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# Advisory Committee on the Maternal, Infant and Early Childhood Home Visiting Program Evaluation

Internet-based Meeting

March 23, 2011



## Welcome & Opening Remarks

Charge of the Committee

9:00 to 9:30 am

**Peter van Dyck (Co-chair)**

Associate Administrator for Maternal and Child Health, Health Resources and Services Administration (HRSA)

**Naomi Goldstein (Co-chair)**

Director, Office of Planning, Research, and Evaluation, Administration for Children and Families (ACF)



# Advisory Committee on the Maternal, Infant and Early Childhood Home Visiting Program Evaluation

Introduction of Committee Members

9:30 to 10:30 am



# Morning Break

Webcast will resume at 10:45 am Eastern

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# Affordable Care Act Maternal, Infant and Early Childhood Home Visiting Program

Audrey M. Yowell, PhD, MSSS

U.S. Department of Health and Human Services  
Health Resources and Services Administration;  
Maternal and Child Health Bureau  
Administration for Children and Families

# Overview of Presentation

- Legislative authority and program goals
- Program timeline and steps for applying for FY 2010 funding
- Status on Updated State Plan and Key Components
- Role of Secretary's Advisory Committee

# Legislative Authority

- Section 2951 of the Affordable Care Act of 2010 (P.L. 111-148)
- Amends Title V of the Social Security Act to add Section 511: Maternal, Infant and Early Childhood Home Visiting Programs
- \$1.5 billion over 5 years
  - \$100 m FY 2010
  - \$250 m FY 2011
  - \$350 m FY 2012
  - \$400 m FY 2013 and FY 2014
- Grants to States (with 3% set-aside for grants to Tribes, Tribal Organizations, or Urban Indian Organizations and 3% set-aside for research, evaluation, and TA)
- Requirement for collaborative implementation by HRSA and ACF

# Legislation Purposes

- (1) To strengthen and improve the programs and activities carried out under Title V of the Social Security Act;
- (2) To improve coordination of services for at-risk communities; and
- (3) To identify and provide comprehensive services to improve outcomes for families who reside in at-risk communities.

# Home Visiting Program Goal

Through high-quality, “evidence-based” home visiting programs targeted to pregnant women, expectant fathers, and parents and primary caregivers of children aged birth to kindergarten entry in at-risk communities, promote:

- Improvements in maternal and prenatal health, infant health, and child health and development;
- Increased school readiness;
- Reductions in the incidence of child maltreatment;
- Improved parenting related to child development outcomes;
- Improved family socio-economic status;
- Greater coordination of referrals to community resources and supports; and
- Reductions in crime and domestic violence.

# Additional Program Goals

- Support the development of statewide systems in every State to ensure effective implementation of evidence-based home visiting programs grounded in empirical knowledge
- Establish home visiting as a key early childhood service delivery strategy in high-quality, *comprehensive* statewide early childhood systems in every State
- Foster collaboration among maternal and child health, early learning, and child abuse prevention leaders in every State
- Promote collaboration and partnerships among States, the Federal government, local communities, home visitation model developers, families, and other stakeholders

# “Evidence-Based” Policy

- Requires grantees to implement evidence-based home visiting models
  - Federal Register Notice published July 23<sup>rd</sup> inviting public comment on proposed criteria for assessing evidence of effectiveness of home visiting program models
- Allows for implementation of promising strategies
  - Up to 25% of funding can be used to fund “promising and new approaches” that would be rigorously evaluated

# Tribal Program

- Administered by ACF Office of Child Care, in collaboration with HRSA
- 3 percent set-aside - \$3 million in FY 2010
- Discretionary grants to Tribes (including consortia of Tribes), Tribal Organizations, and Urban Indian Organizations
- 13 five-year cooperative agreements awarded September 28, 2010
- 5 additional grants anticipated to be awarded in FY2011
- Tribal grants, to the greatest extent practicable, are to be consistent with the grants to States and territories and include conducting a needs assessment, meeting evidence-based criteria, and establishing benchmarks

# Timeline for FY 2010 State MIECHV Funding

Step 1: State applications in response to Funding Opportunity Announcement	Due July 9, 2010
Step 2: Supplemental Information Request for the Submission of the Statewide Needs Assessment	Due September 20, 2010
Step 3: Supplemental Information Request for the Submission of the Updated State Plan for a State Home Visiting Program	Due within 90-120 days of issuance (May 9 through June 8, 2011)

# Funding for FY2010 and FY2011

- States have 27 months to *obligate* their FY10 funds (funds must be expended by September 30, 2012)
- The states must receive their allocation of FY11 funds by 9/30/2011
- Each State will continue to receive at least its FY10 allocation in FY11 through FY15; HHS will also be awarding funds on a competitive basis beginning in FY11

# Needs Assessment

- Within 6 months of enactment, States must conduct a statewide needs assessment in order to receive FY2011 MCH Services block grant
- The assessment must identify:
  - Communities with concentrations of premature birth, low-birth weight infants, and infant mortality, including infant death due to neglect, or other indicators of at-risk prenatal, maternal, newborn, or child health; poverty; crime; domestic violence; high rates of high-school drop-outs; substance abuse; unemployment; or child maltreatment.

# Updated State Plan

- The third and final step in the FY 2010 application process
- Issued on 2/08/11, the SIR provides guidance to States for making the final designation of the targeted at-risk community(ies), updating and providing a more detailed needs and resources assessment, and submitting a specific plan tailored to address these needs
- The SIR identifies criteria for establishing evidence of effectiveness of home visiting models, and lists the models determined to be evidence-based

# SIR for an Updated State Plan: Overview

## Sections:

1. Identification of the State's Targeted At-Risk Communities
2. Goals and Objectives
3. Selection of Proposed Models
4. Implementation Plan
5. Plan for Meeting Legislatively-Mandated Benchmarks

# SIR for an Updated State Plan: Overview

6. Plan for Administration of State HV Program
7. Plan for Continuous Quality Improvement
8. Technical Assistance Needs
9. Reporting Requirements

## Attachments:

- Memorandum of Concurrence
- Budget

# Selection of Home Visiting Model(s)

- Proposed criteria for identifying home visiting models with evidence of effectiveness published in the Federal Register July 23, with comments due August 17, 2010
- Following analysis of 130 letters submitted, final criteria was developed, provided in Appendix A of the SIR. Responses to public comments in Appendix F.

# Selection of Home Visiting Model(s)

- Models meeting criteria for evidence of effectiveness are specified in Appendix B and on the Home Visiting Evidence of Effectiveness Review (HomVEE) website: <http://homvee.acf.hhs.gov/>

# Models that Meet the Criteria for Evidence Base

- Early Head Start – Home-Based Option
- Family Check Up
- Healthy Families America
- Healthy Steps
- Home Instruction Program for Preschool Youngsters
- Nurse-Family Partnership
- Parents as Teachers

# Selection of Home Visiting Model(s)

States may:

- Select a model(s) that meets criteria for evidence of effectiveness from Appendix B
- Propose another model not reviewed by HomVEE study
- Request reconsideration of an already-reviewed model
- Propose use of up to 25% of funds for a promising approach

# Selection of Home Visiting Model(s)

- States must describe how the model(s) meets need of community(ies) proposed
- Within 45 days, States must secure approval by developer(s) to implement model(s) as proposed, including any acceptable adaptations

# Meeting Legislatively-Mandated Benchmarks

- States must provide a plan for data collection for each of the 6 benchmark areas:
  1. Improved maternal and newborn health
  2. Prevention of child injuries, child abuse, neglect, or maltreatment, and reduction of emergency department visits
  3. Improvement in school readiness and achievement
  4. Reduction in crime or domestic violence
  5. Improvements in family economic self-sufficiency
  6. Improvements in the coordination and referrals for other community resources and supports

# Meeting Legislatively-Mandated Benchmarks

## Major requirements:

- States must collect data on all 6 benchmark areas
- States must collect data for all constructs under each benchmark area
- To demonstrate improvements, the state must show improvement in at least half of the constructs under each benchmark area
- We recommend that programs utilize these and other appropriate data for continuous quality improvement

# Updated State Plan Review

- Reviewed by Federal project staff
- The review will consider:
  - Justification of targeted community(ies) at risk
  - How the model(s) addresses specific community needs
  - Plan for meeting benchmarks and collecting data
  - Overall feasibility of plan
  - Level of commitment and concurrence among required partners

# Independent, Expert Advisory Panel

- The Secretary, in accordance with subsection (h)(1)(A), shall appoint an independent advisory panel consisting of experts in:
  - Program evaluation and research
  - Education
  - Early childhood development

# Independent, Expert Advisory Panel Charges

- To review, and make recommendations on, the design and plan for the evaluation required within 1 year of March 23, 2010
- To maintain and advise the Secretary regarding the progress of the evaluation
- To comment, if the panel so desires, on the report submitted to Congress

# Evaluation Components

(A) An analysis, on a State-by-State basis, of the results of the statewide needs assessments, including indicators of maternal and prenatal health and infant health and mortality, and State actions in response to the assessments

# Evaluation Components

## (B) An assessment of:

- Effect of ECHV programs on child and parent outcomes (including specified benchmark areas and participant outcomes)
- Effectiveness of programs on different populations, including ability to improve participant outcomes
- Potential for activities, if scaled broadly, to improve health care practices, eliminate health disparities, and improve health care system quality, efficiencies, and reduce costs

# Report Requirements

- No later than March 31, 2015, the Secretary shall submit a report to Congress on the results of the evaluation conducted
- And shall make the report publicly available

# Questions?

**Audrey M. Yowell, PhD, MSSS**

**Chief, Early Childhood Health and Development  
Branch**

**National Program Director, Maternal, Infant and Early  
Childhood Home Visiting Program**

**Health Resources and Services Administration**

**Maternal and Child Health Bureau**

**Thank you!**

# Research and Evaluation on the Maternal, Infant and Early Childhood Home Visiting Program

Naomi Goldstein, Ph.D.

Director, Office of Planning, Research and Evaluation  
Administration for Children and Families



# Research and Other Evaluation Activities

- Secretary shall carry out a continuous program of research and evaluation activities to increase knowledge about the implementation and effectiveness of home visiting programs, using random assignment designs to the maximum extent feasible.

# Research and Other Evaluation Activities, continued

- Secretary shall ensure
  - Evaluation of a specific program or project is conducted by persons or individuals not directly involved in the operation of such program or project; and
  - Conduct of research and evaluation activities includes consultation with independent researchers, State officials, and developers and providers of home visiting programs on topics including research design and administrative data matching.

# Research and Other Evaluation Activities, continued

- Interagency federal workgroup of agencies with responsibility for administering or evaluating programs that serve eligible families to coordinate and collaborate on research on these programs.

# Reservations

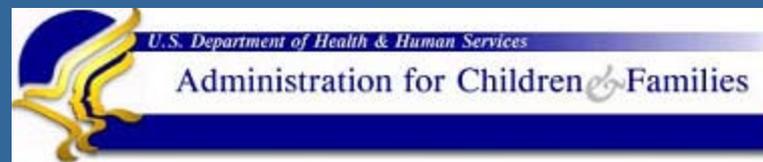
- 3% of funding each year is for the purposes of:
  - The national evaluation
  - Ongoing portfolio of research and evaluation
  - Technical assistance around the Corrective Action Plan (specified in the legislation)

# Design Options for Home Visiting Evaluation (DOHVE)

- In September 2010, the Office of Planning, Research and Evaluation entered into a contract with MDRC with subcontractors James Bell Associates, Cincinnati Children's Hospital Medical Center and a number of academic consultants
- Co-Principal Investigators are Virginia Knox (MDRC), Charles Michalopoulos (MDRC), and Anne Duggan (Johns Hopkins University)
- Purpose of this contract is to:
  - Design a national evaluation following specifications in the legislation
  - Conduct technical assistance to grantees around evaluation of promising models, benchmarks, continuous quality improvement and management information systems

# Next Steps

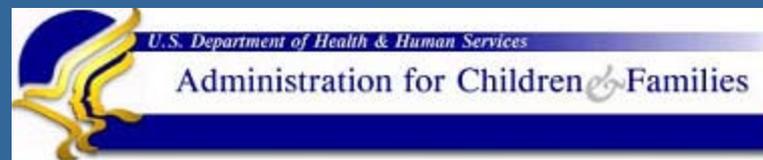
- No later than June 1, 2011 a Request for Proposals for the national evaluation must be published
- New contract for carrying out the national evaluation must be awarded no later than September 30, 2011



## Mid-Day Break

Webcast will resume at 1:00 pm Eastern

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**Broadcast Continues**

Thanks again for joining us

# **Design Options for Maternal, Infant Early Childhood Home Visiting Evaluation (DOHVE)**

## **Meeting of the Secretary's Advisory Committee**

Virginia Knox, MDRC

Anne Duggan, Johns Hopkins University

Charles Michalopoulos, MDRC

March 23, 2011

# Maternal, Infant, Early Childhood Home Visiting (MIECHV) national evaluation design options: What we will cover today

- ❑ Evidence-based programs, prior research, and unanswered questions
- ❑ HHS goals for the national evaluation
- ❑ Challenges in developing the design
- ❑ Opportunities to advance the field's understanding of what works for whom, and why
- ❑ Timeline for the evaluation
- ❑ Feedback from SAC on specific design questions

# Program goals

<b>Early Head Start</b>	<b>Family Check-Up</b>	<b>Healthy Families America (HFA)</b>	<b>Healthy Steps</b>	<b>Home Instruction for Parents of Preschool Youngsters (HIPPY)</b>	<b>Nurse Family Partnership (NFP)</b>	<b>Parents as Teachers (PAT)</b>
<p>Enhance child intellectual and emotional development</p> <p>Assist pregnant women in accessing preventative care</p>	<p>Reduce problem behaviors and mental health problems in children and adolescents</p> <p>Help parents address challenges that arise with youth before they become more serious</p>	<p>Ensure child health and development</p> <p>Promote positive parenting</p> <p>Encourage parent support systems and link to resources</p>	<p>Promote child development and school readiness</p> <p>Promote positive parenting</p> <p>Encourage relationship between child health care provider and parents</p>	<p>Promote preschooler school readiness by supporting parents in their instruction</p>	<p>Improve child health and development</p> <p>Improve pregnancy outcomes by encouraging prenatal health</p> <p>Help parents develop vision for future, plan subsequent pregnancies, complete education, find work</p>	<p>Increase child school readiness and success</p> <p>Detect developmental delays and health issues early</p> <p>Improve parenting practices</p> <p>Prevent child abuse and neglect</p> <p>Increase parent knowledge of early childhood development</p>

# Target population

<b>Early Head Start</b>	<b>Family Check-Up</b>	<b>Healthy Families America (HFA)</b>	<b>Healthy Steps</b>	<b>Home Instruction for Parents of Preschool Youngsters (HIPPY)</b>	<b>Nurse Family Partnership (NFP)</b>	<b>Parents as Teachers (PAT)</b>
<p>Low-income families</p> <p>Pregnant women</p> <p>Children with disabilities</p> <p>Children under 3</p>	<p>Families with some level of socioeconomic risk</p> <p>Families and children with other risk factors</p>	<p>At-risk pregnant women</p> <p>Newborns</p>	<p>Parents with children under 30 months old</p> <p>Families served by participating medical practice or organization</p>	<p>Families with children ages 3 to 5</p> <p>Parents who lack confidence in their ability to prepare their children for school</p> <p>Parents with limited financial resources</p>	<p>First-time, low-income mothers and their children</p> <p>Prenatal mothers</p> <p>Children under 2</p>	<p>Families with prenatal mothers and their children</p> <p>Children until they enter kindergarten</p>

# Target age at enrollment

<b>Early Head Start</b>	<b>Family Check-Up</b>	<b>Healthy Families America (HFA)</b>	<b>Healthy Steps</b>	<b>Home Instruction for Parents of Preschool Youngsters (HIPPY)</b>	<b>Nurse Family Partnership (NFP)</b>	<b>Parents as Teachers (PAT)</b>
Children between birth and age 2	Families with children age 2 to 17 years	First assessment to occur prenatally or within two weeks of the birth of a child	First visit to occur when the child is 3-6 days old	Prefer three-year program (serves children from age 3 to 5)  Offer two-year program (serves children from age 4 to 5)	First home visit to occur no later than the end of week 28 of gestation	Enrollment to occur prenatally or soon after birth

# Home visitor qualifications

Early Head Start	Family Check-Up	Healthy Families America (HFA)	Healthy Steps	Home Instruction for Parents of Preschool Youngsters (HIPPY)	Nurse Family Partnership (NFP)	Parents as Teachers (PAT)
<p>Site-specific standards</p> <p>Knowledge of: child development and early childhood education; child health, safety, and nutrition; adult learning; family dynamics</p>	<p>Recommend a doctoral or master's degree in psychology or a related field and previous experience carrying out family-based interventions</p> <p>Given additional support, also allow a bachelor's or associate's degree</p>	<p>No specific requirements</p> <p>Willingness to work in, or experience working with: culturally diverse communities, families with multiple needs</p>	<p>Recommend bachelor's degree with training or education in child development, family studies, nursing, psychology, or a related field</p> <p>Prefer knowledge about: early child growth and development, parent-child relationship; experience working in a medical setting or with health professionals</p>	<p>Require home visitors come from targeted community and have a child of HIPPY age, or one with whom they can engage in the curriculum</p> <p>Other qualifications may be specified by the local implementing agency</p>	<p>Require nurse home visitors to be registered professional nurses with a minimum of a Baccalaureate degree in nursing</p>	<p>Not specific requirements</p> <p>Qualifications for parent educators are focused on PATNC training</p>

# Implementation support by national program office or university

<b>Early Head Start</b>	<b>Family Check-Up</b>	<b>Healthy Families America (HFA)</b>	<b>Healthy Steps</b>	<b>Home Instruction for Parents of Preschool Youngsters (HIPPY)</b>	<b>Nurse Family Partnership (NFP)</b>	<b>Parents as Teachers (PAT)</b>
<p>Office of Head Start in the Administration for Children and Families (ACF) of the U.S. Department of Health and Human Services (DHHS)</p> <p>Regional offices guide programs in their jurisdiction</p>	<p>Child and Family Center (CFC) at the University of Oregon</p> <p>No state-level support for implementation</p>	<p>Prevent Child Abuse America (PCA America)</p> <p>Twelve states have systems to support HFA implementation</p>	<p>Boston University School of Medicine, Department of Pediatrics</p> <p>No information is available about state-level support for implementation.</p>	<p>HIPPY USA National Office</p> <p>Ten states have HIPPY coordinating offices</p>	<p>Nurse Family Partnership National Service Office (NSO)</p> <p>Five states have partnerships for NFP consultative services</p>	<p>Parents as Teachers National Center (PATNC)</p> <p>No information is available about state-level support</p>

# Training required or available?

<b>Early Head Start</b>	<b>Family Check-Up</b>	<b>Healthy Families America (HFA)</b>	<b>Healthy Steps</b>	<b>Home Instruction for Parents of Preschool Youngsters (HIPPY)</b>	<b>Nurse Family Partnership (NFP)</b>	<b>Parents as Teachers (PAT)</b>
Home visitors are required to participate in pre-service training	There is a Family Check-Up training available. Unclear as to whether this is mandatory.	All staff required to complete mandatory HFA training	Recommend that clinicians who will see families participate in Healthy Steps training	Require coordinators to complete a week-long HIPPY pre-service training, but does not require of home visitors	Require nurse home visitors and nursing supervisors to complete core education sessions offered by NFP NSO	Qualifications for both parent educators and supervisors are focused on attending PATNC training

# MIS system

<b>Early Head Start</b>	<b>Family Check-Up</b>	<b>Healthy Families America (HFA)</b>	<b>Healthy Steps</b>	<b>Home Instruction for Parents of Preschool Youngsters (HIPPY)</b>	<b>Nurse Family Partnership (NFP)</b>	<b>Parents as Teachers (PAT)</b>
No specific infrastructure or data system requirements Recommend programs use record-keeping systems	Prefer implementing agencies have high-speed Internet to upload digital images of sessions for supervision	Require implementing agencies to use the Program Information Management System (PIMS)	No information available	Require that sites implement the HIPPY management information system (MIS) a computer program	Require implementing agencies to use web-based data system, Clinical Information System (CIS)	No information available

# Prior research

- ▶ Evidence of effects for seven national models
  - No single model has improved all benchmark areas for all high risk groups
  - There are few studies for some groups specified in the Affordable Care Act (ACA)
  
- ▶ Moreover
  - Several key studies conducted by model developers
  - Results vary substantially across studies
  - Measures vary across studies
  - Minimal information on program implementation
  - Many local programs adapt the evidence-based models

# Unanswered questions that the national evaluation can inform

- ▶ What are the impacts of home visiting programs as operated with the MIECHV funding?
- ▶ What are the impacts of home visiting programs when outcomes are measured consistently across programs and across domains of interest, by an independent evaluator?
- ▶ What is the variation in effects for different groups of families to whom home visiting is extended in MIECHV?
- ▶ What are the relationships between features of the service model and implementation system, services delivered, and impacts?

# Broad HHS goals for the national evaluation

- ▶ Use a rigorous design for assessing effectiveness overall and for key populations
- ▶ Learn about effectiveness in all ACA domains
- ▶ Systematically study program implementation
- ▶ Gain information to strengthen programs into the future
- ▶ Reflect the national diversity of communities and populations

# A few challenges for the evaluation design

- ▶ Seven very different models in one evaluation
- ▶ Thousands of home visiting programs already exist
- ▶ Home visiting services are highly decentralized
- ▶ Collecting data across all domains
- ▶ States have not yet submitted their updated plans
- ▶ Timeline between now and 2015 report to Congress

# HHS goal: Use a rigorous design

- ▶ ACA requires an assessment of MIECHV program effectiveness
- ▶ Preferred design is random assignment
- ▶ Despite some uncertainties in the environment, random assignment does appear feasible
  - Need to determine feasibility community-by-community
  - Choose sites that cannot serve all eligible families
  - New funding may present opportunities to study expanding programs

# HHS goal: Learn about overall effectiveness of MIECHV program

- ▶ Seven program models differ in many respects
  - Some local programs blend features of more than one model
- ▶ Diversity both a challenge and an opportunity
  - Can be difficult to compare so many different approaches
  - Different age groups of children increases costs of data collection
  - But diversity of approaches provides opportunity to understand what works best for whom
- ▶ Cost-effectiveness analysis presents a way to summarize and compare effects
  - What is the cost of achieving a particular outcome, such as reductions in low birthweight or child maltreatment?
  - How does this differ by features of programs or by subgroup?

# HHS goal: Learn about impacts in all ACA domains

- ▶ Evidence-based programs vary in targeted outcomes
  - Prevention (risks to maternal and infant health, child maltreatment)
  - Promotion of social-emotional development through positive parenting
  - Promotion of school readiness
  - Attention to economic security, parental health, intimate partner violence
- ▶ Implications for the national evaluation
  - Design should consistently measure all domains across all programs
  - Some domains must be measured differently by age of child
  - Some domains measured through direct assessments or observations
  - Administrative data needed for outcomes not reliably reported by parents (e.g., child abuse and neglect)

# HHS goal: Represent diversity of communities, populations, programs

- ▶ Home visiting programs currently exist in thousands of communities
- ▶ MIECHV funding may greatly increase number of programs, expand existing programs
- ▶ Evaluation should seek to study broad range of communities, families, and program models
  - Avoid having one program model or type of location dominate the results
  - Allows examination of variation in impacts by program features

# Achieving geographic diversity

- ▶ Option 1: Choose sites from throughout the country
  - Could more closely represent geographic diversity of programs
  - May most closely address what MIECHV funds are purchasing
  - But difficult and expensive to carry out research in many, widely dispersed sites

# Achieving geographic diversity

- ▶ Option 2: Concentrate sites in a subset of states
  - Sites could be purposefully chosen to ensure diversity across program models and populations served
  - Clustering can reduce evaluation costs (e.g., data collection)
  - Results can be weighted to reflect distribution of programs or populations
  - If focus on very few states, could reduce diversity of programs and implementation systems

# Achieving geographic diversity

- ▶ Option 3: Focus on well-operated programs in major cities
  - Further reduces evaluation costs
  - Less opportunity to learn from a diversity of programs
  - May be difficult to find multiple well-operated programs in any one city

# Programs will be diverse in other respects

## ▶ Maturity of program

- MIECHV may result in many new programs or expand existing programs
- Including new programs would provide greater diversity but new programs take time to fully implement, likely less effective than when steady state

## ▶ Target population

- Program models vary in age of children served
- Local programs may target particular groups of disadvantaged parents

## ▶ Program model

- Some models may be chosen by few local sites

## ▶ Quality of implementation

- An opportunity to learn from variation in implementation

# Analysis of state needs assessments

- ▶ States complete three–step application process to receive MIECHV funding
  - Second step: identify at–risk communities, quality and capacity of existing programs, capacity for providing substance abuse treatment and counseling
  - Third step: (updated plan) more detailed needs assessment and plan for implementing home visiting programs
- ▶ ACA requires an analysis of these needs assessments
- ▶ Analysis may help evaluation to choose sites, understand who is being served and which program models are being used

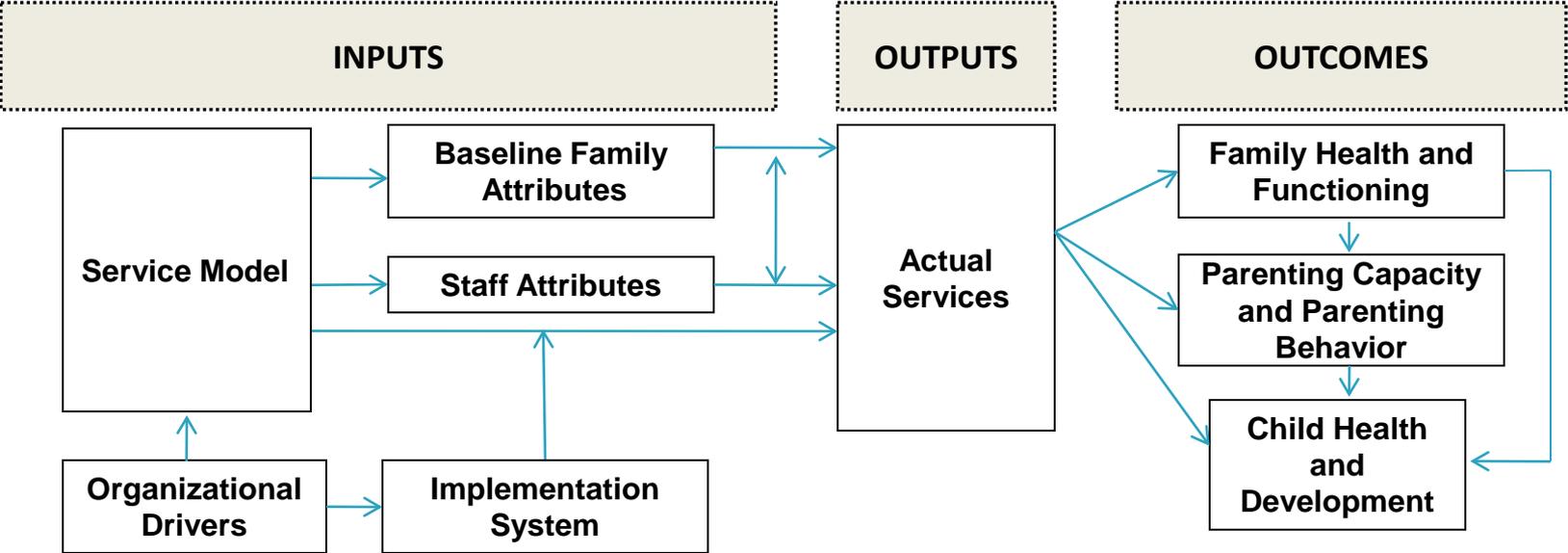
# Challenge for the evaluation: Home visiting services are highly decentralized

- ▶ **Eligibility procedures and criteria vary by local site**
  - Eligibility process may present complications for evaluation enrollment in some sites
  - Raises challenges for comparing impacts across sites
  
- ▶ **Each site adds to evaluation costs**
  - Need to negotiate procedures for recruiting families
  - Implementation research requires data from all sites
  - Surveys and direct assessments require survey staff on location

# HHS goal: Gain information to strengthen future programs

- ▶ Programs vary in many dimensions
- ▶ Key question: Which features of service models and implementation systems are associated with the largest effects?
  - Requires implementation research to measure program features and approaches
  - Rarely addressed in prior evaluations
    - Generally limited information on implementation
    - Different measures used by different evaluators
    - Meta-analyses limited to components identified in literature

# Conceptual model for national evaluation



# Lessons for the MIECHV evaluation design from implementation science

- ▶ Program impacts are influenced by the efficacy of the program model *and* how faithfully the model is implemented
- ▶ Implementation is influenced by the implementation system at multiple levels
  - Clarity of the model
  - Organizational capacity (effective leadership, shared decision-making, administrative support)
  - Supports for individual staff (consultation, feedback)
  - Staff competence to carry out their roles

# Lessons for MIECHV evaluation design from prior home visiting research

- ▶ Actual services provided are expected to influence impacts.
  - Dosage, content, quality
- ▶ Staff and family characteristics influence how services are delivered.
  - Understanding of the program and their roles
  - Willingness and ability to carry out their roles
- ▶ The service model and the implementation system influence staff and family characteristics.
  - Clarity of the service model – intended outcomes, roles
  - Implementation system – how families are recruited, how staff are reinforced in carrying out their roles

# Opportunities for MIECHV national evaluation

- ▶ Can learn whether there are impacts for each domain, for whom, and make important inroads into *how and why* impacts vary.
- ▶ Provide lessons for the future about targeting, adapting or enhancing service models, and strengthening implementation systems.
- ▶ Need to measure how services are delivered and reasons for variation.

# Additional challenge: States have not yet updated their plans

- ▶ Several key pieces of information are unknown
  - Which program models states will use
  - Which groups of families they will serve
  - Which communities will be targeted for MIECHV programs
- ▶ Evaluation design consequently needs to make assumptions
  - Details may need to be modified after state plans are complete



# Implications of timeline to 2015

## Congressional report

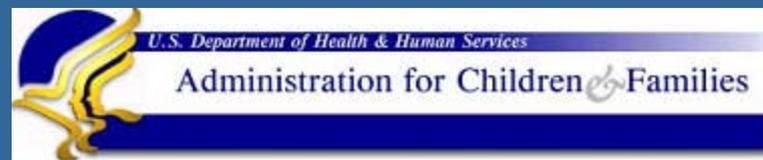
- ▶ Report to Congress in 2015 could cover:
  - Home visitor characteristics at program site entry into study
  - Family characteristics at enrollment
  - Program features and early implementation results
- ▶ Impact study could include:
  - 12 month follow up in a 2017 report
  - 24 month follow up in a 2018 report
- ▶ Assumes site selection and set up of enrollment procedures can be completed efficiently



# Advisory Committee on the Maternal, Infant and Early Childhood Home Visiting Program Evaluation

Committee: Discussion & Expected Next Steps

2:00 to 3:00 pm



# Advisory Committee on the Maternal, Infant and Early Childhood Home Visiting Program Evaluation

Closing Remarks; Adjournment



## Technical Difficulties

Please stand by.

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