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

Formula Grant X10MC29469 Final Report

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I. PROGRAM SUMMARY

Indiana's MIECHV program is co-led by the Indiana State Department of Health (ISDH) and the Indiana Department of Child Services (DCS). Indiana's MIECHV Program 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.

Purpose and rationale for grant:

Project Purpose: The purpose of Indiana's MIECHV Program 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). In response to the federal redesign of the FY2016 funding plan, Indiana planned to use this FY 2016 MIECHV Formula award to provide continuity of services for families served by previous Formula and Competitive awards, then gradually decrease the number of MIECHV funded families served (through natural attrition) and ultimately sustain MIECHV funded services beyond 9/30/17. From 10/1/2017 – 9/30/2018, these funds were used to provide home visiting services to 1,145 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) and the 2012 IN Natality Report. These areas include Elkhart, Grant, Lake, LaPorte, Marion, Scott, and St. Joseph Counties.

This FY2016 Formula award funded some level of services from all HFI sites and the Marion County NFP site that are currently serving MIECHV funded families so that appropriate levels of family service can be sustained. Competitive funded HFI and NFP families that were enrolled on 9/30/17 were transitioned to Formula funds beginning 10/1/17. HFI continued the mental health consultation enhancement that was originally conceived through provision of MIECHV Competitive funding and approved by Healthy Families America (HFA). Indiana increased the number of HFI home visiting staff with the Indiana Association of Infant and Toddler Mental Health (IAITMH) Endorsement (IMH-E®) as preferred by current HFA standards. In summary, with this FY2016 Formula award contributed to the provision of MIECHV-funded HFI services for 1,738 families and MIECHV-funded NFP services for 616 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.

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. Two notable changes from previous reporting periods include:

- The 1/1/16 change in the HFI mental health consultation model from a centrally administered model to a locally administered model means that this reporting period is the first reporting

period with only the locally administered model in place. More information about this model is presented in the Evaluation sections of this report, starting on page 18.

- FY16 funds were used to contract with an external CQI provider.

Continuous Quality Improvement (CQI) Efforts Indiana's MIECHV Continuous Quality Improvement Plan 2017 received final approval in November 2017. Each Local Implementing Agency (LIA) has at least one CQI team that selects and conducts projects 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 projects beyond MIECHV specific outcomes, but all projects addressed overall MIECHV goals.

Indiana utilized FY16 funding to contract with CQI provider Michigan Public Health (MPHI) who is now providing technical assistance and specific coordination to LIAs and the State MIECHV team with regard to organizing, conducting, and documenting CQI projects. Support from MPHI includes monthly check in calls with each LIA regarding current CQI projects, "just-in-time" technical assistance upon request, monthly check-in calls with the Indiana state team providing overview of projects and activities, consulting with Indiana state team around prioritization of training for LIAs and development of training to meet LIA needs.

CQI Training has included:

- 2-day Beginning CQI workshop – conducted by Indiana state team members in collaboration with other state and local partners – held at The Institute for Strengthening Families in April 2016, September 2016 and April 2017.
  - ✓ In 2015, Goodwill Industries of Central and Southern Indiana's NFP program participated in the HV COIIN, focusing on developmental screening. A description and walk through of this project was added to the CQI Beginning training in April 2017 as a "bonus module" illustrating rapid cycle PDSAs as well as the Rapid Cycle training provided to HFI providers in 2017. As many CQI projects in Indiana have had fairly long timelines, Indiana is using the team's experience to illustrate and inform other CQI teams about how rapid cycle improvement can create more efficient change based on smaller/shorter tests that build to impact larger improvement goals over time.
  - ✓ In February 2018 and at the Institute for Strengthening Families in September 2018, the 2-day Beginning CQI workshop was conducted by the MPHI team
- CQI refresher course for individuals who had previously received the 2-day training
  - ✓ September 2017 – online, provided by DCS MIECHV Grant Coordinator
  - ✓ September 2018 – provided by MPHI at Institute for Strengthening Families
- Rapid cycle PDSAs – online, September 2017 provided by DCS MIECHV Grant Coordinator to HFI staff members who had previously received Beginning CQI training or train-the-trainer CQI training
- "Learning How to Make Your Data Count: Using Data for Quality Improvement" – provided by MPHI at Institute for Strengthening Families September 2018. Participants included home visiting supervisors, home visitors, program administrators, and state team members.

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

Table #A – Summary of CQI teams/projects.

LIA	Area for Improvement(s)				
Child & Parent Services	Client Retention	Home Visit Completion			
Family Service Society	Family Engagement	Home Visit Completion			
Mental Health America	Spanish-Speaking Family Outreach	Family Goal Plan (FGP)	Depression Screening and Referrals		
Dunebrook	Family Goal Plan (FGP)	Referrals in to Home Visiting			
HealthNet	Safety Topic Completion	Assessment Acceptance			
Eskenazi	Assessment Completion	Home Visit Completion	Family Retention		
Marion County Health Department	Safe Sleep	Birth Spacing			
New Hope Services	Depression Screening	Staff Retention			
Healthnet	Safety Topic Completion				
Family & Children's Services	Community Outreach	Safety Standards	Staff Retention	Family Retention	
Goodwill Central and Southern	Safe Sleep	Breastfeeding	Smoking Cessation	Maternal Depression	Retention

Progress towards meeting community needs as proposed in the formula grant application:

- FY16 (4/1/2016-9/30/2016) – as proposed, Indiana did not use X10MC29469 funds that were available during the FY16 reporting period to provide home visiting services.
- FY17 (10/1/2016-9/30/2017) – During the October 1, 2016 to September 30, 2017 reporting period – due to HRSA's change in the funding structure, and based on HRSA guidance – remaining Competitive D89MC28287 funds were blended with remaining Formula X02MC28219 funds and X10MC29469 funds to provide direct family service. Unless otherwise noted, all YEAR 6 or October 1, 2016 to September 30, 2017 outcomes are based on services to families with blended funds. Entities providing services, evidence-based model(s), families served, maximum caseload, and cost per family for this time period is indicated in Table B below.
- FY18 (10/1/2017-9/30/2018) – Table C below illustrates entities providing services, evidence-based model(s), families served, maximum caseload, and cost per family as funded by X10MC29469 funds.

Table B

MIECHV FY16 Formula Funding contributed to these MIECHV-funded families Served between 10/1/2016 and 9/30/2017						
At-risk Community	MIECHV Site / Local Implementing Agency (LIA)	Home Visiting Model	# of New Families Erolled during Reporting Period 10/1/2016 - 09/30/2017	# of Continuing Families as of 09/30/2017	Maximum MIECHV-funded Caseload (Family Slots) as of 9/30/2017	Estimated Cost Per Family Per Year* as of 9/30/2017
Delaware County	Goodwill Industries	NFP	11	9	23	$ 5,528.00
Elkhart County	Child And Parent Services	HFI	68	72	117	$ 5,165.88
Grant County	Family Service Society	HFI	20	28	34	$ 5,351.16
Lake County	Mental Health America, Lake County	HFI	147	216	216	$ 5,654.16
LaPorte County	Dunebrook	HFI	35	62	71	$ 5,588.16
Madison County	Goodwill Industries	NFP	13	21	25	$ 5,528.00
Marion County	Goodwill Industries	NFP	110	267	302	$ 5,528.00
	Healthnet	HFI	108	155	180	$ 5,940.00
	Health and Hospital (Eskenazi)	HFI	98	90	107	$ 5,151.60
	Health and Hospital (Marion Co Health Dept)	HFI	141	140	160	$ 4,980.00
Scott County	New Hope Services	HFI	19	21	38	$ 5,169.00
St. Joseph County	Family & Children's Center	HFI	82	85	85	$ 5,095.20

Table C

MIECHV Formula funded families Served between 10/1/2017 and 9/30/2018						
At-risk Community	MIECHV Site / Local Implementing Agency (LIA)	Home Visiting Model	# of New Families Erolled during Reporting Period 10/1/2017 - 09/30/2018	# of Continuing Families as of 09/30/2018	Maximum MIECHV-funded Caseload (Family Slots) as of 9/30/2017	Estimated Cost Per Family Per Year* as of 9/30/2018
Delaware County	Goodwill Industries	NFP	0	4	4	$ 5,528.00
Elkhart County	Child And Parent Services	HFI	131	82	117	$ 5,165.88
Grant County	Family Service Society	HFI	9	12	17	$ 5,351.16
Lake County	Mental Health America, Lake County	HFI	138	130	203	$ 5,654.16
LaPorte County	Dunebrook	HFI	56	53	62	$ 5,588.16
Madison County	Goodwill Industries	NFP	1	9	9	$ 5,528.00
Marion County	Goodwill Industries	NFP	287	264	387	$ 5,528.00
	Healthnet	HFI	181	142	195	$ 5,940.00
	Health and Hospital (Eskenazi)	HFI	93	60	107	$ 5,151.60
	Health and Hospital (Marion Co Health Dept)	HFI	159	126	160	$ 4,980.00
Scott County	New Hope Services	HFI	12	20	38	$ 5,169.00
St. Joseph County	Family & Children's Center	HFI	113	57	125	$ 5,095.20

***Cost per Family*:**

HFI uses a Unit Rate to reimburse local HFI providers for home visiting services provided to families. Unit rates are established for each LIA by DCS, using a variety of data such as the proportion of families at each level of service, including Creative Outreach[1]; salaries and benefits for staff, office supplies, equipment, travel, professional development, community outreach expenses, and annual HFA affiliation fee. Unit rates do not include costs for the centralized Quality Assurance services, data system or evaluation services, which are provided by contracted providers of DCS. A Unit Rate is paid to each provider each month for each family that received appropriate service for level assigned, defined by the model and includes length and frequency of visits and documentation completion. The estimated cost per family slot for each year is calculated multiplying the monthly unit rate times 12 months. In 2016, DCS conducted a review of the unit rate system used to reimburse providers for families served. This review identified the need for unit rates to be increased to cover expenses as described above. HFI sites serving MIECHV funded families received a 0% to 11.5% increase of unit rates during the availability period of this Formula funding. Estimated annual cost per family slot for HFI sites serving MIECHV funded families as of 9/30/2018 ranged from $4,980.00-$5,940.00 per year.
NFP's cost per family was calculated as $5,528. A complete team of nurse home visitors (8 NHV) can serve up to 200 families. The total cost per team per year is approximately $1,105,600. The cost per client is calculated by dividing the total cost per team per year by the maximum capacity of one team.

Promising Approach:

Indiana did not implement a promising approach with these funds.

II. SUMMARY OF OVERALL ACCOMPLISHMENTS

Indiana successfully implemented MIECHV Formula-funded services in the communities outlined in the HRSA-16-172 (FY16) grant application. As of September 30, 2018, Indiana has

[1] HFA Best Practice Standards, Effective July 1, 2014 – December 31, 2017 3-3-B states "The site places families on creative outreach, as defined by their policy and procedures, and continues creative outreach for at least three months, only concluding creative outreach services prior to three months when families have (re)engaged in services, refused services or moved from the area."

served 8,963 families through 203,585 home visits with MIECHV funding since its inception.

The Indiana team worked closely with LIAs, monitoring funds, services, outcomes and general practices that influenced the success of the MIECHV Formula X10MC29469.

Goals and Objectives: The overall vision of Indiana's MIECHV Program 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 9/30/18, continue program implementation serving at least 1,640 new and continuing families.*
      - ✓ X10MC29469 funds supported direct home visiting service of 2,354 new and continuing MIECHV-funded families via 26,062 home visits provided during the October 1, 2017 through September 30, 2018 reporting period.
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 9/30/18, inform organizations in Indiana [that currently serve as a referral source for home visiting programs] regarding referral coordination and expansion of services in order to provide appropriate, targeted, and unduplicated services to all children, mothers, and families who are high-risk throughout Indiana.*
      - ✓ 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. INHVAB membership includes: ISDH, DCS, Indiana Department of Corrections (DOC), 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 April 2017, the INHVAB and Early Childhood Comprehensive Systems (ECCS) state advisory council meetings were combined. As many of the same individuals were being asked to sit on both boards, this not only created one less meeting for individuals to attend, but strengthened the collaboration to provide coordinated services for Hoosier families.
      - ✓ As part of the implementation process leading up to the launch of the pilot for Help Me Grow Indiana[2], several community meetings were conducted introducing Help Me Grow Indiana to local community service providers. Additionally, a 4-day site visit from Help Me Grow national office was held in January 2018 in which many state and local partners were introduced to Help Me Grow Indiana through the lens of enhancing community services for home

[2] Implementation and pilot activities for Help Me Grow Indiana funded by joint effort of MIECHV UH4 Innovation funds and ECCS Impact funds.

visiting families and families with young children who may be at risk of developmental delay.

b. By 9/30/18, continue to increase the number of home visiting staff with the IMH-E®.

- Indiana created the opportunity for 29 home visiting staff to begin the endorsement process and 3 home visiting staff members at the sites serving MIECHV-funded families achieved IMH-E utilizing X10 funds. Additional home visiting staff have achieved endorsement utilizing other funding. However, Indiana is still working though barriers related to Endorsement that include value of Endorsement by staff and employers and limitation on some endorsement categories due to a lack of qualified Endorsed individuals to provide reflective supervision that counts toward Endorsement. Two members of the Indiana MIECHV state team and one HFI program manager from a site serving MIECHV-funded families sit on the Endorsement Advisory Committee for Infancy Onward as Indiana continues to support growing capacity for individuals to seek and maintain Endorsement.

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.

a. By 9/30/18, at least 95% of families that require additional services beyond home visiting receive a referral to an appropriate available community resource.

- 91% of primary caregivers who reported smoking or using tobacco at enrollment were referred to cessation counseling
- 90.61% of primary caregivers who screened positive for intimate partner violence received referral to appropriate community resource

b. *By 9/30/18, at least 75% of families receiving appropriate referrals will have a confirmed receipt of service.*

- 5.8% of primary caregivers referred to appropriate community resource for positive depression screen confirmed receipt of service[3]
- 64.12% of target children with positive screen for developmental delay were reported to receive appropriate community service

c. Help Me Grow Indiana did not launch until after the reporting period for this grant. However, much work was completed in designing the data collection system and feedback loop for Help Me Grow Indiana during the reporting period to meet the following:

- to better track referrals to appropriate resources beyond home visiting,
- to assist families in accessing community resources,
- and to follow-up with home visitors regarding the receipt of services beyond home visiting.

Indiana's goals and objectives were determined in alignment with the overall goals and objectives of the entire MIECHV project. Both projects aimed 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 provided statewide comprehensive services to improve outcomes such as: improved maternal and child health;

[3] Receipt of service is self-report by family receiving home visiting services

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.

Continuing Partnerships and Collaborations

Families that participate in home visiting services have other needs that are better addressed through other community resources. Education regarding available resources requires an ongoing commitment to regular communication with local communities and staying informed regarding state-level initiatives. In addition to the INHVAB, Indiana illustrates many examples of meaningful support and collaboration vital for the proposed activities within Indiana's FY16 Formula project as described below in Table D:

Table D:

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 and in 2016, was awarded an ECCS Impact competitive award. The Impact award supports the enhancement of early childhood systems building and demonstrate 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, implementation and sustainability of 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.
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: HMG is not a program, but instead is a system approach to designing a comprehensive, integrated process for ensuring developmental promotion, early identification, referral and linkage. 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. The Help Me Grow system is used to implement effective, universal, early surveillance and screening for all children and then link them to existing quality programs through organization and leverage of existing resources in order to be serve families with children at-risk. HMG implementation in Indiana is a collaboration MIECHV Innovations and the ECCS Impact Grant.
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 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.
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.
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.

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

HFI is accredited[4] by HFA which serves as a resource for model specific questions. During 2018, Indiana participated in the accreditation process that occurs every five years for Indiana's multi-site system, and anticipates a successful 2018 accreditation status in early 2019. Indiana regularly has representation at the national HFA conference. Additionally, many HFI sites have staff members who serve as peer reviewers for other states/HFA sites outside of Indiana seeking accreditation. HFI's contribution to the national model includes HFA panel representatives, piloting online training and data tracking systems and participation in national HFA committees.

Indiana works closely with the NFP National Service Office (NSO) and their technical support team as necessary. The NFP NSO holds a contract with ISDH to provide 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 is available to answer any data or program related questions on a continual basis and is under contract to continue their relationship with ISDH in this manner.

Each program (NFP, HFI) has 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 Director of Children's Health attended NFP NSO's Administrator Orientation in November 2016. The purpose of this training is 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

[4] Most recent full accreditation was completed during 2013.

Visiting Initiatives (ASTHVI) meetings in Washington DC in 2016, 2017 and 2018, MIECHV All Grantee meeting in Washington DC in 2016, 2017 and 2018, HFA national conferences, Help Me Grow conferences in 2017 and 2018, and on-line educational opportunities as provided through this grant and other resources presenting relative topics to grant activities.

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 2016 and 2017. 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 2016, 2017, and 2018. 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: NFP NSO provides Bachelor-prepared nurses with the required education and skills needed to support clients served. Core education for nurse home visitors and supervisor consists of two distance education components and two face-to-face education units. All NFP staff received Unit training and continued to participate in Consultative Coaching, as prescribed by the national model. In addition to the required NFP NSO training, Goodwill provided training on the following subjects: HIPAA awareness for healthcare providers, motivational interviewing, Goodwill's 5 basic principles training, Safety and Loss prevention training, documentation education and community outreach training.

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. Additionally, every nurse participated in a Certified Lactation Counselor or specialist training within the first year. Every nurse also receives Tobacco Treatment Specialist Training from the Center for Tobacco Treatment

Research and Training Center at the University of Massachusetts. Nurse supervisors and directors have participated in Goodwill leadership trainings. Several nurses and other staff have received six sigma training, earning their green belts.

Finally, CQI training has been available as described in the *Funded Activities* / *CQI Efforts* section, page 3 above.

Staff Recruitment, Hiring, and Retention -- High-quality supervision / reflective supervision

Turnover at the state-level did not inhibit Indiana's progress toward originally outlined goals of this project. Indiana's high-quality service providers subcontracted to assist this project in areas of data collection and analysis, quality assurance, and program management did not experience turnover and provided additional staff to accommodate additional needs created by this funding.

HFI sites serving MIECHV Formula-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 work with experienced staff balancing fresh perspective with well-founded best practices. During 2017, one HFI site serving MIECHV Formula families experienced turnover in the Program Manager position, a different HFI site serving MIECHV-funded families experienced Program Manager turnover in 2018.

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.

NFP maintains high staff retention through Goodwill's principles-based organization rather than rules-based, 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 NFP/Goodwill.

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.

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 formed key relationships among hospital systems, community agencies, and schools in order to develop home visiting referrals and service networks for Marion County's high-risk communities. MOUs have been signed by key leaders with organizations such as 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 who supports

referrals and assistance from the faith community. Outreach to community agencies include many unique partners. The Indianapolis Housing Agency (IHA), Indianapolis Metropolitan Police Department (IMPD), the Fathers & Families Center are three examples of these community partnerships.

Goodwill supportive services offer referral to educational resources such as the Indy Metropolitan High School and Excel Centers (public charter adult high school). Workforce Development and placement services are offered through Goodwill Talent Source. Re-entry and expungement services are available through Goodwill New Beginnings.

Participant recruitment / retention / attrition

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 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/Family Stress Checklist. As HFI sites only engage families who score 40[5] or above on the Parent Survey/Family Stress Checklist it is important to note that these higher risk families are inherently more difficult to engage and retain in a voluntary program.

Goodwill NFP continuously builds their referral system with community partners through ongoing outreach and networking. Primary referral sources are Eskenazi, Marion County's safety net hospital, who refer all eligible women to NFP. Additionally, Goodwill 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 link on the Goodwill NFP web site. Outreach to local organizations and attendance at community events has led to a significant portion of referrals (7-12%) that are self-referrals. Nurses attend weekly obstetric registration days to enroll clients. The outreach coordinator and/or nurse home visitors also visit hospital clinics monthly to ensure appropriate, eligible clients were referred to NFP.

Goodwill NFP has data integration agreements with two hospital systems, which provides access to electronic medical records, as well as ability to message providers when necessary. Schools continue to be a referral source, and Goodwill NFP has established relationships with both IPS

[5] Note: If families score 25 or above on the Parent Survey/Family Stress checklist and have specific additional risk factors– they may also be offered services,

and township schools in Marion County.

Goodwill NFP actively participates in a client retention CQI project. Two rapid PDSA cycles have been accomplished, with a third scheduled for the last quarter of 2018. Run charts will be concluded at the end of the year to determine results of this CQI projected early 2019.

As previously mentioned X10MC29469 grant dollars contributed to the blended support of MIECHV-funded families in the communities originally identified in Indiana's MIECHV Formula grants for the 2016-2017 reporting period. Attritions rates for these same LIAs for the 2016-2017 reporting period can only be represented for all MIECHV-funded families, as illustrated in Table E:

Table E

Attrition Rates		Form 4** 2016-2017 reporting period				Form 4 2017-2018 reporting period			
LIA	*Model*	*1st Qtr*	*2nd Qtr*	*3rd Qtr*	*4th Qtr*	*1st Qtr*	*2nd Qtr*	*3rd Qtr*	*4th Qtr*
Goodwill Industries - Delaware	NFP	15.63%	10.34%	57.69%	9.09%	0.00%	0.00%	0.00%	0.00%
CAPS	HFI	15.09%	14.41%	13.39%	18.87%	16.07%	17.36%	28.21%	19.40%
Family Service Society	HFI	5.66%	17.31%	15.38%	10.26%	48.65%	10.00%	36.36%	5.26%
MHA - Lake Co	HFI	15.61%	21.43%	13.64%	14.62%	17.51%	15.29%	29.55%	22.60%
Dunebrook	HFI	10.67%	13.51%	12.16%	14.29%	9.86%	7.59%	23.08%	20.51%
Goodwill Industries - Madison	NFP	23.08%	3.13%	19.35%	16.00%	9.09%	0.00%	0.00%	0.00%
Goodwill Industries - Marion	NFP	7.89%	12.09%	11.41%	8.99%	7.59%	6.29%	6.48%	3.29%
Healthnet	HFI	11.30%	11.74%	13.30%	16.92%	15.03%	19.89%	24.15%	8.80%
Eskenazi	HFI	26.67%	22.64%	27.18%	21.55%	23.36%	21.15%	38.93%	17.92%
Marion Co. Health Dept	HFI	16.67%	24.69%	21.71%	16.28%	18.01%	22.62%	32.44%	10.59%
New Hope Services	HFI	12.00%	6.25%	11.76%	30.30%	16.13%	12.00%	21.43%	4.00%
Family & Children's Center	HFI	27.42%	25.60%	20.42%	22.32%	15.69%	25.62%	41.56%	20.80%

***includes all MIECHV-funded families for 2016-2017 reporting period.*

***Local activities to coordinate services**:* Most often, families participating in home visiting services have other needs that can be addressed through other 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, while not implemented during this reporting period, 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. NFP gathers key

stakeholders quarterly in a central Community Advisory Board with executive representation from the four major health care systems operating within Indiana, as well as, members such as the Minority Health Coalition, Indiana Housing Agency, and others. 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.

In order to address needs of families beyond the scope of home visiting, NFP implemented the Goodwill Guides program. Guides work with nurse home visitors as a support service to provide referrals to services outlined above and for the entire household. Goodwill Industries of Central and Southern Indiana implemented Nurse-Family Partnership in Indiana through an innovative public/private partnership. Goodwill wraps its innovative program, Goodwill Guides (Guides), around NFP. The Guides serve as community liaisons with the goal of identifying existing, appropriate, quality resources, develop more appropriate quality resources to fill documented gaps, and to create a systematic approach that will streamline the referral process in order to create a referral process that is effective, efficient, and easier to navigate.

Goodwill has numerous experiences working with populations that are low-income and high-risk, and recognized that NFP is based on developing supportive relationships with families, similar to their approach to helping high school students achieve academic success. The goal of guide support is to identify existing, appropriate, quality resources, develop more appropriate quality resources to fill documented gaps, and to create a systematic approach that will streamline the referral process in order to create a referral process that is effective, efficient, and easier to navigate.

Meeting Legislatively Mandated Reporting: Performance Measurement - As detailed in Indiana's 2016 and 2018 MIECHV Performance Measurement, Data Collection, and Data Analysis Plans, 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 evaluation staff also reviewed data specific to 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 X10MC29469 funds contributed to these Performance Indicator outcomes for YEAR 6 (2016-2017):

- 86.8% of primary caregivers were screened for depression within 3 months of enrollment or within 3 months of delivery (for those enrolled prenatally);
- 54% of children received the last recommended well-child visit;
- 50.5% of mothers enrolled in home visiting prenatally or within 30 days after delivery received postpartum visit with healthcare provider within 8 weeks of delivery;
- 85.6% of primary caregivers who reported using tobacco or cigarettes at enrollment were referred to tobacco cessation counseling or services within 3 months of enrollment;
- 62.2% of infants were always placed to sleep on their backs, without bed-sharing or soft bedding;
- 78.4% of children had a family member that read, told stories, and/or sang songs daily during a typical week;
- 79.2% of children were screened for developmental delays;

- 51.1% of primary caregivers received an observation of caregiver-child interaction by the home visitor using a validated tool[6];
- Caregivers were asked if they had any concerns regarding their child's development, behavior, or learning on 95% of the home visits;
- 97% of primary caregivers were screened for intimate partner violence (IPV) within 6 months of enrollment;
- 77.2% of primary caregivers who screened positive for IPV received referral information to IPV resources.

Indiana's X10MC29469 funds contributed to these Performance Indicator outcomes for YEAR 7 (2017-2018):

- 88.1% of children received the last recommended well-child visit;
- 91.4% of primary caregivers who reported using tobacco or cigarettes at enrollment were referred to tobacco cessation counseling or services within 3 months of enrollment;
- 86.7% of children had a family member that read, told stories, and/or sang songs daily during a typical week
- 78.9% of children were screened for developmental delays;
- Caregivers were asked if they had any concerns regarding their child's development, behavior, or learning on 97.4% of the home visits;
- 98.3% of primary caregivers were screened for intimate partner violence (IPV) within 6 months of enrollment;
- 90.6% of primary caregivers who screened positive for IPV received referral information to IPV resources;
- 80.5% of primary caregivers had continuous health coverage for at least 6 consecutive months;

III. CHALLENGES AND STRATEGIES

***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 developed to identify challenges with data prior to federal reporting and improve issues around missing data.

***Staff Turnover*:** During YEAR 6[7], DCS experienced turnover in the Deputy Director of Programs and Services and the Prevention Coordinator. The ISDH MCH team also experienced turnover during YEAR 6 and YEAR 7[8] for the Director of Programs and the MIECHV Coordinator/Home Visiting Program Manager. The MCH Director and interim staff assisted in the transition continuing to work hard to minimize impact of change on MIECHV funded services and sustain working relationships within the Indiana MIECHV team. A new Home Visiting Program Manager and MIECHV Coordinator were hired late in the YEAR 7 reporting period. The ISDH MCH team made structural changes in their organizational chart to strengthen the support of home visiting by implementing a Home Visiting Program Manager role which reports directly to the MCH Director. Locally, staff turnover was a challenge many home visiting sites experienced. Throughout the project period, LIA leadership addressed

[6] Please note that Indiana HFI programs use CHEERS on each home visit, however, the CHEERS Check-in Tool – which is the validated instrument for CHEERS approved by HRSA was not available until July 2017. HFI sites serving MIECHV-funded families received the materials in late July, trained their staff in August and were only able to implement/utilize the tool in September of 2017.

[7] Year 6=10/1/2016-9/30/2017

[8] Year 7=10/1/2017-9/30/2018

challenges through practical staff recruitment, additional training and collaborative 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.

***WIC Referrals*:** Prior to the project period, HFI sites were affected by a reduction in Women, Infants, and Children (WIC) referrals (previously a major referral source) due to direction the state WIC office received from United States Department of Agriculture (USDA) that resulted in changes in how referrals were shared between local WIC and HFI sites. In response, a centralized referral process was developed at the state level which initially resulted in a 30-60 day delay in HFI sites receiving referral information, creating significant impact on local HFI site's ability to engage referred families in services within HFA eligibility guidelines. HFI sites have addressed this barrier by expanding the development of collaborations with local service providers, finding ways to creatively reach families that would benefit from home visiting, and leverage community support to further assist HFI clients. In 2015, an MOU was executed between DCS HFI and ISDH WIC outlining agreements to electronically share appropriate referral information on a weekly basis that will assist families in getting connected to both HFI and WIC, as well as establishing regular reporting of referrals that result in HFI and WIC enrollment. This change has resulted in increased referrals that resulted in program enrollment and continued participation in services for HFI and WIC

***Data Collection Forms*:** The NFP National Service Office (NSO) began overhauling their NFP Data Collection System in 2018 to save time, improve data accuracy and timeliness, and collect exact data needed to meet customers and NFP NSO needs. This change also consisted of revisions to the 30+ data collection forms utilized by nurse home visitors as of July 1, 2018. While this did not significantly impact nurse home visitors, it created challenges for data analysis and reporting. The MIECHV state team worked with external provider and LIA to update local data systems and variables, as well as coding for analysis and reporting.

IV. LESSONS LEARNED AND BEST PRACTICES/INNOVATIONS

Indiana began utilizing quarterly benchmark analysis in early 2013 to reduce potential data challenges around DGIS reporting. 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. 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. 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 identifies the quarterly benchmark analysis as a true success in achieving data collection and reporting.

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.

V. EVALUATION SUMMARY

A. Evaluation Questions, Study Design, and Target Population

The FY2016 study builds on prior studies by examining the extent to which Mental Health Consultation (MHC) enhancements within local implementing agencies serving MIECHV-funded families enhance HFI program implementation. The FY2016 evaluation was designed to examine the relationship between MHC services and staff perceptions of self-efficacy, competence, access to resources, levels of secondary trauma, burnout, compassion satisfaction, and training quality. The study explored staff perceptions of the influence of MHC on job-related outcomes, including home visitor retention, through a qualitative study. Finally, the FY2016 evaluation examined the extent to which MHC model components are implemented with fidelity.

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

A. Research Questions	B. Study Design	C. Target Population
RQ1 - To what extent does participation in the Mental Health Consultation enhancement influence home visitors' perceived self-efficacy, competence, access to resources, levels of secondary trauma and compassion satisfaction, and training quality	Quasi-experimental non-equivalent comparison groups design	Population of home visitors providing the HFI program (approx. 400) Note: Home visitors in Decatur County were excluded from the comparison group because the vendor agency implements a different model of MHC through a separate funding source. Home visitors from the vendor agency in Marion County that does not serve MIECHV-funded families were excluded because they implement a prior model of MHC
RQ2 - What aspects of Mental Health Consultation are perceived to be associated with job retention and related characteristics of stress/burnout and job satisfaction?	Qualitative design using semi-structured interviews	Stratified purposeful sample of the 90 current home visitors who were employed for over three months and receive MHC at HFI sites serving MIECHV-funded families
RQ3 - To what extent has the Mental Health Consultation enhancement been implemented with fidelity?	Fidelity study using 1) descriptive design using existing administrative data to explore the program outputs and 2) qualitative design using semi-structured interviews to explore staff perceptions of MHC implementation	All nine current mental health consultants who provided MHC at HFI sites serving MIECHV-funded families during the Spring 2018

B. Major Findings

Research Question 1

Training Quality, Self-Efficacy, Reflective Supervision Self-Efficacy, Competence, Compassion Satisfaction, Burnout, and Secondary Traumatic Stress. To examine group differences (MHC vs. Non-MHC[9]) in ratings of training quality, self-efficacy, reflective supervision self-efficacy, competence, compassion satisfaction, burnout, and secondary traumatic stress, a multivariate analysis of covariance (MANCOVA) was conducted. After

[9] *MHC* home visitors are defined as home visitors who receive Mental Health Consultation at HFI sites serving MIECHV-funded families (using the MIECHV Mental Health Consultation model). *Non-MHC* home visitors are defined as home visitors who do not receive Mental Health Consultation and serve non-MIECHV-funded families at HFI sites not serving MIECHV-funded families.

controlling for home visitor education and length of time in position, no significant differences were observed[10], $F(7, 217) = .451$, $p = .869$, $\Lambda = .99$, $\eta^2 = 0.01$.

Supplemental Analysis - Frequency of Supervisor Guidance. Home visitors receiving MHC reported significantly greater frequency of supervisor guidance related to stress and mental health ($U = 6528.50$, $z = -30.6$, $p = .002$) and healthy adult relationships ($U = 6807.50$, $z = -2.26$, $p = .024$), compared to home visitors not receiving MHC[2].

Supplemental Analysis - Access to Support from Other Professionals. Home visitors who receive MHC were significantly more likely have access to support from professionals other than their supervisor in the areas of substance use ($\chi^2(1, N = 68) = 11.68$, $p = .001$), stress and mental health ($\chi^2(1, N = 80) = 16.08$, $p < .001$), healthy adult relationships ($\chi^2(1, N = 62) = 8.89$, $p = .003$), and parenting to support child development ($\chi^2(1, N = 68) = 4.81$, $p = .028$), compared to home visitors not receiving MHC[2].

Supplemental Analysis – Actual Use of Support from Other Professionals. Home visitors who receive MHC were significantly more likely to report actually receiving support from professionals other than their supervisor in the areas of substance use ($\chi^2(1, N = 46) = 5.80$, $p = .016$), stress and mental health ($\chi^2(1, N = 65) = 4.58$, $p = .032$), and healthy adult relationships ($\chi^2(1, N = 44) = 6.22$, $p = .013$), compared to home visitors not receiving MHC[2].

Research Question 2

The relationship between MHC and retention appears to be indirect, with home visitors perceiving it as a resource for stress and burnout. The greatest contributor to job retention appeared to be home visitors' dedication to their work with families.

Table 2. Home visitor perceptions of job retention, stress/burnout, and job satisfaction

Most Commonly Occurring Themes					
Stress and Burnout		Job Satisfaction		Job Retention	
Contributors	Moderators	Barriers	Promoters	Barriers	Promoters
Client Issues (64%; 21/33)	Non-MHC Resources (94%; 31/33)	Compensation (36%; 12/33)	Professional Development & Training (58%; 19/33)	Compensation (21%; 7/33)	Dedication To Home Visiting (70%; 23/33)
Caseloads (62%, 21/34)	MHC Resources (48%; 16/33)	Caseloads (27%; 9/33)	Positive Management/Supervisor Interactions (52%; 17/33)	Caseload (15%; 5/33)	Support From Colleagues (45%; 15/33),
Job Expectations (53%; 18/34)	Individualized Self-Care Strategies (45%; 15/33)		Opportunity To Make A Difference (48%; 16/33)		Flexible Scheduling (39%; 13/33)
			Flexible Scheduling (45%; 15/33)		Non-MHC Professional Development And Training (42%; 14/33)

Research Question 3

Table 3. Fidelity Study - Summary of Program Outputs

Subquestion	Model Expectation	Finding	Status
Research question 3a: Are all MIECHV-funded families being reviewed by the clinicians for high risk and Mental Health Consultation?	All Families Assigned Clinical Risk	Clinical risk was not assigned for all families. Risk status (i.e., high risk or no risk) was assigned for 56% ($n = 1056$) of families, while risk status was not assigned (i.e., blank) for 44% ($n = 825$).	Not Met
Research question 3b: Are families identified for Mental Health	All Families Reviewed Monthly	Most MIECHV-funded families did not receive monthly review by the clinician during each month enrolled in the program. For the 998 MIECHV-funded families for whom Secondary Activity Reports were	Not Met

[10] Because a quasi-experimental non-equivalent comparison groups design was employed, no causation may be attributed based on these results.

Consultation services followed and reviewed each month?		available, 29% (*n* = 289) of families were reviewed through MHC during each month enrolled.	
Research question 3c: Are all home visitors who serve MIECHV-funded families engaging in consultation at least once per month?	All Home Visitors Participate in Monthly Consultation	Some eligible home visitors did not participate in monthly clinical consultation. From January 2016 to December 2017, across all sites, the number of home visitors receiving consultation per month ranged from 0 to 80 (*M* = 54.67, *SD* = 19.95), while the number of home visitors employed during the study period ranged from 109 to 139 (*M* = 123.29, *SD* = 6.50).	Not Met
Research question 3d: Are clinicians providing at least bi-monthly training to home visitors?	One Training Every Two Months per Site	From January 1, 2016 to December 31, 2017, trainings were offered inconsistently across sites. During 2016, trainings were offered at least bi-monthly at one site (11%). During 2017, trainings were offered at least bi-monthly at three sites (33%).	Not Met
Research question 3e: How often are families directly receiving Mental Health Consultation services?	Process Data – No Target	From January 2016 to December 2017, a total of 1927 families were served at least one time. The number of MHC Secondary Activities provided per family ranged from 1 to 40 (*M* = 4.01, *SD* = 5.55). The number of months during which services were provided per family ranged from 1 to 21 (*M* = 3.12, *SD* = 3.49). The number of MHC Secondary Activities provided to each family per month ranged from 1 to 5 (*M* = 1.28, *SD* = 0.52). Of families receiving services in two or more months (*N* = 1097), 51% *(n* = 555) received one or more services during all of the months between their first and last service.	N/A
Research question 3f: Are clinicians providing at least one hour of reflective practice per month for each home visitor serving MIECHV-funded families?	All Home Visitors Receive Monthly Reflective Practice	The study found that most home visitors did not receive monthly reflective practice during all months eligible. Of the 168 home visitors for whom data were available, 11% (*n* = 18) received reflective practice during all of the months that they were employed during the study time period.	Not Met
Research question 3g: Are clinicians meeting at least once each month with each home visitor serving MIECHV-funded families?	All Home Visitors Meet Clinician Monthly	Some eligible home visitors did not meet monthly with a clinician. From January 2016 to December 2017, across all sites, the number of home visitors meeting with a clinician per month ranged from 1 to 111 (*M* = 82.88, *SD* = 26.61), while the number of home visitors employed during the study period ranged from 109 to 139 (*M* = 123.29, *SD* = 6.50).	Not Met
Research question 3h: How many families are being addressed through Mental Health Consultation each month?	Process Data – No Target	From January 2016 to December 2017, a total of 1927 families were served at least one time. The number of families served monthly through MHC ranged from 11 to 345 (*M* = 250.58, *SD* = 78.89).	N/A
Research question 3i: How often are clinicians providing shadow or supportive home visits?	Process Data – No Target	From January 2016 to December 2017, 43 supportive home visits and 17 shadowing visits were provided.	N/A

Research question 3j: To what extent do staff descriptions of Mental Health Consultation provide evidence of consultation quality? Interview responses provided evidence of consultation quality. Key themes aligned with characteristics of consultation quality from the literature (e.g., Johnston & Brinamen, 2012) and/or Indiana model expectations (Model Expectation: Evidence of Quality).

Table 4. Staff perceptions of consultation quality

Most Commonly Occurring Themes		
Home Visitors	Clinicians	Clinician Scenario Responses
Ease of access (100%, 33/33), resource sharing (85%; 28/33), positive consultant-consultee relationships (85%; 28/33), clinician cultural awareness (70% 23/33), reflective atmosphere (70%; 23/33), and shared inquiry (70%; 23/33)	Ease of access (100%, 9/9), positive atmosphere (100%, 9/9), resource sharing (100%, 9/9), power/authority (100%; 9/9), positive relationships (100%; 9/9), consultation impacts (89%; 8/9), appreciation for subjective experience (78%; 7/9), authentic caring and compassion (78%; 7/9), shared inquiry (67%; 6/9), and emotional support (67%; 6/9)	Shared inquiry (68%; 17/25), resource sharing (64%; 16/25), and appreciation for subjective experience (44%; 11/25)

Research question 3k: To what extent do home visitors view the consultation being received as relevant and useful in performing their role as a home visitor? There was evidence that home visitors perceive MHC as relevant and/or useful; 88% (29/33) of respondents described

consultation as relevant or useful in their work with families. Home visitors reported that mental consultation supports their work by increasing their confidence, furnishing targeted resources for specific family needs, providing an additional perspective when reviewing cases, and offering access to specialized expertise (Model Expectation: Evidence of Usefulness & Relevance).

C. Study Limitations

Research Question 1. A quasi-experimental non-equivalent comparison groups design was employed. Without random assignment or a pretest, pre-treatment equivalency of the groups cannot be guaranteed; therefore, differences between the groups cannot be attributed specifically to the enhancement. Differences between groups are reported, but no causation is attributed.

Research Question 2. Home visitors selected to participate were given the opportunity to opt out of the study. It is possible that those who chose to participate differed from those who did not. To address this, a large sample (33 home visitors) that was proportional to the number of home visitors at each site was utilized. Secondly, in self-report interviews, positive and/or negative bias are always a possibility. Finally, it is possible that the distinction between HFI supervision and MHC differed for individual participants, which may impact descriptions of MHC and study outcomes.

Research Question 3. Upon receipt of these administrative data, the evaluation team learned that home visitors were not linked systematically to these data, which created challenges for addressing 3c, 3f, and 3g. The evaluation team matched a portion of Secondary Activities with home visitor data using the family ID or the manually-entered home visitor name, but successful data merges were not possible all Secondary Activity Reports, which may result in underreporting the number of home visitors meeting with clinicians. Second, comparisons of the Secondary Activity Reports and Employment Records revealed some discrepancies. Finally, HFI Program Managers report that in some sites, home visitors only receive MHC in months when they are serving MIECHV-funded families; however, there were no data available to determine when staff served these families. In some situations, home visitors identify the families whom they would discuss, rather than discussing all families. Due to limitations, supplemental analyses were completed to allow results to be triangulated.

D. Implications of Evaluation Findings

The findings from RQ1 suggest that a relationship may exist between participating in the enhancement and access to and actual receipt of support from professionals other than supervisors related to family substance use, stress and mental health, healthy adult relationships, and parenting to support child development. While no causation can be assigned, results may demonstrate that clinicians are a valuable addition to HFI programming by providing additional resources and support to home visitors alongside their HFI supervisor. The findings suggest that home visitors in enhancement sites may have increased access to their supervisor, which is consistent with the model design. The clinicians may provide added value by supplementing the resources provided by other staff and/or fulfilling a resource-provider role that is normally occupied by other staff who may be less equipped to provide quality resources to home visitors. Conversely, the study found no relationship between participation in the enhancement and home visitors' perceived self-efficacy, competence, levels of secondary trauma and compassion satisfaction, and training quality. Because the enhancement is theorized to demonstrate impacts in these areas, it is possible that home visitors are not receiving consultation services that are aligned with these outcomes. Moreover, fidelity concerns may limit the extent these outcomes should be reasonably expected.

Findings from RQ2 provided insights into the ways in which home visitors experience stress,

burnout, job satisfaction, and job retention. The relationship between MHC and retention appears to be indirect, with home visitors perceiving their clinician as a resource for stress and burnout. When combined with other supports available to home visitors, meeting with their clinician appears to have some influence on how home visitors cope with client issues, caseloads, and challenging job expectations. Participation in consultation may indirectly support the supportive workplaces, supervision quality, and non-MHC professional development opportunities cited by home visitors as contributing to job retention and satisfaction. Given the possible relationship between the enhancement and access to supervision, the potential for MHC to support outcomes linked with supervision may be considered. Overall, the data suggest benefits of MHC for home visitors who are prone to stress and burnout.

The findings from the fidelity study suggest that the MHC enhancement has not been implemented with fidelity across all sites. It appears that some families and home visitors do not receive the level of service dictated by the model. Findings demonstrate inconsistent implementation across the model expectations examined. Clinician retention also emerged as a concern across sites and likely impacted sites' ability to meet model expectations. The literature suggests that fidelity concerns may explain why interventions that performed well in research environments fail to achieve desired results when employed in real-life conditions (Breitenstein et al., 2010; Fixsen et al., 2005; Mihalic, 2004). These factors likely influenced the system, site, home visitor, and family outcomes reported in the FY2016 and prior studies of the enhancement. Further, these findings may have tangible consequences for program stakeholders.

While concerns related to model adherence were noted, there appears to be evidence that consultation activities between home visitors and clinicians are implemented with quality. Both home visitor and clinician interview responses suggest that MHC aligns with key indicators of consultation quality, specifically Johnston and Brinamen's (2012) work on transformational consultation relationships. Staff interview responses provided evidence of positive relationships between clinicians and home visitors, ease of access to the clinicians, a consultation atmosphere that is conducive to home visitor reflection, resource sharing, shared inquiry when examining cases, appreciation for the subjective experiences of all parties, authentic caring and compassion, emotional support, and cultural awareness, all of which are consistent with the model's theory of change. Home visitors reported that MHC supports their work by increasing their confidence, furnishing targeted resources for specific family needs, providing an additional perspective when reviewing cases, and offering specialized expertise. Consistent with the theory of change, the findings suggest that the clinicians serve as a source of high quality resources, facilitate reflection, and provide support to home visitors who consistently face emotionally challenging situations.

E. Lessons Learned

RQ3 provides the most compelling findings for immediate enhancements. The study suggests that MHC is implemented inconsistently, and the results show that some home visitors and MIECHV-funded families did not receive the level of service dictated by the model. Recommendations provided herein suggest that consideration be given to modifications to the data system to facilitate more efficient collection/reporting of program outputs, reviews of model expectations and data collection requirements with key staff, and ongoing fidelity monitoring. RQ1 provides some evidence to suggest a relationship between participation in the enhancement and increased access to resources. Based on these findings, the development of infrastructure to facilitate resource sharing among MHC participants should be considered as the model is enhanced. RQ2 identified dedication to their work as the most common reason that home visitors remain in their positions, so consideration should be given to continuing and expanding features

of MHC that empower home visitors to succeed in their work with families, provide resources to support their work, and alleviate barriers that cause stress and burnout.

VI. 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. Dan Diehl and Sam Crecelius were Co-Principal Investigators for the FY2016 evaluation and were supported by Doug Berry and Jason Chadwell who are senior 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.

B. Evaluation Rationale

The FY2016 evaluation was designed to 1) examine the effects of MHC services on staff perceptions of self-efficacy, competence, access to resources, levels of secondary trauma, burnout, compassion satisfaction, and training quality, 2) explore staff perceptions of the influence of MHC on job-related outcomes through a qualitative study, and 3) examine the extent to which the localized model of MHC was implemented with fidelity. The current study draws from recent studies of reflective practice by focusing more intentionally on staff outcomes that are aligned with MHC, as opposed to targeting only general home visiting outcomes. While relationships between MHC and retention have been observed in Indiana and elsewhere, recent studies of similar programs (e.g., Watson et al., 2016) have suggested that existing scales measuring job-related outcomes may be inadequate for staff receiving this type of consultation. The qualitative study was intended to support future research by identifying additional job-related outcomes. The current study aimed to expand the knowledge base through its focus on Indiana's localized service model, which places local clinicians directly in the HFI sites. Prior to this study, a fidelity study focusing specifically on the localized model had not been completed in Indiana.

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 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; (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 related trainings.

Table 5. Comparison of Model Components

Original Model	Revised Model
Single licensed clinician provided oversight for three AFSS.	No "oversight" of clinicians as a group beyond contract requirements. Reflective supervision group available for clinical support.
Licensed clinicians did not meet directly with home visitors.	Licensed clinicians meet directly with home visitor.
AFSS met with home visitors.	AFSS role eliminated; services provided directly by licensed clinicians.

Three AFSS served nine sites in seven counties.	Single localized licensed clinician serving each site.
AFSS may not be from or familiar with local community.	Licensed clinician from local community.
AFSS reviewed family record.	Licensed clinician reviews family record.
AFSS provided MHC.	Licensed clinician provides MHC.
AFSS provided reflective supervision as part of the HFI model.	Licensed clinician 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 based at local site.
AFSS provided training upon request.	Licensed clinician required to provide staff training at a minimum of once every other month.

D. Use of Prior Evaluation Findings

The FY2016 study builds on prior studies by further examining the extent to which MHC enhancements within local implementing agencies serving MIECHV-funded families enhance the HFI program implementation.

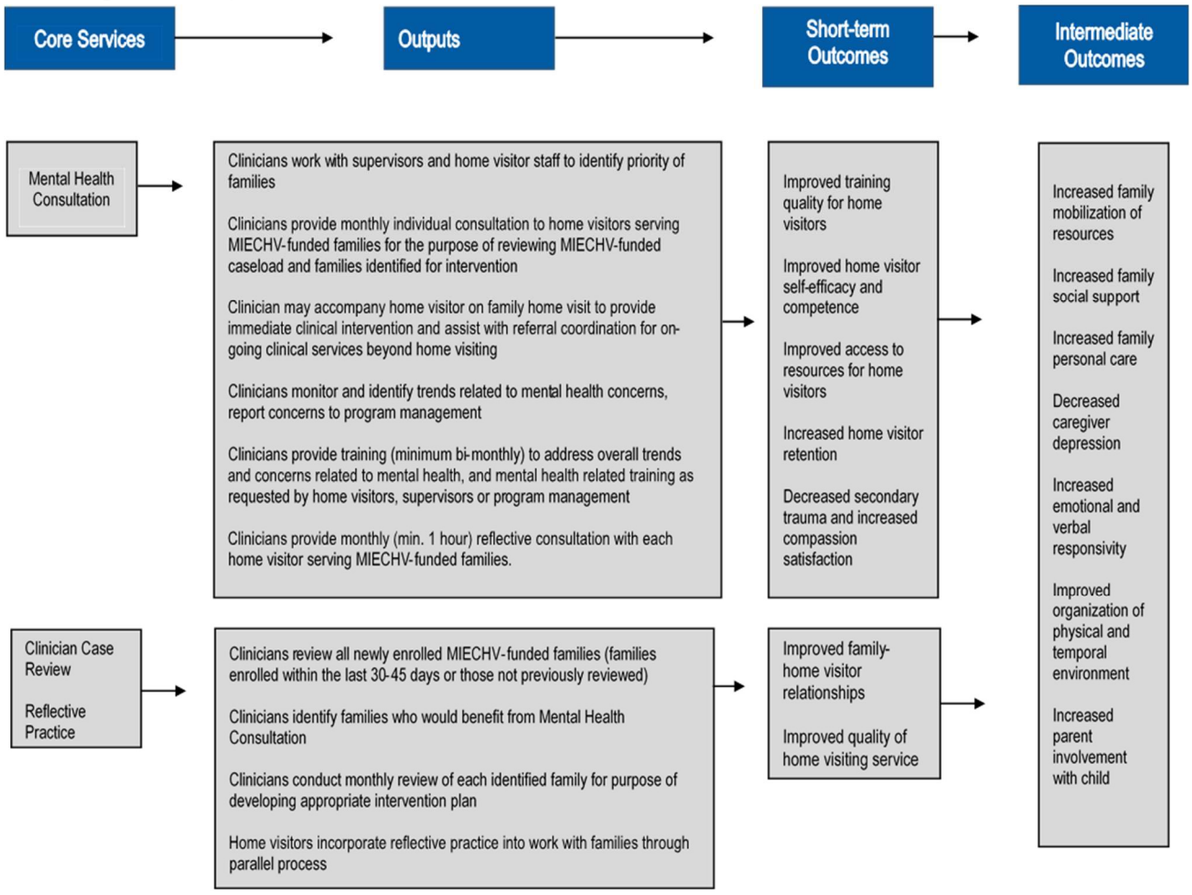
Table 6. Evaluation Research Question Cross Walk (FY2011, FY2015, FY2016)

FY2011	FY2015	FY2016	Value Added FY2016
Research question 4: To what extent does working in a funded site vs. a non-funded site predict home visitors' perceived skill/effectiveness and reduced stress in providing mental health supports to families?	**Research question 2:** To what extent do HFI site-level staff perceive the Mental Health Consultation model and the role of the mental health consultant as effective in supporting HFI site-level staff in their work with families?	**Research question 1:** To what extent does participation in the Mental Health Consultation enhancement influence home visitors' perceived self-efficacy, competence, access to resources, levels of secondary trauma and compassion satisfaction, and training quality as measured by the adapted *Reflective Supervision Self-Efficacy Scale for Supervisees,* the *Professional Quality of Life Scale,* and the *IN MIECHV Survey for HFI Home Visitors*?	The FY2016 evaluation utilizes instruments and subscales that are theorized to align more closely with the type of consultation provided by clinicians. Specifically, these outcomes are detailed in the logic model and build on the FY2011 and FY2015 evaluations.
Research question 5: Are there identifiable patterns related to rates of staff retention over time in funded and non-funded sites?	**Research question 3:** To what extent does receiving Mental Health Consultation predict home visitors' levels of job-related "burn-out," perceived professional efficacy, accomplishment, and rates of retention?	**Research question 2:** What aspects of Mental Health Consultation are perceived to be associated with job retention and related characteristics of stress/burnout and job satisfaction?	The FY2011 evaluation found that staff receiving MHC were significantly less likely to leave their positions compared to those not receiving MHC. The FY2016 evaluation builds on these findings by using a qualitative design to identify the model components that are related with this outcome. Findings from this research question may contribute to subsequent evaluation questions and the existing knowledge base.

E. Theory of Change

The MHC Model was designed to support home visitors, strengthen home visitors' skills, and increase home visitors' competence 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. Theoretical support for the model is described below. MHC is based on the theory that change occurs within the context of the relationships that consultants build with home visitors. 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 et al., 2016; Watson et al., 2016). The consultant establishes a climate of mutuality, reciprocity, and collaboration through which he/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. 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, competence, and capacity for reflection; and the additional resources provided by the clinician are theorized to improve the quality of home visiting services (Hunter et al., 2016; Johnston & Brinamen, 2012; Watson et al., 2016).



F. Outcomes

Table 7. Summary of evaluation outcomes by research question.

Research Question	Outcomes	Data Collection
Research Question 1	1) Home visitor training quality, 2) home visitor self-efficacy, 3) home visitor competence, 4) home visitor access to resources, 5) home visitor secondary trauma, and 6) home visitor compassion satisfaction	Home visitor surveys: (1) *Reflective Supervision Self-Efficacy Scale for Supervisees*, (2) *Professional Quality of Life Scale*, and (3) *IN MIECHV Survey for HFI Home Visitors*
Research Question 2	1) Home visitor perceptions of job retention, 2) home visitor perceptions of stress/burnout, and 3) home visitor perceptions of job satisfaction	Home visitor interviews: *Home Visitor Semi-Structured Interview Guide*
Research Question 3	1) Home visitors and mental health consultants perceptions of consultation	Home visitor interviews: *Home Visitor Semi-Structured Interview Guide*

	quality and 2) home visitor perceptions of consultation relevance and usefulness in performing their role as a home visitor	Mental health consultant interviews: *Mental Health Consultant Semi-Structured Interview Guide*

G. Target Populations

Research Question 1 (Home Visitor Survey). Non-equivalent comparison groups were drawn from the population of home visitors participating in the HFI program. This consisted of 154 home visitors who received MHC at HFI sites serving MIECHV-funded families (using the MIECHV MHC model), as well as 260 home visitors who did not receive MHC and served non-MIECHV-funded families at HFI sites not serving MIECHV-funded families. Home visitors in Decatur County and the vendor agency in Marion County that does not serve MIECHV-funded families were excluded. Home visitors were selected to participate in evaluation activities identified under RQ1 because of their firsthand experience with the staff outcomes explored by this research question.

Research Question 2 and Research Question 3 (Home Visitor Interview). Interview responses were drawn from a stratified purposeful sample of the 90 current home visitors who were employed for at least three months and received MHC at HFI sites serving MIECHV-funded families. DCS/HFI staff provided the evaluation team with a list of current home visitors receiving the enhancement during the evaluation period, and from these names, a random sample (stratified by site and supervisory team) was selected. The interviews focused only on staff members currently employed as home visitors. Home visitors were selected to participate in evaluation activities under RQ2/RQ3 because of their firsthand experience with the staff outcomes explored by this research question.

Research Question 3 (Mental Health Consultant Interview). Interview responses were drawn from all nine mental health consultants who provided MHC during Spring 2018. DCS/HFI staff provided the evaluation team with a list of all current consultants. Mental health consultants were selected to participate in evaluation activities under RQ3 because of their firsthand experience with aspects of consultation quality and implementation characteristics explored by this research question.

H. Evaluation Questions

To address study goals, three research questions were identified.

Table 8. Summary of research questions.

- **Research question 1:** To what extent does participation in the Mental Health Consultation enhancement influence home visitors' perceived self-efficacy, competence, access to resources, levels of secondary trauma and compassion satisfaction, and training quality as measured by the adapted *Reflective Supervision Self-Efficacy Scale for Supervisees,* the *Professional Quality of Life Scale,* and the *IN MIECHV Survey for HFI Home Visitors*?
- **Research question 2:** What aspects of Mental Health Consultation are perceived to be associated with job retention and related characteristics of stress/burnout and job satisfaction?
- **Research question 3:** To what extent has the Mental Health Consultation enhancement been implemented with fidelity?
  - **Research question 3a:** Are all MIECHV-funded families being reviewed by the clinicians for high risk and Mental Health Consultation?
  - **Research question 3b:** Are families identified for Mental Health Consultation services followed and reviewed each month?
  - **Research question 3c:** Are all home visitors who serve MIECHV-funded families engaging in consultation at least once per month?
  - **Research question 3d:** Are clinicians providing at least bi-monthly training to home visitors?
  - **Research question 3e:** How often are families directly receiving Mental Health Consultation services?
  - **Research question 3f:** Are clinicians providing at least one hour of reflective practice per month for each home visitor serving MIECHV-funded families?
  - **Research question 3g:** Are clinicians meeting at least once each month with each home visitor serving MIECHV-funded families?
  - **Research question 3h:** How many families are being addressed through Mental Health Consultation each month?
  - **Research question 3i:** How often are clinicians providing shadow or supportive home visits?

- **Research question 3j:** To what extent do staff descriptions of Mental Health Consultation provide evidence of consultation quality?
- **Research question 3k:** To what extent do home visitors view the consultation being received as relevant and useful in performing their role as a home visitor?

I. Evaluation Design

Table 9. Summary of Evaluation Design

Research Question	Design	Aims	Measurement
RQ1	A quasi-experimental non-equivalent comparison groups design was employed. Home visitors who received MHC at HFI sites serving MIECHV-funded families (using the MIECHV MHC model) were considered the treatment group, and home visitors who did not receive MHC at HFI sites not serving MIECHV-funded families were considered the comparison group.	This research question examined the extent to which levels of perceived self-efficacy, competence, access to resources, levels of secondary trauma and compassion satisfaction, and training quality differed between treatment and comparison group participants.	Outcomes were measured by the *Reflective Supervision Self-Efficacy Scale for Supervisees*, the *Professional Quality of Life Scale*, and the *Training*, *Competence*, *Self-Efficacy*, and *Availability of Resources* subscales from the *IN MIECHV Survey for HFI Home Visitors*.
RQ2	A qualitative design using semi-structured interviews was employed. Interview responses were drawn from a stratified purposeful sample (Patton, 2002) of HFI home visitors who received.	This research question explored staff perceptions of job retention, stress/burnout, job satisfaction, and aspects of MHC that may be associated with these attributes.	A member of the evaluation team administered the telephone interviews using a semi-structured interview guide.
RQ3	A fidelity study was completed that 1) incorporated a descriptive design using existing administrative data to explore program outputs and 2) utilized a qualitative design using semi-structured interviews to explore staff perceptions of MHC implementation.	This research question examined fidelity using program outputs and staff perceptions of implementation quality and MHC relevance/usefulness.	Program outputs were drawn from Secondary Activity Reports recorded by clinicians as part of their normal duties. Staff perceptions were collected via telephone interviews using a semi-structured interview guide.

J. Rationale for Design

Research Question 1. A quasi-experimental non-equivalent comparison groups design was employed. Based on the nature of the intervention, it was not feasible to provide MHC under true experimental conditions during the FY2016 evaluation (e.g., ethical considerations, inability to randomize subjects and locations) (Harris et al., 2006). Other designs considered included matched comparison groups design, pretest-posttest nonequivalent-groups design, and time series designs; however, three major concerns prohibited their use. Reducing the data collection burden for home visitors was a primary concern during the FY2016 evaluation. The responsibilities placed on home visiting staff by their normal obligations, additional duties specific to the 2018 calendar year, and the concurrent FY2015 evaluation necessitated a less intrusive approach. Secondly, as an evaluation of an ongoing intervention, collecting true baseline data would have proven problematic, potentially producing biased results. Finally, due to final approval of the evaluation plan in late 2017, only three months were available for FY2016 data collection activities, limiting the feasibility of time series and pretest-posttest designs. The use of the current design allowed the team to address the research question, respond to staff data collection concerns, and to complete the project within the required time period and budgeted cost.

Research Question 2. A qualitative design using semi-structured interviews was employed. Interview responses were drawn from a stratified purposeful sample of home visitors who received MHC. Semi-structured interviews were selected because they allow the interviewer to examine specific pre-determined concepts, while providing the flexibility to explore particular themes or concepts in greater detail within the interview. Two additional approaches were considered during the planning process. Completing interviews for the entire population of home visitors was considered but ultimately abandoned due to feasibility concerns. The literature

suggested that by utilizing a sample of information-rich respondents, credible conclusions could be drawn from the data while maximizing study resources (Patton, 2002). The use of structured interviews utilizing an interview protocol was also considered, but because of the exploratory nature of the study, final questions were open-ended and included prompts to encourage new ideas.

Research Question 3. A fidelity study was completed that 1) incorporated a descriptive design using existing administrative data to explore program outputs and 2) utilized a qualitative design using semi-structured interviews to explore perceptions of implementation. Rationale related to the use of semi-structured interviews for RQ3 is consistent with descriptions provided for RQ2. In a full scale fidelity study, observations would be a preferred method for examining quality of delivery (Mowbray et al., 2003); however, given time limitations on the evaluation, the development of observation instruments and the completion of observations was not feasible. The use of existing administrative data was identified as the most accurate and efficient method for collecting program outputs.

K. Evaluation Timeline

Table 10. Evaluation Timeline

Deliverable Task	2016			2017												2018									
	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		■																							
Submit Revised Evaluation Plan						■				■	■				■										
Staff Survey (RQ1)																■									
Semi-Structured Staff Interviews (RQ2)																	■	■							
Secondary Activity Collection (RQ3) *	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■										
Analysis of Fidelity Data (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

RQ1 - Reflective Supervision Self-Efficacy Scale for Supervisees. The 15-item *Reflective Supervision Self-Efficacy Scale for Supervisees* (Shea et al., 2012) is designed to assess supervisees' confidence in skills associated with reflective supervision. Each item is scored on a 5-point Likert-type scale (No Confidence to Extremely High Confidence). The scale was adapted so that the treatment group provided ratings of their experiences with their MIECHV mental

health consultant and their HFI Supervisor separately. Comparison group participants provided ratings of their experiences with their HFI Supervisor. Due to the scale revision, 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 76% of the variance. All items loaded successfully on the first factor, with loadings of .83 or greater. These findings were consistent with intentions of the scale developers. Acceptable levels of internal consistency were observed when completed for HFI supervisors (α = .97) and MIECHV mental health consultants (α = .97). *Rationale:* The scale includes items that are aligned with the style of supervision provided to home visitors through the enhancement.

RQ1 - The Professional Quality of Life Scale. The 30-item *Professional Quality of Life Scale* (Stamm, 2009) is designed to assess compassion satisfaction and compassion fatigue among professionals in the helping professions. Compassion satisfaction is measured by the *Compassion Satisfaction Subscale* and compassion fatigue is measured by the *Burnout* and *Secondary Traumatic Stress Subscales*. Items are scored on a 5-point Likert-type scale (Never to Very Often). Acceptable levels of internal consistency were observed for *Compassion Satisfaction* (α = .92), *Burnout* (α = .78), 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 in this theory and reflected in the logic model.

RQ1 - IN MIECHV Survey for HFI Home Visitors. The *IN MIECHV Survey for HFI Home Visitors* utilizes subscales from the *MIHOPE Home Visitor Survey – Baseline* that were modified for the purposes of this study. The scales have been adapted to include only items that are reflected in the theory of change. The *Training* (6 items), *Self-Efficacy* (6 items), and *Competence* (6 items) subscales were utilized to examine perceptions of training and support. Each item is scored on a 7-point Likert scale (Strongly Agree to Strongly Disagree). Acceptable levels of internal consistency were observed for the *Training* (α = .87), *Self-Efficacy* (α = .87), and *Competence* (α = .89). Additionally, *Availability of Resources* items (6 items) were included for Substance Use, Stress and Mental Health, Healthy Adult Relationships, and Parenting to Support Child Development. *Availability of Resources* items include 5-point and 8-point Likert-type items, as well as binary (Yes, No) items. *Rationale:* MHC is theorized to provide better training and greater access to resources than offered in non-enhancement sites, and differences in staff perceptions of training may be observed. Staff in the treatment group are theorized to have higher levels of competence and self-efficacy.

RQ2/RQ3 - Home visitor and clinician semi-structured interview guide. Semi-structured home visitor and clinician interview guides were developed for the current project based loosely on similar studies from Illinois (Spielberger et al., 2012; 2013). The interview guides provided the interview questions, prompts, and guidance for the interviewer regarding the structure of the interview (Cherry, 2000; Lindof & Taylor, 2011). Home visitor open-ended interview questions were developed to determine the factors influencing staff retention, burnout/stress, and job satisfaction including the role MHC may have on these characteristics. Mental health consultant interview questions incorporated Johnston and Brinamen's (2012) consultant characteristics that correlate with change.

M. Data Collection

Table 11. Data collection summary.

Data Collection Activity	Data Collection Instrument(s) Used	Respondents	Frequency of Data Collection

Home Visitor Surveys	(1) Reflective Supervision Self-Efficacy Scale for Supervisees, (2) Professional Quality of Life Scale, and (3) IN MIECHV Survey for HFI Home Visitors	98 Home Visitors Receiving MHC 178 Home Visitors Not Receiving MHC	Winter 2018 (Jan/Feb)
Home Visitor Interviews	Home Visitor Semi-Structured Interview Guide	33 Home Visitors	March 2018
Mental Health Consultant Interviews	Mental Health Consultant Semi-Structured Interview Guide	9 Mental Health Consultants	March 2018
Secondary Activity Data	Secondary Activity Data Collection - FamilyWise	17 Mental Health Consultants	Ongoing (Jan 2016 to Dec 2017)

N. Sampling Plan

Sampling was employed only for the home visitor semi-structured interviews conducted for research questions 2 and 3. A stratified purposeful sample (Patton, 2002) of HFI home visitors who receive MHC at HFI sites serving MIECHV-funded families (using the MIECHV MHC model) was identified. The sample was proportional to the number of home visitors per site (Patton, 2002). Home visitors receiving the enhancement of MHC for less than three months were excluded from the sample. Purposeful sampling strategies are widely employed in qualitative research to identify information-rich cases in order to maximize resources. In the current project, home visitors with over three months of experience were determined to be the most knowledgeable about and experienced with MHC (Cresswell & Plano Clark, 2011; Palinkas, et al., 2016). *Rationale:* Qualitative studies employ stratification and randomization to capture major variations in the phenomenon of interest and to lend credibility to the results, respectively (Palinkas, et al., 2016; Patton, 2002).

O. Statistical Power

Cohen's (1988) guidelines for f^2 were employed to inform the minimum sample size for question 1. An *a priori* power analysis conducted via the G*Power 3 software (Faul et al., 2007) revealed that a total sample of 104 respondents was necessary to detect a medium effect (f^2 = .15) with a power (1 – β) of .80 and an alpha of .05. A total sample of 247 participants completed the scales selected for RQ1, which suggests adequate power for the analyses conducted. All conditions under which analyses were completed were consistent with assumptions utilized in the *a priori* power analysis. Power analyses were not appropriate for the analytic methods used for RQ2/RQ3.

P. Analytic Methods

Table 12. Summary of Analytic Methods

Research Question	Analytic Methods
RQ1	Inferential statistics (univariate and multivariate) were used to determine if statistically significant differences exist between the treatment and comparison groups in perceived self-efficacy, competence, access to resources, levels of secondary trauma, burnout and compassion satisfaction, and training quality. Due to the multivariate nature of the research question (i.e., multiple dependent variables), a MANCOVA was used to test for overall effects (while controlling for covariates) (Borgen & Seling, 1978; Bray & Maxwell, 1982). Covariates of interest included years of employment and education. Appropriate effect sizes were calculated for all analyses. Because no multivariate effects were observed, univariate follow-up analyses were not completed. The primary analysis was supplemented with additional inferential statistics. The evaluation team utilized 2X2 Pearson's chi-squared tests (with Benjamini-Hotchberg (1995) corrections) to determine if there were significant associations between group and access to and receipt of support from other professionals related to Substance Use, Stress and Mental Health, Healthy Adult Relationships, and Parenting to Support Child Development. Odds ratios were reported to examine the effect size. Mann-Whitney non-parametric analyses (with Benjamini-Hotchberg corrections) were utilized to examine group differences in ratings of frequency of supervisor guidance, helpfulness of supervisor guidance, and helpfulness of support from other professionals. These analyses were used in response to assumption violations/concerns in the data for these staff outcomes. Finally, descriptive statistics were utilized to provide additional context.

RQ2/3	Content analysis procedures, using the framework method (Ritchie & Spencer, 1994), were employed to examine interview responses. 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 may be 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 related using a framework matrix. Specifically, charting allowed data to be arranged and summarized, with each column representing a theme and each row a case (home visitor). 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 et al., 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.
RQ 3	Descriptive statistics were utilized to examine the data drawn from the Secondary Activity Reports. Specific analyses included frequencies and descriptives. Data were be presented graphically where appropriate.

Q. Evaluation Cost

Total evaluation costs were $100,000 for a two-year period. Cost were based on a standard group rate of $100 per hour for consulting staff assigned to the project. The group rate includes employee salaries (commensurate with education and evaluation and analytic experience), employer expenses (fringe benefits, FICA (Social Security and Medicaid) and IN-SUTA), and indirect costs. Group rates align with current market rates for proposed services. DCG committed four senior consultants and two associate consultants to support the project (500 hours per contract year).

VII. EVALUATION RESULTS

A. Results

Research Question 1

Primary Analysis - Training Quality, Self-Efficacy, Reflective Supervision Self-Efficacy, Competence, Compassion Satisfaction, Burnout, and Secondary Traumatic Stress

To examine group differences in ratings of training quality, self-efficacy, reflective supervision self-efficacy, competence, compassion satisfaction, burnout, and secondary traumatic stress, a multivariate analysis of covariance (MANCOVA) was conducted. After controlling for home visitor education and length of time in position, no significant differences were observed, $F(7, 217) = .451$, $p = .869$, $\Lambda = .99$, $\eta^2 = 0.01$. It should be noted that because a quasi-experimental non-equivalent comparison groups design was employed, no causation may be attributed based on these results.

Table 13. Home visitor ratings of training quality, self-efficacy, reflective supervision self-efficacy, competence, compassion satisfaction, burnout, and secondary traumatic stress.

	Training Quality (6-42)[a]		Self-Efficacy (6-42) [a]		Competence (6-42) [a]		Reflective Supervision Self Efficacy (12-60) [a]		Compassion Satisfaction (10-50) [a]		Burnout (10-50) [ab]		Secondary Traumatic Stress (10-50) [ab]	
Group	***M***	***SD***	***M***	***SD***	***M***	***SD***	***M***	***SD***	***M***	***SD***	***M***	***SD***	***M***	***SD***
MHC Home Visitors (*n* = 73)	35.8	4.7	35.8	4.4	35.7	4.3	51.2	7.4	41.5	6.6	19.1	5.8	17.3	4.8

Non-MHC Home Visitors (*n* = 154)	35.7	5.5	35.7	5.5	35.4	5.3	50.8	8.7	41.3	5.8	19.4	5.2	17.1	4.2

N = 247 Notes: [a] Scale range [b] Lower scores indicate lower levels of burnout or secondary traumatic stress.

Supplemental Analysis - Availability of Resources

Home visitors responded to items from the IN MIECHV Survey for HFI Home Visitors related to availability of resources in four areas: Substance Use, Stress and Mental Health, Healthy Adult Relationships, and Parenting to Support Child Development.

Supplemental Analysis - Frequency of Supervisor Guidance. Mann-Whitney tests (with Benjamini-Hochberg corrections) were conducted to examine differences between home visitors receiving MHC and home visitors not receiving MHC's ratings of the frequency of supervisor guidance. Home visitors receiving MHC reported significantly greater frequency of supervisor guidance related to stress and mental health and healthy adult relationships. No significant differences were observed for substance use or parenting to support child development.

Table 14. Analysis of ratings of frequency of supervisor guidance by group.

Support Type	Group	Median	Mann-Whitney *U*	*z*	*p*	Benjamini Hochberg Adjusted *p-value*
Substance Use	MHC Non-MHC	5.00 5.00	8120.00	-.32	.749	.749
Stress and Mental Health	MHC Non-MHC	8.00 7.00	6528.50	-3.06	.002	.008
Healthy Adult Relationships	MHC Non-MHC	7.00 6.00	6807.50	-2.26	.024	.048
Parenting to Support Child Development	MHC Non-MHC	8.00 8.00	7615.50	-1.23	.219	.292

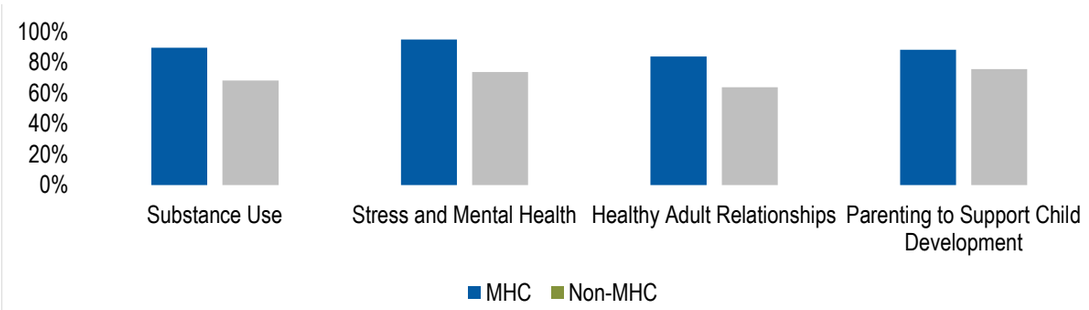
Note: False Discovery Rate = 25% (McDonald, 2014)

Supplemental Analysis - Helpfulness of Supervisor Guidance. Mann-Whitney tests (with Benjamini-Hochberg corrections) were conducted to examine differences between home visitors receiving MHC and home visitors not receiving MHC's ratings of supervisor guidance helpfulness. No significant differences were observed for substance use ($U = 6533.50$, $z = -.22$, $p = .826$), stress and mental health ($U = 7790.00$, $z = -.52$, $p = .603$), healthy adult relationships ($U = 7300.00$, $z = -.99$, $p = .323$), or parenting to support child development ($U = 7290.00$, $z = -1.51$, $p = .131$).

Supplemental Analysis - Access to Support from Other Professionals. Home visitors who receive MHC were significantly more likely to report having access to support from professionals other than their supervisor in the areas of substance use ($\chi^2(1, N = 68) = 11.68$, $p = .001$), stress and mental health ($\chi^2(1, N = 80) = 16.08$, $p < .001$), healthy adult relationships ($\chi^2(1, N = 62) = 8.89$, $p = .003$), and parenting to support child development ($\chi^2(1, N = 68) = 4.81$, $p = .028$). The odds of reporting access to substance use support from professionals other than their supervisor were 3.95 times greater for home visitors receiving MHC. The odds of reporting access to stress and mental health support from professionals other than their supervisor were 7.06 times greater for home visitors receiving MHC. The odds of reporting access to healthy adult relationship support from professionals other than their supervisor were 2.91 times greater for home visitors receiving MHC. The odds of reporting access to parenting to support child development support from professionals other than their supervisor were 2.41 times greater for home visitors receiving MHC.

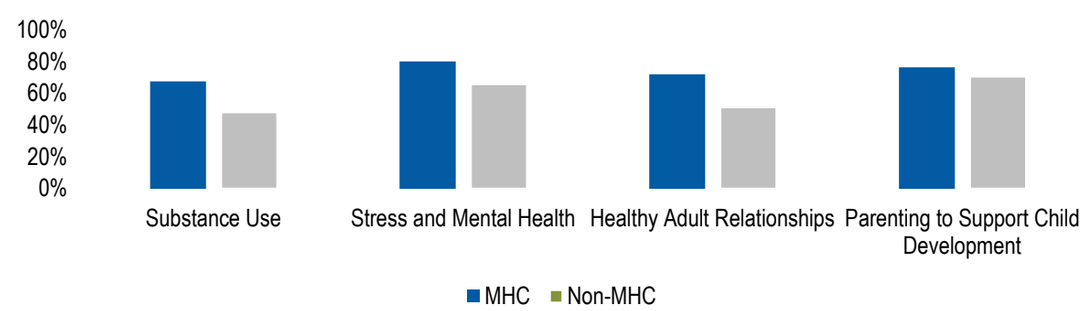
Figure 1. Home visitors receiving MHC were more likely to have access to support from professionals other than their HFI supervisor in the areas of substance use, stress and mental

health, healthy adult relationships, and parenting to support child development compared to home visitors not receiving MHC.



Supplemental Analysis – Actual Receipt of Support from Other Professionals. Along with access, the study also examined the extent to which home visitors took advantage of other professionals when seeking out support. Home visitors who reported having access to support from other professionals were asked to indicate if they had actually received support from professionals other than their supervisor in the areas of substance use, stress and mental health, healthy adult relationships, and parenting to support child development. Home visitors who receive MHC were significantly more likely to report receiving support from professionals other than their supervisor in the areas of substance use ($\chi^2(1, N = 46) = 5.80$, $p = .016$), stress and mental health ($\chi^2(1, N = 65) = 4.58$, $p = .032$), and healthy adult relationships ($\chi^2(1, N = 44) = 6.22$, $p = .013$). The odds of receiving substance use support from professionals other than their supervisor were 2.24 times greater for home visitors receiving MHC. The odds of receiving stress and mental health support from professionals other than their supervisor were 2.09 times greater for home visitors receiving MHC. The odds of receiving healthy adult relationship support from professionals other than their supervisor were 2.46 times greater for home visitors receiving MHC.

Figure 2. Of home visitors who had access to support from other professionals, home visitors receiving MHC were significantly more likely to actually receive support from professionals other than their HFI supervisor for substance use, stress and mental health, and healthy adult relationships.



Supplemental Analysis - Helpfulness of Support from Other Professionals. Home visitors who indicated that they had actually received support from professionals other than their supervisor were asked to rate the helpfulness of these professionals. Mann-Whitney tests (with Benjamini-Hochberg corrections) were conducted to examine differences between home visitors' ratings of other professionals' helpfulness. No significant differences were observed in ratings of helpfulness for substance use ($U = 906.00$, $z = -.34$, $p = .733$), stress and mental health ($U =$

2122.50, z = -.43, p = .668), healthy adult relationships (U = 782.00, z = -1.12, p = .261), or parenting to support child development (U = 1778.00, z = -.09, p = .925).

Table 15. Analysis of ratings of helpfulness of support from other professionals by group.

Support Type	Group	Median	Mann-Whitney *U*	*z*	*p*	Benjamini Hochberg Adjusted *p-value*
Substance Use	MHC Non-MHC	4.00 4.00	906.00	-.341	.733	.925
Stress and Mental Health	MHC Non-MHC	4.00 4.00	2122.50	-.429	.668	.925
Healthy Adult Relationships	MHC Non-MHC	4.00 4.00	782.00	-1.123	.261	.925
Parenting to Support Child Development	MHC Non-MHC	5.00 5.00	1778.00	-.094	.925	.925

Note: False Discovery Rate = 25% (McDonald, 2014)

Research Question 2

Interviews were completed with 33 home visitors to explore to what extent aspects of MHC were perceived to be associated with job retention and related characteristics of stress/burnout and job satisfaction. Using the framework method (Richie & Spencer, 1994), key themes were identified (e.g., mentioned by 40% or more of respondents). Key themes are discussed in the following sections. Frequencies are provided to present the percentage of home visitors mentioning themes.

Contributors to Stress and Burnout

Analysis of home visitor interview responses revealed a number of contributors to stress and burnout, and the most common themes involved client issues (64%; 21/33), caseloads (62%, 21/34), and job expectations (53%; 18/34).

Client Issues. Home visitors reported stress and burnout as the result of secondary trauma, perceived limited impacts, and disengaged families.

Secondary trauma. Many home visitors play an active role in the lives of the families that they serve, and often families experience serious trauma. Supporting families through difficult issues creates stress and secondary trauma, which can contribute to burnout.

"The other thing is we are in our clients lives, we are in their homes. They tell us their problems and situations. Sometimes, it is hard not to be affected by those things emotionally. I know that that can lead to burnout and stress because you are taking on too much of other people's problems."

Perceived limited impacts. Home visitors report that for some families, it is difficult to see impacts of the home visiting program, which may contribute to burnout.

"Then I get to the point I feel I'm spinning wheels here, using gas money, using time, and getting nowhere. There are so many problems that are so overwhelming sometimes. They will shock you with what is going on, and at that moment, you don't know what to do about it."

"There are times you feel burnt out as a home visitor when you are not seeing progress with a family."

Disengaged families. Home visitors report that limited follow through from families encourages burnout. Providing resources is an important role for home visitors, and they become discouraged when families fail to utilize resources they have identified or to adhere to plans developed during home visiting sessions.

"There are other families that are not accepting of the information you bring out. They are really negative, so it is hard to keep positive all the time."

"They have an issue, and [we] will talk [about] how they can help themselves through this issue, or I will connect them to resources that can help them. Then they don't do anything further than that but they still complain about the same issue."

"I'm the one that goes to find the resource, bringing them, presenting them, and make the call and the appointment; then they won't go. That's the burnout."

Caseloads. The size of caseloads and individual family needs/requirements were described by participants as contributing to stress and burnout.

Caseload size. Home visitors reported that caseloads can consist of more families than they believe they can serve. Moreover, caseloads fluctuate for many home visitors based on staffing levels at their site. Stress and burnout may result when caseloads exceed levels that home visitors believe they can handle.

"The stress of trying to fit in the workload and maintain a family is hard. I think it looks like it always works out on paper, but reality is it is a lot more hours than what it comes out to on the paper."

"I would say it is the caseload, the number of families you have, and the number of families on your caseload that you are seeing on a weekly basis."

"Trying to do your job but not having the amount of time required to do your job well is the most stressful thing for me."

Individual needs/requirements. The amount of time devoted to a particular family (and associated stress) may vary based on a number of factors, including their individual needs, risk status, and progression in the program. Stress and burnout may be influenced by the number of families in a particular home visitor's caseload with additional needs and requirements.

"The number of families we have and how often we are required to see them depending on where they are at in the program. Sometimes, we have to see them every week or twice a month, or once a month."

"If you have a caseload that is all serious mental health issues, that is going to drain you."

"The time that I was the most stressed out is when the majority of my families having those weekly [home visits]."

Job Expectations. Two key expectations described by home visitors included documentation and travel.

Paperwork/Documentation. Home visitors reported that to comply with their job expectations, extensive documentation must be completed within a short timeline (e.g., 48 hours, 72 hours). To complete this documentation within the deadline and accurately, home visitors report utilizing flexibility in their schedules to make time for required documentation.

"They want to know pretty much word for word what was said, how the mother responded. In order to do that kind of in-depth documentation, you have to take good notes. You have to then go do the documentation on that."

"The required tools and other things that are required of this job can be extremely stressful when we are dealing with families with the issues that they have while meeting the deadline and the requirements."

"The amount of paperwork that goes into one family on a routine basis is very overwhelming sometimes."

Travel. For some home visitors, the distance between home visits results in a sizeable portion of time spent in their vehicles and a substantial number of miles traveled. Unplanned events (e.g., traffic, family cancellations, severe weather) may contribute to stress and burnout.

"Personally for me it is hard to do so much driving. I understand the importance of being in the family's environment. The heart of the program is the in-home visiting, but it is definitely tiring to have to drive so much, especially if the family isn't going to be home. It puts a lot of wear and tear on the vehicle and having to be in traffic all the time."

"Driving all day. For me, it is… driving."

Support for Mitigating Stress and Burnout

Home visitors identified a variety of supports available to them for reducing work-related stress and burnout. Non-MHC resources (94%; 31/33) (i.e., employer-provided resources that were not directly related to the MHC enhancement) were the most commonly described support, followed by MHC resources (i.e., specifically describing the clinician or MHC) (48%; 16/33) and individualized self-care strategies (i.e., developed or identified by individual home visitors own self-care) (45%; 15/33).

Non-MHC Stress and Burnout Resources. The most commonly occurring resources were supervisor support/relationships, Employee Assistance Program (EAP), supportive work atmosphere, employee programs, and professional development.

Supervisor support/relationships. Home visitors noted that their supervisors were both 1) vigilant for symptoms of burnout and 2) responsive and supportive when home visitors experienced burnout.

"The number one resource we have is our supervision every week. That is an opportunity for me to sit down with my supervisor and talk to her about what is going on. A time to get a third person's view of what is going on and how I can better serve my families. I never have had that any place I've worked; positive supervision is a great resource."

"Our supervisors hold us accountable, but they are also very nurturing at the same time. I feel I can tell anyone anything, I can say anything, and I'm not going to be judged. I'm allowed during supervision that sacred protected time where I can let it all out and be myself. I think that is extremely important. If I felt like I was going to be judged or shamed for being honest then that would not work."

Employee Assistance Program (EAP). Home visitors identified counseling services through the EAP as a resource that is utilized to reduce stress and burnout. Home visitors have access to these services through their employer and can utilize both free and paid counseling.

"We have EAP services. I think it can positively affect burnout. I have utilized their services before, and it made me feel better."

"We have an EAP here. We get five free counseling sessions a year. It goes from the first of October to the end of September, then it goes by our co-pay after that."

Supportive work atmosphere. Home visitors noted that management in their sites was aware of the stresses associated with home visiting and worked to maintain an atmosphere that minimized stress and promoted work-life balance.

"[Site] does a good job of being aware that we do have a stressful job and making sure we are being supported, not by supervisors but just providing stuff for us… Keeping workers taken care of and not feeling burnout or stressed and that they can't do their job anymore."

"At [site name], they are extremely good at making sure we have adequate amount of time, making sure we have a caseload that isn't too heavy for us, the stress is minimal, and if we do have stress, we have supervisors to talk to who help minimize it in any way they can."

"The thing I like about [my site] is they are very family-oriented. I was really sick, didn't have any PTO and [my supervisor] told me I could make the hours up within the two weeks. They are very understanding if something happens. It's not like you are just a number, and they just want you to hit these numbers. They are actually concerned with what you have going on in your life."

Employee programs. Home visitors identified a variety of employee programs and activities provided by their employers that are designed to lessen stress and burnout, including physical and mental wellness programs, team building, staff appreciation days, and social committees/events.

"They also have a meditation room in our office where we can go relax for an hour or so."

"We do have different committees within our company. We have a Wellness Committee, Social Committee that puts together events like yoga or Zumba."

Professional development. Home visitors reported that professional development serves a duel role in reducing stress and burnout by 1) providing resources specific to stress and burnout and 2) provide a respite from their normal schedules to focus on personal growth/learning.

"I've been to a few trainings on actual stress and burnout. Those resources were very helpful. Before, I never noticed the warning signs of when I'm becoming stressed or burned out. Knowing the warning signs allows me to be more effective in the services I provide. Going to those trainings and receiving resources on stress and burnout have been helpful."

"One thing for me that is helpful is the Institute for Strengthening Families. Being able to take some time… I've been able to take different classes on how to manage stress in this job. It has been a nice break from home visiting, but I'm also increasing my knowledge on different things related to the job. So, being able to do different trainings has been helpful because I'm strengthening by knowledge while giving me a break from having to do home visits."

MHC Stress and Burnout Resources. Support from the clinician was the most commonly referenced MHC-related resource.

"With the supervision that we have, not only with our regular supervisors, but we have this [mental health clinician] there. I feel like we have the resources to prevent burnout."

"In my times with the clinician [we talk] about my mental state, if I'm stressed, and what I am doing to take care of myself, if I need to take a vacation. They offer suggestions and advice. Recently our clinician started a bulletin board in the office. Every month she puts suggestions for self-care, fun stuff in the city, a list of movies and books that are out, and other suggestions."

Individualized Self-Care Strategies. A variety of strategies were identified including getting an appropriate amount of sleep, taking short breaks between home visits, creating personal work-life balance boundaries, utilizing Paid Time Off (PTO), and participating in hobbies.

"I have learned to do a lot of self-care. Self-care can start for me the minute I leave that visit and get in my car. I put on some music that helps uplift me or I do positive affirmations and self-talk."

"I think taking days off are definitely something that helps to minimize the stress and burnout when you need it."

Job Satisfaction Promoters

Analysis of home visitor interview responses revealed factors contributing to job satisfaction, and the most common themes included non-MHC professional development and training (i.e., not related to the enhancement) (58%; 19/33), positive management/supervisor interactions (52%; 17/33), opportunity to make a difference (48%; 16/33), and flexible schedule (45%; 15/33). Descriptions of the clinician or MHC in relation to job satisfaction were present in 9% (3/33) of responses.

Non-MHC Professional Development and Training. The most commonly described resources were professional development provided by sites, outside training opportunities that were shared by sites, and employer-supported continuing education opportunities.

"I do enjoy some of the trainings that are offered. I recently went for half a day to learn about domestic violence by the prosecuting attorney here in [county name]. That was so informative and opened my eyes to a lot of stuff I didn't know and different ways I can help the families I serve. Work allowed me to go to it, and there was no charge for me to attend that. That is a perk. Continuing my education."

"We have the tuition reimbursement. If this isn't your career goal or you want to further your education in this area, you can go to school and get reimbursed."

Positive Management/Supervisor Interactions. Interactions that communicated appreciation, provided recognition, encouraged input in decision making, and conveyed empathy were identified as positively influencing satisfaction.

"They do kudos. They do different things to tell us thank you, try to make us a part in the decision making. They ask us how can we keep people, how can we keep people from leaving."

"The program manager and everyone are very supportive and have been in the home visiting shoes. They understand the stresses and everything we go through and are able to connect with us in that way too. Just the amount of support helps me feel satisfied at the end of the day."

Opportunity to Make a Difference. Staff described watching families make progress and meet milestones, sharing in families successes, making connections with families, and meeting and interacting with new people.

"In this job, you aren't going in it to get rich, but you are going in it to help people. When you finally get through to a family, it is something that is extremely satisfying."

"I tell people I love my job because I get to talk to people, and I'm helping them. They are ready and waiting for our visits; they are excited to tell me they accomplished their goals. It makes me feel like I'm doing a service to people. I don't feel like I'm taking away from them or causing them any harm."

"There are other intangibles: seeing a baby walk for the first time, crawling for the first time, or getting their first tooth, a mom having a success."

Flexible Schedule. The schedule allows staff to take PTO when needed, create their own work schedule, make time for their own children/families, and work in multiple settings.

"Flexibility is one. Knowing that I can be flexible with my day and get things done with things that come up in my life is a good feeling to have."

"For me it is the flexibility. I'm divorced with two kids, and with home visiting, I set my own schedule. Fridays I choose not to work past 1pm. It is one day a week my kids don't have to go to afterschool care. I live 35 minutes from where our office is, so if I had to be there by 8am every day, I would choose to work somewhere else. For me, it is the flexibility piece."

Job Satisfaction Barriers

Along with exploring factors that promote satisfaction, the study examined barriers that impede job satisfaction. Analysis of home visitor interview responses revealed the most common barriers to job satisfaction included compensation (36%; 12/33) and caseloads (i.e., caseload size and completion expectations associated with providing services to families) (27%; 9/33).

Compensation. Home visitors described low base pay and limited opportunities for bonuses and salary increases as playing a negative role in job satisfaction.

"Of course, I would like to be making more money. I have a degree, and I don't feel I make enough money."

"Money is a big deal. We have families that work here that are on food stamps or get Medicare for their kids. I think that is sad. I think that is why people leave because they know there is better money out there."

Caseloads. Caseload size and completion expectations associated with providing services to families were identified as barriers.

Caseload size. Along with creating stress and burnout, maintaining a large caseload can reduce job satisfaction according to home visitors. As caseloads increase, the amount of time required to complete duties increases (e.g., documentation, planning, travel), especially when serving a large number of high-risk families.

"I think definitely keeping the caseloads within the criteria they are supposed to be; not going over those numbers is important. Those numbers are set for a reason and that is for us to be able to get everything in every week."

"Going in the amount of homes that are high risk families is very stressful."

Completion rates and service requirements. Home visitors report that with larger caseloads, home visit completion rates become more difficult to meet due to logistical considerations. Because participation is voluntary, a family may cancel a home visitor or decline services at any time, which adversely affects completion rates. Because many home visitors felt that caseload size and family behaviors are often out of their control, these factors may contribute negatively to home visitors' satisfaction with their position.

''We have productivity goals. When people don't meet those or they are hard to reach, they don't feel they are doing their job and cause enough to not be satisfied here."

"The home visit completion rate is a huge stressor with our staff. This is a voluntary program, and our HFA/HFI has these standards they placed on us. Yes, we understand why; however, this is voluntary and when these families don't meet with us that affect our role satisfaction. We share with them this is a voluntary program, at any point in time you can decline services. It has a huge role on job satisfaction. The home visit completion rate has a negative effect."

"I think for a while the caseloads were pretty high, so meeting the criteria for getting the amount of home visits in was difficult."

Job Retention Promoters

Home visitor interview responses were examined to determine what factors influence their decision to remain employed as home visitors. The most commonly observed themes included dedication to home visiting (70%; 23/33), support from colleagues (45%; 15/33), flexible scheduling (39%; 13/33), and non-MHC professional development and training (42%; 14/33). Descriptions of the clinician or MHC in relation to job retention were present in 18% (6/33) of responses.

Dedication to Home Visiting. Home visitors described relationships with the families they serve, positive program impacts, passion for helping others, sharing in family successes, and the feeling of making a difference. This feeling of "dedication" appears to trump compensation concerns for many home visitors.

"Feeling that rewarding feeling when you are with the family for the long haul. You have seen progress and you've gotten attached to the family. That is why I have stayed because those relationships build."

"Just because they want to help people, it is meaningful. They are making a difference in someone's life. Sometimes, I am the only person that some of these families see. They have no friends. Not that I'm their friend, but they look forward to seeing me even if it's only for 60 minutes. I am that constant. I make a point not to be late or miss their day."

"The passion of social work. If you are in social work, it is not for the money. People's own personal passions keep them here. People's experience in the work field keep them here."

Support from Colleagues. Home visitors noted that support from their supervisors, other management, and their peers contributed to their decision to remain employed in their current position.

"I have great coworkers that have become my friends. A lot of people here would say that is their experience as well. They do a good job promoting. We do have good relationships with the people we work with because that is a huge support for us. They are the only people that maybe know what you are going through or have been through something similar. It's nice we can lean on our coworkers for that support. From my experience, that is why I stay here."

"The people we work with at my site really motivate you to stay here and do your job."

"When a person feels supported by their administration and staff, it keeps them here."

Non-MHC Professional Development and Training. Home visitors reported that professional development and training prepared them to be more successful in their work, improving their likelihood of remaining in their position.

"The training, there is a lot of training. It helps us feel more comforted to go out and do our jobs."

"Their training is awesome. I have the opportunity to go out with my coworkers to see how they home visit before they even threw me out there to do it on my own. [It] was a great benefit."

Flexible Schedule. Along with influencing job satisfaction, the flexible schedule has a direct relationship with job retention for some home visitors. The flexible schedule allows staff to take PTO to support work-life balance, create their own work schedule, fulfill parenting obligations, and work in multiple settings.

"The flexibility of our job. I kind of set my own schedule as far as my visiting. If I want to get all my visits done during the day, I can do that and be in my office the rest of the day; however I want to break that up. Flexibility is why people stay."

"What we lack in pay we make up in vacation time and the flexibility to schedule. A lot of us are parents ourselves, and there are times we need to call off at the last minute or leave in the middle of the day."

Job Retention Barriers

Home visitor interview responses were examined to identify the factors that influence home visitors' decisions to seek alternative employment. The most commonly observed theme was compensation (21%; 7/33), followed by caseload concerns (15%; 5/33).

Compensation. Home visitors described low pay and limited opportunities for advancement and salary increases as playing a role in job retention. Travel costs and associated reimbursements were described as barriers. Home visitors described these concerns as especially salient for those paying off students loans and raising families.

"Why I see people leaving here and just talking amongst others is the money aspect. I made more money waitressing. I see people leaving or they are going back to school for something else and continuing their education."

"We only get .38 cent a mile for mileage."

Caseload. As with stress, burnout, and job satisfaction, links were noted between caseloads and job retention. Home visitors (15%; 5/33) noted that caseload size, travel associated with serving

one's caseload (e.g., distance between homes), stress related to completion expectations, and needs/risks associated with individual families may negatively influence retention.

"Your caseload is another thing that will have you stay or not. Location of families… making sure you don't have families located at all ends of the earth that you have to see all the time, so you aren't driving but meeting with your family because you are spending most of your day driving."

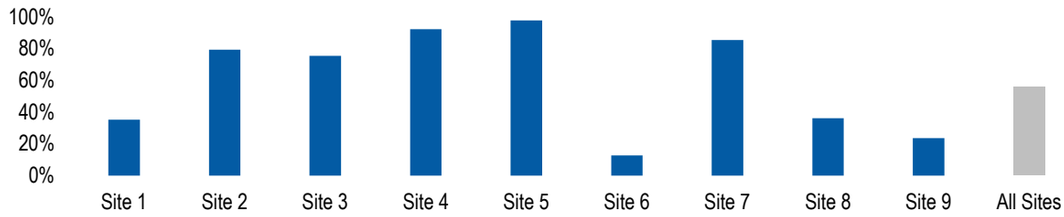
"Maybe the high expectations as far as having to get up a certain percentage of home visits in every month, when it is a voluntary program. A lot of employees have felt that pressure because it is how we get funded is through home visits. It is understandable but at the same time it's not the home visitor's fault if the family doesn't want a visit or if they cancel, or they decide they don't want to be in the program any more. A lot of employees stress over their numbers every month. We do what we can to reschedule with the family for that week, but if they are sick or tell us that they are sick, or if they just don't want to visit that week there is not much we can do. I feel like a lot of employees have left because the stress of having to get in a certain percentage [of home visits] every month has taken a toll on them."

Research Question 3

Research question 3a: Are all MIECHV-funded families being reviewed by the clinicians for high risk and Mental Health Consultation? (Model Expectation: 100% of families)

Primary Analysis – Clinical Risk Status. Family Assessment Reports completed from January 1, 2016 to December 31, 2017 were exported from Datatude for all MIECHV-funded families enrolling during the study period to address RQ3a. Data were available for 1881 families. Clinical risk status (i.e., high risk: yes or no) was assigned for 56% (n = 1056) of families, while risk status was not assigned (i.e., no status entered) for 44% (n = 825) of families.

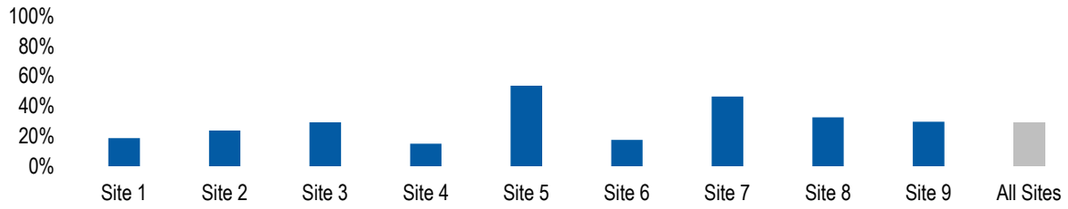
Figure 3. Clinical risk status was assigned for the majority of MIECHV-funded families; however, there was variance across sites.



Research question 3b: Are families identified for Mental Health Consultation services followed and reviewed each month? (Model Expectation: 100% of families)

Primary Analysis - Percentage of Families Reviewed Through Mental Health Consultation During Each Month Enrolled. RQ3b examined the extent to which MIECHV-funded families (enrolled between January 1, 2016 and December 31, 2017) were followed and reviewed each month by the mental health consultant. Family-Specific Secondary Activities were merged with family data (MIECHV-funded families, enrolled between January 1, 2016 and December 31, 2017) to determine if families received a Family-Specific Secondary Activity in each of the months enrolled. For the purposes of MHC, direct family activities are defined as those logged as Family-Specific Secondary Activities, which include reviews and associated activities conducted on behalf of a specific family and entered with their unique family id number. Family-Specific Secondary Activities entered into FamilyWise include: Agency/Other Professional, Attempted Phone Contact, Case Conference, Clinical Case Review, Clinical Consultation, Electronic Message, Phone Contact, Response to Depression Screen, Safety Plan Completed, Security, and Supportive Home Visits. A total of 4279 secondary activities were successfully merged with family data, representing 998 unique families. For these families (N = 998), the number of total linked activities ranged from 1 to 38 (M = 4.29, SD = 5.57). For the 998 MIECHV-funded families for whom Secondary Activity Reports and enrollment records were available, 29% (n = 289) of families were reviewed through MHC services during all months enrolled.

Figure 4. Across all sites, 29% of MIECHV-funded families were reviewed during each month enrolled.



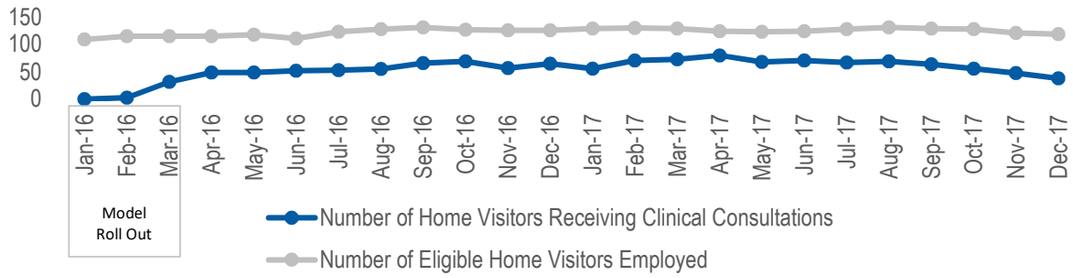
Note: Sample consist of MIECHV-funded families enrolling between January 1, 2016 and December 31, 2017.

Research question 3c: Are all home visitors who serve MIECHV-funded families engaging in consultation at least once per month? (Model Expectation: 100% of home visitors) Primary Analysis – Home Visitors Receiving Consultation per Month. Using the FamilyWise data system, mental health consultants logged clinical consultation as part of their Secondary Activity Reports. The number of home visitors receiving consultation each month is provided along with the number of home visitors employed during the time period. The number of home visitors employed was drawn from employment records exported from FamilyWise and reviewed by site managers to identify home visitors expected to receive MHC. It reflects all home visitors employed during a given month who were identified by site managers as being expected to receive MHC. The number of clinicians entering data is presented as a proxy for the number of clinicians employed; it was drawn from the total number of unique clinicians entering Secondary Activity Reports. Across all sites, the number of home visitors receiving consultation per month ranged from 0 to 80 (M = 54.67, SD = 19.95), while the number of home visitors employed during the study period ranged from 109 to 139 (M = 123.29, SD = 6.50).

Table 16. Home visitors receiving consultation per month.

	Home Visitors Receiving Consultation						
	Home Visitors Receiving Consultation	2016 Total Home Visitors Employed	Clinicians Entering Data		Home Visitors Receiving Consultation	2017 Total Home Visitors Employed	Clinicians Entering Data
January	0	109	3	January	56	129	10
February	3	115	4	February	71	130	9
March	32	115	9	March	73	129	9
April	49	115	9	April	80	124	10
May	49	118	9	May	68	123	10
June	52	111	9	June	71	124	10
July	53	123	9	July	67	128	9
August	55	128	9	August	69	131	9
September	66	131	9	September	64	129	8
October	69	127	8	October	56	128	7
November	57	126	8	November	48	121	8
December	65	126	8	December	38	119	8

Figure 5. From January 2016 to December 2017, the number of home visitors receiving consultation per month across all sites ranged from 0 to 80 (M = 54.67, SD = 19.95).



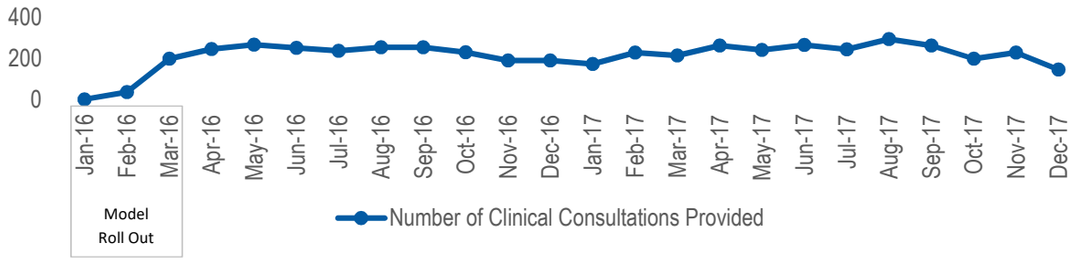
Supplemental Analysis – Monthly Consultation Activities Provided. Mental health consultants logged clinical consultation activities provided as part of their Secondary Activity Reports. The number of consultation activities provided each month is reported along with the number of home visitors employed during the time period. The number of home visitors employed was drawn from employment records exported from FamilyWise and reviewed by site managers to identify home visitors expected to receive MHC. It reflects all home visitors employed during a given month who were identified by site managers as being expected to receive MHC. The number of clinicians entering data is presented as a proxy for the number of clinicians employed; it was drawn from the total number of unique clinicians entering Secondary Activity Reports. Across all sites, the number of clinical consultation activities provided per month ranged from 1 to 293 (M = 212.29, SD = 68.91). It should be noted that clinical consultation activities are recorded by family. Therefore, multiple consultation activities may be attended by a single home visitor based on caseload. Additionally, multiple clinical consultations may occur during a single meeting with the clinician (e.g., during a single meeting, a home visitor may discuss multiple families with the clinician). Due to concerns related to data availability for this research question (see *E. Study Limitations*), this analysis was completed to supplement the primary analysis.

Table 17. Monthly consultation activities provided.

	Consultation Activities Provided						
	2016				2017		
	Total Consultation Activities	Total Home Visitors Employed	Clinicians Entering Data		Total Consultation Activities	Total Home Visitors Employed	Clinicians Entering Data
January	1	109	3	January	173	129	10
February	36	115	4	February	227	130	9
March	198	115	9	March	213	129	9
April	245	115	9	April	262	124	10
May	266	118	9	May	240	123	10
June	251	111	9	June	265	124	10
July	236	123	9	July	243	128	9
August	253	128	9	August	293	131	9
September	253	131	9	September	262	129	8
October	229	127	8	October	198	128	7
November	190	126	8	November	227	121	8
December	189	126	8	December	145	119	8

Note: Clinical consultation activities are recorded by family. Therefore, multiple consultation activities may be attended by a single home visitor based on caseload. Additionally, multiple clinical consultations may occur during a single meeting with the clinician (e.g., during a single meeting, a home visitor may discuss multiple families with the clinician).

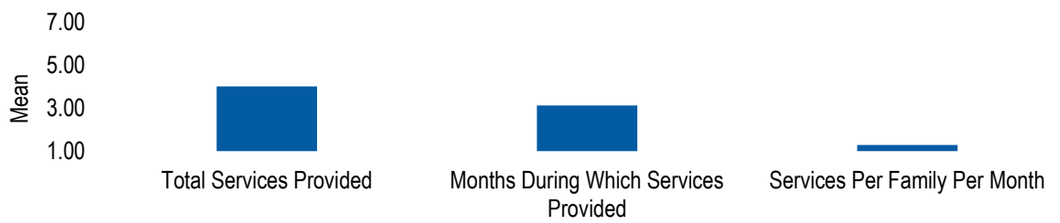
Figure 6. From January 2016 to December 2017, the number of clinical consultations activities provided per month across all sites ranged from 1 to 293 (M = 212.29, SD = 68.91).



Research question 3d: Are clinicians providing at least bi-monthly training to home visitors? (Model Expectation: Minimum of one training every two months per site)
Primary Analysis – Monthly Trainings Completed. Secondary Activity Reports completed by mental health consultants between January 1, 2016 and December 31, 2017 were exported to address RQ3d. Using these data, a count of trainings provided per month by site was created. From January 1, 2016 to December 31, 2017, trainings were offered inconsistently across sites. Across all sites, a total of 59 trainings were provided in 2016, and 78 were provided in 2017. During 2016, trainings were offered at least bi-monthly at one site (11%). During 2017, trainings were offered at least bi-monthly at three sites (33%).

Research question 3e: How often are families directly receiving Mental Health Consultation services? (Model Expectation: No target. Process data collection to support implementation planning and future evaluations)
Primary Analysis – Direct Family Mental Health Consulting Services Received By Unique Families. Secondary Activity Reports completed by clinicians between January 1, 2016 and December 31, 2017 were exported. For the purposes of MHC, direct family activities are defined as those logged as Family-Specific Secondary Activities, which include reviews and associated activities conducted on behalf of a specific family and entered with their unique family id number. Family-Specific Secondary Activities include: Agency/Other Professional, Attempted Phone Contact, Case Conference, Clinical Case Review, Clinical Consultation, Electronic Message, Phone Contact, Response to Depression Screen, Safety Plan Completed, Security, and Supportive Home Visits. During the study period, 1927 families were served at least one time. The number of services provided per family ranged from 1 to 40 (M = 4.01, SD = 5.55). The number of months during which services were provided ranged from 1 to 21 (M = 3.12, SD = 3.49). The number of services provided to each family per month ranged from 1 to 5 (M = 1.28, SD = 0.52). Of families receiving services in two or more months (N = 1097), 51% (n = 555) received one or more services during all of the months between their first and last service.

Figure 7. On average, families received 4.01 total services, received services for 3.49 months, and received 1.28 services per month.



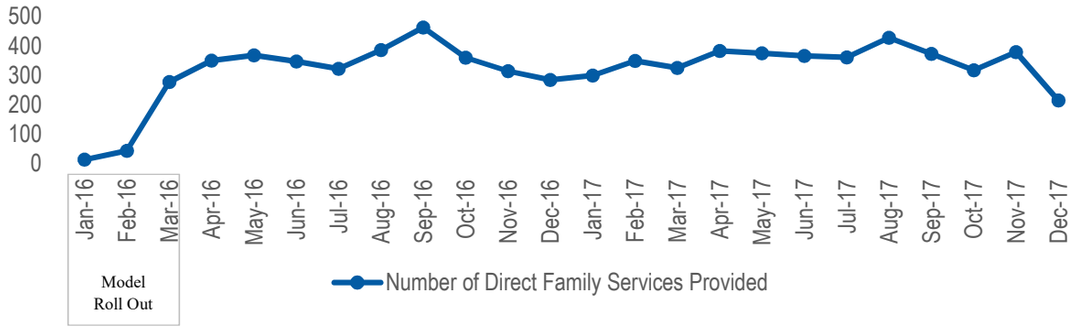
Supplemental Analysis – Direct Family Mental Health Consulting Services Provided by Sites. From January 2016 to December 2017, a total of 7721 family-linked MHC services were

provided. For the purposes of MHC, direct family services include those logged as Family-Specific Secondary Activities (see above). Clinical consultation (67%, *n* = 5155) and clinical case reviews (29%, *n* = 2231) were the most commonly provided. During the study period, the total number of direct family mental health consulting services provided per month at all sites ranged from 15 to 463 (*M* = 321.71, *SD* = 102.98). This analysis was completed to supplement the primary analysis and to allow triangulation of results.

Table 18. Number of family services provided by county and program (January 2016 to December 2017).

Direct Family Mental Health Consulting Services	
County/Program	*n*
Site 1	672
Site 2	262
Site 3	640
Site 4	1289
Site 5	657
Site 6	356
Site 7	2964
Site 8	396
Site 9	485

Figure 8. From January 2016 to December 2017, the number of direct family mental health consulting services provided per month ranged from 15 to 463 (M = 321.71, SD = 102.98).



Research question 3f: Are clinicians providing at least one hour of reflective practice per month for each home visitor serving MIECHV-funded families? (Model Expectation: 100% of home visitors)

Primary Analysis – Home Visitors Receiving Monthly Reflective Practice During Each Month Employed. From January 1, 2016 to December 31, 2017, mental health consultants recorded 2217 clinical reflective practice sessions. Of these, 2049 reflective practice sessions included the name of the associated staff member in a notes field. From these, 211 staff names were extracted. Employment records were reviewed by site managers to identify home visitors expected to receive MHC. Clinical reflective practice records from the Secondary Activity Reports were successfully merged with employment records for 168 home visitors. To examine the research question, length of each home visitor's employment (during the study period) was calculated in months using a start date (the later of either the first home visit or study start date) and end date (the earlier of either termination date or study end date). For this group (*N* = 168), the total number of reflective practice sessions received ranged from 1 to 71 (*M* = 10.85, *SD* = 9.35). The number of months employed (during the study time period) ranged from 1 to 24 months (*M* = 15.33, *SD* = 8.22). The number of months during which reflective practice was received ranged from 1 to 22 (*M* = 9.52, *SD* = 6.56). Of the 168 home visitors successfully merged, 11% (*n* = 18) received reflective practice during all of the months that they were

employed during the study time period. The reflective practice completion rate for this group was 62.1%.

The majority of home visitors received reflective practice during at least half of months employed during the evaluation period. The percentage of months employed during which reflective practice was received is presented below by gradations.

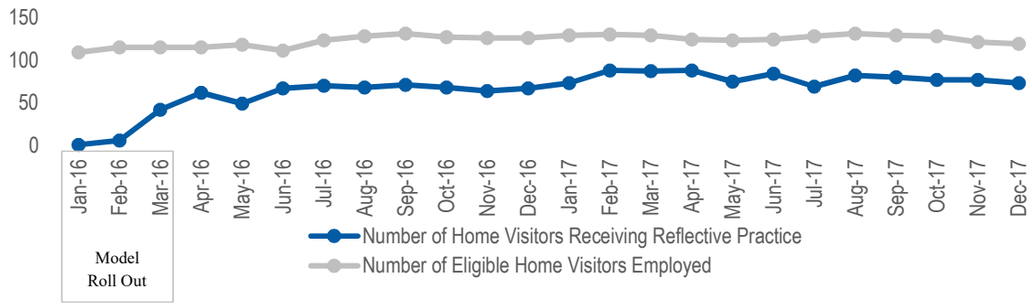
Table 19. Months employed receiving reflective practice by gradation.

Months Employed Receiving Reflective Practice By Gradation		
Percentage of Months Employed Receiving Reflective Practice	*n*	*%*
100% of months employed	18	10.7
90-99% of months employed	13	7.7
80-89% of months employed	21	12.5
70-79% of months employed	38	22.6
60-69% of months employed	21	12.5
50-59% of months employed	15	8.9
Less Than 50% of months employed	42	25.0

Note: Sample consists of home visitors with matched employment records and clinical reflective practice records (*N* = 168).

Supplemental Analysis – Home Visitors Receiving Reflective Practice per Month. Due to concerns related to data availability for this research question (see *E. Study Limitations*), the following analysis was completed to supplement the primary analysis. The number of home visitors receiving reflective practice each month is provided along with the number of home visitors employed during the time period. The number of home visitors employed was drawn from employment records reviewed by site managers to identify home visitors expected to receive MHC. It reflects all home visitors employed during a given month who were identified by site managers as being expected to receive MHC. The number of clinicians entering data is presented as a proxy for the number of clinicians employed; it was drawn from the total number of unique clinicians entering Secondary Activity Reports. Across all sites, the number of home visitors receiving reflective practice per month ranged from 1 to 88 (*M* = 66.17, *SD* = 22.24), while the number of home visitors employed during the study period ranged from 109 to 139 (*M* = 123.29, *SD* = 6.50).

Figure 9. From January 2016 to December 2017, the number of home visitors receiving reflective practice per month across all sites ranged from 1 to 88 (M = 66.17, SD = 22.24).

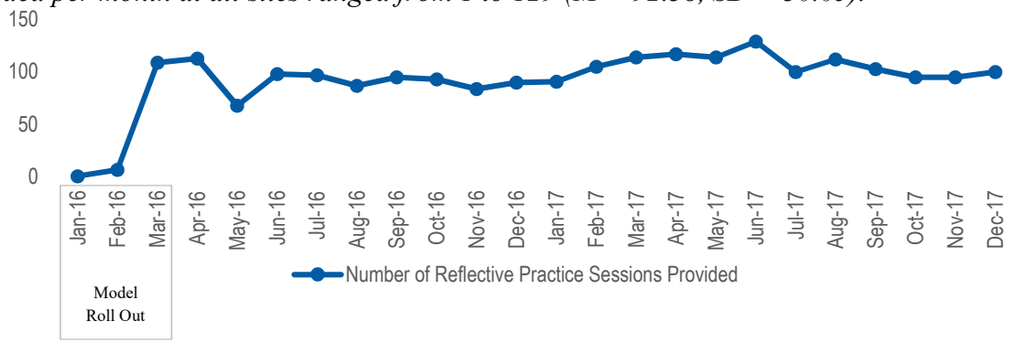


Supplemental Analysis – Reflective Practice Offered. From January 2016 to December 2017, a total of 2217 clinical reflective practice sessions were provided. From January 2016 to December 2017, the number of reflective practice sessions provided per month at all sites ranged from 1 to 129 (*M* = 92.38, *SD* = 30.05).

Table 20. Number of reflective practice sessions provided by month.

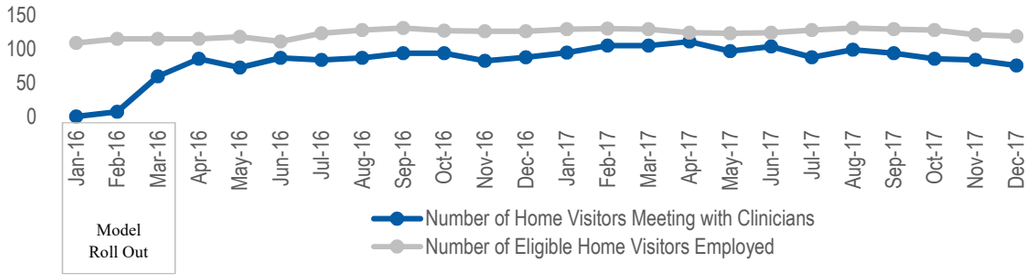
Reflective Practice					
2016			2017		
Month	Reflective Practice Provided	Number of Clinicians Entering Data	Month	Reflective Practice Provided	Number of Clinicians Entering Data
January	1	3	January	91	10
February	7	4	February	105	9
March	109	9	March	114	9
April	113	9	April	117	10
May	68	9	May	114	10
June	98	9	June	129	10
July	97	9	July	100	9
August	87	9	August	112	9
September	95	9	September	103	8
October	93	8	October	95	7
November	84	8	November	95	8
December	90	8	December	100	8

Figure 10. From January 2016 to December 2017, the number of reflective practice sessions provided per month at all sites ranged from 1 to 129 (M = 92.38, SD = 30.05).



Research question 3g: Are clinicians meeting at least once each month with each home visitor serving MIECHV-funded families? (Model Expectation: 100% of home visitors) Primary Analysis – Home Visitors Meeting with Clinicians per Month. Mental health consultants logged meetings with home visitors (i.e., case conferences, clinical consultation, clinical reflective practice, response to depression screening, safety plan completion, and safety plan review) as part of their Secondary Activity Reports. A total of 4473 records were successful merged with home visitor employment data (representing 83 unique home visitors). The number of home visitors meeting with clinicians each month is provided along with the number of home visitors employed during the time period. The number of home visitors employed was drawn from employment records reviewed by site managers to identify home visitors expected to receive MHC. It reflects all home visitors employed during a given month who were identified by site managers as being expected to receive MHC. The number of clinicians entering data is presented as a proxy for the number of clinicians employed; it was drawn from the total number of unique clinicians entering Secondary Activity Reports. The number of home visitors meeting with their clinician per month ranged from 1 to 111 (M = 82.88, SD = 26.61), while the number of home visitors employed during the study period ranged from 109 to 139 (M = 123.29, SD = 6.50).

Figure 11. From January 2016 to December 2017, the number of home visitors meeting with clinicians per month across all sites ranged from 1 to 111 (M = 82.88, SD = 26.61).



Supplemental Analysis – Monthly Home Visitor Meetings Provided. The number of meetings provided each month is reported along with the number of home visitors employed during the time period. The number of home visitors employed was drawn from employment records exported from FamilyWise and reviewed by site managers to identify home visitors expected to receive MHC. It reflects all home visitors employed during a given month who were identified by site managers as being expected to receive MHC. The number of clinicians entering data is presented as a proxy for the number of clinicians employed; it was drawn from the total number of unique clinicians entering Secondary Activity Reports. Across all sites, the number of meetings provided per month ranged from 2 to 418 (*M* = 311.29, *SD* = 98.87), while the number of home visitors employed during the study period ranged from 109 to 139 (*M* = 123.29, *SD* = 6.50). Due to concerns related to data availability for this research question (see *E. Study Limitations*), this analysis was completed to supplement the primary analysis.

Table 21. Monthly meetings provided.

	Meetings Provided						
	Meetings Provided	2016 Total Home Visitors Employed	Clinicians Entering Data		Meetings Provided	2017 Total Home Visitors Employed	Clinicians Entering Data
January	2	109	3	January	274	129	10
February	43	115	4	February	339	130	9
March	308	115	9	March	331	129	9
April	359	115	9	April	385	124	10
May	335	118	9	May	364	123	10
June	351	111	9	June	398	124	10
July	335	123	9	July	348	128	9
August	345	128	9	August	412	131	9
September	418	131	9	September	367	129	8
October	330	127	8	October	295	128	7
November	281	126	8	November	322	121	8
December	284	126	8	December	245	119	8

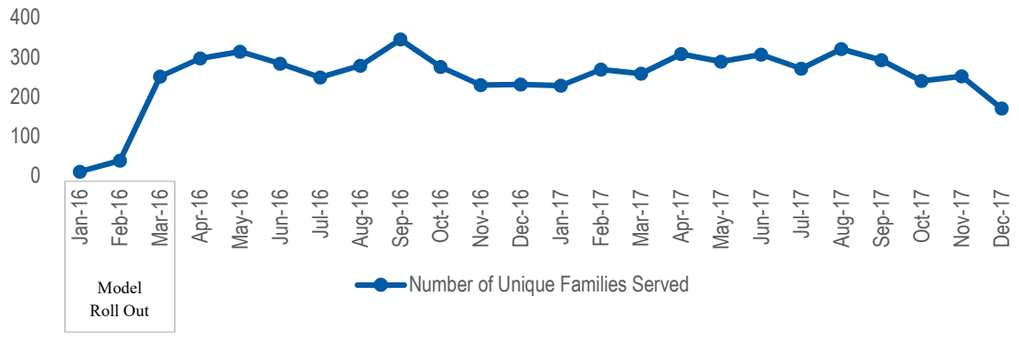
Note: Multiple meetings may be provided for each home visitor based on caseload. Family-Specific Secondary Activities are recorded by family. Therefore, multiple Family-Specific Secondary Activities may be attended by a single home visitor based on caseload. Additionally, multiple Family-Specific Secondary Activities may occur during a single meeting with the clinician.

Research question 3h: How many families are being addressed through Mental Health Consultation each month? (Model Expectation: No target. Process data collection to support implementation planning and future evaluations)

Primary Analysis – Families Addressed by Consultation. Secondary Activity Reports completed by mental health consultants were exported to address RQ3h. Using these data, a count of unique families served during each month was created. The number of clinicians entering data is presented as a proxy for the number of clinicians employed; it was drawn from

the total number of unique clinicians entering Secondary Activity Reports. From January 2016 to December 2017, a total of 1927 families were served at least one time. The number of families served monthly through mental health consulting activities ranged from 11 to 345 (*M* = 250.58, *SD* = 78.89).

Figure 12. From January 2016 to December 2017, the number of unique families served monthly through mental health consulting activities ranged from 11 to 345 (M = 250.58, SD = 78.89).



Research question 3i: How often are clinicians providing shadow or supportive home visits? (Model Expectation: No target. Process data collection to support implementation planning and future evaluations)

Shadowing and Supportive Home Visits. RQ3i examined the frequency with which two specific activities were offered by clinicians: shadowing and supportive home visits. Shadowing (Non-Client Secondary Activity) is defined as *any time a clinician attends home visit to observe but does not provide any intervention. This would typically be in response to a request from a supervisor or by you in order to monitor staff skill.* Supportive home visits (Family-Specific Secondary Activity) are defined as *any visit where a clinician accompanies FSW.* The following analyses provided a count of only these activities. From January 2016 to December 2017, 43 supportive home visits and 17 shadowing visits were provided.

Table 22. Number of supportive home visits provided by county and site.

	Supportive Home Visits
County/Program	*n*
Site 1	5
Site 2	0
Site 3	0
Site 4	20
Site 5	3
Site 6	1
Site 7	1
Site 8	7
Site 9	6

Table 23. Number of shadowing visits provided by county and site.

	Shadowing Visits
County/Program	*n*
Site 1	0
Site 2	0
Site 3	0
Site 4	0
Site 5	0
Site 6	1
Site 7	10
Site 8	4
Site 9	2

Research question 3j: To what extent do staff descriptions of Mental Health Consultation provide evidence of consultation quality? (Model Expectation: Staff response provide evidence of quality)

The fidelity study utilized a qualitative design using semi-structured interviews to explore staff perceptions of implementation. Definitions of efficacy were drawn from Johnston and Brinamen's (2012) work on transformational consultation relationships that promote positive consultant-consultee relationships and encourage parallel process. Interviews of home visitors and mental health consultants were examined for evidence of consultation quality using the framework method (Ritchie & Spencer, 1994). For the purposes of this study, key themes were those mentioned by 40% or more of respondents. Frequencies are provided for main themes to demonstrate the frequency with which a particular theme was mentioned by a home visitor or clinician.

Evidence of Consultation Quality – Home Visitor Interviews

Home visitor interviews provided evidence of consultation quality. Key themes uncovered in the data aligned with characteristics of consultation quality from the literature and/or Indiana model expectations. Specifically, ease of access (100%, 33/33), resource sharing (85%; 28/33), positive consultant-consultee relationships (85%; 28/33), clinician cultural awareness (70% 23/33), reflective atmosphere (70%; 23/33) and shared inquiry (70%; 23/33) were present within responses from the majority of home visitors. Emotional support (48%; 16/33) was observed in nearly half of responses.

Ease of Access. All respondents reported having access to their mental health consultant through their monthly scheduled meetings. The majority of home visitors noted having access to the clinician outside of their scheduled meeting times either through email, cell phone/text messages, an open-door policy, or other methods. Meeting barriers and changes in access were limited.

"Once a month for an hour, but [the clinician] is always available. We can call or text her or email [the clinician]. [The clinician] is in the office very frequently. I see [the clinician] almost every day, and we are always welcome to knock on [the clinician's] door to ask for help or if we have a problem. [The clinician is] accessible."

"I feel like I can call [clinician] out of the blue if I needed to, I can text [the clinician], or talk to [the clinician] right quick"

Meeting Barriers. Barriers hindering home visitors from meeting with clinicians appear to be rare. Specific barriers described included illness, emergencies, and scheduling issues (e.g., tardiness, missed phone calls) with a prior mental health consultant.

Changes in Access. While limited, changes in access were noted by home visitors, with many the result of clinician turnover. Additionally, some home visitors stated that their clinician was a new hire, and they were unable to gage any changes in access.

"I know some of the clinicians in the past, I didn't feel were available, and I did not feel as safe with. [Current clinician] is very available, and I feel safe in approaching [the clinician] when I need to."

Resource Sharing. Common resources provided included written tools, general coaching/advice, outside referrals for services, and new ideas/techniques. Less common resources included shadowing home visits and training.

Written tools. Home visitors report that their clinicians provide a variety of written tools to support their work with families including, but not limited to, handouts, activity sheets, checklists, and book excerpts. These tools are provided both in physical and electronic formats.

"For instance, I had a family that was having a difficult time with co-parenting, and [the clinician] gave me a handout on co-parenting. [The clinician] also gave me a structured handout on how you want to have your home structured. Rather than taking the handout and formally giving it to each parent, I took it, read it, and in an informal manner, I engaged them like a motivational interview with the parent to see what their barriers were there when it came to co-parenting. The information [the clinician] gave was very helpful because I didn't know how to ask both parents or engage them without them both arguing. That was the barrier. They couldn't get past the arguing. Once I filled out the handout, I noticed a dynamic change in their engagement."

Coaching/Advice. Home visitors described utilizing their clinicians as a source for coaching and advice, especially related to mental health issues.

"[The clinician] is there to provide insight that we are not experienced in. Recently, I've had a family that is involved with substance abuse, so [the clinician] has been helpful giving me signs to look for, ask if the family member is using again, and any other community resources I could refer her to. That is a common topic lately."

"[The clinician] was able to explain the difference between a manic depressed and just the depressed. It was helpful to help me identify where one of my mom's was at that point. I do have one assessment that [the clinician] identified that mom may have had a personality disorder. [The clinician] was able to help me to process going into the home initially and how to handle some of those first time conversations."

Referrals. Home visitors reported relying on the clinicians' knowledge of local resources when seeking out referrals for services.

"I have a client who came here from another country, and I'm trying to help her with as much as I can. She had her baby, and this young lady went through a terrible time in her country. [The clinician and I] had to try and find her counseling. It's hard to find counselors that are Spanish speaking."

New ideas/techniques. Home visitors identified the clinician as a source for new ideas and techniques.

"[The clinician] gives me fresh ideas, and [the clinician] has a mental health background, helpful ideas, and things we can work on with moms who have certain issues. [The clinician's] ideas are more up-to-date on certain techniques that we can use during a home visit."

"If we get a family that I don't know anything about that culture, [the clinician] can find me information from the other office or can give me advice on what has worked for other home visitors. We've had a lot of different cultures lately that we don't normally serve. If [the clinician] doesn't know the answer, [the clinician] will find it."

Positive Relationships. In discussing positive relationships, home visitors described their clinicians using terms such as open, encouraging, cooperative, helpful, friendly, reliable, supportive, and approachable.

"[The clinician] is very encouraging because [the clinician] is aware of the difficulties of being a home visitor. [The clinician] is very supportive in us being mindful of our limits and that self-care kind of thing."

"Pretty good, honest. We've built a rapport. I can tell [the clinician] just about anything from my own personal life to of course, work-related issues. [The clinician] is very attentive to me, my needs, and what I need as a worker to do my job. [The clinician] is open and makes me comfortable talking to [the clinician] about anything related to myself or my families."

Cultural Awareness. Home visitors noted that clinicians have knowledge of and experience working with the cultures served by the program, as well as a willingness to learn about unfamiliar cultures through research and open-ended questions about families.

"I would say [the clinician] is definitely culturally sensitive. [The clinician] will ask a lot of open-ended questions about the client's past history, family, just to get a better overall perspective on what might be going on and which route we can take to better serve the client and the family."

"[The clinician] is very culturally aware. I have an array of families, so every time I talk to [the clinician] about a different family, [the clinician] shares something about that person's culture that helps me to do my job. I had a Hispanic mother. [The clinician] shared something about that culture that helped me understand what maybe was going on."

Reflective Atmosphere. A reflective consultation atmosphere consists of clinician behaviors or environmental conditions that promote reflection by the home visitor during consultation. In descriptions of a typical consultation, home visitors indicated that the clinician begins by asking the home visitor to identify any specific families or issues (e.g., general, multi-family, or personal) that he or she would like to discuss. The atmosphere allows home visitors to guide the

direction of the consultation session, with the clinician supporting a home visitor's reflection with open-ended questions and feedback.

"We go in, and [the clinician] asks me if there is anything that I specifically I want to talk about or a family I feel is important to talk about. [The clinician] always puts that ball in my corner first. [The clinician] listens, and I'll ask [the clinician] what [the clinician] thinks or how can I help mom see that how dad is talking to her isn't the best way to be talking to her."

"The initial part of the meetings together [the clinician] will just see how I am doing, how I'm feeling with my caseload, and we will take 5 minutes to talk about that. Then [the clinician] will start with wherever I want to start off with clients."

Shared Inquiry. When shared inquiry is present in consultation, the consultant and consultee work together to develop shared understanding of issues and create plans for addressing them collaboratively. Rather that serving solely as a teacher or expert, the clinician uses strategies that foster a consultee's reflection and self-discovery (Johnston & Brinamen, 2012; Brinamen et al., 2012).

"It helped me have more of an understanding of how to deal with the mental health that is not being treated in these parents and also being aware of myself and how it is affecting me and the frustrations I have. [The clinician] asks that question: 'And how is that for you after you left the visit?' [The clinician] has challenged me to be more self-aware, so I don't get super frustrated."

"Overall, it is nice to get a mental health clinician's perspective on things. Or if I need further understanding on something I'm struggling with, that is really helpful to me. It's nice to be able to collaborate ideas to get overall better understanding of what may be going on."

Emotional Support. Home visitors noted that clinicians inquire about their wellbeing during meetings and provide support and resources (e.g., coping mechanisms, self-care strategies) when they are stressed.

"When something is bothering me [the clinician] helps me work through it, help me connect some of the dots where maybe I missed that. It also helps with stress management because it can be a stressful job."

"[The clinician] doesn't only ask and provide consultation for the families, but [the clinician] is devoted to how we as the workers are handling the stresses of the job. We go into homes and support, and the [clinician] really provides a constant support for us as employees but also with our more difficult families."

Evidence of Consultation Quality – Mental Health Consultant Interviews

As with home visitors, mental health consultant interviews provided evidence of consultation quality. Key themes uncovered in the data aligned with characteristics of consultation quality from the literature and/or Indiana model expectations. Key themes emerging in the majority of response included ease of access (100%, 9/9), positive atmosphere (100%, 9/9), resource sharing (100%, 9/9), power/authority (100%; 9/9), positive relationships (100%; 9/9), consultation impacts (89%; 8/9), appreciation for subjective experience (78%; 7/9), authentic caring and compassion (78%; 7/9), shared inquiry (67%; 6/9), and emotional support (67%; 6/9). Additionally, barriers to consultation quality were identified by 78% (7/9) of mental health consultants.

Ease of Access. Participants reported providing monthly, scheduled meetings with home visitors, as well making themselves available for unscheduled meetings. Participants described making themselves available through an open-door policy when on site, telephone/text messages, and email. Scheduled meetings typically were held in the supervisors or clinicians' offices, and unscheduled meetings were held in the clinicians' offices (if available).

"I meet with a home visitor once a month. It is almost always scheduled. We normally meet in the supervisor's office. It's normally during their supervision time, except they meet with them weekly, and I meet with them once a month."

"I've always prided myself on the fact that I can be available to people. I say I'm around in one or the other offices, three days a week. I've also made it clear that anytime you want to call or anytime you want to send a text or email about a situation, I will be happy to respond to you and encourage you to do that because you aren't set up to see me for another four weeks, but I am available. I say it to supervisors and workers."

"The reflective practice times are one hour per month and the consultation times are as needed. They know they can stop by my office to talk about specific cases, they can email me and set a specific time to talk about those cases, I allow [home visitors] to determine when those times are needed; or if I have reviewed an assessment or looked at a case note that they have entered in to family lives, and I see an area of concern, I would initiate that with them"

Positive Atmosphere. Clinicians described the consulting atmosphere as pleasant, laid-back, relaxed, safe, therapeutic, and encouraging.

"Very lighthearted, try to include laughter, and very positive. The cases themselves can be heavy and challenging, so I have done my best to create a culture of positive thinking within that hour focusing on the family's strengths, focusing on the worker's strengths, focusing on the supervisor's strengths. Not as much on the supervisor's strengths, but the supervisor is in there, and so the better the supervisor has with the worker, the better that it all goes. Even just affirming her role in the cases as well."

"It is very supportive, encouraging. Sometimes it is difficult what the families are facing. There aren't any great solutions for. It is supportive, sometimes it is heartbreaking."

Reflective atmosphere. Along with a general positive atmosphere, clinicians noted specifically that the consulting atmosphere was intentionally designed to be conducive to reflection. Clinicians described using open-ended, reflective questions to engage home visitors in reflection.

"I will often ask the home visitor what particular families first that they would like to discuss and we go from there. I want to make sure the home visitor is in control of that entire [consultation]. I want to make sure that they are engaged and not with me. So often times, we'll start with where they want to go, and from there, as families they might not have hit on, I find to be clinically helpful to discuss, I will bring those families up, if they haven't. I'm very big on using open-ended questions. Very reflective questions, things that would draw out more of the worker to be talking and thinking about things."

Strategies to maintain atmosphere. In addition to indicating that the consulting atmosphere was positive, clinicians described various efforts to maintain/improve the atmosphere. This includes changes to the physical space (e.g., arranging chairs, hanging pictures), as well as verbal and nonverbal strategies (e.g., active listening, using affirmation).

"The framework that I've laid down is a high level of respect, so we all respect each other. That promotes an open dialogue when you know you can speak and be respected and heard."

"Turning the cell phones off and keeping the door shut is really important, so it is a focused one-on-one time."

"It is also intentional where I sit. I don't sit behind my desk when I'm talking to them. I pull up a chair next to them to make sure they understand that this is something we are doing together as a team."

Resource Sharing. All participants reported providing resources to home visitors. Specific resources included strategies and techniques, written tools, general mental health guidance, and structured training.

Strategies and techniques. Clinicians stated that they provided resources related to strategies and techniques to home visitors using a variety of approaches including verbally and through modeling.

"If they have a difficult conversation they need to have we'll roleplay, model it. We'll talk through it ahead of time, and it makes them feel better about what they are going into. Just helping them process the whole experience about being a home visitor. It is different and unique."

"When I have a home visitor that has a client that has been diagnosed with bipolar disorder, and they're not currently on their medication, I'll let them know and give them information, sometimes verbally, written, or handout information on things to look out for and make sure they're not starting to cycle again."

Written tools. Clinicians reported that they provide a variety of written tools to support home visitors' work with families including, but not limited, handouts, checklists, websites, books, and worksheets. Tools are provided both in physical and electronic formats.

"Resources would be anything like handouts, worksheets, curriculum, honestly at my site at [site name], they have a lot of really good curriculum. The supervisors have been there a while, so they have a lot of good resources on things, but generally it might be evidence-based approaches, information on the given diagnosis, if it's kind of a more rare diagnosis they're not familiar with."

"Basically worksheets, handouts, presentations. There are at times online resources that I'll direct them to a particular website, books."

General mental health guidance. Clinicians described providing general mental health guidance to home visitors. This involved education, coaching and support related to mental health topics.

"Support is a huge resource. I do a lot of education on mental health and helping them understand what that can look like. I do offer some resources for if they have a specific mental health need."

"A time of psychoeducation in learning more about complexities of mental health and how that might impact their work with families, as well as providing that clinical lens that is unique to this position that they might not receive during their regular supervision time."

Structured training. Clinicians described their structured trainings provided as a resource for home visitors.

"In specific trainings I developed, I think I've done three trainings so far in the six months I have been there. I've been very intentional about asking them what they wanted the trainings to be focused on, so they created a list of six topics for me, and I've gone and prioritized based upon their current needs, and that is what I have based the trainings on."

"There is also a monthly training I do regarding various topics regarding mental health: screening, how to approach things like suicidal ideation, depression, anxiety, these types of things."

Power/Authority. Clinicians reported that minor power differentials may exist in MHC due to differences in education, experience, and licensure between clinicians and home visitors. Some clinicians are uncertain as to how they are viewed by home visitors. Clinicians prefer to be viewed as a resource, as opposed to an authority figure.

"I don't perceive that they see me as anyone who has any kind of 'power' over them or their work. I don't evaluate them. I'm pretty sure they know I don't evaluate them."

"I think sometimes initially when they come in, they are like, 'Oh, she's the licensed clinical social worker or she's the mental health consultant.' I think there is a little bit of not sure what that relationship looks like, in the initial stages. From the feedback I receive and from what I observe, I see people just being able to relate and just talk about themselves or their struggles."

"I don't believe they see me as their administrative supervisor. I don't know how. I often wonder how they view the power dynamic. I think they know I can do therapy or have a clinical license. I guess as far as educational standpoint, I think they know I have an education. I do have the supervisors come to me and ask questions or we just talk about things. I don't think they see me as an administrative supervisor, but I do think they see me as having some power."

Maintaining preferred power dynamics. Clinicians employee a variety of strategies including avoiding administrative supervisory activities (e.g., discussions of documentation, home visit completion, productivity), clearly communicating their role, building relationships, and demonstrating verbal and nonverbal evidence of equality.

"The very first time I meet with someone. When I started and the people that had already been there before. I remind them or inform them, I give them a handout on what my role is and what our meeting will generally look like, and I make sure I say my role is not administrative. We don't talk about tool completion or your home numbers or level changes."

"I look at this like a very even playing field and when I begin a home visitor, especially in the beginning I made sure to elaborate that. This is a group effort and that their opinion and their experiences matter just as much as the clinical piece that I'm bringing to this. I try to make it a team effort when we are exploring interventions, when we're wondering about different things and when we are reflecting on that. It very much feels like a team effort between them on that. I try to remove that power kind of thing."

Positive Relationships. Positive relationships were noted by all clinicians; however, some clinicians observed that the strengths of relationships varied across home visitors and that these relationships must be built (creating barriers for new clinicians). Overall, clinicians reported that positive relationships were important, if not essential, for consultation to succeed.

"I haven't had any concerns in my relationship with them."

"It varies from visitor to visitor in some ways because some people are much more open and willing to be self-aware, able to be vulnerable, and for others I think it is very hard. It kind of depends on their own view of the process and how comfortable they feel being somewhat vulnerable and being self-aware."

"I believe that at the beginning, it is a little slower and a little harder for new clinicians when they are coming in because you're asking the workers to be pretty vulnerable at times. It took a good three, four months to build up that trust and rapport. Now, I'm at the point that I do get a lot of reflection, personal feelings, things that come up, and they say it's very helpful to talk to me and get it off their chest, so to speak."

Strategies to build/maintain relationships. Clinicians described using a variety of strategies to build and/or maintain relationships with home visitors. These included, but were not limited to, listening, building rapport, finding common ground, and communicating openness and approachability.

"The listening is always really important. Just trying to come in, not with my own ideas but really trying to understand what this work means to each individual person. And how each individual person communicates with their families, works with their families, and what they enjoy and what they struggle with. It's all about listening, trying to clarify where they stand."

"Rapport building. When I came in January I didn't start meeting with home visitors and that reflective supervision until February, but really spending some time and getting to know them over rapport building. Letting them get to know me so they will feel comfortable, easing into this process. Also, I think it has been helpful when I've been able to provide interventions for them or help them guide to interventions and then to see them working for families. Earning that respect and trust with them. I think it is a top priority. Very important."

Consultation Impacts. Impacts of the consultation included evidence that home visitors are using techniques, home visitor empowerment, access to mental health expertise, and home visitor knowledge.

"I am noticing a lot of workers utilizing techniques or information I've given them, or suggestions."

"I've gotten feedback from people that when they leave my office they feel empowered that they can help families."

"I think they are often getting the mental health piece that I can offer and helps them understand why families might be doing things that they are doing. Let's face it, it's easier to handle some behavior that you don't feel as highly functional if you understand where that dysfunction comes from. Also, just helping them understand the different mental disorders, medications, and that is often something that, besides myself, I don't think an agency has that kind of experience."

Appreciation for Subjective Experience. Appreciation for subjective experience was reported by the majority of clinicians. Johnston and Brinamen (2012) describe appreciation for subjective experience within consultation as interaction strategies that communicate respect for the consultee and the family he or she serves. It encourages both parties to consider the experiences of others when examining situations described during consultation.

"We spoke about this situation from the home visitor's perspective, and she was sharing her frustration. So I went back to that: how do you think that felt for her in the moment? How did that feel for you in the moment? If you were to view that from a camera or video, objectively, and you saw this interaction. What would your suggestion be for that person? I go through that route to have them do their own problem solving and coming to it. She was able to do that."

"I think reflecting on… for the worker to reflect on what occurred in the home visit, reflecting on their own emotional feelings and thoughts. Their own thoughts about why they reacted the way they do but also have them reflect on how the mother/family/child was viewing or seeing the situation that was unfolding, to help them gain a perspective of how maybe their reaction or their intervention may have affected the family. Then wondering with the worker if a different intervention was utilized or a different interaction was utilized. How might that have impacted the family differently? Trying to have them see the range of cause and effect on perhaps their reaction or their inappropriate behavior directly impacted that family."

Authentic Caring and Compassion. The majority of clinicians provided evidence of authentic caring and compassion in their interactions with home visitors. This involves verbal and nonverbal responses that communicate empathy, genuine interest, and support (Johnstone & Brinamen, 2012).

"I try to keep things light, and I do use humor when appropriate. I think I also just show them respect, kindness, empathy, and listen to what they have to say. Not only really listen to what they say but think about it in a way they can tell I'm engaged and also able to lead them in a direction to solving a question or a concern they might have. I follow through too, it's important too."

"Building on the strengths they have, the intent they have, and the motivation they have. As I was saying in the last example, I know you are always looking out what is best for this family. I know you did this and this, so I know what you are saying is because you are trying to do your best and get the best positive outcome for this family. Always trying to acknowledge where that is coming from."

Shared Inquiry. Shared inquiry was described in responses from most clinicians. When shared inquiry is present in consultation, the clinician avoids serving solely as a teacher or expert but rather uses strategies that foster a consultee's reflection and self-discovery (Johnston & Brinamen, 2012; Brinamen et al., 2012).

"We talk about how/what they are thinking/feeling when they are at home visits. You said that seems awkward for you, can you tell me a little bit about what made that feel awkward? Can you help me understand what that looked like? Through that process, usually, they will have what I call an "ah-ha" moment as I didn't realize that's what made that feel awkward, I didn't realize I had a bias about fathers, and because he was standing there, I assumed that maybe he was thinking something negative and here he just wanted to hear what was going on."

"This is a group effort, and their opinion and their experiences matter just as much as the clinical piece that I'm bringing to this. I try to make it a team effort when we are exploring interventions, when we're wondering about different things and when we are reflecting on that. It very much feels like a team effort between them on that."

Emotional Support. Mental health consultants noted providing self-care strategies and support, helping home visitors to process traumatic events, offering encouragement, and facilitating reflection.

"A more experienced home visitor just had a situation where the child wasn't home, but the family member opened [the door], and all this marijuana smoke came out. It's a mom she had been working with for quite a while, and she had been caught off guard and surprised, she felt a little hurt by that as well. So we processed that, just through the feelings because it was very…it was obvious when she was talking about it, so I reflected back and gave her voice to those feelings. We processed through that those actions were not her fault because she felt she should have seen this coming or something like that."

"A lot of these cases are kind of working with victims of trauma or with moms or dads in really rough situations, and there could definitely be emotionally taxing components, and we want to make sure they feel open to talk about it and explore those feelings and know it's a healthy place to do that and make sure they feel comfortable to do that in their individual weekly supervisions to. I let them know that I'm open and available, so even if it's not a monthly or technical time that they're welcome to meet with me in my office if they have any concerns or anything they want to process."

Presence of Supervisor. The majority of clinicians discussed the impact of the supervisor on the quality of consultation with home visitors. Overall, perceptions of these impacts were mixed. Some clinicians described the supervisor's presence during consultation as a barrier. They stated that when the supervisor was present, clinicians perceived home visitors as less open due to fears of disciplinary actions. This feeling was not monolithic, and one clinician reported preferring the supervisor's presence. There were suggestions that supervisors participate in one-on-one consultations with clinicians. There appears to be variance in the extent to which supervisors participate in consultation with home visitors.

"If I had to choose a preference, I would like to have the supervisor present because I feel like it engenders overall communication and better understanding between people. I do understand some people find it a barrier."

"I do a couple of consultations without a supervisor. I think those go better in so far as the exchange between myself and the worker because there is more time to get to know the worker and the perspective of where they are coming from."

"I think if home visitors had a time when they met alone with a clinical consultant and brought their concerns without their supervisor present. And supervisors perhaps also met with clinical consultants on some sort of regular basis, formally and informally, would help."

Barriers to Consultation Quality. Barriers to quality included the severity of family needs, home visitors' education/experience, and uncertainty about the mental health consultant role.

"Sometimes I think [home visitors] are really uncomfortable, especially when it comes to mental health."

"Our families are in constant states of emergency. Yeah, the worker might have a really good script for talking to mom about how she didn't see her baby's cues last week, let's talk about that. She may go there having that script, and the mom might say I have an eviction notice and have to be out in two days. Out goes that script. Then we are talking about how to have the mom and the baby not end up on the street. There are all kinds of things that can happen with families, so the interventions we had with a family don't work out as we envisioned."

"There is so much more I could be doing and would like to be doing. It would be helpful to have some extra guidance on my end so I could help [home visitors] better."

Evidence of Consultation Quality – Mental Health Consultant Scenarios

In addition to open-ended questions, the clinician interviews included three scenarios to which clinicians responded. The scenarios asked clinicians to respond to situations in which home visitors came to them for support related to domestic violence, depression, and mental health diagnoses. Twenty-five responses (provided by nine mental health consultants) were analyzed using the framework (Ritchie & Spencer, 1994) method to identify evidence of consultation quality. Shared inquiry (68%; 17/25) and resource sharing (64%; 16/25) were identified in the majority of scenario responses. Additionally, appreciation for subjective experience was identified in nearly half (44%; 11/25) of responses.

Shared Inquiry. Clinicians described asking questions to understand the situation (e.g., diagnosis), encouraging reflection, validating and normalizing home visitor reactions, and collaborating with home visitors to develop plans/responses. Responses were consistent with descriptions of consultation quality provided in the literature, which suggest that consultants work with consultees collaboratively to develop shared explanations of events, understanding, and actions.

"First of all, we would talk about their feelings. How does it feel knowing that someone is in this situation, and they aren't willing to get help? Or what is it like knowing they shared that information with you but yet they aren't willing to take any of the help resources that you provided? We would process feelings, we would talk about other ways to come at it. How can you share information about healthy relationships? How can you help empower mom? Maybe she wants to get to eventually decide she wants to do something different. How can you help her know that there are resources for her safety and the baby's safety?"

"Can you help me understand how you think you aren't being effective? What are the areas you feel are impacted by the diagnosis that this parent has? We talk and explore that piece and then there might be some strategies in terms of understanding that diagnosis a bit better, understanding some symptoms or signs that could show you they are progressing or regressing in whatever state that they experience those symptoms. Then empowering them with how they can reach that parent."

Resource Sharing. Specific resources included referrals, strategies and techniques, tools, and mental health guidance/education.

Referrals. When responding to the scenarios, clinicians described providing local referrals as an aspect of resource sharing with home visitors.

"*We have a great place, YWCA, they do a lot of work with domestic violence. I would encourage her to give those referrals and offer to take the mom if necessary."*

"I would respond by talking to the worker about the client's right to self-determination and the importance of making appropriate referrals of a medical doctor who can do an evaluation or talking to the MOB about resources in the community to engage in counseling or to have a medical evaluation or an evaluation with a psychiatrist."

Strategies and techniques. When responding to the scenarios, clinicians described identifying specific strategies or techniques for home visitors to use during their interactions with families. Clinicians described the importance of providing strategies/techniques that were appropriate and considered other internal and external factors (e.g., family safety, legal obligations, diagnosis).

"If we were concerned about risk of suicide, obviously we would want to do safety planning around that and referrals. If there is no risk of suicide, we can only empower the mom. So maybe doing some activities, some skill building, doing some other positive things."

"Giving [the home visitor] practical information she can share with the mom regarding ways she can alleviate her depression. Talking about the difference between clinical depression and circumstantial depression."

Tools. When responding to the scenarios, clinicians described specific tools that they provided to home visitors for use with families who are facing domestic violence, depression, and mental health diagnoses.

"We have some handouts to give to the mom about if the child is witness to domestic violence what that does to the child's brain."

"The CESD or the EPDS are some good tools to start the conversation with mom."

Mental health guidance/education. Clinicians described providing mental health guidance and education to home visitors. Both general and diagnosis-specific education was noted.

"But I'd also assess for a psycho education: What does the worker understand about domestic violence and the complexities of domestic violence, and why someone may or may not leave?"

"I would talk to the HV about what depression looks like because that is pretty typical of someone who scores high and may not be willing or ready to talk about it. Talking with the home visitor about giving them some education about depression, what that looks like."

"But in general, when it comes to that I would probably provide information regarding the diagnosis and some signs and things to look out for. Some things they might want to consider."

Appreciation for Subjective Experience. Responses suggested that when responding to home visitors' mental health concerns, clinicians carefully consider the experiences and perspective of both the home visitor and the family.

"Let's think of what could be some reasons why mom is not [leaving a violent relationship]. Typically, that would be monetary, so then we have to talk about, from mom's point of view how important is to have a roof over your head and food on the table. It's helping the worker see it more from the mom's perspective. I'm trying to see it from the worker's perspective. The worker is trying to see it from the mom's perspective. We can come up with some reasons why mom is not doing what we would hope her to do."

"What is the worker's own views about a child living in that environment? Does the [home visitor], does she have some of her own thoughts that are either impacting by the way she would respond in this case and ask her to share those during reflective practice time."

Research question 3k: To what extent do home visitors view the consultation being received as relevant and useful in performing their role as a home visitor? (Model Expectation: Staff response provide evidence of relevance and usefulness)

Relevance and Usefulness of Mental Health Consultation

Telephone interviews were completed by 33 home visitors to examine the extent to which home visitors perceived consultation as relevant and useful in their work. Using the framework method (Richie & Spencer, 1994), themes were extracted from interview responses. For the purposes of this study, key themes were those mentioned by 40% or more of respondents. Frequencies are provided to present the percentage of home visitors mentioning each key theme. Overall, there was evidence that home visitors perceive MHC as relevant and/or useful. Specifically, 88% (29/33) of respondents described consultation as relevant or useful in their work with families. Home visitors reported that mental consultation supports their work by increasing their confidence, furnishing targeted resources for specific family needs, providing an additional perspective when reviewing cases, and offering access to specialized expertise.

Increased Confidence. Home visitors reported having increased confidence to engage families in services, especially when families suffered from specific challenges or had serious needs.

"It gives me a bit more confidence when I see that mom again. I have some other avenues to look at, some questions to ask to see if this works, and I've noticed having that extra little knowledge."

"[The clinician] empowers me and helps to think through how I would bring this up, how I would address this, what information or curriculum or referrals would I bring to help the family."

Targeted Resources for Family Needs. Home visitors identified MHC as providing access to resources for specific family needs. Home visitors described individual family issues to their clinician, and the clinician was able to provide support and resources targeted specifically for the families discussed during consultation.

"As far as being relevant to my families' particular needs, it is very relevant. I have not come across something [the clinician] has given to me where I'm thinking, 'Why has [the clinician] given me this?' As far as usefulness, [the clinician] has given me a lot of things in particular, with this family that suffers from schizophrenia and bipolar."

"It helps when I have clients that are in situations I have never encountered before. Right now I have a client that is planning to give her baby up for adoption. She is not due until June, so this client doesn't want to focus on child development or things I would normally go over. That is an obstacle just trying to figure out what I can do with her week after week. In situations like that, that are new to me, I appreciate having my clinician's feedback."

Additional Perspective. Home visitors noted that through MHC they have access to additional perspectives from their clinician. These perspectives were beneficial to home visitors because of the clinicians' education, expertise, and experience. Meeting with the clinicians encouraged home visitors to think differently about their cases and to try new/different approaches where appropriate.

"We aren't mental health therapists. We are there to support for mom, and it can be helpful to see what [the clinician] thinks about some of the things going on with mom's behavior. It can be explained when [the clinician] talks about some of the mental health problems and is the most helpful part."

"It helps give a different perspective than some things I'm not thinking about. [The clinician] gives me advice to where to go if I'm lost with what to do with the family next."

Specialized Expertise. Due to their education and background, clinicians provide home visitors with access to specialized expertise that is relevant for addressing a variety of family needs. Expertise related to mental health was identified most commonly.

"[The clinician's] knowledge and experience. It is very relevant because we work with a lot of mental health, even if it is just post-partum, even if they don't have a history of mental health. Being able to talk to someone about it who knows it really well, who has experienced post-partum herself as a mom and who has worked with women who have had it. Even other mental health issues, [the clinician] has seen it all. I find it to be relevant in our job, and she has so much knowledge that it is nice we are able to have her as someone to go to."

"It is very relevant because it is a mental health clinician, and we are dealing with a lot of mental health issues. Many of them have come from abusive backgrounds themselves or parents that were substance abuse, incarcerated. It is nice to have somebody who is a professional because we aren't. They give good insight."

B. Sample

Research Question 1

The sample was drawn from the full population of home visitors who receive MHC at HFI sites serving MIECHV-funded families (using the MIECHV MHC model). The evaluation team provided a survey link to the DCS designee who forwarded the link to HFI Site Managers for administration to the home visitors. Participants received a link to electronic surveys via email. Survey links were sent to 154 home visitors receiving MHC, and 98 completed at least one scale item (response rate = 63.6%). The majority of participants were female (97%; $n = 97$), and three (3%) were male. Participants identified as white (74%; $n = 70$), black or African American (24%; $n = 23$), multiracial (1%; $n = 1$), and American Indiana or Native Alaskan (1%; n = 1). Eighty-eight (88%) were non-Hispanic, and 12% ($n = 12$) were Hispanic. Years of home visiting varied among participants: 5-10 years (21%; $n = 21$), less than one year (21%; $n = 21$), 1-2 years (20%; $n = 20$), more than 10 years (19%; $n = 19$), 3-5 years (18%; $n = 18$). Respondent age varied: 20-29 (27%; $n = 27$), 40-49 (27%; $n = 27$), 30-39 (25%; $n = 25$), 50-59 (16%; $n = 16$), and 60 or older (5%; $n = 5$). Most participants held a bachelor's degree (70%; $n = 69$), followed by some college, no degree (9%; $n = 9$), master's degree (8%; $n = 8$), associate's degree (6%; $n = 6$), high school/GED (4%; $n = 4$), some high school, no degree (1%; $n = 1$), vocational technical (1%; $n = 1$) and professional degree (1%; $n = 1$). The largest group of responded identified other (28%; $n = 32$) as their field of study, followed by social work/social welfare (24%; $n = 28$), psychology (22%; $n = 25$), child development (12%; $n = 14$), education (11%, $n = 13$) early childhood education (6%; $n = 7$), and nursing (3%; $n = 3$).

Home Visitor Interviews. Interview responses were drawn from a stratified purposeful sample of 90 current home visitors who received MHC at HFI sites serving MIECHV-funded families. The qualitative analysis utilized semi-structured interviews of 33 current home visitors. DCS/HFI staff provided the evaluation team with a list of all current home visitors receiving the enhancement during the evaluation period, and from these names, a sample was selected using SPSS. Home visitors receiving the enhancement of MHC for less than three months were excluded from the sample. The interviews focused only on staff members currently employed as home visitors. Years of home visiting varied among participants: 3-5 years (36%; *n* = 12), less than one year (21%; *n* = 7), more than 10 years (18%; *n* = 6), 1-2 years (15%; *n* = 5), and 5-10 years (9%; *n* = 3). The majority of participants served both MIECHV-funded and non-MIECHV-funded families (67%; *n* = 22), and 33% (*n* = 11) served only MIECHV-funded families. Participant county/program of employment was proportional to the total number of home visitors per site: Site 1 (12%; *n* = 4), Site 3 (6%; *n* = 2), Site 4 (18%, *n* =6),), Site 5 (3%; *n* = 1), Site 6 (18%; *n* = 6), Site 7 (30%; *n* = 10), Site 8 (6%; *n* = 2), and Site 9 (6%; *n* = 2)

Mental Health Consultant Interviews. Interview responses were obtained from all nine mental health consultants who provided MHC at HFI sites serving MIECHV-funded families during the Spring 2018. The sample consisted of eight females (89%) and one male (11%). Participants represented all nine enhancement sites (with one clinician serving two Marion County sites, two clinicians serving Lake County, and the remaining six clinicians serving one site each).

C. Non-equivalent Comparison Group

A non-equivalent comparison group was employed for RQ1; no comparison groups were utilized for RQ2 or RQ3. The non-equivalent comparison group was drawn from the population of home visitors who did not receive MHC and serve non-MIECHV-funded families at HFI sites not serving MIECHV-funded families. The evaluation team provided a survey link to the DCS designee who forwarded the link to HFI Site Managers for administration to the home visitors. Participants received a link to electronic surveys via email. Survey links were sent to 260 home visitors not receiving MHC, and 178 completed at least one scale item (response rate = 68.5%). The majority of participants were female (98%; *n* = 179), and three (2%) were male. Participants identified as white (95%; *n* = 164), black or African American (3%; *n* = 5), multiracial (1%; *n* = 2), and American Indiana or Native Alaskan (1%; *n* = 2). One hundred sixty four (92%) were non-Hispanic, and 8% (*n* = 15) were Hispanic. Years of home visiting varied among participants: more than 10 years (38%; *n* = 69), 1-2 years (23%; *n* = 41), 3-5 years (17%; *n* = 30), 5-10 years (15%; *n* = 27), and less than one year (8%; *n* = 14). Respondent age varied: 40-49 (25%; *n* = 45), 50-59 (24%; *n* = 43), 30-39 (22%; *n* = 40), 20-29 (20%; *n* = 37), and 60 or older (9%; *n* = 17). Most participants held a bachelor's degree (53%; *n* = 95), followed by some college, no degree (18%; *n* = 33), associate's degree (13%; *n* = 23), high school/GED (9%; *n* = 16), master's degree (3%; *n* = 6), vocational/technical training program (3%; *n* = 5) some high school, no degree (1%; *n* = 1) doctorate degree (1%, *n* = 1), and professional degree (1%; *n* = 1). The largest group of responded identified other (29%; *n* = 57) as their field of study, followed by social work/social welfare (26%; *n* = 41), psychology (16%; *n* = 32), child development (16%; *n* = 32), early childhood education (16%; *n* = 32), education (10%; *n* = 19), and nursing (4%; *n* = 7). The majority of participants were female (98%; *n* = 179), and three (2%) were male. Participants identified as white (95%; *n* = 164), black or African American (3%; *n* = 5), multiracial (1%; *n* = 2), and American Indiana or Native Alaskan (1%; *n* = 2). One hundred sixty four (92%) were non-Hispanic, and 8% (*n* = 15) were Hispanic. Years of home visiting varied among participants: more than 10 years (38%; *n* = 69), 1-2 years (23%; *n* = 41), 3-5 years (17%;

n = 30), 5-10 years (15%; *n* = 27), and less than one year (8%; *n* = 14). Respondent age varied: 40-49 (25%; *n* = 45), 50-59 (24%; *n* = 43), 30-39 (22%; *n* = 40), 20-29 (20%; *n* = 37), and 60 or older (9%; *n* = 17). Most participants held a bachelor's degree (53%; *n* = 95), followed by some college, no degree (18%; *n* = 33), associate's degree (13%; *n* = 23), high school/GED (9%; *n* = 16), master's degree (3%; *n* = 6), vocational/technical training program (3%; *n* = 5) some high school, no degree (1%; *n* = 1) doctorate degree (1%, *n* = 1), and professional degree (1%; *n* = 1). The largest group of responded identified other (29%; *n* = 57) as their field of study, followed by social work/social welfare (26%; *n* = 41), psychology (16%; *n* = 32), child development (16%; *n* = 32), early childhood education (16%; *n* = 32), education (10%; *n* = 19), and nursing (4%; *n* = 7). The majority of participants were female (98%; *n* = 179), and three (2%) were male. Participants identified as white (95%; *n* = 164), black or African American (3%; *n* = 5), multiracial (1%; *n* = 2), and American Indiana or Native Alaskan (1%; *n* = 2). One hundred sixty four (92%) were non-Hispanic, and 8% (*n* = 15) were Hispanic. Years of home visiting varied among participants: more than 10 years (38%; *n* = 69), 1-2 years (23%; *n* = 41), 3-5 years (17%; *n* = 30), 5-10 years (15%; *n* = 27), and less than one year (8%; *n* = 14). Respondent age varied: 40-49 (25%; *n* = 45), 50-59 (24%; *n* = 43), 30-39 (22%; *n* = 40), 20-29 (20%; *n* = 37), and 60 or older (9%; *n* = 17). Most participants held a bachelor's degree (53%; *n* = 95), followed by some college, no degree (18%; *n* = 33), associate's degree (13%; *n* = 23), high school/GED (9%; *n* = 16), master's degree (3%; *n* = 6), vocational/technical training program (3%; *n* = 5) some high school, no degree (1%; *n* = 1) doctorate degree (1%, *n* = 1), and professional degree (1%; *n* = 1). The largest group of responded identified other (29%; *n* = 57) as their field of study, followed by social work/social welfare (26%; *n* = 41), psychology (16%; *n* = 32), child development (16%; *n* = 32), early childhood education (16%; *n* = 32), education (10%; *n* = 19), and nursing (4%; *n* = 7).

D. Detailed Discussion and Interpretation

Research Question 1

RQ1 explored the extent to which participation in the MHC enhancement influenced home visitors' perceived self-efficacy, competence, access to resources, levels of secondary trauma and compassion satisfaction, and training quality. The results suggest that home visitors participating in the enhancement experience most of the aforementioned job-related outcomes similarly to their peers who do not participate in the enhancement, with the exception of access to resources. This suggests a potential relationship between participation in the enhancement and increased access to home visiting resources, specifically resources and support from professionals other than supervisors that are related to family substance use, stress and mental health, healthy adult relationships, and parenting to support child development. This finding is consistent with a key objective of the enhancement, which is to provide individualized resources and guidance to home visitors.

The primary analysis examined group differences (MHC vs. Non-MHC) in ratings of training quality, self-efficacy, reflective supervision self-efficacy, competence, compassion satisfaction, burnout, and secondary traumatic stress. When home visitor education and length of time in position were controlled, no significant differences were observed between groups. As noted in *Section VIII. C. Challenges* (pg 65), pre-treatment equivalency of the two groups could not be guaranteed due to design limitations, and as such, it is likely that other factors had some influence on ratings of job-related outcomes. Based on open-ended responses to the *IN MIECHV Survey for HFI Home Visitors*, home visitors not receiving the enhancement have access to support from a variety of professionals in their sites, including, but not limited to, program

managers and directors, their colleagues, and therapists. Moreover, the helpfulness of HFI supervisor guidance, which was rated similarly by both groups (i.e., no significant differences), may also contribute to similar ratings of outcomes. Variance in implementation fidelity across sites (discussed under RQ3) may contribute to the results.

While differences were not observed for the majority of staff outcomes, significant differences between groups were noted for availability of resources: frequency of supervisor guidance, access to support from professionals other than their supervisor, and receipt of support from other professionals. Should a relationship between the enhancement and access to resources exist for home visitors, it would be consistent with the enhancement's objectives. Home visitors receiving MHC reported significantly greater frequency of supervisor guidance related to stress and mental health ($U = 6528.50$, $z = -30.6$, $p = .002$) and healthy adult relationships ($U = 6807.50$, $z = -2.26$, $p = .024$). This suggests that a relationship may exist between participation in the enhancement and more frequent guidance from supervisors related to stress and mental health and healthy adult relationships. Significant differences in frequency of guidance were not observed for substance use or parenting to support child development. While there may be a relationship between frequency of supervisor guidance and participation in the enhancement, there was no relationship between participation in the enhancement and ratings of the helpfulness of supervisor guidance. These findings are consistent with the model specifications and contractual obligations, which require the supervisor to participate in consultation activities with the clinician and home visitor. Opportunities for guidance from the supervisor should increase for home visitors participating in the enhancement. Observed differences in stress and mental health and healthy adult relationship guidance are consistent with mental health consultant interview responses, which indicated a focus on these areas (particularly mental health topics) during consultation activities.

The results revealed a significant relationship between participating in the enhancement and 1) having access to support from professionals other than one's supervisor and 2) actually receiving support from professionals other than one's supervisor. Home visitors who receive MHC were significantly more likely to have access to support from professionals other than their supervisor in the areas of substance use ($\chi^2(1, N = 68) = 11.68$, $p = .001$), stress and mental health ($\chi^2(1, N = 80) = 16.08$, $p < .001$), healthy adult relationships ($\chi^2(1, N = 62) = 8.89$, $p = .003$), and parenting to support child development ($\chi^2(1, N = 68) = 4.81$, $p = .028$). Home visitors who receive MHC were significantly more likely to report actually receiving support from professionals other than their supervisor in the areas of substance use ($\chi^2(1, N = 46) = 5.80$, $p = .016$), stress and mental health ($\chi^2(1, N = 65) = 4.58$, $p = .032$), and healthy adult relationships ($\chi^2(1, N = 44) = 6.22$, $p = .013$). When asked to specify the professions providing support, home visitors receiving MHC identified clinicians most frequently, followed by other supervisors. These findings suggest a possible relationship between participation in the enhancement and increased access to and receipt of support from other professionals, with the clinician most commonly providing this support. This relationship is consistent with the objectives of enhancement and interview responses provided by home visitors and mental health consultants. It is theorized that through MHC, home visitors should have greater access to support from professionals other than their supervisor and they should be receiving support from these individuals.

Research Question 2

Telephone interviews were completed for 33 home visitors to explore to what extent aspects of MHC were perceived to be associated with job retention, stress/burnout, and job satisfaction.

Contributors to Stress and Burnout. The most common themes involved client issues (64%; 21/33), caseloads (62%, 21/34), and job expectations (53%; 18/34). For many home visitors, the

client issues they encounter when working with families created stress and burnout. Home visitors reported stress and burnout as the result of secondary trauma, perceived limited impacts, and disengaged families. In the majority of interviews, caseloads were identified as a contributor to stress and burnout. The size of caseloads and individual family needs/requirements were described by participants as contributing to stress and burnout. Approximately half of home visitors identified job expectations as a cause of work-related stress and/or burnout. Two key stress-inducing expectations described by home visitors included paperwork/documentation and travel.

Support for Mitigating Stress and Burnout. Non-MHC resources (94%; 31/33) were the most commonly described support, followed by MHC resources (48%; 16/33) and individualized self-care strategies (45%; 15/33). The most commonly occurring non-MHC-related resources were supervisor support/relationships, Employee Assistance Program (EAP), supportive work atmosphere, employee programs, and professional development. Support from the clinician was the most commonly referenced aspect of MHC. A variety of self-care strategies were identified, including getting an appropriate amount of sleep, taking short breaks between home visits, creating personal work-life balance boundaries, utilizing Paid Time Off (PTO), and participating in hobbies.

Job Satisfaction Promoters. The most common themes included non-MHC professional development and training (i.e., not related to the enhancement) (58%; 19/33), positive management/supervisor interactions (52%; 17/33), opportunity to make a difference (48%; 16/33), and flexible schedule (45%; 15/33). The most commonly described Non-MHC resources were professional development provided by sites, outside training opportunities that were shared by sites, and employer-supported continuing education opportunities. Interactions that communicated appreciation, provided recognition, encouraged input in decision making, and conveyed empathy were identified as positively influencing satisfaction. Staff described watching families make progress and meet milestones, sharing in families' successes, making connections with families, and meeting and interacting with new people. The flexibility of working as a home visitor bolstered job satisfaction for interview participants. The schedule allows staff to take PTO when needed, create their own work schedules, make time for their own children/families, and work in multiple settings.

Job Satisfaction Barriers. The most common barriers to job satisfaction included compensation (36%; 12/33) and caseloads (27%; 9/33). Home visitors described low base pay and limited opportunities for bonuses and salary increases as playing a negative role in job satisfaction. Caseload size and completion expectations/service requirements were identified as barriers.

Job Retention Promoters. The most commonly observed themes included dedication to home visiting (70%; 23/33), support from colleagues (45%; 15/33), non-MHC professional development and training (42%; 14/33), and flexible schedules (39%; 13/33). The majority of home visitors interviewed described dedication to their work as a reason for remaining employed as a home visitor. They described relationships with the families they serve, positive program impacts, passion for helping others, sharing in family successes, and the feeling of making a difference. Support from colleagues was described by nearly half of respondents. They noted that support from their supervisors, other management, and their peers. Professional development and training was described by home visitors as promoting job retention. Home visitors reported that these opportunities prepared them to be more successful in their work, improving their likelihood of remaining in their position. Over one-third of respondents mentioned flexibility in relation to job retention. The flexible schedule allows staff to take PTO to support work-life balance, create their own work schedule, fulfill parenting obligations, and work in multiple settings.

Job Retention Barriers. Home visitors (21%; 7/33) described low pay and limited opportunities for advancement and salary increases as playing a role in job retention. Travel costs and associated reimbursements were described as barriers. Home visitors (15%; 5/33) noted that caseload size, travel associated with serving one's caseload, stress related to completion requirements, and needs/risks associated with individual families may negatively influence retention.

Research Question 3

A fidelity study was completed that 1) incorporated a descriptive design using existing administrative data to explore the program outputs and 2) utilized a qualitative design to explore staff perceptions of MHC implementation. Results drawn from program outputs were mixed, suggesting that individual sites implement the MHC enhancement with varying levels of fidelity. Data show inconsistencies in clinician retention across sites, which adversely affects sites' ability to meet this model expectation. Staff interview responses provided evidence of implementation quality and relevance usefulness.

RQ3a examined the extent to which MIECHV-funded families were reviewed by the clinicians for high risk and MHC. Clinical risk status was assigned for 56% (n = 1056) of families, a clinical risk status was not assigned for 44% (n = 825) of families.

Research questions 3b, 3e, and 3h explored family participation in MHC activities. The results revealed that while families received a variety of services across their enrollment, these activities were offered inconsistently and model specifications were not met. For January 2016 to December 2017, 7721 family-linked MHC services were provided. A total of 1927 families were served at least one time, and the number of families served monthly through mental health consulting activities ranged from 11 to 345 (M = 250.58, SD = 78.89). The number of services provided per family ranged from 1 to 40 (M = 4.01, SD = 5.55). The number of months during which services were provided per family ranged from 1 to 21 (M = 3.12, SD = 3.49). For the 998 MIECHV-funded families, 29% (n = 289) of families were reviewed through MHC services during all months enrolled. These findings suggest that while a variety of services are provided to families, Family-Specific Secondary Activities are offered inconsistently across sites. Most families were not reviewed and followed monthly.

RQ3c examined the extent to which home visitors who serve MIECHV-funded families engaged in consultation at least once per month. No site provided consultation to all home visitors during all of the months examined; however, individual sites met the model expectation during individual months. Across all sites, the number of home visitors receiving consultation per month ranged from 0 to 80 (M = 54.67, SD = 19.95), while the number of home visitors employed during the study period ranged from 109 to 139 (M = 123.29, SD = 6.50). The number of home visitors receiving consultation was lower than the number of home visitors employed, indicating that at least a portion of home visitors were not receiving monthly consultation with the clinician. These results suggest that consultation activities were offered inconsistently at most sites. Furthermore, in spite of data limitations related to this sub-question, it appears that model specifications were not met.

RQ3d examined the extent to which clinicians provided training at least bi-monthly. During 2016, trainings were offered at least bi-monthly at one site (11%). During 2017, trainings were offered at least bi-monthly at three sites (33%). The results demonstrate that the majority of home visitors are not receiving the amount of training dictated by the model.

RQ3f examined the extent to which home visitors who serve MIECHV-funded families engaged in reflective practice at least once per month. Overall, data suggest that model specifications for reflective practice were not met during the evaluation period. Only a small portion (11%, n = 18)

of home visitors received monthly reflective practice during all months employed. While data concerns related to this question placed limitations on the conclusions that may be drawn from this analysis, supplemental analyses provided further evidence that reflective practice is offered inconsistently across sites.

RQ3g examined the extent to which home visitors who serve MIECHV-funded families met with their clinician at least once per month. No site provided meetings to all home visitors during all of the months examined; however, individual sites met the model expectation during individual months. Across all sites, the number of home visitors meeting with their clinician per month ranged from 1 to 111 (M = 82.88, SD = 26.61), while the number of home visitors employed during the study period ranged from 109 to 139 (M = 123.29, SD = 6.50). The number of home visitors meeting with their clinician was lower than the number of home visitors employed, indicating that at least a portion of home visitors were not receiving monthly meetings with the clinician. In spite of data limitations related to this sub-question, findings suggest that model expectations are not being met.

RQ3i examined the extent to which supportive home visits and shadowing visits were provided. From January 2016 to December 2017, 43 supportive home visits and 17 shadowing visits were provided. No model expectations exist for supportive home visits and shadowing; these process data were collected to support implementation planning and future evaluations.

RQ3j examined the extent to which home visitors' and mental health consultants' descriptions of MHC provided evidence of quality. Overall, home visitor and mental health consultants provided evidence of quality when describing MHC. Key themes aligned with characteristics of consultation quality from the literature and/or Indiana model expectations. The majority of home visitors noted ease of access, resource sharing, positive consultant-consultee relationships, clinician cultural awareness, reflective atmosphere, and shared inquiry when describing MHC. Mental health consultants referenced ease of access, positive atmosphere, resource sharing, power/authority, positive relationships, consultation impacts, appreciation for subjective experience, authentic caring and compassion, shared inquiry, and emotional support when asked to describe the enhancement. In addition to open-ended questions, the clinician interviews included three scenarios to which clinicians were asked to respond. Shared inquiry and resource sharing were identified in the majority of scenario responses. Appreciation for subjective experience was identified in nearly half of responses.

RQ3k provided evidence that home visitors perceive MHC as relevant and/or useful. Most commonly, home visitors reported that mental consultation supports their work by increasing their confidence, furnishing targeted resources for specific family needs, providing an additional perspective when reviewing cases, and offering access to specialized expertise.

E. Limitations

Limitations are described in *Section VIII. C. Challenges*, page 65.

VIII. EVALUATION SUCCESSES, CHALLENGES, AND LESSONS LEARNED

A. Strategies That Facilitated Evaluation Implementation

The evaluation was implemented as a partnership between Diehl Consulting Group and state-level HFI leadership, with support from site managers, other program staff, and the database provider. The FY2016 evaluation utilized state- and site-level HFI leaders as the conduit through which evaluation instruments were administered to home visitors. These procedures increased buy-in and participation from staff. Members of the evaluation team met the HFI site managers from vendor agencies serving MIECHV-funded families to share information about the evaluation and to gain additional perspectives about the program sites. Site managers and staff

were able to share data collection challenges with the evaluation team and to learn about proposed methods. State-level leaders were heavily involved in the evaluation process and met with the evaluation team at least monthly. The evaluation utilized Secondary Activity Reports recorded by mental health consultants and housed in the FamilyWise system. Exports of required data were readily available from the database provider, and state HFI leadership facilitated interactions between the evaluation team and the database vendor and provided contextual support for data requests.

B. Evaluation Successes

The FY2016 evaluation provided the first opportunity for Indiana to examine the extent to which the localized model is being implemented with fidelity using clinicians' Secondary Activity Reports. Quality of implementation was also utilized to examine fidelity. The evaluation has provided Indiana with the data necessary to identify variations in implementation at the site level across multiple fidelity criteria. The evaluation benefited from strong buy-in from state leadership, site leadership, and home visiting staff. Leadership provided feedback and support for evaluation planning and implementation. Leaders facilitated the data collection process by administering survey links and securing contact information for interviews. State leadership supported analysis and reporting by reviewing data and providing feedback on preliminary results. Finally, as demonstrated by acceptable response rates (> 60%), home visiting staff (including those not participating in the enhancement) were responsive when solicited to participate in the evaluation.

C. Challenges

Issues uncovered in the review of Secondary Data Reports created challenges for the evaluation. Upon receipt of data, the evaluation team learned that home visitors were not linked systematically to the Secondary Activity Reports. To address these challenges, the evaluation team extracted home visitors' names (where applicable) from text variables in the Secondary Activity Report or used family ID numbers to link home visitors to Family Specific Secondary Activities. While these approaches were largely successful, the associated home visitor could not be identified in all MHC activities, which may have resulted in underreporting of home visitor participation in MHC. To mitigate these limitations, supplemental analyses were completed to allow findings to be triangulated. Due to the length of the evaluation planning and approval process, only three months were available for FY2016 data collection activities, limiting the feasibility of more rigorous designs for RQ1. This short data collection window may have inadvertently placed burdens on home visiting staff and created participation barriers. To address these challenges, the evaluation team worked closely with state leadership to ensure that evaluation activities were implemented using the least intrusive procedures. Health Resources and Services Administration (HRSA) and Institutional Review Board (IRB) approval were obtained specifically for RQ1 prior to full study approval to administer surveys in February 2018. Finally, it is possible that the staff outcome scales selected for RQ1 were inadequate for staff receiving this type of consultation, which would be consistent with current research that has identified deficiencies in instruments used in the mental health consultation field (e.g., Watson et al., 2016).

D. Adherence to Proposed Plan

The FY2016 evaluation was completed in adherence to the approved evaluation plan. No deviations were made to the design, evaluation questions, data collection instruments or procedures, or timeline. Additional analyses were completed to supplement the analytic strategies identified in the evaluation plan to 1) address limitations in the data and/or 2) respond

to feedback/questions posed by state leadership following reviews of preliminary findings. Where employed, supplemental analyses are identified and rationale provided in the results section.

IX. CONCLUSIONS, IMPLECATION OF FINDINGS, AND RECOMMENDATIONS

A. Key Findings

The FY2016 evaluation revealed that home visitors participating in the enhancement experience most of the job-related outcomes examined by the study similarly to their peers who do not participate in the enhancement, with the exception of access to resources, including increased access to their supervisor. This may suggest a relationship between participation in the enhancement and increased access to home visiting resources, specifically resources and support from professionals other than supervisors that are related to family substance use, stress and mental health, healthy adult relationships, and parenting to support child development.

Home visitors face a variety of job-related factors that influence stress and burnout: Issues with the clients they serve (e.g., secondary trauma, limited perceived impacts, and family disengagement), the size and difficulty of their caseloads, and paperwork/documentation and travel expectations. Fortunately, they described a variety of resources that are available to mitigate the effects of stress and burnout. These included general resources/conditions provided by their sites (e.g., supervisor support, EAP, supportive climate, and programming), their clinician provided through MHC, and individually-developed self-care strategies. Similar factors influence job satisfaction, with compensation and caseloads serving as barriers. Professional development, positive interactions with management/supervisors, the opportunity to make a difference, and flexible scheduling were identified as promoting satisfaction. Ultimately, in spite of some dissatisfaction with their compensation and caseloads, home visitors opt to remain in their positions mainly due to their dedication to the work, along with support with colleagues, flexible schedules, and professional development opportunities. Based on these findings, the relationship between MHC and retention appears to be indirect, with home visitors perceiving it as a resource for stress and burnout.

Program sites varied in the extent to which they offered the enhancement with fidelity, with the majority of sites not meeting model expectations for family clinical risk assignment, monthly family reviews, monthly consultations for home visitors, bi-monthly home visitor training, monthly reflective practice, and monthly clinician meetings. Additionally, the data show inconsistencies in mental health consultant retention across sites, which adversely affects sites' ability to meet model expectations. Overall, home visitor and mental health consultants provided evidence of quality when describing MHC. Key themes uncovered in the data aligned with characteristics of consultation quality from the literature (e.g., Johnston & Brinamen, 2012) and/or Indiana model expectations. There was evidence that home visitors perceive MHC as relevant and/or useful. Most commonly, home visitors reported that MHC supports their work by increasing their confidence, furnishing targeted resources for specific family needs, providing an additional perspective when reviewing cases, and offering access to specialized expertise.

B. Implications of Findings

Findings from RQ1 suggest that a relationship may exist between participating in the enhancement and access to and receipt of resources and support from professionals other than supervisors that are related to family substance use, stress and mental health, healthy adult relationships, and parenting to support child development. Quantitative and qualitative results may demonstrate that mental health consultants serve as a valuable addition to HFI programming by providing additional resources and support to home visitors alongside their HFI supervisor.

Findings suggest that home visitors in enhancement sites may have increased access to their supervisor, which is consistent with the model design. Clinicians may provide added value by supplementing the resources provided by other staff and/or fulfilling a resource-provider role that is normally occupied by other staff who may be less equipped to provide quality resources. The study found no relationship between participation in the enhancement and home visitors' perceived self-efficacy, competence, levels of secondary trauma and compassion satisfaction, and training quality. Because the enhancement is theorized to demonstrate impacts in these areas, it is possible that home visitors are not receiving consultation services aligned with these outcomes. Moreover, fidelity concerns may have limited the extent to which these outcomes should be reasonably expected.

RQ2 provided new insights into the ways in which home visitors experience stress, burnout and job satisfaction, along with other factors influencing job retention. The relationship between MHC and retention appears to be indirect, with home visitors perceiving their clinician as a resource for stress and burnout. Specifically, when combined with other supports available to home visitors, meeting with their clinician appears to have some impacts on how home visitors cope with client issues, caseloads, and challenging job expectations. Participation in consultation may indirectly contribute to the supportive workplaces and non-MHC professional development opportunities cited by home visitors as contributing to job retention. Given the possible relationship between participation in the enhancement and increased access to supervision, the potential for MHC to support outcomes linked with supervision may be considered. Data suggest job-related benefits of MHC for home visitors who are prone to stress and burnout.

The MHC enhancement has not been implemented with fidelity to the model across all sites. Some families and home visitors do not receive the level of service dictated by the model. Site-level findings demonstrate inconsistent implementation in the areas of clinical risk assignment for families, monthly family reviews, monthly consultation, bi-monthly training, monthly reflective practice, and monthly clinician meetings. Clinician retention emerged as a concern across sites, which likely impacted sites' ability to meet model expectations during the evaluation period. The literature suggests that fidelity concerns may explain why interventions that performed well in research environments fail to achieve desired results when employed in real-life conditions (Breitenstein et al., 2010; Fixsen et al., 2005; Mihalic, 2004). In practice, diminished fidelity of implementation can limit program outcomes, causing fruitful interventions to appear ineffective (Breitenstein et al., 2010). These factors likely influenced the system, site, home visitor, and family outcomes reported in the FY2016 and prior studies of the enhancement.

While concerns related to model adherence were noted, there appears to be evidence that consultation activities between home visitors and clinicians are implemented with quality. Both home visitor and clinician interview responses suggest that MHC aligns with key indicators of consultation quality. Staff interview responses provided evidence of positive relationships, ease of access to the clinicians, a consultation atmosphere that is conducive to reflection, resource sharing, shared inquiry when examining cases, appreciation for the subjective experiences, authentic caring and compassion, emotional support, and cultural awareness, which are consistent with the model's theory of change. Home visitors reported that MHC supports their work by increasing their confidence, furnishing targeted resources for specific family needs, providing an additional perspective when reviewing cases, and offering specialized expertise. Consistent with the theory of change, the findings suggest that the clinicians serve as a source of high quality resources, facilitate reflection, and provide support to home visitors who consistently face emotionally challenging situations in their work with families. As consultation improves, the quality of home visiting services are theorized to increase.

C. Recommendations

1. Database Modification - Secondary Activity Reports: As Indiana replaces its current data system, consideration may be given to expanding Secondary Activity Reports functionality to link home visitors to the Secondary Activities (Family-Specific and Non-Client) with which they are associated. Doing so would allow improved tracking and evaluation of fidelity criteria related to home visitor access to MHC. Consideration may be given to a module that logs clinicians' contact with home visitors independent of Secondary Activities.

2. Review of Model Expectations and Data Collection Requirements with Key Staff: The evaluation revealed the model is implemented inconsistently across sites and identified the specific model expectations were not met at the site level. State leaders are encouraged to explore the findings in greater detail with key site staff to contextualize the results and to determine areas in which modifications to site-level implementation and/or model expectations are warranted. Consideration may also be given to the feasibility of site-level adherence to model expectations, given current staffing. Staff should review clinician data entry guidelines to ensure all requirements are aligned with model expectations. As needed, data entry training should be provided to clinicians and other staff entering Secondary Activity Reports.

3. Ongoing Fidelity Monitoring: Due to the implementation inconsistencies identified by the fidelity study, 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).

4. Infrastructure to Facilitate Resource Sharing: The results suggest that there may be a relationship between home visitor participation and increased access to resources. Consideration may be given to strategies that promote continued excellence and ongoing improvement in this area. Infrastructure improvements to facilitate the identification, maintenance, and sharing of quality resources may be considered. Clinician feedback should be solicited and incorporated into enhancements. Future evaluations may consider examining further the barriers and supporting factors experienced by clinicians as they share resources, as well as the home visitor perceptions of resource needs.

5. Strategies to Foster Home Visitor Dedication: Home visitors overwhelmingly cited dedication to their work as a reason they remained in their position. As applicable, MHC should be utilized to promote home visitor dedication by continuing to empower home visitors to succeed in their work with families, provide resources to support their work, and alleviate barriers that contribute to stress and burnout. Successful program components identified in the FY2016 evaluation should be continued and expanded, as applicable.

X. PLANS FOR DISSEMINATION OF EVALUATION FINDINGS

Select sections of this report will be included in Indiana's MIECHV X10MC29469 Formula Grant Final Report. Indiana will post a copy of the approved X10MC29469 Formula Grant Final Report on the Indiana MIECHV website, and share with LIAs, INHVAB and other state partners by March 2019. Indiana intends to present findings from the FY16 Evaluation at The Institute for Strengthening Families and may share data from this study with HFA and other national model conferences. Indiana will continue to use the data and lessons learned to inform practice and quality improvement within home visiting and collaborative early childhood efforts.

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