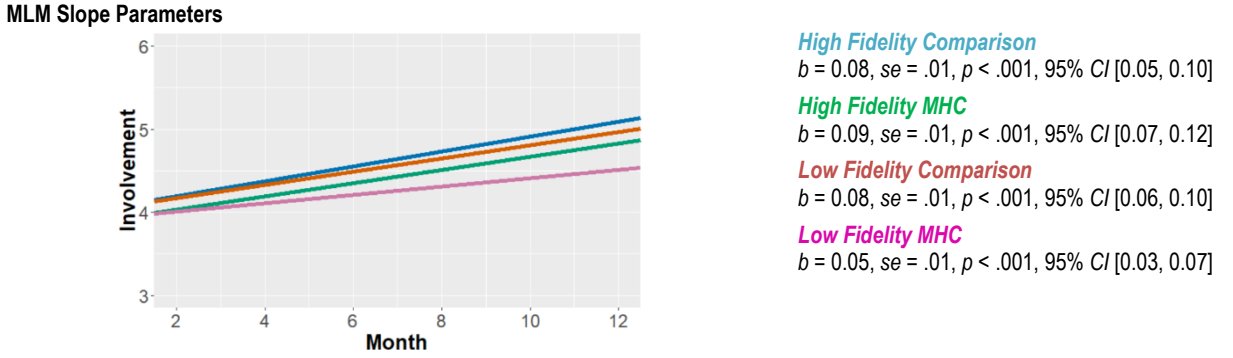
improvement over time than the other groups.

Figure 5. Organization subscale – MLM Slope Parameters and Raw Data Descriptives



HOME – Involvement. For the involvement subscale of the HOME (Figure 6), all groups showed significant improvement over time, but again, the Low Fidelity MHC group showed the least amount of improvement, having the smallest slope of the four groups (b = 0.05).

Figure 6. Involvement subscale – MLM Slope Parameters and Raw Data Descriptives



HFPI Subscales. There were no significant interactions between group and month for the High Fidelity MHC group and the High Fidelity Comparison group, but there were significant interactions between group and month for the Low Fidelity MHC group and the Low Fidelity Comparison group. As with the HOME subscales, this interaction in the low fidelity analysis reflects the Low Fidelity MHC group showing poorer improvement in outcomes relative to the Low Fidelity Comparison group.

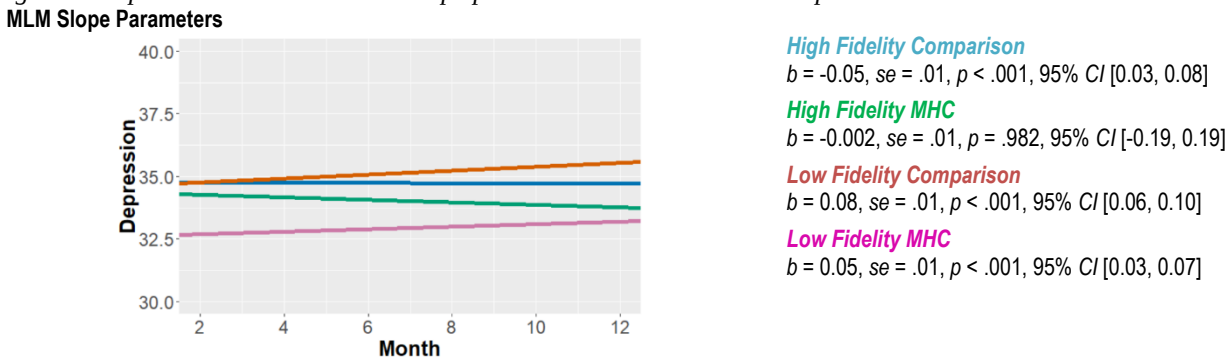
able 27. Results of analyses for HFPI subscales for MHC treatment groups and propensity matched comparison groups.

					Depression Subscale				
	Effects	***High Fidelity MHC vs. Matched Comparison***				***Low Fidelity MHC vs. Matched Comparison***			
Fixed		***b***	***SE***	***p***	***95% CI***	***b***	***SE***	***p***	***95% CI***
	group	-0.41	1.61	.799	-3.56, 2.74	1.99	2.02	.326	-1.98, 5.95
	month	-0.00	0.09	.982	-0.19, 0.19	-0.34	0.08	<.001	-0.50, -0.19
	group X month	-0.05	0.15	.751	-0.33, 0.24	0.28	0.12	.017	0.05, 0.51
Random		**Var Est**	***SE***		***95% CI***	**Var Est**	***SE***		***95% CI***
	site	4.64	3.09		1.25, 17.12	14.00	4.82		7.14, 27.49
	family	58.67	6.41		47.36, 72.68	71.61	5.46		61.67, 83.16
					Mobilizing Resources Subscale				
	Effects	***High Fidelity MHC vs. Matched Comparison***				***Low Fidelity MHC vs. Matched Comparison***			
Fixed		***b***	***SE***	***p***	***95% CI***	***b***	***SE***	***p***	***95% CI***
	group	0.21	1.10	.850	-1.96, 2.38	0.81	1.34	.547	-1.82, 3.43
	month	0.11	0.06	.072	-0.01, 0.23	-0.17	0.05	.001	-0.27, -0.06
	group X month	-0.08	0.09	.397	-0.26, 0.10	0.25	0.08	.001	0.10, 0.40
Random		**Var Est**	***SE***		***95% CI***	**Var Est**	***SE***		***95% CI***
	site	2.61	1.64		0.76, 8.94	6.22	2.06		3.25, 11.92

	family	29.44	2.81		24.42, 35.49	30.54	2.31		26.33, 35.42
					Personal Care Subscale				
	Effects	***High Fidelity MHC vs. Matched Comparison***				***Low Fidelity MHC vs. Matched Comparison***			
Fixed		***b***	***SE***	***p***	***95% CI***	***b***	***SE***	***p***	***95% CI***
	group	-0.42	0.87	.629	-2.13, 1.29	0.70	0.98	.449	-1.18, 2.66
	month	0.02	0.05	.720	-0.08, 0.12	-0.16	0.04	<.001	-0.24, -0.07
	group X month	-0.04	0.08	.551	-0.19, 0.10	0.16	0.06	.009	0.04, 0.28
Random		**Var Est**	***SE***		***95% CI***	**Var Est**	***SE***		***95% CI***
	site	1.49	0.99		0.40, 5.47	3.05	1.09		1.51, 6.19
	family	18.42	1.79		15.22, 22.30	21.92	1.54		19.10, 25.17

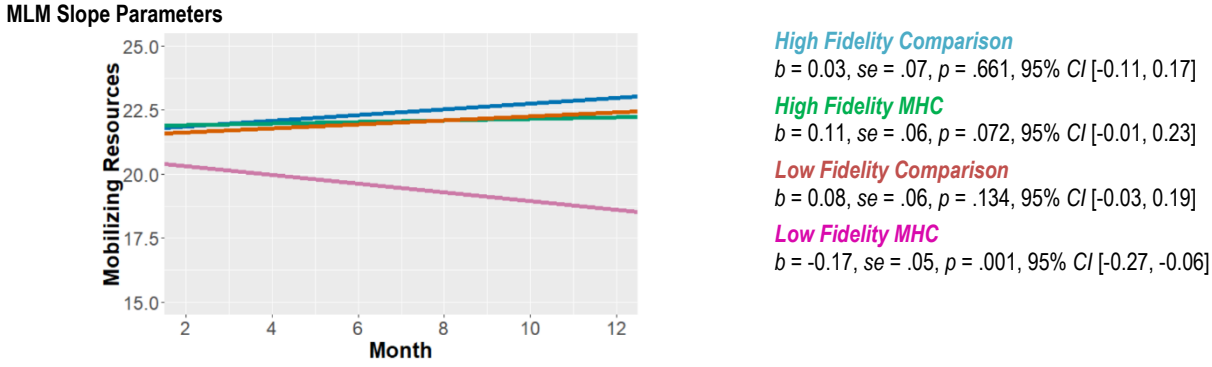
HFPI – Depression. For the depression subscale of the HFPI, there was a slightly different pattern than observed for the HOME subscales when the slopes for the individual groups were examined. The slopes of the High Fidelity MHC group and High Fidelity Comparison group were both negative, although only significantly so for the High Fidelity Comparison group. This negative slope suggests that depression for the High Fidelity Comparison group worsened over time. Both the Low Fidelity Comparison group and the Low Fidelity MHC group had positive slopes, demonstrating improvement in depression over time, with the slope of the Low Fidelity Comparison group slightly better than that of the Low Fidelity MHC group. It is unclear why there was a paradoxical change in depression scores over time for the High Fidelity MHC group and the High Fidelity Comparison group. Before conclusions may be drawn about this relationship, additional evaluation is recommended. Note: On the HFPI, higher scores indicate lower levels of depression, while lower scores indicate higher levels of depression (see LeCroy & Milligan Associates, 2004b). Positive slopes indicate improved depression, while negative slopes indicate worsening depression.

Figure 7. Depression subscale – MLM slope parameters and raw data descriptives.



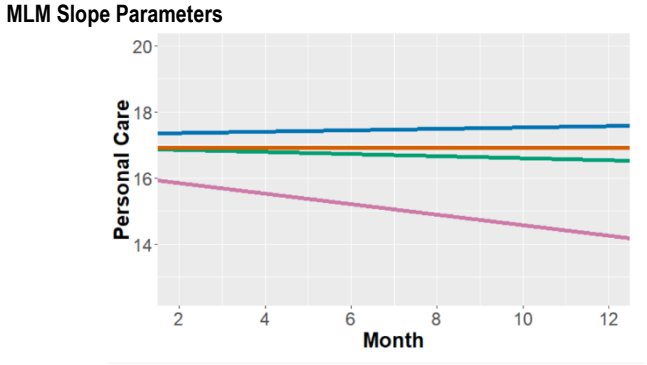
HFPI – Mobilizing Resources. The data show the Low Fidelity MHC group performing worse than the other three groups. In this case, the slopes of the other three groups were positive, but none were significantly different from zero (all *p*s > .05). However, the slope of the Low Fidelity MHC group was negative, suggesting a decrease in the outcome over time.

Figure 8. Mobilizing Resources subscale – MLM parameters and raw descriptives.



HFPI – Personal Care. The results for this subscale are similar to those for the mobilizing resources subscale. The Low Fidelity MHC group had a significant, negative slope (pink line), suggesting a worsening of the outcome over time, while all of the other groups had flat slopes that did not differ significantly from zero.

Figure 9. Personal Care subscale – MLM slope parameters and raw descriptives.



High Fidelity Comparison
b = -0.03, *se* = .06, *p* = .661, 95% *CI* [-0.14, 0.09]

High Fidelity MHC
b = 0.02, *se* = .05, *p* = .720, 95% *CI* [-0.08, 0.12]

Low Fidelity Comparison
b = -0.004, *se* = .04, *p* = .914, 95% *CI* [-0.08, 0.09]

Low Fidelity MHC
b = -0.15, *se* = .04, *p* = .001, 95% *CI* [-0.24, -0.07]

B. Sample and Comparison Group

Research Question 1

Mental Health Consultant Interviews. Interview responses were obtained from seven of the mental health consultants who provided MHC at HFI sites serving MIECHV-funded families during the fall 2019. Participants represented all seven sites, with two mental health consultants serving Lake County and the remaining five mental health consultants serving one site each. Experience ranged from less than one year to three to five years: less than one year (29%, *n* = 2), one to two years (57%, *n* = 4), and three to five years (14%, *n* = 1). **Program Manager Interviews.** Interview responses were obtained from all seven of the program managers who worked at HFI sites serving MIECHV-funded families (using the MHC model) during the fall 2019. Participants represented all seven sites. Experience ranged from less than one year to more than ten years: less than one year (17%, *n* = 1), one to two years (50%, *n* = 3), five to ten years (33%, *n* = 2), and more than ten years (17%, *n* = 1).

Research Question 2

The sample was drawn from the full population of home visitors who receive MHC at HFI sites serving MIECHV-funded families. The evaluation team provided a survey link to the DCS designee who forwarded the link to HFI program managers for administration to the home visitors. Participants received a link to electronic surveys via email. Survey links were sent to 92 home visitors receiving MHC, and 74 completed at least one scale item (response rate = 80.4%). Participant county/program of employment was proportional to the total number of home visitors per site: Site 1 (4%; *n* = 3), Site 2 (12%; *n* = 9), Site 3 (13%; *n* = 10), Site 4 (16%; *n* = 12), Site 5 (3%; *n* = 2), Site 6 (9%; *n* = 7), Site 7 (22%, *n* = 17), and Site 8 (20%; *n* = 15). Two respondents did not indicate the site in which they worked.

Table 28. Home visitor demographics.

Demographics

Characteristic	*n*	%	Characteristic	*n*	%
Years of Home Visiting Experience			*Sex*		
Less than 1 year	17	23%	Female	75	99%
1-2 years	20	27%	Male	1	1%
3-5 years	16	21%	*Education*		
5-10 years	11	15%	Some high school, no degree		
More than 10 years	11	15%	High school/GED	2	3%
Age			Vocational/technical training program	2	3%
20-29	30	39%	Some college, no degree	6	8%
30-39	16	21%	Associate's degree	5	7%
40-49	12	16%	Bachelor's degree	56	75%
50-59	17	22%	Master's degree	3	4%
60 or older	2	3%	Professional degree	1	1%

Demographics					
Characteristic	*n*	%	Characteristic	*n*	%
Race			*Field of Study*[A]		
American Indian or Native Alaskan	1	1%	Child Development	10	13%
Asian	1	1%	Early Childhood Education	10	13%
Black or African American	13	18%	Education	7	9%
Multiracial	4	6%	Nursing	2	3%
White	54	74%	Psychology	19	25%
Other	1	1%	Social Work/Social Welfare	28	37%
Ethnicity			Other	27	36%
Non-Hispanic	60	81%			
Hispanic	14	19%			

Note: [A] Select all that apply.

Research Question 3

Samples utilized for RQ3 were drawn from the full population of families participating in HFI from January 1, 2016 to December 31, 2019 for whom necessary outcome data were available. This consisted of 1,692 MIECHV-funded families receiving the MHC enhancement and 6,251 non-MIECHV-funded families.

Summary of MHC cases. The MLMs proposed for RQ3 required at least one datapoint for each subscale across the three months assessed. As a result, the sample size for most analyses involving just the MHC-treated group was N = 1,692. Table 29 provides the total N, complete cases, and proportion of missing values per family for each of the counties.

Table 29. Number of families per county/site.

			Proportion of Missing Values Per Family			
County/Site	Total *N*	Complete Cases	Mean	Median	Min	Max
Site 1	78	36	0.22	0.23	0.00	0.67
Site 2	985	381	0.26	0.33	0.00	0.87
Site 3	865	362	0.24	0.33	0.00	1.00
Site 4	626	245	0.25	0.33	0.00	1.00
Site 5	50	20	0.25	0.30	0.00	0.67
Site 6	203	111	0.20	0.00	0.00	0.87
Site 7	548	326	0.17	0.00	0.00	1.00
Site 8	370	158	0.25	0.27	0.00	1.00

RQ3a - High and Low Fidelity Intervention Families. After the fidelity measures predicting family outcomes were identified and fidelity scores created, the evaluation team separated families receiving the enhancement into a high or low fidelity group using a median split. From the full sample of 1,692 MIECHV-funded families receiving the enhancement, 846 low and 846 high fidelity families were identified.

RQ3b - Matched Groups - Low Fidelity MHC Families. A total of 1,558 families (779 low fidelity intervention families and 779 comparison families) was identified through propensity score matching, and the matching process yielded balanced samples based on the covariates of interest. Multivariate and univariate tests revealed no evidence of imbalance. The overall balance chi-square test (Hansen & Bowers, 2010) was nonsignificant, which indicated that no variable or linear combination of variables was significantly unbalanced after matching. There were no statistically significant differences between the intervention and comparison group on any individual covariates after matching. No standardized differences between treatment and comparison means exceeded .13 for any covariates, which was consistent with recommendations (Ho et al., 2007). Balance was achieved on the covariates required for a moderate study rating from HomVee (2014): 1) race/ethnicity (p = .93, d < .04 for each category), 2) socioeconomic status (income: p = .65, d = .03), and 3) baseline outcomes (HFPI: p = .73, d = .02; HOME: p = .48, d = .04).

RQ3b - Matched Groups - High Fidelity Families. A total of 974 families (487 high fidelity intervention families and 487 comparison families) was identified through propensity score matching, and the process yielded balanced samples based on the covariates of interest. Multivariate and univariate tests revealed no evidence of imbalance. The overall balance chi-square test (Hansen & Bowers, 2010) was nonsignificant. There were no statistically significant differences between the intervention and comparison group on any covariates after matching. No standardized differences between treatment and comparison group means exceeded .16 for any covariates. Balance was achieved on the covariates

required for a moderate study rating from HomVee (2014): 1) race/ethnicity (p = .89, d < .07 for each category), 2) socioeconomic status (income: p = .64, d = .03), and 3) baseline outcomes (HFPI: p = .76, d = .02; HOME: p = .72, d = .02).

Table 30. Demographics for high and low fidelity MHC families and their matched comparison group.

Demographic Characteristic	Low Fidelity				High Fidelity			
	Intervention Group (*N* = 779)		Comparison Group (*N* = 779)		Intervention Group (*N* = 487)		Comparison Group (*N* = 487)	
Race/Ethnicity[1]	*n*	%	*n*	%	*n*	%	*n*	%
African	10	1%	10	1%	12	3%	9	2%
African American Non-Hispanic Origin	252	32%	241	31%	135	28%	120	25%
American Indian/Alaskan Native	0	0%	0	0%	2	0%	3	1%
Anglo/American	330	42%	342	44%	218	45%	23	47%
Asian/Pacific Islander	15	2%	16	2%	7	1%	9	2%
English	1	0%	1	0%	0	0%	0	0%
Hispanic/Latino	120	15%	110	14%	91	19%	88	18%
Multi-ethnic	45	6%	48	6%	15	3%	19	4%
Spanish	0	0%	1	0%	0	0%	1	0%
Other	6	1%	10	1%	7	1%	8	2%
Income[1]	*n*	*M (SD)*	*n*	*M (SD)*	*n*	*M (SD)*	*n*	*M (SD)*
Annual Household Income	760	$10,784.14 ($13,041.39)	759	$10,501.77 ($11,815.49)	476	$11,482.72 ($12,707.21)	472	$11,960.73 ($12,192.70)
Caregiver Age	*n*	*M (SD)*	*n*	*M (SD)*	*n*	*M (SD)*	*n*	*M (SD)*
Age in Years at Consent Date	774	26.10 (5.81)	770	25.64 (6.32)	487	27.08 (6.33)	483	26.54 (6.05)
Education	*n*	%	*n*	%	*n*	%	*n*	%
Less than HS	79	10%	81	10%	42	9%	49	10%
High School Diploma or GED	99	13%	87	11%	61	13%	59	12%
Some College	88	11%	94	12%	49	10%	48	10%
Four Year Degree or Higher	21	3%	22	3%	8	2%	8	2%
Unknown	492	63%	495	64%	327	67%	323	66%
Language Spoken in the Home	*n*	%	*n*	%	*n*	%	*n*	%
English	714	92%	711	91%	421	86%	424	87%
Spanish	49	6%	47	6%	56	12%	53	11%
Other	16	2	21	3%	10	2%	10	2%
County Type (USDA Urban Influence Code)	*n*	%	*n*	%	*n*	%	*n*	%
Large-in a metro area with at least 1 million residents or more	339	44%	357	46%	484	99%	476	98%
Small-in a metro area with fewer than 1 million residents	419	54%	387	50%	0	0%	3	1%
Micropolitan adjacent to a large metro area	21	3%	12	2%	3	1%	1	0%
Noncore adjacent to a large metro area	0	0%	5	1%	0	0%	1	0%
Micropolitan adjacent to a small metro area	0	0%	11	1%	0	0%	3	1%
Noncore adjacent to a small metro with town of at least 2,500 residents	0	0%	3	0%	0	0%	3	1%
Micropolitan not adjacent to a metro area	0	0%	3	0%	0	0%	0	0%
Noncore adjacent to micro area and contains a town of 2,500-19,999 residents	0	0%	1	0%	0	0%	0	0%
History of Mental Illness	*n*	%	*n*	%	*n*	%	*n*	%
No	504	65%	502	64%	321	66%	322	66%
Yes	275	35%	277	36%	166	34%	165	34%
History of Criminality	*n*	%	*n*	%	*n*	%	*n*	%
No	665	85%	664	85%	422	87%	423	87%
Yes	114	15%	115	15%	65	13%	64	13%
Alcohol Use Pre-Pregnancy	*n*	%	*n*	%	*n*	%	*n*	%
No	748	96%	746	96%	464	96%	468	97%
Yes	29	4%	31	4%	20	4%	16	3%
Limited Use of Alcohol by Mother	*n*	%	*n*	%	*n*	%	*n*	%
No	136	19%	143	20%	118	25%	113	25%

Demographic Characteristic	Low Fidelity				High Fidelity			
	Intervention Group (*N* = 779)		Comparison Group (*N* = 779)		Intervention Group (*N* = 487)		Comparison Group (*N* = 487)	
Yes	598	82%	592	81%	334	75%	345	75%
Alcohol Use Post-Pregnancy	*n*	%	*n*	%	*n*	%	*n*	%
No	755	97%	759	98%	469	97%	468	97%
Yes	21	3%	17	2%	14	3%	16	3%
Drug Use During Pregnancy	*n*	%	*n*	%	*n*	%	*n*	%
No	668	86%	670	87%	433	90%	434	90%
Yes	108	14%	104	13%	50	10%	49	10%
Drug Use Before Pregnancy	*n*	%	*n*	%	*n*	%	*n*	%
No	192	26%	201	27%	138	30%	131	29%
Yes	543	74%	536	73%	325	70%	327	71%
Birth Status of Target Child	*n*	%	*n*	%	*n*	%	*n*	%
Not First Birth	447	57%	428	55%	281	58%	270	56%
First Birth	332	43%	351	45%	204	42%	214	44%
Intimate Partner Violence Status	*n*	%	*n*	%	*n*	%	*n*	%
No Intimate Partner Violence	481	63%	479	63%	330	71%	334	71%
Intimate Partner Violence	278	37%	285	37%	135	29%	137	29%
Edinburgh Postnatal Depression Scale	*n*	*M (SD)*	*n*	*M (SD)*	*n*	*M (SD)*	*n*	*M (SD)*
Initial EPDS Scores	768	5.77 (5.05)	767	5.78 (4.836)	482	5.42 (4.93)	484	5.51 (4.90)
Baseline HFPI Score[1]	*n*	*M (SD)*	*n*	*M (SD)*	*n*	*M (SD)*	*n*	*M (SD)*
3-Month Total HFPI Score	724	234.78 (87.92)	731	234.44 (90.92)	457	229.84 (91.44)	456	231.56 (90.49)
Baseline HOME Score[1]	*n*	*M (SD)*	*n*	*M (SD)*	*n*	*M (SD)*	*n*	*M (SD)*
2-Month Total HOME Score	702	30.44 (12.71)	711	30.64 (13.11)	448	27.97 (13.91)	439	28.94 (14.17)

[1] Note: The baseline equivalence requirement for HomVEE's (2014) moderate study rating (i.e., non-significant differences between groups on race/ethnicity, socioeconomic status, and baseline measures of outcomes) was met.

C. Comparison Group

Research Question 3

Demographic characteristics for comparison groups were reported in the prior section. Because comparison families were identified from the population of non-MIECHV-funded families participating in the HFI program, no recruitment or retention issues specific to these families were experienced. They were recruited and retained by HFI staff as part of normal service delivery.

D. Discussion and Interpretation

The FY2018 evaluation allowed Indiana to build on findings from prior evaluations to examine the role that fidelity plays in MHC from both implementation (RQ1) and outcome evaluation (RQ2 & RQ3) perspectives. Through this design, each evaluation question incorporated fidelity as a lens through which data were analyzed and results were interpreted. When examined collectively, the results reinforce the salience of implementation fidelity within the MHC model. The study demonstrated that increased fidelity was associated with improved family and staff outcomes. It also identified the components of the model that, when implemented with fidelity, were the most predictive of outcomes for families and home visitors. These findings emphasize the importance of a focus on multiple dimensions of fidelity. The results may isolate unique pathways through which home visitors and families benefit from MHC. However, it is important to note that given the small effect sizes observed for all family outcomes, the magnitude of relationships was very limited. Along with providing an increased understanding of the fidelity-outcomes link within MHC, the evaluation identified staff perceptions of current implementation gaps, existing supports and barriers, as well as additional resources that would support improved implementation.

Research Question 1

Supporting Factors. Most respondents agreed that as of summer 2019, most fidelity criteria were being met. Sites' ability to implement MHC was supported by a variety of factors. First, respondents reported

that because MHC was strongly aligned with home visiting work, sites intentionally leveraged the enhancement to improve their work with families. Secondly, as an offshoot of the aforementioned alignment and shared understanding, agency leaders bolstered MHC by integrating the enhancement into all agency activities, communicating the importance of MHC, ensuring that time and resources were appropriately allocated, and involving mental health consultants in meetings and other work. Third, collaboration among mental health consultants promoted improved fidelity by sharing forms for documentation, resources, strategies for supporting home visitors, general information about MHC, and best practices for meeting model expectations. Fourth, mental health consultant's expertise/experience supported the implementation of MHC because mental health consultants' backgrounds were highly aligned with the duties and tasks necessary to implement MHC model expectations with fidelity. Finally, respondents noted the value of MHC-specific training, and they highlighted the May 2019 training.

Deviations from the Model. Two main fidelity concerns existed for sites: documentation and monthly reviews of all MIECHV families. *Documentation.* Staff attributed some challenges with documentation to a lack of clarity related to expectations and limited experience with the data system. Moreover, respondents noted that longstanding documentation issues were compounded by the spring 2019 database transition. Documentation issues are a major concern because secondary activity data are the primary tool for reporting the extent to which model components are completed. Moreover, they are a primary means for assessing MHC fidelity. Another major concern is that documentation challenges are relatively widespread. Over half (57%) of respondents noted challenges completing documentation, which suggests that most site struggle with this expectation. *Monthly Family Reviews.* Most (79%) mental health consultants and program managers reported that all MIECHV-funded families were being reviewed monthly at the time of the interview (August-September 2019); however, participants noted that in most sites, only high priority families had been reviewed and documented monthly prior to the May 2019 training that clarified expectations. Family review inconsistencies had been widespread; 86% (6/7) of mental health consultants said that they had incorrectly completed and/or documented family reviews before May 2019. Some sites (particularly sites with larger caseloads) continue to struggle to review all families each month. Deviations from the model in this area are especially problematic because FY2018 results show increased fidelity of family reviews significantly predicted improved family outcomes.

Barriers. The 2019 data system migration and a lack of clarity related to model expectations hindered most sites from implementing MHC in adherence to all fidelity criteria. Other barriers included caseloads, mental health consultants' time capacity, scheduling challenges, and home visitors' buy-in.

Additional Resources. Respondents requested additional opportunities for collaboration including more frequent in-person meetings and additional reflective practice for mental health consultants. Staff also saw value in training for mental health consultants that was specific to their MHC duties, especially reflective supervision. Finally, respondents indicated that more detailed documentation guidelines would help to alleviate confusion and improve the quality of documentation.

Summary. In summary, staff reported that MIECHV sites have improved the extent to which MHC is implemented with fidelity across the majority of model expectations; however, deficiencies in the areas of documentation and monthly family reviews create notable challenges because of how these fidelity criteria influence overall reporting and family outcomes, respectively. While a variety of barriers and challenges exist, staff believe that with additional opportunities for professional development and collaboration, implementation fidelity can be improved. Because these responses were drawn from nearly all program managers and mental health consultants implementing MHC, the results were generalizable to Indiana's MIECHV sites.

Research Question 2

The results demonstrated the importance of fidelity within the context of MHC. Specifically, this research question demonstrated that specific dimensions of fidelity make at least partially unique contributions to outcomes for home visitors. First, there was a large, significant relationship between delivery quality and perceived quality of resources. Secondly, increased participant responsiveness was associated with greater

self-efficacy and greater compassion satisfaction among the home visitors. Finally, an increase in adherence to the structural aspects of fidelity (exposure and adherence) was associated with an increase in burnout (a small effect), which suggested that home visitors may find participating in MHC demanding and burdensome when it is implemented with fidelity to the model.

Summary. Delivery quality, participant responsiveness, and structural fidelity appear to make unique contribution to staff outcomes. In practice, attention to and quality in each of these areas of fidelity should be associated with better outcomes for staff. Additionally, these findings may provide insight into the unique pathways through which home visitors benefit from MHC. The results seem to suggest that they benefit most from the reflective/relational components. This interpretation is consistent with the MHC theory of change, which states that improved outcomes occur within the context relationships between consultants and home visitors (Hunter et al., 2016; Johnston & Brinamen, 2012; Watson, et al., 2016). Given the sample size (N = 66) and response rate (80.4%), these results are likely generalizable to the population of home visitors participating in MHC.

Research Question 3

Preliminary steps taken to prepare the fidelity score identified individual MHC components that were positively related with family outcomes. Preliminary evidence points to possible benefits associated with family reviews, reflective practice, clinical consultation, clinical risk review, and MHC training. There also appears to be a link between longer family participation in MHC and improved outcomes. In practice, an increased focus on fidelity in these areas may support improved outcomes for families; however, it is important to note that the effect sizes were very small, which suggest that the magnitude of any improvements in family outcomes could be limited.

RQ3a. The results demonstrated that fidelity to the model predicted family outcomes within the MHC treatment group for the HOME outcomes, but not for the HFPI outcomes. For the HOME subscales, there were effects of total fidelity score on the slopes of outcome measure, which indicated greater improvement in the outcome as fidelity increased. For the HFPI subscales, no effects of fidelity on change were observed. For the HOME, these results suggested that within the dose-response framework, increased fidelity was associated with improved outcomes; however, the small effect sizes indicated that the magnitude of the relationships were limited.

RQ3b. On the HOME subscales, all groups tended to improve over time except the Low Fidelity MHC treatment group, which either did not improve over time or demonstrated less improvement than other groups. On the HFPI subscales, the data suggested no changes over time for all groups except the Low Fidelity treatment group, which actually worsened over time on these subscales. Two possible interpretations have emerged from these results. 1) Because the majority of the total fidelity score was determined by factors occurring at the site level rather than at the family level, it is possible that poor performing sites both have difficulty adhering to the MHC model with fidelity and execute their invention more poorly. 2) Within the dose-response framework used for the evaluation, increased fidelity to the treatment model is interpreted as an increased treatment dose. Therefore, an alternative possibility is that because MIECHV sites are specifically selected due to their location in high-risk counties, low fidelity MHC families may represent higher-risk families that essentially did not receive a treatment (based on the theorized dose-response relationship that defines lower fidelity as a lower treatment dose). This may suggest that families from high risk communities not receiving a treatment, or receiving a low-quality treatment, may perform more poorly in general than those from lower risk communities. In this case, the fact that the high fidelity MHC treatment group performed the same as its matched-comparison group may indicate that it is actually performing much better than it otherwise would have without the treatment because it is composed of families from high-risk counties.

Summary. The results of RQ3 reinforce the importance of fidelity when implementing MHC. Improving fidelity of implementation should contribute to improved outcomes for families enrolled in the program. It is important to note that there were small effect sizes observed for all family outcomes, and increased fidelity accounted for approximately 1% to 2% of the variability in the outcomes. While this does not

diminish the importance of fidelity, it does suggest that the magnitude of improvements may be very limited as MHC fidelity is increased. Additionally, the results suggest that home visitors and families benefit from different fidelity criteria, which may elucidate the pathways through which MHC supports improved outcomes for stakeholders. As shown in RQ2, home visitors appear to benefit most from increased fidelity to reflective/relational components (e.g., MHC delivery quality and participant responsiveness). Families, on the other hand, appear to benefit most from increased fidelity to model adherence (e.g., completion of clinical risk assignment, monthly family review, reflective practice, clinical consultation, and training requirements) and exposure components (e.g., amount of time that families spend in the program). However, it is important to note that the theory of change suggests that families benefit from the relational components of MHC when home visitors replicate the supervisor-supervisee relationship in their work with families (i.e., through parallel process). Because these analyses were exploratory, it is possible that the design was not adequate to detect family outcomes driven by parallel process. Additional research and evaluation are needed to understand fully the relationships among fidelity criteria and outcomes.

Unintended Findings

RQ1 – Home Visitor Buy-in. While the majority of program mangers identified home visitor buy-in as a barrier for MHC implementation, this concern was not shared by mental health consultants (Mental Health Consultants: 14%; Program Mangers: 71%). Based on the interview responses, it was unclear why the two groups perceive home visitors' buy-in in MHC differently. **RQ1 – The Presence of Supervisors during Home Visitors' Reflective Practice.** While it did not reach the overall 40% threshold for inclusion in the main results section, the majority of mental health consultants (57%) expressed concerns about including supervisors in reflective practice provided to home visitors. They noted that with the supervisor present, some home visitors were less willing to discuss challenges, which limited the efficacy of reflective practice. Program managers did not share this concern (or were not aware of this issue); however, one program manager noted that his or her site offered reflective practice without the supervisor present and indicated that MHC had benefited by separating reflective practice from supervision. Given its importance for mental health consultants, the supervisor's role in reflective practice should be examined further. **RQ3 – HFPI – Depression.** Throughout all analyses, the HFPI *Depression* subscale behaved inconsistently compared to other scales, the theory of change, and expectations. In Step 1, this scale was shown to be negatively correlated with home visitor ratings of structural fidelity. In matched comparisons, the slopes of the High Fidelity MHC and High Fidelity Comparison groups were negative, suggesting that depression worsened over time. It is unclear why there was a paradoxical change in depression scores over time for these groups. Before conclusions may be drawn, additional evaluation is recommended.

E. Limitations

RQ1. Evaluation data were drawn from self-report interviews, which can create a number of limitations including, but not limited to, social desirability bias, attribution issues, and memory errors. Responses reflected the perceptions of the interviewee and may not be independently verifiable. Finally, responses reflect each participant's understanding of specific MHC model expectations and may have varied across respondents and/or have been inconsistent with MHC contractual expectations. As applicable, efforts have been made throughout this report to triangulate interview responses with other data sources for the most accurate interpretations. **RQ2.** Due to the small sample size, the analysis was "rank deficient" (i.e., more measurement items (88) than observations (N = 66)). As a result, the overall analysis is not as reliable as it would be were it not rank deficient. One should use caution when interpreting any small effects (both their size and direction) because small effects in a small sample may not be present or even reverse direction in a larger sample. Large effects may be viewed as preliminary evidence of relationships among variables; however, these findings would benefit from further investigation either via replication or qualitative methods. **RQ3.** *Propensity Score Matching/Quasi-Experimental Research.* While propensity score matching was used to create comparison groups that were similar to families participating in MHC, the process cannot control all bias and should not be considered equivalent to a true

experimental study. The analyses may be limited by the existence of variables that predict family participation and/or outcomes but were not available to the evaluation team. These analyses should be interpreted as only preliminary evidence of program impacts (Sommers et al., 2013). *HFPI.* Overall, the HFPI appeared less sensitive to detecting changes in family outcomes over time. Currently, it is unclear if these issues are the result of the outcomes themselves (i.e., the types of outcomes the HFPI is designed to detect are particularly resistant to change) or measurement problems (i.e., issues with the scale itself or how it is administered or scored). Alternatively, emerging findings from Oklahoma's MIECHV program (which showed that home environment mediated other outcomes) may provide additional context these results. *Fidelity.* While fidelity has improved, opportunities for sites to improve the implementation of MHC remain, especially in the areas of documentation and family review. It is important to interpret the findings within the context of Indiana's ongoing efforts to improve fidelity. Specifically, while families within the High Fidelity MHC treatment group had higher fidelity scores than families in the Low Fidelity MHC group, it is likely that many of the High Fidelity MHC families received services that did not satisfy model requirements. Moreover, because *a priori* knowledge was limited, a median split was used to determine placement into the high and low fidelity treatment groups. Future research should identify high and low fidelity families based on the clusters of fidelity scores (those below -1, those clustering around 0, and those above 1) identified in the current study (see supplemental analyses in full report). *Home Visitor Fidelity Measures.* Structural fidelity as measured by the home visitor survey (IN MHC Fidelity Scale) was not associated with structural fidelity as measured by the secondary activity data. Additional review of these measures suggested that home visitors may not the best source of information for some aspects of structural fidelity. While they should have strong insights related to the model expectations in which they are directly involved (e.g., clinical consultation, reflective practice, and training), accurately recalling the extent to which all of their families were discussed in clinical consultation or how often training was offered over the course of a year might be difficult. Moreover, home visitors may be less attuned to clinical risk assignment and monthly family reviews because they are not directly involved in these processes. Finally, psychometric concerns emerged related to the IN MHC Fidelity Scale. The development of new tools to assess fidelity should be considered as part of ongoing fidelity improvement.

F. Design Specific Components

Controlling Confounding Factors. Home visiting (and related) evaluation/research have identified a variety of factors that are associated with family outcomes and participation in home visiting interventions (e.g., Boller et al., 2014; CDC, 2020; Daro et al., 2003; MIECHV, 2016). This research was consulted during the development of the study to identify and plan for confounding factors. Resulting variables included caregiver demographics (education, race, age, socioeconomic status, language, urbanicity, substance use, criminality history), family risk (intimate partner violence, family stress, parenting stress, childhood history of care, emotional functioning, attitudes towards and perception of children, discipline of children), mental health, and baseline parenting efficacy. Propensity score matching was employed to control confounding factors. Propensity score matching has been identified as an effective method for addressing confounding factors and reducing bias (Brookhart et al., 2013; Kahlert et al., 2016; Rosenbaum & Rubin, 1983; Schroeder et al., 2016). The literature suggests that when the process has been implemented successfully, "treated and untreated [individuals] tend to have the same distribution of measured confounders, something that we would also achieve using randomization" (Brookhart et al., 2013, p. 2). The FY2018 study was designed to adhere to HomVEE's standards: 1) potential confounding factors have been minimized as recommended by HomVEE (i.e., more than two subjects/participants were represented in the treatment and comparison groups, and data were uniformly collected across all sites) and 2) both baseline demographic characteristics (e.g., race/ethnicity, socioeconomic status) and baseline outcome measures were incorporated into the propensity score.

XII. EVALUATION SUCCESSES AND CHALLENGES, CONCLUSIONS, AND DISSEMINATION OF EVALUATION FINDINGS

A. Strategies That Facilitated Evaluation Implementation

The evaluation was implemented as a partnership between Diehl Consulting Group and state-level DCS Prevention Team, with support from site managers, other program staff, and the database provider. The evaluation utilized the DCS Prevention Team as the conduit through which evaluation instruments were administered to home visitors. DCS Prevention Team staff sent an advance email and recruitment email (with links) to site staff for each evaluation activity that provided an overview of the activity/timing and its importance for HFI. Response rates were reviewed with program managers by DCS Prevention Team staff during data collection windows to identify participation barriers and other issues. These procedures increased buy-in and participation from staff. During February 2019, members of the evaluation team reviewed FY2016 findings with site staff and provided a preview of the preliminary FY2018 data collection timeline. Opportunities were provided for questions and feedback. The evaluation utilized data housed in the Enlite system. Exports of required data were readily available from the database provider; state HFI leadership facilitated interactions between the evaluation team and the database vendor and provided contextual support for requests. The evaluation team provides regular updates to the Indiana Home Visiting Advisory Board (INHVAB). State-level leadership are heavily involved in the evaluation process and meet with the evaluation team at least monthly.

B. Evaluation Successes

The FY2018 evaluation provided Indiana with the opportunity to explore MHC implementation and outcomes through the lens of fidelity. By accounting for fidelity in the study, nuanced evaluation questions were proposed that contributed to a more robust understanding of MHC and its benefits for families and staff. The FY2018 evaluation incorporated more rigorous statistical methods than prior evaluations, which increased the validity of the findings and the resulting conclusions. Using more rigorous methods identified relationships that were overlooked in prior evaluations, which contributed to an increased understanding of how MHC benefits stakeholders. While findings generally confirmed the MHC theory of change, they also challenged existing assumptions (e.g., the relationships between individual fidelity dimensions and outcomes). In practice, these findings will help Indiana to understand more specifically how MHC can benefit stakeholders, supports and barriers influence the implementation, and resources could support model improvements. A second success was that strategies to increase survey responses rates for home visitors were fruitful during the FY2018 evaluation. The response rate for the home visitor survey in FY2018 was 80.4%, compared to 63.6% for a similar survey in FY2016.

C. Challenges

During spring 2019, Indiana transitioned to a new data system for HFI. While the evaluation team was not directly affected by this change, frontline staff noted a variety of challenges collecting and entering data during the transition. Some data integrity issues were identified in the weeks and months immediately following the transition. Moreover, additional time devoted to data collection affected staff capacity in other areas. To mitigate these challenges, the evaluation timeline was designed to minimize data collection activities during the transition window. Specifically, 1) staff surveys and interviews were completed in late summer 2019 to accommodate staff capacity concerns, and 2) data requests were completed either a) prior to the transition (in collaboration with the previous vendor) or b) during winter 2020 (in collaboration with the current vendor). These strategies lessened burdens on staff and reduced the risk of inaccurate or incomplete data. Because all data collection had occurred by December 31, 2019, the COVID-19 pandemic created no challenges for the FY2018 evaluation.

D. Adherence to Proposed Plan

The evaluation was completed in adherence to the approved evaluation plan.

E. Key Findings

RQ1. Overall, mental health consultants and program managers reported that the majority of model expectations were met; however, responses suggested that most sites experienced challenges meeting documentation expectations and that some sites struggled to complete monthly reviews for all MIECHV-funded families. Furthermore, the majority of sites noted that monthly reviews were not completed and/or documented in adherence to model expectations prior to May 2019. When asked to describe implementation supports currently available, participants identified MHC alignment with existing work (93%), agency/management support for MHC (86%), collaboration among mental health consultants (57%), mental health consultants' expertise/experience (50%), and MHC training provided in May 2019 (43%). Analysis of interview responses revealed three additional supports that would benefit implementation: increased collaboration among mental health consultants (50%), training for mental health consultants that focuses specifically on their MHC responsibilities (50%), and additional documentation guidelines (43%). Key barriers impeding implementation fidelity included spring 2019 data system migration (86%), model expectation clarity (79%), caseloads (57%), mental health consultants' time capacity (57%), scheduling challenges (43%), and home visitors' buy-in (43%).

RQ2. A fully linked statistical model was created that explored the unique relationships between each fidelity measure and each staff outcome. The model suggested that the individual aspects of fidelity make different, at least partially unique contributions to the home visitor outcomes. There was a large, significant relationship between delivery quality and perceived quality of the resources; as ratings of the quality of delivery increased, increases were observed in perceived quality of resources. Increased participant responsiveness (i.e., confidence completing key aspects of MHC) was associated with greater self-efficacy (a medium-sized effect) and greater compassion satisfaction (a small effect) among the home visitors. An increase in adherence to the structural aspects of the MHC model was associated with an increase in burnout (a small effect). This latter relationship suggests that home visitors may find participating in MHC demanding and burdensome when it is implemented with fidelity; however, because this was a small effect, these results suggest a need to further explore the obstacles home visitors may encounter.

RQ3a. Fidelity to the MHC model predicted family outcomes within the MHC treatment group for the HOME outcomes, but not for the HFPI outcomes. For the HOME subscales, there were effects of total fidelity score on the slopes of outcome measure, which indicated greater improvement in the outcome as fidelity increased. Effects were very small, with fidelity accounting for 1% of the variance in the change in the HOME outcomes over time. For the HFPI, no effects of fidelity on the change in these subscales were observed. In summary, RQ3a results suggest an effect of fidelity to the MIECHV treatment model on HOME outcomes, albeit a small one.

RQ3b. On the HOME subscales, all groups tended to improve over time except the Low Fidelity MHC treatment group, which either did not improve over time or demonstrated less improvement than other groups. On the HFPI subscales, the data suggested no changes over time for all groups except the Low Fidelity treatment group, which actually worsened over time on these subscales.

F. Implications of Findings

The results of this evaluation suggest that participation in MHC may provide benefits for families, home visitors, and agencies; however, implementing the enhancement with fidelity to the model is essential for improving outcomes for stakeholders. For families in particular (RQ3), the evaluation found that increased fidelity to the treatment model was associated with improved outcomes in the areas of *emotional/verbal responsivity* ("the communicative and affective interactions between the caregiver and the child"), *organization of physical and temporal environment* ("how the child's time is organized outside the family house, [and] what the child's personal space looks like), and *parent involvement* ("how the adult interacts physically with the child") (Totsika & Sylva, 2004, p. 26). Moreover, matched-comparison analyses may suggest that when implemented with higher levels of fidelity, MHC could provide some mitigation for negative parenting outcomes experienced by families in high-risk

communities. The evaluation also provided preliminary evidence that identified the model components that appear to have the strongest relationships with family outcomes when implemented with fidelity. Specifically, preliminary evidence points to possible benefits specifically associated with family reviews, reflective practice, clinical consultation, clinical risk assignment, and MHC training. Moreover, there appears to be a link between longer family participation in MHC and improved outcomes. However, it is important to note that given the small effect sizes observed for all family outcomes, the magnitude of family improvements may be very limited as fidelity is increased. For home visitors (RQ2), the study identified how individual dimensions of MHC fidelity contribute to better outcomes. Specifically, the quality of MHC delivery was positively associated with perceived *quality of resources*. Increased home visitor responsiveness (i.e., confidence completing key aspects of MHC) was associated with greater *self-efficacy* (i.e., confidence providing support in the areas of drugs/alcohol, mental health, partner violence, behavior management, and child development) and greater *compassion satisfaction* (i.e., job satisfaction related to helping others) among the home visitors. While the effect size was small, there was some evidence to suggest that when MHC is implemented with higher levels of structural fidelity (i.e., model adherence and exposure), there was greater *burnout* among home visitors, and this finding is important to consider as adaptations to the model are considered. At the program level (RQ1), qualitative interview responses indicated that while improvements to implementation fidelity have occurred, some sites continue to struggle with documentation and monthly reviews for all MIECHV-funded families. Moreover, at the time of the interviews, strategies to maximize fidelity were still in the early stages of implementation. Mental health consultants and HFI program managers identified a variety of factors that are currently in place that support the implementation of MHC, as well as barriers that hinder implementation with fidelity. Finally, respondents provided recommendations for improving the quality of implementation. In summary, findings examining family and home visitor outcomes (RQ3 and RQ2, respectively) provide preliminary support for continuation of the model, especially with strategies in place to improve the fidelity of implementation. Interview responses (RQ1) provide valuable insight to understanding deficiencies in current implementation, identifying strengths and gaps, and developing strategies to strengthen the model and its implementation. Preliminary findings from the FY2018 evaluation were presented to DCS Prevention Staff during spring 2020, and these data were used to guide the development of the Indiana's FY2020 MIECHV application, particularly through strategies to improve MHC and increase fidelity across sites through a variety of new supports and resources. Moving forward, the data suggest that by increasing MHC fidelity across participating sites, Indiana may experience improved outcomes for families participating in the program; however, given the small effect sizes observed, the magnitude of family improvements may be very small as fidelity is increased.

G. Recommendations

Across all research questions, the findings emphasize the importance of fidelity for improving outcomes for families and home visitors. Greater fidelity to the model is associated with better outcomes, which indicates that continuing to emphasize improved fidelity is important for the implementation teams at the state level. Grounded in the FY2018 evaluation findings, the following recommendations provide guidance for improving fidelity, measurement, and evaluation.

1. Ongoing Training and Support for MHC Implementation: The findings suggest that sites would benefit from additional training and support that are directly related to completing and documenting MHC expectations. The data suggest that Indiana should consider training that covers multiple aspects of implementation fidelity (see James Bell Associates, 2009). As applicable, recommendations from mental health consultants and program managers should be considered: increased opportunities for mental health consultants to collaborate, training for mental health consultants that is specific to their MHC role, and documentation guides.

2. Ongoing Fidelity Monitoring: Consideration may be given to developing strategies to monitor implementation fidelity on an ongoing basis. Doing so would allow leadership to identify implementation issues and make real-time course corrections. Implementation fidelity is improved when program components are defined *a priori* and monitored for compliance (Mihalic, 2004).

3. Review and Revision of Model Expectations: The results have provided initial evidence of the extent to which individual model expectations are related to staff and family outcomes. Where applicable, existing fidelity criteria should be reviewed and revised to increase the focus on the model components that have the strongest relationships with program outcomes.

4. Develop and/or Refine Fidelity Instruments. Concerns were noted related to the *IN MHC Fidelity Scale*, which was developed as part of the FY2018 evaluation. Valid and reliable measures for assessing MHC fidelity are essential for monitoring compliance and ultimately, improving fidelity (Prinz & Moncher, 1991). Therefore, the development of new tools to assess fidelity should be considered as part of ongoing fidelity improvement.

5. Further Evaluation and Research. Further evaluation and research should utilize designs that allow outcomes to be examined within the context of fidelity. Given the implementation improvements that mental health consultants and program mangers described, future evaluation should include a focus on MHC implementation after May 2019. Finally, results from the Depression subscale from the HFPI were inconsistent with the theory of change, and additional research is recommended before conclusions can be drawn about the relationship between MHC and depression.

H. Detailed Plan for Dissemination

The dissemination plan will include opportunities for sharing lessons learned to all MIECHV recipients and to the home visiting field broadly. 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 implementing agencies and the Indiana Home Visiting Advisory Board (INHVAB). Sharing opportunities include MIECHV and home visiting related meetings, conferences, and the 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. Finally, conference presentations, including the Institute for Strengthening Families, will be considered during the project.

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