Help Me Grow National Center

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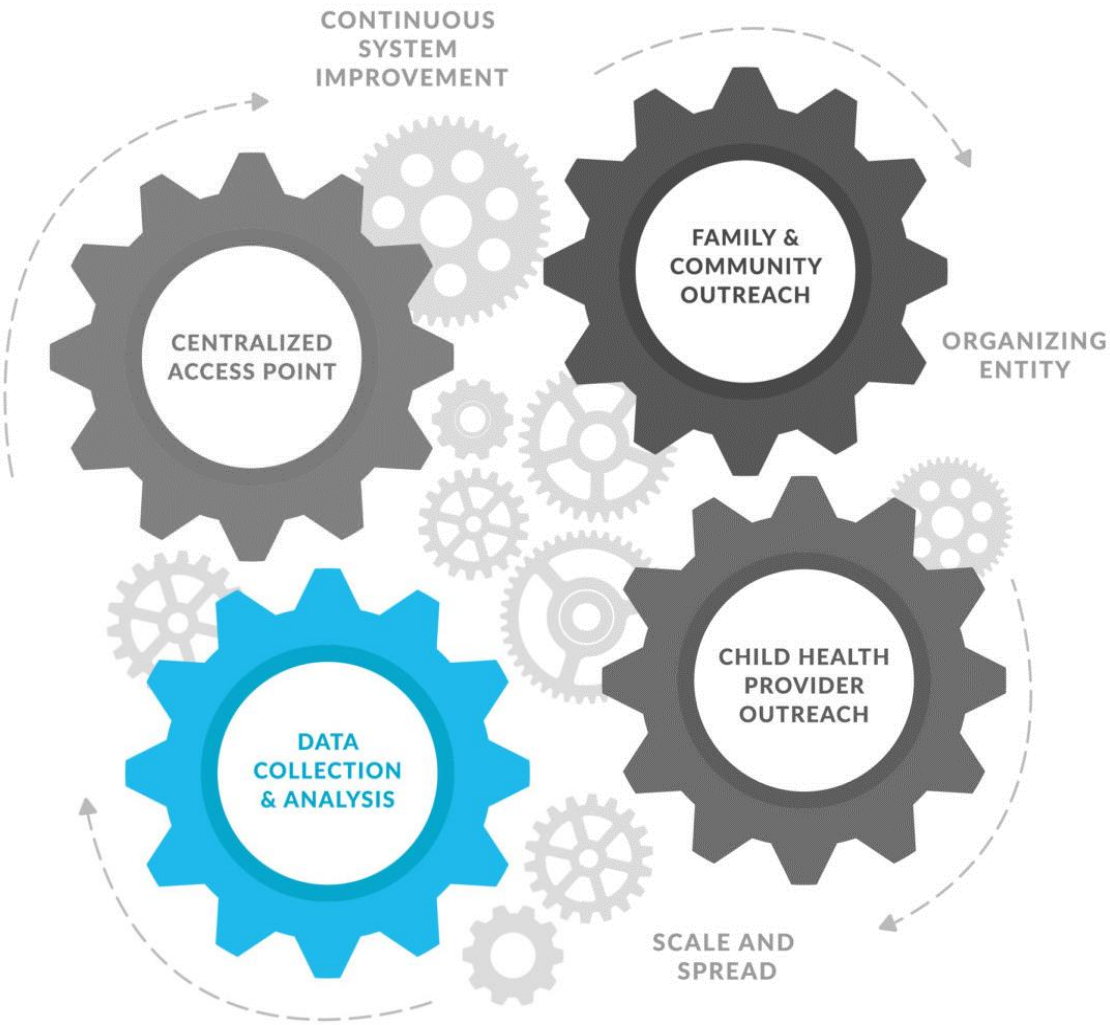
Common and Impact Indicators
Guidelines for Data Collection and Reporting

Help Me Grow National Center

SYSTEM MODEL



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Dear *Help Me Grow* affiliates,

Having a shared measurement platform is essential to collective impact. Agreement on our shared common agenda is illusionary without agreement on the ways our impact will be measured and reported. Collecting data and measuring our results consistently with a concise list of indicators across all *Help Me Grow* implementations not only ensures that our efforts remain aligned, it also enables us to hold each other accountable and learn from each other's successes and failures.

As Einstein argued, "not everything that counts can be counted and not everything that is counted really counts".

Help Me Grow shared measures allow us to:

- Improve Our Data Quality
- Track Our Collective Progress Toward a Shared Goal
- Enable Coordination and Collaboration
- Learn and Course Correct
- Catalyze Action

Not surprisingly, establishing and using an effective shared measurement system is easier said than done. Even the most committed and talented communities of practice run up against challenges that thwart their best efforts to overcome a pattern of disjointed measurement systems. We often say, "Seeing one Help Me Grow system, means you have seen one Help Me Grow system" which also means, evaluating and measuring one Help Me Grow system, or only one part of a system – is just that. Through the committed effort of a diverse set of appointed affiliate representatives on the *Help Me Grow* Evaluation Advisory Board (EAG), our shared measurement platform reflects diverse organizations tackling complex issues, targeting slightly different groups and employing different strategies and activities agreed on a set of common and impact indicators that are shared and adequately reflect the important nuances of this work.

We look forward to communicating the shared learnings that result through this process. Thank you for your continued commitment to partnering with us in identifying the ways we can optimally support developmental promotion, early detection, referral, and linkage to services – ensuring children reach their full potential.

Sincerely,

Kimberly Martini-Carvell, MA
Executive Director, *HMG* National Center

The Purpose of the Guidelines

As a National Network, we have come to truly appreciate that isolated initiatives often fail to generate and sustain change in the lives of young children and families, but the Network, which spans more than half the country, stands at the other end of the spectrum from an isolated initiative. Our collective potential is vast, and in order to move the needle and bring about broad impact, we must move forward as a coordinated and aligned network, maximizing both our resources and our influence. The more we promote a common agenda and alignment in strategy, the greater our likelihood of addressing the complex and multi-faceted barriers that prevent the development of comprehensive, effective early childhood systems.

Critical to supporting collective impact is alignment in measurement; our methods to document the impact of our systems and communicate and leverage those lessons learned are essential to enhance our capacity to operate as a movement and strengthen our potential to generate policy change at the local, state, and national level. These guidelines are intended to serve as a framework to support *HMG* evaluation efforts of local *HMG* affiliates. These guidelines are expected to be helpful for affiliates in the early stages of exploring *HMG,* as communities explore potential metrics to assess the impact of *HMG*, as well as for affiliates that are further along in *HMG* implementation, to further enhance the degree to which *HMG* affiliates across the network are engaging in shared measurement and leveraging opportunities to identify system enhancements and best practices.

Our approach for shared measurement was described in Parts 2 and 3 of the Making Change webinar series, a four-part series intended to embed the efforts of *HMG* in a framework for Collective Impact. Affiliates are encouraged to review the webinars for additional context and background information supplemental to these guidelines.

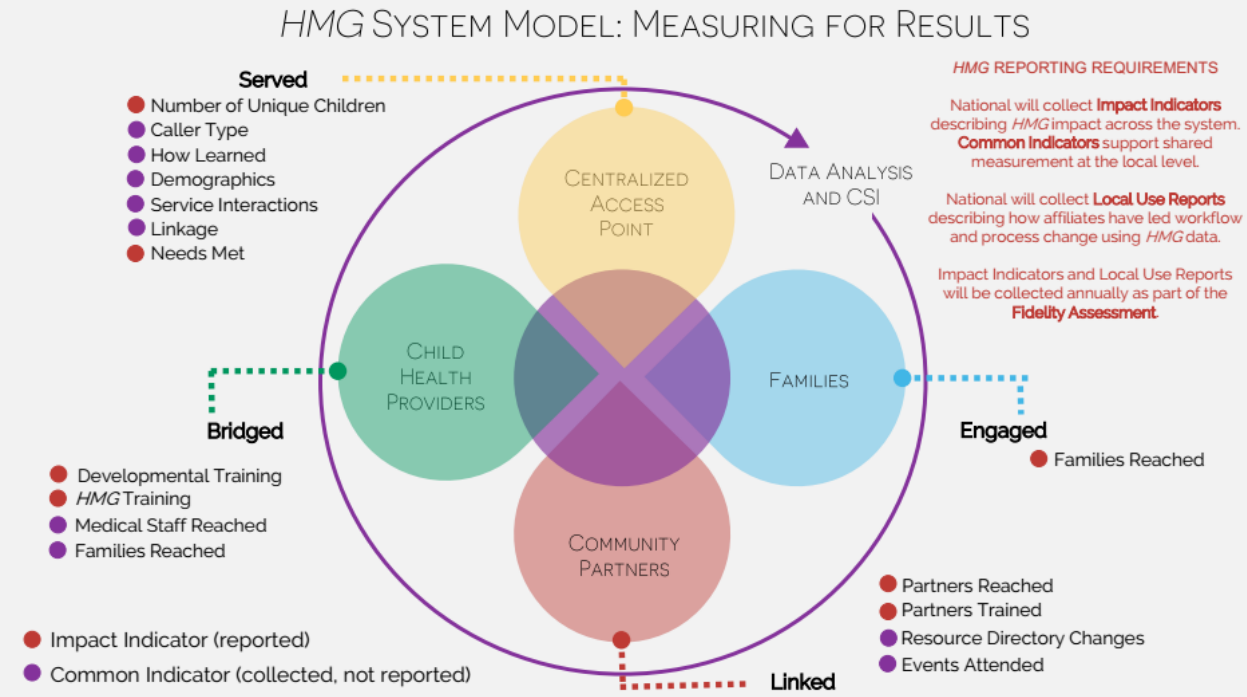
HMG National would like to thank members of the *HMG* Evaluation Advisory Group for their time and thoughtful review and reflection of the types of metrics most relevant to *HMG* and most valuable to the network as a whole. Their comments, thoughts, and suggestions directly informed the approach described in these guidelines.

The Indicators

COMMON AND IMPACT INDICATORS

The *HMG* National Center distinguishes between Common Indicators and Impact Indicators, two terms to describe metrics that serve unique purposes. Common Indicators are a shared set of metrics among affiliates that: are heavily influenced by local variations in *HMG* systems and inform local continuous quality improvement and system enhancements. Impact Indicators are a shared set of metrics among affiliates that, conversely: tell the same story regardless of local context and, in the aggregate, inform the national narrative of *HMG.* All *HMG* affiliates are expected to track Common Indicators at the local level and report Impact Indicators to *HMG* National. Together, Common and Impact Indicators enable *HMG* affiliates to monitor progress, share lessons learned, advocate for change, and consult with other affiliates.

Figure 1. *HMG* System Model: Measuring for Results



As depicted in Figure 1, the Common and Impact Indicators expand across the *HMG* system model. While the centralized access point is typically the primary point of contact between *HMG* and children, families, and providers, it is only one mechanism *HMG* affiliates use to advance developmental promotion, early detection, referral and linkage. The **Served** metrics, based in the Centralized Access Point, are often collected through the electronic intake system tied to a specific call center. The **Bridged, Linked,** and **Engaged** metrics that reflect outreach to child health providers, community partners, and families, may similarly be tracked through an electronic data system or may be documented separately using a different mechanism. In either case, documenting both outreach activities and those activities of the centralized access point are essential to capturing the scope of *HMG* impact in a community.

INDICATORS OF THE CENTRALIZED ACCESS POINT

SERVED METRICS

IMPACT INDICATOR 1. NUMBER OF UNIQUE INTERACTIONS

The number of *HMG* calls over a given time period. Measure 1 is comprised of three distinct categories:

1a. Information-only, no referral. The number of interactions where information was provided (anticipatory guidance, name of a resource) but not a referral to a particular program or service.

1b. Referral, agreed to follow-up. The number of interactions for which a referral was provided for a particular service or program and for which the family agreed to be contacted at a future date by *HMG* to ensure that the family was successfully connected to the referred resource and that there were no other outstanding needs.

1c. Referral, no agreement for follow-up. The number of interactions for which a referral was provided for a particular service or program and for which the family *did not agree* to be contacted at a future date by *HMG* to ensure that the family was successfully connected to the referred resource and that there were no other outstanding needs.

Note:

HMG systems interact with families and providers in multiple ways. Capturing only calls for which a referral is made is not an accurate reflection of the scope of support provided by HMG, as families that receive information are still receiving support and may reconnect with HMG at a future point in time for additional resource needs. Thus, these three categories comprise the measure, 'Number of Unique Interactions'. Further, this measure defines 'interactions' in lieu of 'children', recognizing that some children may be served more than once by HMG but for distinct concerns; in such instances, they should be counted as distinct interactions. Lastly, only metric 1b (Referral, agreed to follow-up) is used as the denominator for Measure 6, Linkage. Successful connection to services should only be assessed for those families that 1) receive a referral and 2) agree to be contacted in the future to determine if service receipt occurred.

COMMON INDICATOR 2. CALLER TYPE

The specific caller that contacted *HMG* either on their own behalf or on the behalf of a particular family.

Suggested Categories:

Parent/caregiver
Other relative
Child care provider
Early childhood educator
Family resource center staff
Child health care provider
Early intervention staff (Part B or Part C)
School district personnel
Service provider (OT, PT, Speech)
Child welfare representative
Other community-based organization staff

COMMON INDICATOR 3. HOW LEARNED

The method by which the individual contacting *HMG* learned of *HMG* as a community resource.

Suggested Categories:

Community agency
Health care provider
Friend or family member
Developmental screening event or activity
Mental health provider
Early care and education provider
School district
Early intervention provider
HMG outreach (presentation, mailing, website, Facebook, resource fair)
Call center (2-1-1)
Prior caller
Other

COMMON INDICATOR 4. DEMOGRAPHICS

The demographic characteristics of the child for whom *HMG* is providing resources or referral. Measure 4 is comprised of six distinct categories:

4a. Age of the child. The age of the child (ranges from prenatal, if serving an expecting parent, to the maximum age served by the *HMG* call center).

4b. Race of the child. The race of the child (American Indian or Alaskan Native, Asian, Black or African American, Native Hawaiian/Other Pacific Islander, White, Other, Unsure, Decline to answer; more than one race should be able to be documented).

4c. Ethnicity of the child. The ethnicity of the child (Hispanic or Latino; not Hispanic or Latino; Unsure; Decline to answer).

4d. Language spoken in the home.

4e. Gender of the child. Can include male, female, or other categories.

4f. Region and/or relevant geographic element. The geographic area in which the child resides – the specific categories for this measure should be driven by the *HMG* affiliate need to assess reach within a given community and/or representativeness of population served.

COMMON INDICATOR 5. SERVICE INTERACTIONS

The elements related to each *HMG* case presentation and actions taken on behalf of the family. Measure 5 is comprised of three distinct categories:

5a. Presenting Concern. The specific issue(s) or concern(s) that prompted the *HMG* interaction. More than one option should be able to be documented.

Suggested Categories:

Adaptive
Basic needs
Behavior
Child care
Cognitive or learning difficulty

Communication
Diagnosis
Education
Family functioning
Fine motor
General development (for typically developing child)
Developmental concern
Developmental screening
General information
Gross motor
Health or medical concern
Health insurance
Hearing
Living condition
Mental health
Parent support
Social interactions
Vision
Other

5b. Referrals. The specific services or programs to which a family is referred. More than one option should be able to be documented.

Suggested Categories:

Allied health professionals
Advocacy or legal assistance
Basic needs
Behavioral services
Child care
Communication, speech and language
Developmental screening (outside of *HMG)*
Early intervention (Part C)
Early literacy
Educational/enrichment
Equipment
Feeding
Funding
Health care provider
Infant follow-up clinic
Medical subspecialist
Mental health/counseling
Occupational therapy
Physical therapy
Parent support
Parent/child participation
Parenting education
Psychoeducational testing
Recreation
School district/Part B
Respite care
Social skills programs
Specialized services (aquatic, dance)
Other

5c. Barriers. The specific reason why a family did not access a particular service or program. One primary barrier should be documented per case.

Suggested Categories:

Application too difficult
Caregiver-specific
Child care
Connected to alternate service
Cost prohibitive
Declined service
Health insurance
Ineligible for service
Language barrier
Limit in capacity of service to take on new cases
Location of service
Scheduling conflict
Transportation

COMMON INDICATOR 6. LINKAGE

The proportion of families connected to services through *HMG.* Measure 6 is comprised of three distinct categories:

6a. Connected. The child (or child & family) is receiving at least one service. All other referrals can be pending or not connected. The proportion of children connected is calculated by dividing the number of children connected to at least one service by the measure 1b (number of children referred, where family agreed to follow-up).

6b. Not connected. The child (or child & family) received a referral, but is not receiving a service. All referrals are not connected.

6c. Pending service. The child (or child & family) is enrolled, registered, waitlisted, or plans to attend a service but it has not yet started. If parent is open to additional call, follow-up after the start date to determine if connected rather than closing with pending service outcome.

IMPACT INDICATOR 7. NEEDS MET

The proportion of families reporting that their needs were met by *HMG.* This measure would be calculated by dividing the number of families reporting that their needs were met by metric 1, the number of unique interactions.

"Would you say that your needs were met today, yes or no?" is asked to families at the time information OR referral information is initially provided.

- Recommended answer options include No, Yes, or Prefer Not to Answer.
- This question is asked only once per case, and *prior to* a follow-up call (prior to receipt of services to which family may have been referred).
- If a family calls back at a subsequent point in time with a different concern, the Needs Met question would be posed a second time.

Note:

This measure is intended to serve at least two purposes. First, it provides a mechanism of quality assurance by ensuring families have the opportunity to voice concerns about the support they receive through HMG in real time. The "needs", in the case of HMG, include those for care coordination support, information provision, and/or referral to appropriate services, but not the actual receipt of services that may address the initial concern that prompted outreach to HMG. Thus, it is important that families understand the needs that a HMG system is capable of meeting. Many HMG affiliates clarify this early in their interaction with a family, by outlining the type of support that will be provided, which will help ensure more informed responses from families about whether their needs were met. Second, the full set of Common and Impact Indicators across all four components are process-driven; these metrics inform the volume, scope, and outcomes of HMG activities across the system model. However, the Needs Met measure offers the opportunity for a family-driven measure that informs our knowledge of families' experience with HMG. Based on our knowledge of the positive impact of HMG on strengthening the Protective Factors, this measure enables all HMG affiliates to speak to whether HMG provided concrete support in times of need for all families.

IMPACT INDICATOR 8. NUMBER OF TRAININGS ON DEVELOPMENTAL SCREENING AND SURVEILLANCE

This number of trainings provided by *HMG* to medical staff (physicians, nurse practitioners, medical social workers, etc.) on the topic of developmental screening and surveillance.

Note:

*The indicator is the number of trainings, not the number of individuals that attend each training. However, affiliates are encouraged to capture attendance at each training and the Fidelity Assessment will ask for information about attendance in addition to number of trainings. *When a training includes the topic of developmental screening and surveillance AND referral and linkage through HMG, this training should be counted only once, under either Measure 8 or Measure 9. A separate question will be reflected in the Fidelity Assessment to ask what proportion of the trainings were delivered as a combined topic. For example, if an affiliate led 15 trainings on developmental screening & surveillance and 20 trainings on developmental screening, surveillance, referral and linkage through HMG, then 15 would be listed for Measure 8 and 20 for Measure 8 OR Measure 9. In the Assessment, the affiliate would clarify that 20 of these were delivered in a combined manner, which enables an affiliate to document that they are providing training across these topics equitably, even if reporting under just one Measure.*

IMPACT INDICATOR 9. NUMBER OF TRAININGS ON REFERRAL AND LINKAGE THROUGH *HMG*

This number of trainings provided by *HMG* to medical staff (physicians, nurse practitioners, medical social workers, etc.) on the topic of referral and linkage through *HMG*.

Note:

*The indicator is the number of trainings, not the number of individuals that attend each training. However, affiliates are encouraged to capture attendance at each training and the Fidelity Assessment will ask for information about attendance in addition to number of trainings. *When a training includes the topic of developmental screening and surveillance AND referral and linkage through HMG, this training should be counted only once, under either Measure 8 or Measure 9. A separate question will be reflected in the Fidelity Assessment to ask what proportion of the trainings were delivered as a combined topic. For example, if an affiliate led 15 trainings on developmental screening & surveillance and 20 trainings on developmental screening, surveillance, referral and linkage through HMG, then 15 would be listed for Measure 8 and 20 for Measure 8 OR Measure 9. In the Assessment, the affiliate would clarify that 20 of these were delivered in a combined manner, which enables an affiliate to document that they are providing training across these topics equitably, even if reporting under just one Measure.*

COMMON INDICATOR 10. NUMBER OF MEDICAL PROFESSIONALS REACHED

The number of medical professionals reached through external events, such as meetings of American Academy of Pediatrics (AAP) chapters, Continuing Medical Education (CME) events sponsored by partners.

COMMON INDICATOR 11. NUMBER OF FAMILIES REACHED

The number of families reached as a result of child health provider outreach efforts. This measure is calculated by documenting the number of families reporting during their intake call at the centralized access point that they learned about *HMG* through a provider or whose provider calls on behalf of the family.

INDICATORS OF COMMUNITY OUTREACH

LINKED METRICS

IMPACT INDICATOR 12. NUMBER OF PARTNERS REACHED

The number of individuals (non-families) representing community agencies reached through a *HMG*-coordinated or *HMG*-led event in order to promote awareness of or create a connection to *HMG.*

- Examples include individuals reached through networking events or outreach conducted to inform the resource directory.
- This measure does not include contacts made with individuals at non-*HMG*-led events.
- This measure is not an unduplicated count; individuals may be counted more than once across multiple events.

IMPACT INDICATOR 13. NUMBER OF PARTNERS TRAINED

The number of non-medical professionals trained on developmental screening and/or referral and linkage through *HMG.*

- Examples include individuals from sectors such as early care and education, home visitation, social services, etc.
- This measure is not an unduplicated count; individuals may be counted more than once since they may attend second training on a different tool.

COMMON INDICATOR 14. RESOURCE DIRECTORY CHANGES

The number of changes (additions, revisions, updates) made to a program/service in the resource directory as a result of outreach efforts. This measure can include even minor, routine changes.

COMMON INDICATOR 15. NUMBER OF EVENTS ATTENDED

The number of events, meetings, etc. attended on behalf of *HMG.*

- This measure is a count of each individual event attended by *HMG*, regardless of the number of staff that attend.

INDICATORS OF FAMILY OUTREACH

ENGAGED METRICS

Impact Indicator 16. Number of Families Reached

The number of individuals (parents, caregivers, other family members) reached through events led or coordinated by *HMG* to promote awareness of child development and/or *HMG.*

- Examples include family members reached through a community outreach event coordinated by *HMG*
- This measure is not an unduplicated count; individuals may be counted more than once
- This measure does not include a count of children, only adult family members
- Event can include but is not limited to or required to include developmental screening

LOCAL USE REPORTS

HMG affiliates will also be asked to provide brief reports describing local use of data, to describe how data has supported workflow and process change and to enhance our collective awareness of best practices in supporting families through the *HMG* system model. Local use reports consist of two measures:

LOCAL USE 1. TREND

Report at least one **trend** that was identified and acted upon using *HMG* data within the last year.

For example, a HMG affiliate reaches out to a community partner in response to noting a low connection rate for families referred to that program.

LOCAL USE 2. SMART AIM

Identify an annual SMART aim based on *HMG* implementation.

A SMART aim is an aim that is Specific, Measurable, Achievable, Realistic, and Time-Bound, and is a useful tool to guide planning and implementation efforts. Annual SMART Aims and their results should be reported each September through the Fidelity Assessment. This will include the identified aim and the progress towards this aim to date.

For example, by September 1, 2018, we will implement a new workflow procedure to ensure that the resource directory is updated on a quarterly basis.

The Process for Collecting the Indicators

HOW

The Indicators and Local Use Reports will be collected from all *HMG* affiliates through the annual *HMG* Fidelity Assessment. The Fidelity Assessment was first administered in 2016 and will continue to be administered on an annual basis, as a tool to support *HMG* advancement at both the local and national level. The Assessment enables local affiliates to document their progress in completing those activities essential to each of the four core components of the *HMG* model, identify priority areas to focus on in the coming year, and share new strategies or approaches and lessons learned and support awareness of best practices across the network. At the National level the Assessment captures the progress of *HMG* implementations across the country, and ensures a standardized approach to classifying affiliates as being in a stage of exploration, installation, or implementation based on their achievement of key milestones.

Impact Indicators will be collected through the Fidelity Assessment, for two primary reasons: first, collecting the Indicators through the Assessment minimizes the number of data reporting requests that *HMG* National makes of *HMG* affiliates each year, and because affiliates use different technologies to support data collection, there is no way for data to be exported or shared with National through any other means. Second, embedding the Indicators within the Assessment ensures that both the local affiliate and National have needed context to interpret the data points. For example, knowing the developmental stage of a *HMG* call center can clarify variations in call volume. Over time, we can better assess the relationships between duration of implementation and *HMG* reach in a community. An understanding of the infrastructure and approach used by each affiliate is essential to understanding the data collected.

FROM WHOM

The Fidelity Assessment was designed to and will continue to be administered at the level of the *call center*. Each HMG call center is considered to be the centralized access point for its distinct HMG 'system'. The Assessment solicits information about the structure of a particular call center, as well as Child Health Care Provider Outreach, Family & Community Outreach, and Data Collection efforts that support the functioning of that call center. In a state with a single *HMG* system in place, one Fidelity Assessment will be completed by the *HMG* lead (or designee) in that state. In states with multiple *HMG* systems (or as states develop and implement new sites within their state), *HMG* National will collect individual Fidelity Assessments from each system, in partnership with the state lead. Information across multiple systems should not be aggregated in the Fidelity Assessment.

WHEN

The Indicators will be collected for the first time with the next Fidelity Assessment, administered September 1, 2017 and due to *HMG* National by September 30, 2017, and each year thereafter during the same time frame.

How *HMG* National will use the Indicators

Collecting data and measuring results is a core strategy to promote collective impact. While our network grows, it can be inferred that our growth in new *HMG* implementations across the country is sufficient to demonstrate our progress. However, our true impact is ultimately at the community and family level: how much does *HMG* do, how well are we doing it, and is anyone better off? Our capacity to answer these questions not just through one implementation but across a network is incredibly powerful, and enables continued learning about the degree to which *HMG* supports young children in reaching their optimal developmental potential.

For this reason, *HMG* National seeks to invite more frequent and intensive attention to data, data analysis, evaluation findings, and continuous quality improvement. Just as the National Network convenes to discuss relevant initiatives, progress, new funding opportunities, etc., so too do we need to create and sustain a dialogue about the impact of our efforts. To that end, we will be intentional in ensuring greater visibility and transparency around the data that we collect. We intend to collect these data to assess our progress as a network; in the early stages, our focus will be mainly on describing the landscape: How many children are served? What proportion of families report that their needs were met by *HMG*? In the future, we anticipate that having longitudinal data across a growing number of *HMG* systems will be incredibly impactful. First, we will gain greater awareness of how *HMG* implementation supports increased spread and scale: How does the backbone entity of *HMG* influence community partnerships? What is the typical staffing structure of a *HMG* call center? Second, we will be able to establish informed targets for our collective performance over time. *HMG* operates in many states, yet we recognize that we cumulatively serve only about 50,000 children per year; based on the population of children *HMG* is intended to serve, we anticipate and expect this number to increase over time. Gaining a sense of the volume of children served each year allows us to establish realistic goals and strategies for how we can serve a greater number of families. Lastly, we are confident that growth of our network and having access to a set of shared measures across the system will open the door to new areas of focus for our Communities of Practice, as well as new funding opportunities in support of *HMG*.

HMG National will summarize the data to the network in the form of a *hybrid report*. The hybrid report will: share aggregate data points from across the network, and may also highlight specific affiliate approaches, successes, or data points in the event such information would be helpful for the network. We view the report as providing *HMG* affiliates with critical information about other implementations and guiding continued evolution and success in *HMG* implementation.

How the Indicators Inform the Broader Framework for Evaluation

The evolution of *HMG* from an isolated program operating in one community to a National Network of affiliate implementations, each tailored to align with local priorities, suggests our need to expand beyond a traditional program evaluation framework. As such, in lieu of seeking to isolate the direct impact of *HMG,* our goal is to better understand the impact of multiple *HMG* implementations all operating under a shared model that comprises the four core components and three structural requirements. Further, we also shift our focus from an emphasis on proof of the efficacy of the intervention to an emphasis on continuous learning that allows us to continue to improve the *HMG* model and strengthen what we know about designing optimal early childhood systems to support young children and families.

Our broader evaluation approach is informed by key principles of Collective Impact, including the need to develop strategies to measure, for a given initiative, *context, design and implementation,* and *process and impact.* Our efforts to measure *context* are supported by a growing portfolio of tools of the *HMG* National Center, including strategies to measure community support for *HMG* as well as relationships among those partners considered vital to *HMG* implementation. Our efforts to measure *design and implementation* and directly informed by fidelity, which offers a standardized approach to measuring the approach to implementation of the model in a growing number of communities. Lastly, our efforts to measure *process and impact* are supported in part through *HMG* affiliate use of Common and Impact Indicators to guide their local measurement. In the future, we are eager to expand our knowledge of *HMG* impact on communities and systems.

FAQ

Will I be expected to report on *all* of the Indicators, including the new ones, in September 2017?

Some of the Indicators described above are consistent with the previous metrics collected by HMG National while some are newly developed. HMG National understands and expects that affiliates not previously collecting a specific Indicator may need more time to begin collecting data than that available between the distribution of these Guidelines and the Fidelity Assessment. However, as described above, our goal is to create consistency across the Network in terms of metrics; as such, we encourage all affiliates to develop a plan to enable eventual reporting of the Indicators, ideally by the 2018 Assessment. HMG National is happy to connect individually with affiliates to discuss further and identify opportunities to align with the new data reporting requirements.

What if a particular Indicator listed above does not apply to my system, because of our internal structure and approach?

A strength of HMG is the capacity for local communities to adapt the HMG model in ways that support fit and feasibility of implementation. However, such variation makes the identification of measures that can apply to all systems challenging. The Indicators above were selected based on a recognition that these measures reflect core activities of HMG and should be applicable to HMG affiliates. That said, we recognize that as systems evolve, performance on certain Indicators may vary based on the approaches taken by local affiliates with respect to these activities. The Fidelity Assessment provides needed context to interpret data entered for specific Indicators.

What if the Indicators do not align with the data points that are expected or required of a funder or other key partner?

We understand that there are many priorities for data collection and reporting, often influenced by the backbone agency of HMG and funder expectations. For this reason, the HMG *National Center has intentionally developed the requested data to revolve around basic functions of critical activities of the* HMG *model. We expect that this information will be beneficial as local metrics to measure reach and progress over time as well as to provide contextual information for any additional measures submitted to funders or other partners.*

If you have additional questions about the new reporting requirements, please contact Von Jessee at VJessee@connecticutchildrens.org.