The Bridgespan Group

Help Me Grow National Center Strategic Growth Plan

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THE BRIDGESPAN GROUP

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Help Me Grow® National Center

Help Me Grow National Center
Strategic Growth Plan

Help Me Grow (HMG) is a national network of over 100 systems in 31 states building early childhood infrastructure to support the healthy development of all children 0-5 and their families. HMG systems offer a central point of contact for families to navigate a real-time directory of resources, from basic needs (like diapers, formula, and housing) to child development supports like home visiting, speech therapy, and much more. In cases where those resources don't exist in a community, HMG marshals the data they've collected on needs and concerns and uses it to identify gaps and barriers to access like lack of transportation, distance, and cultural fit. In many cases, HMG systems are using this data to advocate for changes to local service provision. While HMG is a universally available system, the strategies it employs (when fully implemented) must target support to the families most likely to experience barriers to system engagement, and use family input as a way to improve the system itself so that the community moves towards equitable outcomes.

Over the years, HMG has built a reputation as a strong asset for communities pursuing systems-building, as illustrated by recent interviews with leaders of other national systems-building initiatives (see **Appendix Section A** for list of interviewees). In particular, the way that HMG brings together multiple groups of stakeholders who otherwise may not have venues for collaboration, is noted: *"HMG has developed a really impressive network, including with well-positioned and expert people at the state level and with community practitioners."* In addition, HMG builds bridges with both families and the systems that serve them: *"HMG enhances the understanding of your system. I love that HMG has constituencies of families and pediatricians. You're hearing from communities and from the system pieces."*

The HMG network consists of systems, affiliates, and the National Center (see **Appendix Section B** for roles of systems, affiliates, and the National Center). **Today, HMG affiliates are overseeing systems at various levels of fidelity to the model** and, by extension, various levels of ability to achieve intended outcomes. In order to accelerate the HMG network's growth and impact, the HMG National Center has engaged in strategic planning in 2020 to name strategic growth priorities for the next five years. **To guide this strategy, the National Center partnered with Bridgespan to define "full potential" across several dimensions**, and conducted a landscape of the current state of the network relative to that potential.

Recall that this definition (which may evolve further) included five elements:

- **Fidelity:** State affiliates and systems should be fully implementing the model, with a statewide agenda for robust funding and policies to support the model (see **Appendix Section C** for detail on what fully implementing the model entails)

- **Outcomes:** Systems should be meeting family needs, and HMG's presence should be helping communities and states improve ultimate child/family outcomes, particularly those that families/parents name as most important
- **Equity:** Systems and states should be serving demographically representative populations and collecting data so that outcomes can be disaggregated by race/ethnicity
- **Diffusion:** Systems and states should be engaging in continuous system improvement with the National Center and implementing best practices from the network
- **Growth/presence:** State affiliates should have a plan for statewide coverage, and systems should be conducting outreach in 100% of their defined geographic area, ensuring that service is equitable/accessible across demographic groups

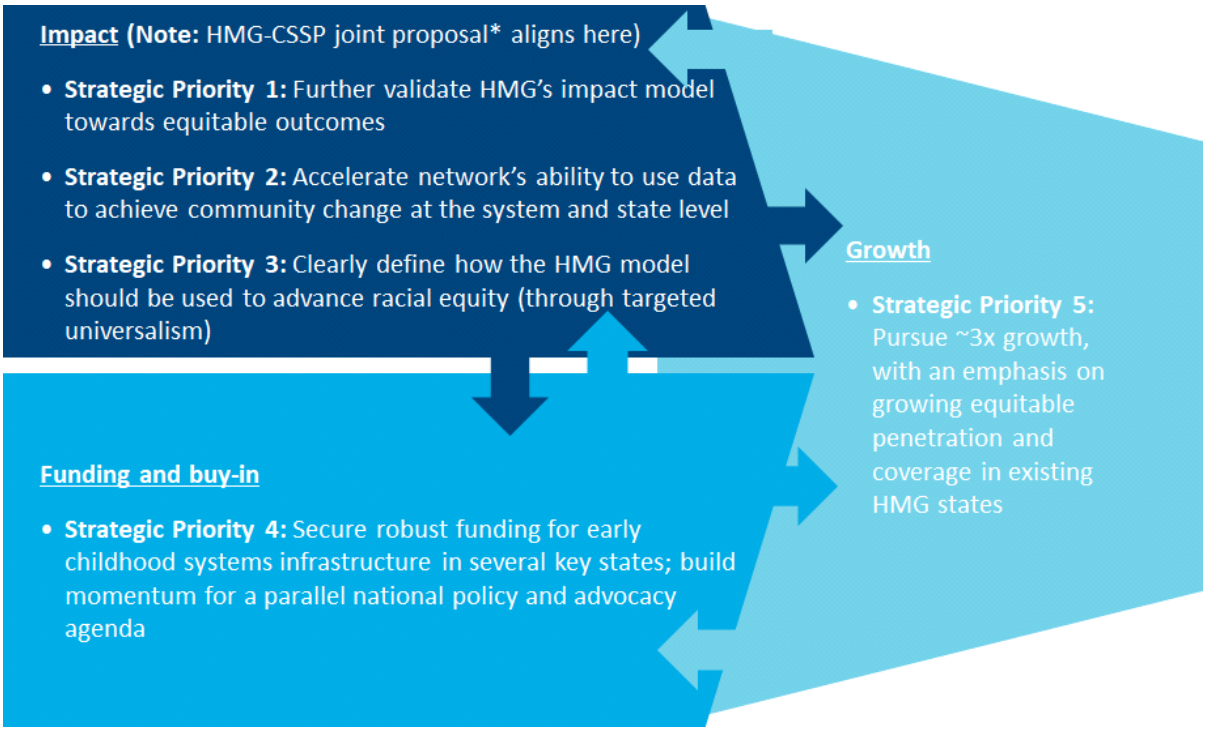
Engaging the National Center staff, affiliates, systems, funders, and national systems-building leaders, HMG identified the gaps relative to full potential, and a handful of eleven potential strategies were evaluated in terms of their importance and their feasibility for the NC, affiliates, and systems.

The resulting five strategic priorities, which reinforce each other (see **Fig. 1**), are to:

- **Further validate HMG's impact model** and measure network performance towards equitable outcomes (including those defined by communities)
- **Accelerate the network's ability to use data to achieve community change** at the state and system level (including investment in services that are culturally appropriate)
- **Clearly define how the HMG model should be used to advance racial equity** (through the components of targeted universalism)
- **Secure robust funding for early childhood systems infrastructure** in several key states to build momentum for a parallel national policy and advocacy agenda
- **Pursue ~3x growth, emphasizing equitable growth within existing states** to serve populations that mirror racial/ethnic demographics of communities

It is worth noting that while Priority 3 does focus exclusively on defining for the full network how the model should be used to advance racial equity, **HMG will take a racial equity lens across all five priorities.** Ensuring equitable access to and benefits from supports for healthy child development is a defining goal of all of HMG's work.

Figure 1: HMG's strategic priorities reinforce each other



Priority 1: Further validate HMG's impact model connecting fidelity to ultimate outcomes, and identify metrics (both centrally-chosen and locally co-created with families) that will enable the network to measure for learning and improvement towards equitable outcomes

Rationale for this priority: To date, HMG has defined a fidelity model that works well to bring structure to the *activities* that system implementations are doing along four core components. In the current state, about half of HMG's ~100 systems are either fully performing all activities, or very close to doing so. HMG's annual Fidelity Assessment also measures system performance on a number of *outputs* that are important to well-functioning systems, such as rates of linkage to services and families reporting that their needs are met. *However, there are a few areas in which the HMG National Center could enhance its current approach*:

- *Measuring, across the full network, the system-level outputs or outcomes* that would demonstrate that systems are functioning better as a result of HMG's presence (e.g., degree to which agencies are communicating with each other or investing in services)
- *Linking HMG affiliates' and systems' work to child- and family-level outcomes*, at the individual and population level
- *Further engaging families and parents in co-defining the ultimate outcomes* that systems are working towards (while the ability to do this is present in some systems, it is not yet standardized across the network).

There is no question that *individual systems and states are having effects on system outcomes like screening rates and family outcomes like empowerment measures*, as demonstrated by individual studies and the current work that HMG is doing to clarify the "return on investment" (ROI) of local implementations (see **Appendix Section D** for a brief description of this work). A 2016 study published by Marcia Hughes et al. in *Infants & Young Children* found that parents report a positive change in protective factors as a result of calling HMG and the information and services they receive. For example, over 80% of parents responded that HMG helped them "extremely" or "quite a bit" to be able to access services if they need them and to have a better understanding of their child's development and how to meet their needs. Similarly, a 2018 Alameda County study found that children served by HMG attend preventative primary care and well-child visits more regularly than children not served by HMG in the county.

However, without a network-wide process for measuring all systems and states on these outcomes, HMG does not yet have a perspective on the levels of intermediate outcomes (e.g., screening rates or rates of interaction with HMG) that indicate that a system is functioning well. It also does not yet have a firm perspective on which factors need to be in place to lead to ultimate outcomes like family empowerment and kindergarten readiness.

National leaders and funders in the early childhood systems-building space (as well as HMG affiliates themselves) believe it is important for HMG to know: 1) how each system in the network is performing on outputs and outcomes; 2) how each system is remaining accountable to achieving local outcomes that communities and parents prioritize; and 3) how intermediate outcomes like better functioning systems link to ultimate outcomes like kindergarten readiness (at the population level and potentially at the individual level). The current work that the National Center is undertaking to measure ROI by tying systems to metrics like family strengthening, early detection of need, developmental surveillance and screening, and school readiness, provides an important foundation for this work that will be built on. This investment in building HMG's evidence base and understanding network performance will ultimately improve HMG's ability to secure more diverse funding from state and national public and Medicaid funding streams, and fuel growth (see **Fig. 1**).

High level activities that HMG would undertake for this priority: Develop a measurement plan building on the Fidelity Assessment by adding intermediate system-level, child/family-, and population-level outcomes (see initial outcomes in **Appendix Section E**); analyze network performance against achievement of outcomes disaggregated by race/ethnic background; develop technical assistance to fill gaps in network performance; compensate parent advisory groups to consult on community-specific outcomes; communicate existing evidence base with continued publications to support evidence and efficacy of the model (e.g., ROI work); fill gaps in evidence base (e.g., establish the link between high-functioning systems and better child/family- level and population-level outcomes).

Priority 2: Accelerate the network's ability to use data to achieve community change at the system and state level, building towards greater local investment in services that are accessible, equitable and culturally appropriate for all families

Rationale for this priority: HMG has defined "achieving community change through data" as one of the key activities of the HMG fidelity assessment. However, the type of community change required, or the ways in which data should be used to achieve it, can take different forms in each community, and at the state level. Through interviews with affiliates and national leaders of systems-building initiatives, it has emerged *that HMG's unique ability to collect data on gaps in services and barriers to access* (such as transportation, distance, eligibility, cultural fit, etc.) is a key part of its value proposition. In some communities, systems are using this data to advocate for new or different types of services, and having success. In fact, HMG's ability to collect this data is crucial to its ability to advocate for stronger and more equitable early childhood systems at both the local and state level.

It is important to note that HMG *does not see itself as an arbiter of quality of services*, that is, systems do not monitor whether services in a community have an established evidence base. HMG systems are aware that communities and states may prioritize a range of outcomes including and in addition to outcomes like kindergarten readiness, and may choose to prioritize outcomes like family satisfaction or affordability over learning outcomes in some cases. Overall, HMG systems that are aware of the outcomes that the community prioritizes (connected with **Priority 1**) will work with them towards ensuring that local services meet those needs.

High-level activities that HMG would undertake for this priority: Identify, document, and share with a broad range of audiences the success stories of affiliates creating community change; build affiliates' capacity to use data to create community change by providing frameworks, creating communities of practice, and engaging Implementation Expert support.

Priority 3: Clearly define how the components of the HMG model should be used to advance racial equity, through targeted universalism

Rationale for this priority: HMG has a "targeted universalism" approach, that is, while HMG is available universally to all families in a community, systems should be documenting barriers that prevent families from reaching or benefiting from the system, and developing targeted strategies to reduce those barriers in order to achieve racial equity in access and benefits. While many affiliates do see themselves as employing targeted universalism strategies, *the National Center does not currently hold all systems accountable for implementing targeted universalism or provide a barometer for how well the network is doing on this dimension*. The ability to collect outcomes disaggregated by race and ethnicity is not yet standardized across the network (though it is recommended), and collecting this data is required for understanding how well targeted universalism is functioning to achieve equity.

A recent survey of systems that do collect data disaggregated by race and ethnicity showed that the average system is serving a disproportionately higher number of Black, Latinx, and Indigenous families than is represented by local population demographics. Yet, the leadership of HMG and the agencies in which it sits remains largely white-led in many states. In order to match the priorities of the population that HMG is serving, many systems have incorporated

parent advisory groups to ensure that policies being developed are centering the needs of families being served, but this practice is not yet a standard across the network.

The National Center has always seen its role as facilitating and elevating the good work that affiliates are already doing. Indeed, many affiliates in the network are ahead of the National Center on defining how targeted universalism and racial equity are a part of their local models. The ability of many states to respond to basic needs of families during the pandemic is another piece of evidence showing that the network is already doing this component, and likely ready to formalize it. HMG and the Center for the Study of Social Policy (CSSP) are planning to jointly begin work in a handful of communities to engage parents in the creation of a framework and success measures for building anti-racist early childhood systems. This work will include: working with parent leaders to co-design processes for landscape scanning, capacity building, and measurement; testing and refining these processes for broader diffusion throughout the HMG and CSSP networks; and disseminating the findings more broadly to the public.

It is important to note that *while this priority is focused on racial equity, HMG's work on racial equity is not limited to this priority*. HMG is taking a racial equity lens, incorporating community and parent involvement to all other priorities as well, as described in the priorities themselves.

High level activities that HMG would undertake for this priority: Develop and manage process engaging the network and families to refine the Fidelity Assessment; use Fidelity Assessment to develop strategies that affiliates can use to partner authentically with families and racial justice-focused organizations in individual communities; develop portfolio of technical assistance supports to enable affiliates/systems to build capacity for targeted universalism.

Priority 4: Secure robust funding for early childhood systems infrastructure in several key states that will build momentum for a parallel national policy and advocacy agenda

Rationale for this priority: HMG's ability to deepen outreach and to expand in a state is driven in large part by the robustness of the state's funding model for systems infrastructure (see **Fig. 1**). The key costs for HMG systems are personnel who build relationships with families and providers, and personnel who coordinate referral for families served. Thus, the more resources states are willing to invest in HMG, the more likely HMG will be able to deepen penetration and cover the full state, which is an important tipping point for state-level partnerships (see **Priority 5**). However, it will likely be difficult for many states to be able to secure robust funding models without a national subsidy for early childhood systems infrastructure. For this reason, *HMG must push state-level and national-level policy agendas forward simultaneously.*

Unlike other program-based models that operate in a single sector (e.g., home visiting, pediatric screenings, etc.), HMG is a system that knits multiple sectors together and advances a variety of goals for a community. *This multi-sector reality offers a positive story for funding models:* while there is unlikely to be a clear "one-size-fits-all" funding model that works in every community, there are likely a range of outcomes (or "returns on investment") that HMG can provide to communities, and therefore a range of policy and funding levers that can be pulled.

For example, HMG's ongoing ROI research has found that while some communities may include HMG infrastructure in child welfare policies to prevent out-of-home placements, other communities may include HMG in education strategies to achieve Part C goals for early identification of developmental delays.

Securing robust funding for early childhood systems infrastructure at the state and national level will also contribute to funding HMG's national infrastructure. While the National Center will stay small to reflect the fact that most of HMG's outreach, care coordination, and data collection is done at the local level, it will need to grow beyond its ~$1M annual budget in order to accelerate the network's growth and impact. Philanthropy will likely always remain a core piece of the National Center's funding model in the long term, but the proportion of funding coming directly from affiliates for fees and technical assistance should also increase beyond the 14-18% of the National Center budget that it is today (see **Fig. 2**). Currently, affiliates likely cannot pay much more for technical assistance given their own lack of funding. Thus, building more robust state funding models, and delivering more value to the network through national policy work, will likely also serve to make the NC's funding model more diversified. To maximize this possibility, the National Center will gather feedback from affiliates throughout the execution of this plan, to ensure that the value of national activities remains meaningful to potential "customers."

High level activities that HMG would undertake for this priority: Develop a depth/breadth of knowledge of potential state funding strategies and directly advise affiliates on securing these through state policy advocacy; gather feedback from state affiliates to ensure national activities are meeting customer needs for policy/advocacy; formalize partnerships with other integrated systems-building initiatives (see **Appendix Section A**); build on these partnerships and data collected from measurement framework (**Priority 1**) to advance national-level policy agenda.

Priority 5: Pursue ~3x growth (to <u>directly</u> serve 325K-350K total families in five years), with an emphasis on growing equitable penetration and coverage in existing HMG states

Rationale for this priority: HMG is currently operational in 31 states, and directly served ~112K families in 2019. There is room for HMG to grow within states and existing coverage areas before focusing on advancing its presence to new states. HMG is fully statewide (covering 100% of the state) in six states (see **Fig. 3**), though other states do have plans for statewide expansion. There is also room to grow the proportion of the 0-5 population directly interacting with HMG in the counties where systems are operational. As seen in **Fig. 4**, the percentage of 0-5 year-olds directly interacting with HMG (out of the total families with 0-5 year-olds in the "catchment areas" covered by HMG systems) ranges widely, between 0.5%-15%. HMG systems actually do not intend to reach 100% of families with 0-5 year-olds every year, but one potential goalpost is that 30% of children on average are thought to be at risk of, but not currently manifesting, a developmental delay. HMG systems would increase impact by being able to serve this population more consistently, as this population is oftentimes not eligible for early intervention services. It is worth noting that estimating those at risk of developmental delays is difficult to quantify and likely to vary from community to community.

National leaders say there is an important tipping point when HMG reaches statewide coverage, as this allows HMG to partner more productively with other statewide systems like Part C and the CDC *Learn the Signs. Act Early.* program. In addition, national peer leaders emphasized that the variation in HMG's presence and depth in communities can create confusion about what HMG is and what it can accomplish if fully operational. For these reasons, *HMG may focus primarily on achieving growth by driving statewide expansion and depth of penetration in existing states, though it will likely continue to adopt new states at a measured pace (2-3 states over the next five years)*. It will be prudent for HMG to create a set of criteria for growth to new states, looking first for presence of a strong state affiliate and/or a credible path to statewide coverage before investing in new state expansion.

HMG has long made "scale and spread" a goal of local implementations, such that systems hold ownership for advancing efforts to deepen penetration of existing areas (i.e., "scale"), and affiliates hold ownership for advancing the "spread" of system coverage across the entire state. In speaking with both affiliates and systems, it is clear that driving scale and spread is most directly influenced by robust funding (see Priority 4). In addition to funding, affiliates say they could benefit from technical assistance that would help them develop coordinated expansion plans (particularly in multi-system states) as well as data analysis and templates to help pinpoint areas where there is need for HMG but low engagement with the system (particularly where engagement varies by racial/ethnic background). Given the strong role that local funding and influence plays in an affiliate's ability to expand, the NC's efforts are likely best focused on helping stronger states make progress towards coverage goals, while in parallel allocating some national funding to states that are higher need, and which have fewer local resources to drive growth. The first phase of implementation of this plan would include deep interaction with both systems and affiliates to set goals for penetration and coverage. The below section on "demand strategy" provides a draft segmentation of states for each growth priority.

High level activities that HMG would undertake for this priority: Adopt a segmented approach to helping states set realistic expansion goals; develop targeted technical assistance to clarify the elements of strong state expansion plans and help states tailor ROI calculator to stakeholders in state context; help systems form state-wide coalitions (with multiple agencies) to advance coordinated expansion plans; channel private funds/TA to states where there is high need and less ability to secure statewide expansion.

HMG aims to accelerate their growth in the next five years. While each state affiliate and system will set its own growth goals, **HMG has set an overall target of directly serving 325K-350K families annually by 2026** (i.e., five years from the implementation of this plan), effectively tripling its direct reach.

To achieve this growth, the HMG network will pursue three avenues over the next five years, with an emphasis on the first two:

- **Increase in penetration:** Growth to families in existing counties (prioritizing reaching racial/ethnic demographics representative of the local population)
- **Increase in existing state coverage:** Growth to new counties in existing states
- **Increase in national presence:** A small amount of growth to families in new states, given the ramp up time typically needed to begin fully implementing a HMG system

The HMG National Ceter will target different geographies for each of these growth avenues. To develop growth estimates, all US states and territories have been categorized into five segments: (1) existing "exemplar" states, (2) existing "strong and growing" states, (3) existing "expanded and strengthening" states, (4) existing "steady" states, and (5) new states (see **Fig. 5**). **Appendix Section F** provides more detail on which states are in each segment.

Segment	Existing exemplar	Existing strong and growing	Existing expanded and strengthening	Existing steady	New
# of states	7 states	6 states	5 states	13 states	12 states
Attributes	• Strong or somewhat strong state affiliate • Good coverage • Most systems at fidelity	• Strong or somewhat strong state affiliate • Low coverage • Most systems at fidelity	• Less strong or unclear state affiliate • Good coverage • Few systems at fidelity	• Less strong or unclear state affiliate • Low coverage • Few systems at fidelity	• No current HMG presence • High potential and high need for HMG
Primary owner of growth	Systems for increasing penetration State affiliates for increasing coverage				National Center
Ballpark assumptions for growth	• Penetration: 30-35% annual increase in families served • Coverage: 100% by 2026, with current state penetration rate served in new counties	• Penetration: 10-15% annual increase in families served • Coverage: 100% by 2026, with current state penetration rate served in new counties	• Penetration: 5-10% annual increase in families served • Coverage: 100% by 2026, with current state penetration rate served in new counties	• Penetration: 3-7% annual increase in families served • Coverage: No growth	• At low range, expansion to 3 states with low 0-5 pop; at high range, 3 states with high 0-5 pop • Penetration: 0.2-0.4% by 2026 • Coverage: 50-60% by 2026

The first way the HMG network will grow is through *increasing families served in existing counties (i.e., increase in penetration)*. HMG aims to increase system penetration in all existing counties, growing the number of families served by 158K-178K (from 112K in 2019 to 270K-290K by 2026). That said, systems are likely to set different targets for increasing penetration depending on which segment they are in. Some systems, such as those in "exemplar" states, might increase penetration by as much as 30-35% annually, while other systems, such as those in "steady" states, might increase penetration by 3-7% annually. While the National Center can provide some technical assistance for growth, *the driving force behind increasing penetration will come from systems on the ground.* While many systems have been increasing penetration over time, most have not previously set goals for penetration increase, or considered what it might take to reach specific goals.

To help systems increase penetration:

- **The National Center will:** provide states with a framework and guidance for setting goals for and reporting out progress on penetration, disaggregated by race and other dimensions; potentially couple TA with funding in areas of high need that are unable to secure local funding; and potentially conduct national analyses to determine the penetration rate required to achieve impact goals.
- **HMG systems will:** set goals for annual increase in system penetration; regularly track and report out the number of families served and reached, disaggregated by race and other dimensions; and work with state affiliates to secure funding to finance increased outreach and care coordination activities for more families.

The second way the HMG network will grow is through *serving families in new counties in existing states (i.e., increase in state coverage).* HMG aims to increase state coverage to 100% in all existing segments except the "steady" segment of states, serving 40K-60K families in new counties in existing states by 2026. Again, while the National Center can provide technical assistance for this type of growth, *the driving force behind increasing state coverage will come from state affiliates.*

To help state affiliates increase statewide coverage:

- **The National Center will:** clarify the elements of a strong state expansion plan; determine to what extent each state has these elements; provide targeted TA, especially in multi-system states where systems will likely have to develop expansion plans jointly with other systems; and potentially be more prescriptive about what is required to claim "coverage" of a county (e.g., there must be a functioning Centralized Access Point).
- **State affiliates will:** execute on NC-provided TA to develop strong state expansion plans, including identifying high need areas for near-term expansion; and, in multi-system states in particular, form statewide advisory groups on coordinated expansion plans.

States in the "steady" segment (i.e., those with low state coverage and less strong state affiliates) will likely require substantial additional funding in order to expand their state coverage, and thus are not expected to grow coverage as part of these growth estimates. If increased funding were to become available (potentially as a result of **Priority 4** of this plan) then these states could represent additional opportunity for growth.

The third way the HMG network will grow is through *serving families in new states.* HMG currently has a presence in 31 states and territories, leaving 21 without any HMG presence. Going forward, the HMG National Center will adopt a more intentional approach when considering which new states to expand to, creating a set of criteria by which to evaluate if a state is well-suited to becoming a HMG affiliate. *Included in these criteria will be whether the state has both high potential and high need.* Currently, HMG has defined high potential as being in the "sweet spot" between having too little early childhood infrastructure, where there might

not be enough buy-in at the state level to support HMG, and having already established an advanced system, where there might potentially be less value for HMG to add. HMG has defined high need as having a low percentage of children between nine and thirty-five months receiving developmental screening. There are twelve states that tentatively meet the criteria of high potential/high need, and these vary in size from 40K 0-5 year-olds to 800K 0-5 year-olds. Given that it typically takes around 18 to 24 months for a new state affiliate to begin fully implementing a HMG system, it is expected that the number of families directly served in new states will remain small, such that new state growth has minimal contribution to HMG's overall growth estimates by 2026. While HMG does not currently know which of these states will join the HMG network, HMG expects that 0.5K-5K families will be served in 2-3 new states by 2026.

It is important to note that *engagement with HMG has already increased significantly during the Covid pandemic.* HMG has already experienced a 74% increase in the number of families directly served between 2019 and 2020 (increasing from 112K to 195K), many of which were from families looking for assistance around accessing basic needs. Given the uncertainty around how this increased exposure will affect the number of families served in future years, this trend has not been built into these growth projections.

Finally, it is also important to note that *all of these growth projections will be refined during the first stages of implementation.* They are the best estimates based on available research and engagement with affiliates to date. However, they have not yet been fully vetted by the affiliate network, which will be a key next step for the first phase of implementation.

High-level roles and investments for implementation

In the new organization, the Executive Director will have three direct reports managing the main functions of the organization: Implementation and System Building (including Impact and Network Performance, Evaluation, and Technical Assistance), Advocacy and Public Policy, and Business Development/Operations.

Draft Phase I investments (first ~12 months)
Three immediate new hires and a consultant will be prioritized to further define the plan to implement the strategic priorities and begin execution:

- **Director of Impact and Network Performance (see Priority 1):** This role will design a measurement framework for improving network performance by tracking outputs, intermediate outcomes, and ultimate outcomes of affiliates in the network; and partner with affiliates and system to implement to capture, analyze, and use data, including analyzing patterns in data to understand levels of intermediate outputs needed to achieve desired outcomes.
- **Director of Advocacy and Policy (see Priority 4):** Initially, this role's focus will be split between state and national advocacy activities. They will develop a directory of state-level funding and policy levers; advise/provide technical assistance to a handful of states

in securing robust funding models; and design/execute a federal level advocacy and policy strategy aligned with goals for state-level funding models.

- **Racial equity consultant (see Priorities 1-3):** Working from frameworks that have been developed individually at the affiliate level, this consultant will facilitate a network-wide process to develop a shared racial equity strategy/framework for the network that includes fidelity activities, outcomes, and strategies for achieving outcomes.
- **TA Specialist (see Priority 4):** This position may be needed to backfill for current TA staff pivoting to focus on supporting policy/advocacy marketing and communication priorities.

Beyond these positions, other Phase I recurring investments will include: budget for existing National Center staff and affiliates to execute strategic priorities, compensation for Implementation Experts, and stipends for family engagement in communities. Lastly, a two-year capability building investment with an external research organization will be required to define and establish the link between system-level and child/family-level outcomes in specific communities.

Phase II investments (~years 2-5 of plan)

Phase II investments are estimated to begin in 2022 and continue for four years through to 2026. In addition to the recurring investments named in Phase I, new roles may include the following:

- **Senior-level racial equity lead (see Priority 3):** Continue racial equity work started by racial equity consultant, including implementation and technical assistance for the network
- **Data Analyst Specialist (see Priority 1):** This position would provide support to the Director of Impact and Network Performance, to analyze network wide data on outputs and outcomes, and look for trends that may identify needs
- **Policy Analyst (see Priority 4):** This position would provide support to the Director of Advocacy and Public Policy in providing technical assistance to states and gathering "customer" feedback from state affiliates to ensure national activities are meeting customer needs for policy/advocacy
- **Community of Practice (CoP) Specialist (all priorities):** This position would work with Director of Implementation and System Building to implement new network enhancements through CoPs (e.g., for community change through data)
- **Administrative Assistant (all priorities):** This position would support Executive Director as well as extended staff (10-15 FTEs) with administrative tasks for strategic priorities
- **Business Development and Operations Coordinator (all priorities):** This position will support the Director of Business Development and Operations in coordinating the HMG financial and business activities and collaborating with the Connecticut Children's Medical Center (e.g., grant and contract management, payroll, invoicing, etc.).

In addition to the roles listed above, the National Center will also invest in 2021 in piloting an integrated, modular, technology platform that is currently being designed for Phase 2 of the Pediatrics Supporting Parents (PSP) project. This technology build will connect parents,

community based organizations, the Centralized Access Point, and medical homes within two systems in 2021. While the 2021 funding to pilot this approach is *not* included in the above estimates, this investment is highly aligned with strategic priorities, such that funds to scale the platform across the network post-pilot are included in Phase II in years 2022-23.

HMG has identified preliminary milestones that will guide key decisions and next steps before moving on to Phase II of implementation. Tracking each milestone will be critical to continue investing in each priority respectively:

- Measurement framework will be designed and piloted
- Affiliates and systems will be able to start reporting data for measurement framework
- National Center will collect a set of success stories from affiliates and systems that can be replicated elsewhere with technical assistance from Implementation Experts and/or national staff
- National Center will identify, with affiliate input, the shared measures that have successfully advanced community action and change

Priority 3:

- The Fidelity Assessment will be refined to include expectations for advancing racial equity through targeted universalism
- The National Center will identify ongoing technical assistance priorities where National Center would play a clear role, that would justify the extension of a long-term senior role with expertise

Priority 4:

- The National Center will create an initial directory to verify that various potential paths towards robust funding exist for states
- Policy levers specific to HMG infrastructure and funding will be identified (e.g., through child welfare policies, special education Part B, early intervention Part C policies, Medicaid policies, etc.)

Priority 5:

- The National Center will verify that their role in helping systems set penetration targets and helping states set statewide expansion/coverage targets helps to drive growth
- The National Center will determine if there are other national roles to drive growth centrally

Overall:

- The National Center will gain clarity about which state affiliates are operating as HMG affiliates with fidelity, and which are still on the pathway
- External stakeholders will gain clarity about which states are operating HMG with fidelity/as ideal, vs. which states are still on the pathway

As mentioned above, further sizing of the affiliate-level investments that will be needed to implement this plan should be done in the first phase of implementation of this plan.

For affiliates, high-level resources required may include:

- State lead affiliate capacity to execute on plans for expansion and funding (where this exists or is possible)
- System capacity for increased outreach and care coordination to reach more families
- Engagement of parent advisory groups (subsidized by stipends for families from the National Center)

It is not yet apparent that philanthropy plays a role in supporting these investments with catalytic funding, but answering that question will be a goal of Phase I of implementation.

As HMG begins to implement Phase I of implementation to gain clarity on the above milestones, the National Center and Bridgespan have identified the following questions that may be helpful to answer. *In the next month, these questions will be further prioritized to identify those that are most critical to driving growth and impact.*

- What key roles will affiliates (states) and systems have in operationalizing the strategic priorities?
- How does the current draft segmentation need to be refined, and how should this segmentation drive the needed supports that the National Center could provide to affiliates and systems to execute on each strategic priority?
    - Given the larger roles that state affiliates will likely have in executing some of these activities, particularly Priorities 4 and 5, how should the National Center drive impact and growth in states that do not have strong or clearly-identified affiliates?
- Based on more detailed input and planning from affiliates, how may growth goals need to be modified? How confident are affiliates and HMG National Center that they can achieve growth goals, and what are the conditions that appear to be linked to faster growth?
- What other capabilities, actions, or behavior will National Center and affiliates have to change to successfully execute each strategic priority?
- What pilots can HMG invest in to build momentum for each of the five priorities together with affiliates?
- What is the purpose or primary objectives of the Fidelity Assessment? *E.g. assess affiliate standing with the network, measure and evaluate the network or impact, identify gaps in state coverage, understand funding models, etc.*
- What action(s) will the HMG National Center take if systems and state affiliates do not meet the requirements set out by the refinements to the Fidelity Assessment (e.g., targeted universalism, reporting on outputs and outcomes, etc.)?

- How can the National Center promote widespread buy-in to the concept of fidelity among affiliates, particularly if more is requested/required of state-level affiliates?
- What are the key technical assistance "service offerings" National Center might offer to support implementation and sustainability of priorities? How do these differ by affiliate need?
- How should these offerings be priced?
- How should affiliate fees be structured, and what proportion of National Center revenue should come from affiliate fees?

- What organizational and financial resources will be required to fully implement the strategy, at both the HMG National Center and network level? *Note: HMG's Policy/Advocacy Director would likely lead work to understand financial resources and funding model required at affiliate level*
- What will the funding model look like at the HMG National Center level, including the role of fees and technical assistance revenue from affiliates?
- How will the forthcoming ROI model contribute to funding and sustainability of states?
- Beyond the next year of implementation activities that HMG has laid out, what should be the implementation plan beyond Phase I, with timeline, roles and responsibilities?

Appendix Section A: Input from leaders of other national systems-building initiatives

Table A1: List of leaders of other national systems-building initiatives interviewed

Name	Organization	Title
Debra Waldron	AAP	Senior Vice President
Florence Rivera	AAP	Director
Eileen Reilly	AAP	Senior Manager
Katie Green	CDC Learn the Signs. Act Early.	Team Lead
Dina Lieser	HRSA MCHB Division of Home Visiting and Early Childhood	Senior Advisor
Christy Kavulic	DoE IDEA Part C Early Childhood and Parents Team	Associate Division Director
Maureen Greer	DoE IDEA Infant and Toddler Coordinators Association	Executive Director
Charles Bruner	InCK Marks	Resource Manager
Kay Johnson	Johnson Group Consulting	President
Susan Hibbard	The Build Initiative	Executive Director
Rahil Briggs	HealthySteps	National Director
Debbie Cheatham	ZERO TO THREE	ECCS CoINN Senior Technical Assistance Specialist
Jamie Colvard	ZERO TO THREE	Director of State Policy
Cynthia Osborne	Child and Family Research Partnership	Director
Wally Patawaran	JPB Foundation	Program Officer
Brenda Blasingame	Pritzker Children's Initiative	Program Manager
Kathy Stohr	Pritzker Children's Initiative	Project Manager

National leaders from the following organizations shared potential action steps for integrating HMG with their systems-building initiatives.

- Those at the national level recommend that local AAP chapters explore a partnership with HMG, but do not require it
- Partnerships between local APP chapters and HMP are stronger in some instances than others. Having conversations with specific AAP chapters where partnerships are strong versus where partnerships are not strong could be a starting point for getting clearer on what drives this

Centers for Disease Control and Prevention (CDC) "Learn the Signs. Act Early." Program

- Those at the national level encourage state Act Early Ambassadors to explore a partnership with HMG, but do not require it

- Act Early Ambassadors operate at the state level. Therefore, it is generally easier for Ambassadors to partner with HMG in states where HMG is statewide. In those cases, HMG tends to be the #1 go-to.
- On the other hand, partnership can be challenging in states where HMG only operates in a handful of counties as Act Early Ambassadors would then have to identify similar resources for each individual county, as opposed to using HMG as a one-stop shop

Early Childhood Comprehensive Systems Collaborative (ECCS)

- Of the 12 current ECCS Impact grantee states, nine of them are currently in the HMG network
- One possibility for further integration with ECCS is offering TA to entities outside of the network or entities that are not necessarily interested or committed to becoming affiliates with HMG. Affiliates could be the strongest performers while other government entities, for example, could sign up for specific TA

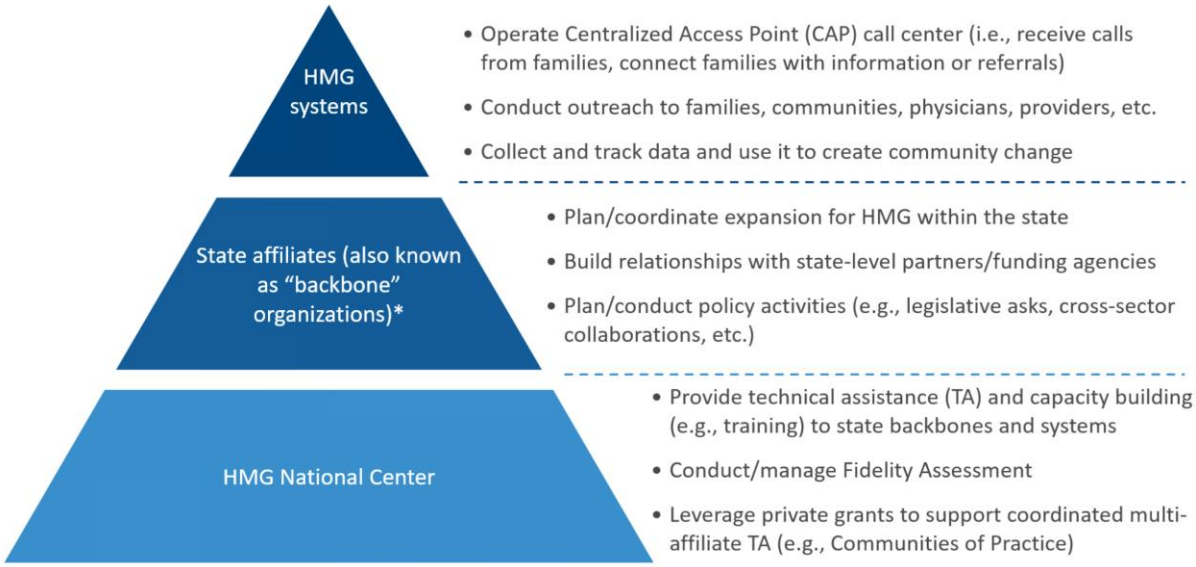
HealthySteps

- One of the core components of the HealthySteps model is care coordination and systems navigation. As part of this core component, HealthySteps specialists refer patients, parents, and families to community resources based on identified needs. This is of course similar to HMG's work
- In communities where HealthySteps and HMG are both present, there could be an opportunity to link HealthySteps and HMG together so that HealthySteps specialists do not conduct care coordination and systems themselves, but instead automatically refer patients, parents, and families to HMG, which would then do this work

Individuals with Disabilities Education Act (IDEA) Part C

- Many IDEA Part C providers are already strapped for resources, which is exacerbated by receiving inquiries from children and families who do not meet state-specific Part C requirements
- HMG and Part C could partner to ensure more accurate referral processes. If a child comes to HMG first, HMG could use the correct set of state-specific referral criteria to ensure that only those children eligible for Part C are referred there. If a child comes to Part C first and is not eligible, Part C could use HMG as the go-to next step
- In order to accelerate this integration it would be helpful for HMG to:
    - Be operating statewide, as Part C does
    - Demonstrate its ability to reduce stress on Part C systems, including through case studies and cost reduction proof points

Appendix Section B: Key activities of systems, state affiliates, and the National Center



*Note: State "backbones" may also operate as systems and perform the key activities listed there

Appendix Section C: Detail on Help Me Grow Fidelity

In order to be fully implementing the HMG Model, state affiliates and systems must be completing the following 16 activities across four core components:

MODEL CORE COMPONENT	KEY ACTIVITIES
Centralized Access Point	• Specialized child development line • Linkage and follow-up • Researching resources • Real-time directory maintenance
Family and Community Outreach	• Engaged community partners • Networking • Community events and trainings • Marketing
Child Health Provider Outreach	• Physician champion • Training on surveillance and screening • Training on referral and linkage • Closing the feedback loop
Data Collection and Analysis	• Data monitoring • Sharing data across partners • Continuous quality improvement • Community change through data

Appendix Section D: Summary of selected current Help Me Grow National Center initiatives accelerated by strategic priorities

Return on Investment research (supports all strategic priorities)
The HMG National Center is currently working with Manatt Health on the development of a return on investment (ROI) calculator that will allow HMG affiliates the ability to estimate the cost savings associated with the HMG model, including short-term and long-term savings across both the health care and non-health care sectors. The ROI calculator is built to provide individual affiliates the ability to modify inputs based on their HMG systems' unique circumstances, recognizing affiliates may vary in how they implement the model locally.

The current draft of the ROI calculator model has been informed by input and data from a subset of affiliates, HMG Implementation Experts, and working sessions with a HMG core team, since June 2020. Information gathered from these various stakeholders resulted in the identification of a diverse and multi-pronged set of services that HMG affiliates provide to their communities. Leveraging findings from an extensive literature review, as well as cost and impact data collected directly from the HMG National Center and affiliates, seven intervention categories where savings could be calculated were identified.

These include:

- Diversion from unnecessary developmental/behavioral assessments and early intervention (IDEA Part C) evaluations
- Referral to early detection and intervention for child developmental delays
- Positive parenting services and supports
- Home visiting program referrals
- Referral for SNAP/WIC benefits
- Maternal depression screening and treatment
- Early Preventative Dental Care

Over the next few months, the ROI calculator will undergo a refinement period, where additional affiliate testing will be conducted. The HMG ROI Calculator is limited to quantifiable savings associated with the model. Other significant benefits to individuals from HMG (e.g., improvements in child development and school readiness, improvement in parenting ability and efficacy, cross-sector coordination of services to improve child health and developmental outcomes) that are not able to be quantified in this model, will be documented in an accompanying HMG Business Case. The National Center anticipates being able to finalize the ROI calculator and business case by spring 2021, at which point activities to introduce the tools and frame key concepts for our HMG network will be conducted.

HMG's positive deviance work aims to increase the National Center's knowledge related to HMG implementation contexts and processes. Its goals are to:

- Identify, through a set of objective criteria, current 'positive deviants' within the HMG National Affiliate Network. This will involve a review of the Fidelity Assessment.

- Assess, among a set of positive deviants, HMG stakeholders' retrospective beliefs, strategies, and decision-making processes as they pertained to HMG implementation. This will involve semi-structured interviews with organizational leaders to yield information about perceptions, decision-making processes, and characteristics associated with HMG implementation.

With 31 states implementing the HMG model under a variety of contexts, there is considerable opportunity to leverage HMG communities to inform broader knowledge about the factors associated with successful implementation and sustainment of the model over time. Those factors, while specific to HMG, will serve to suggest future hypotheses about the variables essential for successful early childhood system building and open the door to future research in a novel and important area.

This positive deviance research study is in its final stage and will be ready to leverage for Phase I of implementation of this strategic plan.

HMG, Family Connects, HealthySteps, and Nurse-Family Partnership are currently in conversation around how these four initiatives might collaborate in communities where two or more of them are present. Thus far, this convening has focused on process (e.g., sharing the types of community-facing tools each initiative is creating and how each initiative is creating them). HMG has also held conversations and presentations around how these initiatives might interface on the local level. For example, HMG and HealthySteps collaborated on a case study around how the two initiatives work together in New York.

The HMG National Center has the unique opportunity to lead the transformation of the pediatric well-child visit through the development of an integrated screening platform that merges several leading tools focused on maximizing parent engagement with the well-child visit and promoting children's social-emotional development. This Pediatrics Supporting Parents Phase II project will leverage findings from an initial planning and exploration phase, conducted in partnership with several early childhood leaders representing a subset of these tools, where it was confirmed that families and pediatric providers are eager to enhance the capacity of practices to strengthen families, enhance protective factors, and promote children's optimal health, development, and well-being.

The purpose of this project is to develop and market a novel, integrated pediatric assessment platform (comprised of various innovative tools), designed for effectiveness at the level of the child, parent, and provider, and will also offer medical integration and the capacity to interface with the EMR. This work will be guided by a group of key advisors, comprised of national experts and key partners with expertise in the policy and practice implications of transforming child health services. In an effort to ensure that this integrated product benefits from a comprehensive array of potential screening and assessment tools, project leads will develop and deploy a structured Letter of Interest release, which will describe the opportunity to participate and solicit interested partners. Upon selection of the tool developers, a prototype will be created, for further testing and refinement, under the direction of Patient Tools, Inc. The

creation of the integrated platform will include direct engagement with the identified tool developers, as well as more passive input from the external advisors.

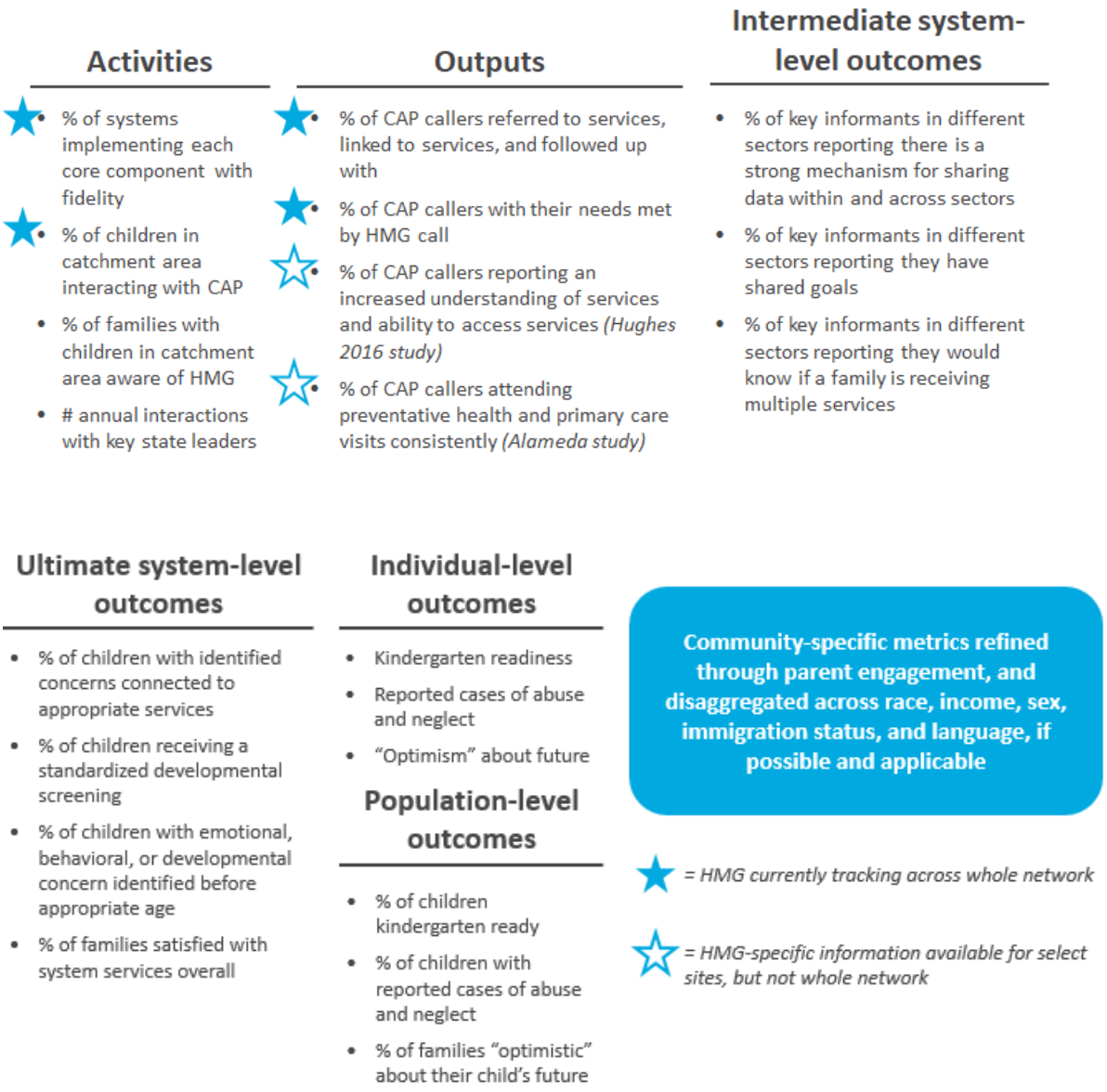
Critical to the scaling of the integrated platform, will be the capacity for such a platform to meaningfully and feasibly connect to other child-serving sectors in the community. As such, the National Center will leverage the network to test a prototype of the integrated platform. The National Center believes that this technology has the potential to radically transform the landscape of child health services.

Appendix Section E: Detail on Priority 1 – Potential activities, outputs, and outcomes that could be measured across Help Me Grow's theory of change

HMG has started to develop an initial list of network-wide metrics to consider for the measurement framework (see **Fig. E1**). This initial list builds on the NC's current measurement approach by adding intermediate and ultimate system-level as well as individual child/family-level and population-level outcomes. It was generated through interviews with national leaders, state affiliates and systems, as well as through external framework research, including those produced by the Build Initiative, the Center for the Study of Social Policy, the National Collaborative for Infants and Toddlers, and Alnoor Ebrahim. Importantly, the National Center will need to engage in conversation with affiliates, systems, providers, families, and other partners to *narrow down this initial list to a shorter set of priority network-wide metrics* that can accurately be measured by affiliates using current data systems. In implementing the new measurement approach, the National Center will need to provide technical assistance to ensure that the network is able to analyze local data disaggregated by race and consistently report out on metrics, as well as conduct national-level analyses of trends in outcomes across the network. Systems will need to execute on by gathering local data and affiliates will need to aggregate this data at the state level.

In addition to network-wide metrics, systems will also identify (through co-creation with families) and measure community-specific metrics, disaggregated by race. Systems will take the lead on engaging communities in order to identify which outcomes matter most to them, with TA support from affiliates and the National Center. This is likely to involve establishing and compensating parent advisory groups across the whole network.

Figure E1: Initial list of National Affiliate Network-wide metrics to consider



Ultimately, the goal of strategic priority 1 is for each system to have a dashboard that combines a set of network-wide metrics measured across the whole network with a set of community-specific metrics defined and measured at the system level, all disaggregated by race and other dimensions (e.g., income, sex, immigration status, and language). An example of what such a dashboard template might look like is below (see **Fig. E2**).

Figure E2: Sample template of system dashboard

Network-wide metrics

Theory of Change stage	Metric	Target					Current status				
		Overall	White	Black	Latinx	Indigenous	Overall	White	Black	Latinx	Indigenous
Activity	% of children in catchment area interacting with CAP										
Output	% of CAP callers referred to services, linked to services, and followed up with										
	% of CAP callers with their needs met by HMG call										
Intermediate system-level outcome	% of key informants in different sectors reporting there is a strong mechanism for sharing data within and across sectors										
Ultimate system-level outcome	% of children with identified concerns connected to appropriate services										
Population-level outcome	% of children kindergarten ready										

Metrics also to be disaggregated across other dimensions including income, sex, immigration status, and language, if possible and applicable

Community-specific metrics

Theory of Change stage	Metric	Target					Current status				
		Overall	White	Black	Latinx	Indigenous	Overall	White	Black	Latinx	Indigenous
Activity	% of systems engaging childcare providers										
Ultimate system-level outcome	% of children receiving a standardized developmental screening										
Population-level outcome	% of families "optimistic" about their child's future										