

Affordable Care Act Maternal, Infant, and Early Childhood

Home Visiting Program

DRAFT

Supplemental Information Request for the Submission of the Updated State Plan for a State Home Visiting Program

On July 21, 2010, Health Resources and Services Administration (HRSA) awarded formula grants to the fifty States and six jurisdictions (collectively referred to as “States” in this document), of which \$500,000 was unrestricted and available to support the home visiting needs assessment and planning process for a Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program. All of the grantees that applied for this grant were awarded home visiting funding. Every grantee has submitted a statewide needs assessment and all of these have been approved. Now each of the 56 grantees is required to develop an Updated State Plan for a State Home Visiting Program.

This Supplemental Information Request (SIR) provides guidance for preparing the Updated State Plan for a State Home Visiting Program, including identification of the community(ies) at risk where home visiting services are to be provided, a detailed assessment of the particular needs of that community(ies) in terms of risk factors, community strengths, and existing services; identification of home visiting services proposed to be implemented to meet identified needs in that community(ies); a description of the State and local infrastructure available to support the program; specification of any additional infrastructure support necessary to achieve program success; and a plan for collecting benchmark data, conducting continuous quality improvement and performing any required research or evaluation. The States are expected to submit within 90 days their Updated State Plans, which will be reviewed and approved on a rolling basis. Technical Assistance will continue to be available to assist grantees in developing their Updated State Plans.

Background

On March 23, 2010, the President signed into law the Patient Protection and Affordable Care Act of 2010 (Affordable Care Act) (P.L. 111-148), historic and transformative legislation designed to make quality, affordable health care available to all Americans, reduce costs, improve health care quality, enhance disease prevention, and strengthen the health care workforce. Through a provision authorizing the creation of the Affordable Care Act Maternal, Infant and Early Childhood Home Visiting Program,¹ the Act responds to the diverse needs of children and families in communities at risk and provides an unprecedented opportunity for collaboration and partnership at the Federal, State, and community levels to improve health and development outcomes for at risk children through evidence-based home visiting programs.

This program is designed: (1) to strengthen and improve the programs and activities carried out under Title V; (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. The legislation reserves the majority of funding for one or more evidence-based home visiting models. In addition, the legislation supports continued innovation by allowing for up to 25 percent of funding to support promising approaches that do not yet qualify as evidence-based models.

HRSA and the Administration for Children and Families (ACF) believe that home visiting should be viewed as one of several service strategies embedded in a comprehensive, high-quality early childhood system that promotes maternal, infant, and early childhood health, safety, and development, as well as strong parent-child relationships. Together, we envision high-quality, evidence-based home visiting programs as part of an early

¹ See http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h3590enr.txt.pdf, pages 216-225.

childhood system for promoting health and well-being for pregnant women, children through age 8 and their families. This system would include a range of other programs such as child care, Head Start, pre-kindergarten, special education, and the early elementary grades. Recognizing that the goal of an effective, comprehensive early childhood system that supports the lifelong health and well-being of children, parents, and caregivers is broader than the scope of any one agency, HRSA and ACF are working in close collaboration with each other and with other Federal agencies and look forward to partnering with States and other stakeholders to foster high-quality, well-coordinated home visiting programs for families in at-risk communities. HRSA and ACF realize that coordination of services with other agencies has been an essential characteristic of State and local programs for many years and will continue to encourage, support, and promote the continuation of these collaborative activities, as close collaboration at all levels will be essential to effective, comprehensive home visiting and early childhood systems.

HRSA and ACF believe further that this law provides an unprecedented opportunity for Federal, State, and local agencies, through their collaborative efforts, to effect changes that will improve the health and well-being of vulnerable populations by addressing child development within the framework of life course development and a socio-ecological perspective. Life course development points to broad social, economic, and environmental factors as contributors to poor and favorable health and development outcomes for children, as well as to persistent inequalities in the health and well-being of children and families. The socio-ecological framework emphasizes that children develop within families, families exist within a community, and the community is surrounded by the larger society. These systems interact with and influence each other to either decrease or increase risk factors or protective factors that affect a range of health and social outcomes.

Steps in completing the FY 2010 Affordable Care Act Maternal, Infant and Early Childhood Home Visiting Program application:

1. The first step was submission of an application for funding; the Funding Opportunity Announcement (FOA) HRSA-10-275 was issued on June 10, 2010, and State applications were due July 9, 2010. These applications were to include plans for completing the statewide needs assessment and initial State plans for developing the program in order to meet the criteria identified in the legislation.
2. The second step was submission of the required statewide needs assessment as a condition for receiving FY 2011 Title V Block Grant allotments. All States submitted needs assessments that identified communities at risk, all needs assessments were approved, and all 56 entities have received their FY 2011 Title V Block Grant funds
3. **This document provides instructions for completing the last step necessary for the release of home visiting grant funds awarded under HRSA-10-275, the submission of an Updated State Plan for a State Home Visiting Program. Guidance is provided for making the State's final designation of the targeted at-risk community or communities, updating and providing a more detailed needs and resources assessment for the targeted community or communities, and submitting a specific plan for home visiting services tailored to address those identified needs. The SIR identifies criteria for establishing evidence of effectiveness of home visiting models and lists home visiting models known to meet those criteria. This document is organized as follows:**

PART A: SUMMARY OF STEPS TO BE COMPLETED IN SUBMITTING THE UPDATED STATE PLAN

PART B: SPECIFIC REQUIREMENTS FOR THE UPDATED STATE PLAN

PART C: UPDATED STATE PLAN SUBMISSION INFORMATION

PART D: UPDATED STATE PLAN REVIEW AND SELECTION PROCESS

PART E: AGENCY CONTACTS

TIMELINE

	<u>Publication Date/Due Date</u>
HRSA-10-275 published	June 10, 2010
State application for funding opportunity due	July 9, 2010
FY 2010 funds awarded to States (with restrictions)	July 21, 2010
Supplemental Information Request (SIR): Statewide Needs Assessment published	August 19, 2010
Statewide Needs Assessment due	September 20, 2010
SIR: Updated State Plan published (including evidence-based criteria)	Date of Issuance
Updated State Plan due	of issuance]

A separate Funding Opportunity Announcement for funding available to Indian Tribes, consortia of Indian Tribes, Tribal Organizations, and Urban Indian Organizations was released on June 24, 2010, and the award of 13 grants, totaling \$3 million, under this program was announced on **September 29, 2010**. A list of FY 2010 Tribal Maternal, Infant, and Early Childhood Home Visiting grantees, along with grantee abstracts, is available at http://www.acf.hhs.gov/programs/ccb/initiatives/hvgp/hvgp_grantees.htm.

PART A: SUMMARY OF STEPS TO BE COMPLETED IN SUBMITTING THE UPDATED STATE PLAN FOR A STATE HOME VISITING PROGRAM

The Updated State Plan should be based on an assessment of needs and existing resources in the community(ies) at risk to be targeted for a State Home Visiting Program. The Updated State Plan should include the following sections. Specific requirements for each section are provided under Part B of the Guidance.

NARRATIVE

- **Section 1: Identification of the State's Targeted At -Risk Community(ies):** States must select a targeted at risk community or communities for which home visiting services can be supported by FY 2010 funding under the MIECHV program. An explanation for this selection should include as much detailed information as possible regarding specific community risk factors, other characteristics and strengths, the need for a home visiting program, and service systems currently available for families in that community, including information on any home visiting programs currently operating and/or recently discontinued (since March 23, 2010). Any other factors regarding the selection of at risk community(ies) should be included in this section.
- **Section 2: State Home Visiting Program Goals and Objectives:** States must specify the goal(s) and objectives for the State Home Visiting Program proposed.
- **Section 3: Selection of Proposed Home Visiting Model(s) and Explanation of How the Model(s) Meet the Needs of Targeted Community(ies):** States must propose a program using one or more evidence-based home visiting models aimed at addressing the particular risks in the targeted community(ies) and the needs of families residing there. States may also propose using up to 25 percent of their grants to support a model that is a promising approach. States must explain their selection of the home visiting model(s) by demonstrating how they will address the needs identified in the targeted community(ies) at risk. For models not listed in this SIR as evidence-based, an explanation must be offered about how they meet criteria for evidence of effectiveness. In the case of a promising approach, the State must indicate what national organization or institution of higher education developed or identified the model and how the model will be evaluated through a well-designed and rigorous process. States should also describe how the community(ies) at risk will be engaged in decision-making regarding the home visiting program.
- **Section 4: Implementation Plan for Proposed State Home Visiting Program:** States must provide a plan for the implementation of the proposed home visiting model(s) and for ongoing monitoring of implementation quality. This section should address the State's plan for administering and managing the State Home Visiting Program overall, including plans for coordinating such functions as ongoing training and supervision for all home visiting personnel, management responsibilities, coordination among existing home visiting programs and other related programs and services, as well as any other administrative structures and functions necessary to support a comprehensive home visiting program in the community(ies) at risk.
- **Section 5: Plan for Meeting Legislatively-Mandated Benchmarks:** States must propose a plan for meeting the benchmark requirements specified in the legislation and described in detail in this SIR.
- **Section 6: Plan for Administration of State Home Visiting Program:** States must describe the existing community and State service and administrative structures available to support the State Home Visiting Program, such as availability of referral services, of management capacity, and other essential structures.

- **Section 7: Plan for Continuous Quality Improvement:** States must propose a plan describing how continuous quality improvement strategies will be utilized at the local and State levels.
- **Section 8: Technical Assistance Needs:** States should include a list of current technical assistance needs and any anticipated technical assistance needs for the future.
- **Section 9: Reporting Requirements:** Information regarding the annual progress reports.

ATTACHMENTS:

- Memorandum of Concurrence: States must provide a Memorandum of Concurrence signed by the required agencies signifying approval of the Updated State Plan for a State Home Visiting Program
- Budget: States must provide an updated budget and justification for their Home Visiting Program.

APPENDICES:

- **Appendix A: Criteria for Evidence-Based Model(s)**
- **Appendix B: Models That Meet The Criteria for Evidence Base**
- **Appendix C: Promising Approaches**
- **Appendix D: Specific guidance Regarding Individual Benchmark Areas**
- **Appendix E: Continuous Quality Improvement**
- **Appendix F: Maternal, Infant, and Early Child Home Visiting Program**
- **Appendix G: Response to Public Comments on Federal Register Notice on Criteria for Evidence of Effectiveness of Home Visiting Models**
- **Appendix H: Glossary**

PART B: SPECIFIC REQUIREMENTS FOR THE UPDATED STATE PLAN FOR A STATE HOME VISITING PROGRAM

The proposed State Home Visiting Program should be viewed as one service strategy aimed at developing a comprehensive, high-quality early childhood system that promotes maternal, infant, and early childhood health, safety and development, and strong parent-child relationships in the targeted community(ies) at risk. The aim is to develop a comprehensive plan that addresses community risk factors and builds on strengths identified in the targeted community(ies), and that responds to the specific characteristics and needs of families residing there.

One or more evidence-based home visiting model should be selected as the intervention on the basis of the population and community it is designed to serve and the issue(s) it was developed to address. The State's program may also include a model that qualifies as a promising approach to address community needs. For example, in a community where the predominant problem to be addressed is a high rate of infant mortality, an evidence-based model should be selected that addresses that issue, while a different model would be selected in a community where the primary risk factor is identified as poor school readiness among children entering kindergarten. Where multiple risk factors are identified, the model(s) selected should target these multiple factors to the extent possible.

In selecting and implementing the State Home Visiting Program for the targeted community(ies) at risk, care should be taken to consider where there are service gaps, as well as to ensure that the proposed model(s) will be complementary, but not duplicative, of any existing home visiting or other services for families residing in the community. The State should also consider how to match the needs in the community(ies) at risk with the home visiting model selected, within the confines of available resources for FY 2010. Finally, the State should consider the capacity and resources of the targeted community(ies) at risk to implement the chosen evidence-based model.

States are encouraged to consider innovative ways of administering and carrying out the State Home Visiting Plan while maintaining fidelity to the evidence-based home visiting model(s) selected for implementation. As one example, several States with contiguous at-risk rural areas might collaborate to launch and evaluate a home visiting model as a promising approach that would address the particular problems associated with serving populations in these areas.

The Plan must identify strategies for enhancing staffing and administrative structures at the State and community levels to ensure continuous quality improvement, implement data systems, and develop high-quality ongoing training and supervision of program staff. The Plan must demonstrate commitment to research and evaluation among all public and private partners involved in carrying out the State Home Visiting Program. The Plan must identify the ways in which State-level staff will be collaborating among all relevant State agencies, as well as with other public- and private-sector partners, to ensure the success of this multi-faceted program that addresses maternal and child health, child development, and the prevention of child maltreatment. In addition, the Plan must include measures that will be taken to support the home visiting model in the targeted community at risk, such as developing community referral systems and service linkages and promoting collaboration among public- and private-sector partners at the local level to support a successful State Home Visiting Program.

In developing the State Home Visiting Program, States must meet the Maintenance of Effort (MOE) requirement as identified in the initial FOA for the MIECHV Program:

Funds provided to an eligible entity receiving a grant shall supplement, and not supplant, funds from other sources for early childhood home visitation programs or initiatives. The grantee must agree to

maintain non-Federal funding (State General Funds) for grant activities at a level which is not less than expenditures for such activities as of the date of enactment of this legislation, March 23, 2010.

NARRATIVE

Section 1: Identification of the State's Targeted At-Risk Community(ies)

The Plan should justify the selection of the at-risk community(ies), from among the communities identified as being at risk in the State's initial needs assessment. For each targeted community proposed, please provide the following information.

- A detailed assessment of needs and existing resources, including:
 - community strengths and risk factors;
 - characteristics and needs of participants;
 - any existing home visiting services² in the community, currently operating or discontinued since March 23, 2010, including
 - the number and types of home visiting programs and initiatives in the community
 - the models that are used by identified home visiting programs;
 - existing mechanisms for screening, identifying, and referring families and children to home visiting programs in the community (e.g., centralized intake procedures at the local or State level); and,
 - referral resources currently available and needed in the future to support families residing in the community(ies);
- A plan for coordination among existing programs and resources in those communities (including how the program will address existing service gaps);
- Local and State capacity to integrate the proposed home visiting services into an early childhood system, including existing efforts or resources to develop a coordinated early childhood system at the community level, such as a governance structures or coordinated system of planning; and,
- A list of communities in the State that were identified as being at risk in the State's initial needs assessment but are not being selected for implementation of the State Home Visiting Program due to limitations on available FY 2010 funding.

Section 2: State Home Visiting Program Goals and Objectives

The Plan should include clearly articulated objectives and outcomes for the State Home Visiting Program. The Plan should also describe how the State Home Visiting Program can contribute to developing a comprehensive, high-quality early childhood system that promotes maternal, infant, and early childhood health, safety, and development and strong parent-child relationships. The Plan should describe strategies for integrating the program with other programs and systems in the State that are related to maternal and child health and early childhood health, development and well-being. The Plan should include a logic model for the proposed State Home Visiting Program as a whole. The logic model for the State Home Visiting Program as a whole may build on the model developer's logic model but should not duplicate it. The logic model should identify inputs, outputs and short-term and long-term outcomes. For guidance on creating logic models see:

<http://toolkit.childwelfare.gov/toolkit/>.

² Including State- funded, Federally-funded, locally-funded, and privately-funded programs in the community. Home visiting programs are defined for purposes of this requirement as those with home visiting as the primary service delivery strategy and in which services are offered on a voluntary basis to pregnant women, expectant fathers, and parents and caregivers of children birth to kindergarten entry, targeting the legislatively mandated participant outcome and benchmark areas.

Section 3: Selection of Proposed Home Visiting Model(s) and Explanation of How the Model(s) Meets the Needs of Targeted Community(ies)

Any home visiting model proposed in the State's response to this SIR must meet the criteria listed in this document to qualify for funding as an evidence-based home visiting model. States may either (a) select from this list a model or models that meets the needs identified in the targeted community(ies) at risk or (b) propose another home visiting model that the State believes meets the criteria for the evidence base but has not yet been reviewed through the Home Visiting Evidence of Effectiveness Review (HomVEE) study. In addition, States may also propose the use of up to 25% of the funds for a promising approach to home visiting.

Selection of Approved Evidence-Based Home Visiting Model

This document identifies seven home visiting models that have been determined to meet the evidenced-based criteria established by HRSA and ACF on the basis of a systematic review conducted through the HomVEE study and the public comments received in response to the Federal Register Notice regarding evidence criteria (see Appendix A). The home visiting models known to meet the evidence criteria are listed in Appendix B. In addition, there is detailed information on each model reviewed, including the evidence available for each model and the reasons why other models reviewed did not meet the criteria available at: (<http://www.acf.hhs.gov/programs/opre/homvee>). Per the authorizing legislation, at least 75% of the funds must be utilized by grantees for evidence-based home visiting models. As noted previously, the State may propose, in addition, to expend up to 25 percent of its total grant to implement a model that qualifies as a promising approach (see the section "Proposing a Promising Approach" later in this SIR).

In some cases, the State may wish to adapt an existing model that has been identified as evidence-based in order to meet the needs of targeted at-risk communities. Adaptations may include broadening the population served, additions or subtractions from the current model or enhancements of the current model. For the purposes of the MIECHV Program, an acceptable adaptation of an evidence-based model includes changes to the model that have not been tested with rigorous impact research but are determined by the model developer *not to alter the core components related to program impacts*. The literature around adaptation of evidence-based programs consistently recommends that implementing agencies should discuss proposed adaptations with the program developers prior to implementation to ensure that changes do not alter core components. Changes to an evidence-based model that alter the core elements related to program outcomes could undermine the program's effectiveness. Such changes (otherwise known as "drift") will not be allowed under the funding allocated for evidence-based models. Any proposed adaptations will be reviewed and approved by HHS during the review of the State plans. Adaptations that alter the core components related to program impacts may be funded with funds available for promising approaches, if the State wishes to implement the program as a promising approach instead of an adaptation of an evidence-based model.

Within 45 days of the posting of this SIR, States electing to implement an approved evidence-based model must include the following information in the Updated State Plan:

- Identify the evidence-based home visiting model(s) to be implemented in the State and describe how each model meets the needs of the community(ies) proposed. It is expected that prior to the submission of this plan, the State will engage the targeted community to assess the fit of the model and the community's readiness to implement it. Community involvement is expected to continue on an ongoing basis throughout the duration of this program;

- Provide documentation of approval by the developer to implement the home visiting model proposed. The documentation should include verification that the model developer has reviewed and agreed to the plan as submitted including any proposed adaptation, support for participation in the national evaluation, and any other related HHS efforts to coordinate evaluation and programmatic technical assistance. This documentation should include the State’s status with regard to any required certification or approval process required by the developer;
- Provide a description of the State’s current and prior experience with implementing the model(s) selected, if any, as well as their current capacity to support the model;
- Submit a plan for ensuring implementation, with fidelity to the model, and include a description of the following: the State’s overall approach to home visiting quality assurance; the State’s approach to program assessment and support of model fidelity; anticipated challenges and risks to maintaining quality and fidelity, and the proposed response to the issues identified;
- Describe the State’s overall approach to home visiting quality assurance; anticipated challenges to maintaining quality and fidelity; and
- Discuss anticipated challenges and risks of selected program model(s), and the proposed response to the issues identified, and any anticipated technical assistance needs.

Proposal for a Home Visiting Model Believed to Meet the Evidence-Based Criteria

The systematic review conducted by HomVEE was unable to review all potential home visiting models in the time allotted. It is possible there are additional home visiting models that meet the HHS criteria for evidence of effectiveness. States may desire to select a home visiting model that has not already been identified as meeting the evidence criteria (see below and in Appendix A). If a State believes one of the models that has already been reviewed by HomVEE but found not to meet the criteria does in fact meet the criteria, please see “Requests for Reconsideration of Evidence Determinations” below.

If a State would like to propose using a home visiting model that has not yet been reviewed by HomVEE, the State must submit a proposal for selecting this alternative model^{3, 1}.

The State should submit a proposal to the HRSA Project Officer within 45 days of the posting of this SIR for a review of the model. (See Project Officer List in Appendix F).

The proposal must include the following information:

- Provide the name of the model (and any other known previous names of the model);
- Identify any affiliated organizations and researchers of the model;
- Provide copies of reports or journal articles for any known research on the model; and

³ For the purposes of the MIECHV, home visiting models have been defined as programs or initiatives in which home visiting is a primary service delivery strategy and in which services are offered on a voluntary basis to pregnant women, expectant fathers, and parents and caregivers of children birth to kindergarten entry, targeting participant outcomes which may include improved maternal and child health; prevention of child injuries, child abuse, or maltreatment, and reduction of emergency department visits; improvement in school readiness and achievement; reduction in crime or domestic violence; improvements in family economic self-sufficiency; improvements in the coordination and referrals for other community resources and supports; or improvements in parenting skills related to child development.

- Discuss how the proposed model meets the legislative requirements of being in existence for at least three years, is grounded in relevant empirically-based knowledge, linked to program-determined outcomes, associated with a national organization or institution of higher education that has comprehensive home visitation program standards that ensure high quality service delivery and continuous quality improvement;

The evidence base for the proposed alternative model will be reviewed by the Secretary of Health and Human Services and a decision will be made regarding approval or disapproval of the proposed alternative model within 45 days. If, upon review, the Secretary of Health and Human Services approves this alternative model for implementation under the MIECHV program, the State will be required to provide the following information:

- Describe how the proposed alternative evidenced-based home visiting model(s) meets the needs of the community(ies) proposed. It is expected that the State will engage the proposed community to assess the fit of the model and the community's readiness to implement the program prior to the submission of the plan and on an ongoing basis after implementation;
- Provide documentation regarding obtaining approval to implement the home visiting model proposed. The documentation should include verification that the model developer has reviewed and agreed to the plan as submitted including any proposed adaptation, support for participation in the national evaluation, and any other related HHS efforts to coordinate programmatic technical assistance. This documentation should include the State's status in any required certification or approval process to implement the home visiting program;
- Provide a description of the State's current and prior experience with implementing the model(s) selected, as well as their current capacity to support the model;
- Submit a plan for ensuring implementation, with fidelity to the model, and include a description of the following: the State's overall approach to home visiting quality assurance; the State's approach to program assessment and support of model fidelity; anticipated challenges and risks to maintaining quality and fidelity, and the proposed response to the issues identified; and
- Discuss anticipated challenges and risks of selected program model(s), and the proposed response to the issues identified and any anticipated technical assistance needs.

The evidence base for the proposed alternative model will be reviewed by the Secretary of Health and Human Services and a decision will be made regarding approval or disapproval of the proposed alternative model within 45 days.

Requests for Reconsideration of Evidence Determinations

If States, researchers, model developers, or others believe the application of the HHS criteria for evidence of effectiveness contained errors, concerns should be submitted to: HVEE@mathematica-mpr.com. Inquiries will only be accepted through this e-mail address. Individuals may request reconsideration based on misapplication of the HHS criteria, or missing information, or errors on the HomVEE website. To ensure independence from the original review, a re-review team composed of members external to the original contractor will conduct the new, independent review. The re-review team will provide assurance they do not have any actual or perceived conflicts of interest. This re-review team will not consist of members who were involved in the original review.

Similar to the original review, the re-review team will be certified and trained in the HomVEE standards. The re-review team will utilize the original empirical articles (see the program reports at: <http://www.acf.hhs.gov/programs/opre/homvee>), any information submitted by the individual raising the concern, the original review team's reports, and make any needed queries made to the original team. HRSA/ACF will issue a final decision whether the standards were accurately applied or not within 45 days of the submission of the concern.

Proposing a Promising Approach

States may implement a home visiting model that conforms to a promising approach for achieving the benchmarks and outcomes required by law. A promising approach is one in which there is little to no evidence of effectiveness; one with evidence that does not meet the criteria for an evidence-based model, or a modified version of an evidence-based model that *includes significant alterations to core components*. The promising approach should be grounded in relevant empirical work and have an articulated theory of change. The promising approach must have been developed by or identified with a national organization or institution of higher education, and States must evaluate this approach through a well-designed and rigorous process. States shall not use more than 25 percent of the amount of the grant paid to the State for the promising approach. In addition, the required evaluation of the promising approach must be funded from the 25% available for promising approaches. A more detailed discussion of promising approaches is included in Appendix C.

If the State would like to propose a promising approach to home visiting, the proposal must:

- Describe the model(s) utilized by the promising approach;
- Identify the national organization or institution of higher learning affiliated with the model(s);
- Specify how the proposed promising approach meets the needs of the communities proposed. It is expected that the State will engage the proposed community to assess the fit of the approach and community readiness to implement it prior to the submission of the plan and on an ongoing basis after implementation begins;
- Provide a description of the State's current and prior experience with implementing the promising approach, as well as its current capacity to support implementation;
- Include an evaluation plan specifying how the proposed promising approach will be evaluated using well-designed and rigorous process (see Appendix C);
- Submit a plan for ensuring implementation, with fidelity to the model, and include a description of the following: the State's overall approach to home visiting quality assurance; the State's approach to program assessment and support of model fidelity; anticipated challenges and risks to maintaining quality and fidelity, and the proposed response to the issues identified; and,
- Discuss the anticipated challenges to implementing or evaluating the promising approach, proposed response to issues identified, and any anticipated technical assistance needs.

Section 4: Implementation Plan for Proposed State Home Visiting Program

States must provide a plan for the implementation of the proposed State Home Visiting Program and for ongoing monitoring of the quality of implementation of chosen model(s) at the community, agency, and participant level. The implementation plan must include the following information:

- A description of the process for engaging the community(ies) at risk around the proposed State Home Visiting Plan, including identifying the organizations, institutions or other groups and individuals consulted;
- A description of the State's approach to development of policy and to setting standards for the State Home Visiting Program;
- A plan for working with the national model developer(s) and a description of the technical assistance and support to be provided through the national model(s). If there is more than one home visiting model selected, a separate plan must be provided for each model;
- A timeline for obtaining the curriculum or other materials needed;
- A description of how and what types of initial and ongoing training and professional development activities will be provided by State or the implementing local agencies, or obtained from the national model developer;
- A plan for recruiting, hiring, and retaining appropriate staff for all positions including contracts and subcontracts;
- A plan to ensure high quality clinical supervision and reflective practice for all home visitors and supervisors;
- The estimated number of families served;
- A plan for identifying and recruiting participants;
- A plan for minimizing the attrition rates for participants enrolled in the program;
- An estimated timeline to reach maximum caseload in each location;
- An operational plan for the coordination between the proposed home visiting program(s) and other existing programs and resources in those communities, especially regarding health, mental health, early childhood development, substance abuse, domestic violence prevention, child maltreatment prevention, child welfare, education, and other social and health services;
- A plan for obtaining or modifying data systems for ongoing continuous quality improvement (CQI);
- An explanation of the State's approach to monitoring, assessing, and supporting implementation with fidelity to the chosen model(s) and maintaining quality assurance;

- A discussion of anticipated challenges to maintaining quality and fidelity, and the proposed response to the issues identified;
- A list of collaborative public and private partners;
- Assurance that the State home visiting program is designed to result in participant outcomes noted in the legislation;
- Assurance that individualized assessments will be conducted of participant families and that services will be provided in accordance with those individual assessments;
- Assurance that services will be provided on a voluntary basis; and
- Assurances that priority will be given to serve eligible participants who:
 - Have low incomes
 - Are pregnant women who have not attained age 21
 - Have a history of child abuse or neglect or have had interactions with child welfare services
 - Have a history of substance abuse or need substance abuse treatment
 - Are users of tobacco products in the home
 - Have, or have children with, low student achievement
 - Have children with developmental delays or disabilities
 - Are in families that include individuals who are serving or have formerly served in the armed forces, including such families that have members of the armed forces who have had multiple deployments outside of the United States.

Research and Evaluation

The legislation does not require States to conduct any evaluation other than to conduct research on promising approaches. The State has provided assurances in the initial FOA of participation in any national evaluation activities. It is the Secretary’s intent to fund and carry out the national evaluation described in the legislation. However, HRSA and ACF will not prohibit a State from conducting research and evaluation outside of the national evaluation. If the State intends to conduct research or evaluation activities using funding under the MIECHV Program, the State should describe those activities in the Implementation Plan (see Appendix C for guidance on information necessary to provide for any proposed research and evaluation activities).

Section 5: Plan for Meeting Legislatively-Mandated Benchmarks

To meet the requirements around quantifiable, measurable improvement in benchmark areas,⁴ each grantee must provide a proposal for the initial and ongoing data collection for each of the six benchmark areas. The following are parameters around the benchmark data collection (see Appendix D for additional detail for each benchmark area):

- The grantee must collect data on all benchmark areas.

⁴ Benchmarks include: Improved maternal and newborn health; Prevention of child injuries, child abuse, neglect, or maltreatment, and reduction of emergency department visits; Improvement in school readiness and achievement; Reduction in crime or domestic violence; Improvements in family economic self-sufficiency; and, Improvements in the coordination and referrals for other community resources and supports. See Section 511 (d) (1).

- The data must be collected for eligible families participating in the program who receive services funded with the MIECHV Program funds.
- Each benchmark area includes multiple constructs. States must collect data for all constructs under each benchmark area.
- If the same construct appears in more than one benchmark area, States may utilize the same data for each applicable benchmark area. These instances are noted in the specific discussion of each benchmark area.
- For the purposes of demonstrating improvements in at least four benchmark areas at the three-year report, showing improvement in at least half of the constructs under a benchmark areas will constitute improvement in that benchmark area.
- Standard measures for the constructs within a benchmark area across home visiting models (if more than one home visiting model is implemented within a State) are strongly encouraged.
- We recommend that programs utilize these and other appropriate data to fulfill the requirement in the legislation of utilizing data for continuous quality improvement (CQI) for program operation and decision-making purposes. HRSA and ACF will provide technical assistance to assist grantees in utilizing data for CQI.
- States may propose either to collect data on each participating family or to use a sampling approach for some or all benchmark areas.
- At a later date, a template will be provided for grantees to report on benchmark progress at the 3- and 5-year points.
- The data collected to fulfill improvement in the benchmark areas may also be utilized to fulfill the legislative requirement to pursue improvement in outcomes for individual families.⁵
- The measures proposed by States must be developmentally appropriate measures for the corresponding constructs and appropriate for use with the populations served by the home visiting program.
- For the purposes of the benchmark requirement, it is recommended that data collected across all benchmark areas be coordinated and aligned with other relevant State or local data collection efforts. In addition to the reporting requirements for each benchmark area, applicants must collect individual-level demographic and service-utilization data on the participants in their program as necessary to analyze and understand the progress children and families are making. Individual-level demographic and service-utilization data include:
 - Family's participation rate in the home visiting program (e.g., number of sessions/number of possible sessions, duration of sessions);
 - Demographic data for the participant child(ren), pregnant woman, expectant father, parent(s), or primary caregiver(s) receiving home visiting services including: child's gender, age of all (including age in month for child) at each data collection point and racial and ethnic background of all participants in the family;
 - Participant child's exposure to languages other than English; and
 - Family socioeconomic indicators (e.g., family income, employment status)

⁵ Section 511 (d)(2)(A).

Technical assistance will be provided to assist a State in selecting or developing benchmark measures.

Benchmark Plan Requirements

States must provide a plan for the collection of the benchmark data. The plan should include information about each construct (e.g., incidence of child injuries) and measure selection (e.g., visits to the emergency department) for each benchmark area, including data collection and analysis. The benchmark plan must include the following information for each benchmark area and its associated constructs:

- Proposed measures:
 - For each construct within each benchmark area (e.g. “general cognitive skills” within the Improvement in School Readiness and Achievement benchmark area), specify the measure (or measures) proposed. If use of administrative data is proposed, please also include an MOU from the agency with responsibility or oversight of those data.
 - Reliability/validity of measure proposed (demonstrating reliability/validity for the population with which the measure will be used).
- Proposed definition of improvement for each element of the individual construct (e.g., “improvement will be quantified as a decrease in the number of children identified as at risk by the ASQ-SE for children’s social-emotional development over one year of program enrollment”).
- Proposed data collection and analysis plan, including:
 - The source of the measure proposed and justification of why it is the most appropriate method of measurement for the construct;
 - The population to be assessed by each measure (e.g., parent or child) and the appropriateness of that measure, in terms of such factors as age of children, and in terms of specific population groups such as dual-language-learner children, children with disabilities, etc.;
 - The plan for sampling, if proposed, that includes the sample selection procedures and data to ensure the sampling approach will produce stable estimates;
 - A plan for data collection schedule including how often the measure/items will be collected and analyzed (the minimum is specified under each benchmark area in Appendix D, but we encourage programs to consider more frequent data collection for CQI purposes).
 - A plan for ensuring the quality of data collection and analysis. The plan should include minimum qualifications or training requirements for administrators of measures, qualifications of personnel responsible for data management at the State and program level, qualifications of personnel responsible for data analysis at the State and program level, and the time estimated for the data collection-related activities by personnel categories.
 - A plan for the identification of scale scores, ratios, or other metrics most appropriate to the measurement proposed.
 - A plan for analyzing the data at the local and at the State level. This should include how data will be aggregated and disaggregated to understand the progress made within different communities and for different groups of children and families.

- Plans for gathering and analyzing demographic and service-utilization data on the children and families served in order to better understand the progress children and families are making. This may include data on the degree of participation in services, the child's age in months, the child's race and ethnicity, the child's home language, the child's sex, the parent's education or employment, and other relevant information about the child and family.
- A plan for using benchmark data for CQI at the local program level, community level, and State level.
- A plan for data safety and monitoring including privacy of data, administration procedures that do not place individuals at risk of harm (e.g., questions related to domestic violence and child maltreatment reporting), and compliance with applicable regulations related to IRB/human subject protections, HIPAA, and FERPA. The plan must include training for all relevant staff on these topics.
- Any anticipated barriers or challenges in the benchmark reporting process (including the data collection and analysis plan), possible strategies for addressing these challenges, and any expected technical assistance needs.

For more details on benchmarks please see Appendix D.

Section 6: Plan for Administration of State Home Visiting Program

The plan must include a description of the statewide administrative structure in place to support the State Home Visiting Program. States must also present a plan that indicates how the State Home Visiting Plan will be managed and administered at the State and local levels. In providing this description, please identify the following:

- The lead agency for the project;
- A list of collaborative partners in the private and public sector;
- An overall management plan for the program at the State and local levels that describes who will be responsible for ensuring the successful implementation of the State Home Visiting Program;
- If the State is supporting more than one home visiting model within a community, a plan for coordination of referrals, assessment, and intake processes across the different models (e.g., a detailed plan for centralized intake, as appropriate);
- Identification of other related State or local evaluation efforts of home visiting programs that are separate from the evaluations of promising approaches;
- Job descriptions for key positions, including resumes; and
- An organization chart.

The plan must also include a detailed description of how the proposed State Home Visiting Program will meet the legislative requirements, including:

- Well-trained, competent staff;
- High quality supervision;
- Strong organizational capacity to implement activities involved;
- Referral and service networks available to support the home visiting program and the families it serves in at-risk communities; and

- Monitoring of fidelity of program implementation to ensure services are delivered pursuant to a specified model.

Efforts should be made to ensure that the plan is coordinated, to the extent possible, with other State early childhood plans including the State Advisory Council Plan and the State Early Childhood Comprehensive Systems Plan. Accordingly, the plan should address the following:

- How the State or community(ies) will comply with any model-specific prerequisites for implementation, including those discussed in the implementation profiles available on the HomVEE website (<http://www.acf.hhs.gov/programs/opre/homvee>);
- Any strategies for making modifications needed to bolster the State administrative structure in order to establish a home visiting program as a successful component of a comprehensive, integrated early childhood system; and
- Any collaborations established with other State early childhood initiatives as identified earlier in this document.

Section 7: Plan for Continuous Quality Improvement

The State Plan should discuss how the State will comply with the legislative requirement around Continuous Quality Improvement (CQI) for evidence-based home visiting models. CQI is a systematic approach to specifying the processes and outcomes of a program or set of practices through regular data collection and the application of changes that may lead to improvements in performance.

The Secretary of Health and Human Services will offer technical assistance around continuous quality improvement strategies.

Section 8: Technical Assistance Needs

HHS intends to provide training and technical assistance to States throughout the grant application process and throughout the implementation of the MIECHV Program. The overall goals of this technical assistance is to build the capacity of the State to submit an Updated State Plan for a State Home Visiting Program that meets requirements, plans for and implements approved programs effectively and with fidelity to evidence-based or promising models, and ensures that the MIECHV program is integrated into a comprehensive statewide system of support for early childhood. HHS will use a multi-dimensional and multi-faceted approach for the provision of technical assistance. HRSA and ACF are working jointly to provide technical assistance that will include collaboration and coordination with other Federal government agencies, the State administrators, and the national model developers.

While HHS recognizes that many home visiting program models that States are likely to implement provide model-specific technical assistance, HHS anticipates providing technical assistances in several areas, including: conducting ongoing needs assessments, strategic planning, collaboration and partnerships, communication and marketing, fiscal leveraging, implementing and supporting home visiting programs, selecting home visiting model(s) to meet the target populations' needs, data and information systems, special topical issues (e.g., substance abuse, mental health, domestic violence, tribal, rural issues), continuous quality improvement/quality assurance, workforce issues, developing training systems, participant outreach and retention, sustainability, and program evaluation. The list of topics is not meant to be exhaustive and HHS intends to tailor technical assistance to meet needs identified by the States.

To assist the Federal Government to plan for and provide the most appropriate type and level of support, the State should include in the Updated State Plan a description of technical assistance needs such as for conducting a home visiting program, developing a statewide early childhood system, implementing models with fidelity, conducting an evaluation of a promising approach, identifying benchmarks, or other topics. The State should also identify other areas in which technical assistance is anticipated to be needed, if applicable.

Section 9: Reporting Requirements

The State must comply with the legislative requirement for submission of an annual report to the Secretary regarding the program and activities carried out under the program. States will be notified in advance of the specific formatting requirements for submitting this report. This report shall address the following:

State Home Visiting Program Goals and Objectives

- Progress made under each goal and objective during the reporting period, including any barriers to progress that have been encountered and strategies/steps taken to overcome them
- Any updates/revisions to goal(s) and objectives identified in updated State plan
- To the extent not articulated above, a brief summary regarding the State's efforts to contribute to a comprehensive high-quality early childhood system, using the logic model provided in the Updated State Plan. Identify updates or changes to logic model, if necessary.

State Home Visiting Program Update

- Updates on the grantee's evaluation of any implemented promising programs;
- If applicable, copies of reports developed in the course of the local evaluation of promising programs and any other evaluation of the overall home visiting program undertaken by the grantee.

Implementation of Home Visiting Program in Targeted Communities of Need

Updates regarding experience in planning and implementing the home visiting programs selected for each community of need, as identified in the Updated State Plan, addressing each of the items listed below. Where applicable, States may discuss any barriers/challenges encountered and steps taken to overcome the identified barriers/challenges.

- An update on the State's progress for engaging the community(ies) at risk around the proposed State Home Visiting Plan;
- Update on work-to-date with national model developer(s) and a description of the technical assistance and support provided to-date through the national model(s);
- Based on timeline provided in Updated State Plan, an update on securing curriculum and other materials needed for the home visiting program;
- Update on training and professional development activities obtained from the national model developer, or provided by State or the implementing local agencies;
- Update on staff recruitment, hiring, and retention for all positions including contracts and subcontracts;
- Update on participant recruitment and retention efforts;

- Status of home visiting program caseload within each at-risk community;
- Update on the coordination between home visiting program(s) and other existing programs and resources in those communities (e.g., health, mental health, early childhood development, substance abuse, domestic violence prevention, child maltreatment prevention, child welfare, education, and other social and health services); and,
- A discussion of anticipated challenges to maintaining quality and fidelity of each home visiting program, and the proposed response to the issues identified.

Plan for Meeting Legislatively Mandated Benchmarks

Update on data collection efforts for each of the six benchmark areas, which would include an update on data collected on all constructs within each benchmark area including definitions of what constitutes improvement and sources of data for each measure utilized Barriers/challenges encountered during data collection efforts and steps taken to overcome them.

Home Visiting Program’s CQI Efforts Proposed Changes to the State Home Visiting Plan

Update on State’s efforts re: planning/implementing CQI for home visiting program. If applicable, copies of CQI reports developed addressing opportunities, changes implemented, data collected and results obtained.

Administration of State Home Visiting Program

- Updated organization chart, if applicable
- Updates re: changes to key personnel⁶, if any (include resumes for new staff, if applicable)
- An update on State efforts to meet the following legislative requirements, including a discussion of any barriers/challenges encountered and steps taken to overcome the identified barriers/challenges:
 - Training efforts for well-trained, competent staff;
 - Steps taken to ensure high quality supervision;
 - Steps taken to ensure referral and services networks to support the home visiting program and the families it serves in at-risk communities; and
- Updates on new policy(ies) created by State to support home visiting programs.

Technical Assistance Needs

An update on technical assistance needs anticipated for conducting program or for developing a statewide early childhood system.

ATTACHMENTS

Memorandum of Concurrence

This requirement is made to ensure agreement among State agencies on the Updated State Plan for a State Home Visiting Program. The purpose is to demonstrate that these agencies are committed to collaboration and are in agreement with implementation of the program, as well as to ensure that home visiting is part of a continuum of early childhood services within the State.

⁶ Changes in key personnel require prior approval

Both the initial FOA and the subsequent SIR for the statewide needs assessment required sign-off by the first four State agencies listed below. For purposes of meeting requirements for this SIR for the Updated Plan for a State Home Visiting Program, States must provide a Memorandum of Concurrence signed by representatives of those four agencies plus two additional agencies, as follows:

- Director of the State's Title V agency;
- Director of the State's agency for Title II of the Child Abuse Prevention and Treatment Act (CAPTA);
- Director of the State's Single State Agency for Substance Abuse Services;
- The State's Child Care and Development Fund (CCDF) Administrator;
- Director of the State's Head Start State Collaboration Office; and,
- The State Advisory Council on Early Childhood Education and Care authorized by 642B(b)(1)(A)(i) of the Head Start Act.

To ensure that home visiting is part of a continuum of early childhood services, HRSA and ACF also strongly urge States to seek consensus from:

- The State's child welfare agency (Title IV-E and IV-B), if this agency is not also administering Title II of CAPTA;
- The State's Individuals with Disabilities Education Act (IDEA) Part C and Part B Section 619 lead agency(ies); and,
- The State's Elementary and Secondary Education Act Title I or State pre-kindergarten program.

The State is encouraged to coordinate this application to the extent possible with:

- The State's Domestic Violence Coalition;
- The State's Medicaid/Children's Health Insurance program (or the person responsible for Medicaid Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program);
- The State's Mental Health Agency;
- The State's identified agency charged with crime reduction;
- The State's Temporary Assistance for Needy Families agency;
- The State's Supplemental Nutrition Assistance Program agency(ies); and,
- The State's Injury Prevention and Control (Public Health Injury Surveillance and Prevention) program (if applicable).

Budget

By completing the budget information in the HRSA Electronic Handbook (EHB), will be completing Form SF-424A – Budget Information for Non-Construction Programs provided with the application package to submit a budget for the Updated State Plan for a State Home Visiting Program. *Please provide a line item budget using the budget categories in the SF-424A for a project and budget period of July 15, 2010 through September 30, 2012.*

Inasmuch as the information submitted in response to this SIR will trigger the release of the State's full FY 2010 Allocation, the budget should indicate how all FY 2010 funds will be spent, including any costs

associated with the statewide needs assessment, the Updated State Plan, and initial implementation of that Plan.

Provide a narrative that explains the amounts requested for each line in the budget. The budget justification should specifically describe how each item will support the achievement of proposed objectives. The budget period is for 27 months. Line item information must be provided to explain the costs entered in the SF-424A. **The budget justification must clearly describe each cost element and explain how each cost contributes to meeting the project's objectives/goals.** Be very careful about showing how each item in the "other" category is justified. The budget justification **MUST** be concise. Do **NOT** use the justification to expand the project narrative.

Include the following in the Budget Justification narrative:

Personnel Costs: Personnel costs should be explained by listing each staff member who will be supported from funds, name (if possible), position title, percent full time equivalency, and annual salary.

Fringe Benefits: List the components that comprise the fringe benefit rate, for example health insurance, taxes, unemployment insurance, life insurance, retirement plan, tuition reimbursement. The fringe benefits should be directly proportional to that portion of personnel costs that are allocated for the project.

Travel: List travel costs according to local and long distance travel. For local travel, the mileage rate, number of miles, reason for travel and staff member/consumers completing the travel should be outlined. The budget should also reflect the travel expenses associated with participating in meetings and other proposed trainings or workshops.

Equipment: List equipment costs and provide justification for the need of the equipment to carry out the program's goals. Extensive justification and a detailed status of current equipment must be provided when requesting funds for the purchase of computers and furniture items that meet the definition of equipment (a unit cost of \$5,000 and a useful life of one or more years).

Supplies: List the items that the project will use. In this category, separate office supplies from medical and educational purchases. Office supplies could include paper, pencils, and the like; medical supplies are syringes, blood tubes, plastic gloves, etc., and educational supplies may be pamphlets and educational videotapes. Remember, they must be listed separately.

Contracts: Grantees are responsible for ensuring that their organization and or institution has in place an established and adequate procurement system with fully developed written procedures for awarding and monitoring all contracts. Grantees must provide a clear explanation as to the purpose of each contract, how the costs were estimated, and the specific contract deliverables. Reminder: recipients must notify potential subrecipients that entities receiving subawards must provide the recipient with their DUNS number.

Other: Put all costs that do not fit into any other category into this category and provide an explanation of each cost in this category. In some cases, grantee rent, utilities and insurance fall under this category if they are not included in an approved indirect cost rate.

Indirect Costs: Indirect costs are those costs incurred for common or joint objectives which cannot be readily identified but are necessary to the operations of the organization, e.g., the cost of operating and

maintaining facilities, depreciation, and administrative salaries. For institutions subject to OMB Circular A-21, the term “facilities and administration” is used to denote indirect costs. If an organization applying for an assistance award does not have an indirect cost rate, the applicant may wish to obtain one through HHS’s Division of Cost Allocation (DCA). Visit DCA’s website at: <http://rates.psc.gov/> to learn more about rate agreements, the process for applying for them, and the regional offices which negotiate them.

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PART C: UPDATED STATE PLAN SUBMISSION INFORMATION

Submit this report online through the HRSA EHBs at <https://grants.hrsa.gov/webexternal/login.asp> [View Grants Portfolio, select your Home Visiting Grant Number, select *GrantHandbooks*, and select *Other Submissions*]. Applicants will upload their Updated State Plan and any related documents as one attachment. Make sure all documents are clearly labeled with your organization's name and HRSA award number. Please call your Project Officer with any questions or concerns (See Appendix F for Project Officer Listings).

Submission Checklist

Please ensure that your application includes the following components, as described previously:

Narrative:

- Section 1: Identification of the State's Targeted At risk Community(ies)
- Section 2: State Home Visiting Program Goals and Objectives
 - Section 3: Proposed State Home Visiting Program and Explanation of How the Program Meets the Needs of Identified Communities
 - Section 4: Implementation Plan for Proposed State Home Visiting Program
- Section 5: Plan for Meeting Legislatively Mandated Benchmarks and Outcomes
- Section 6: Plan for Administration of State Home Visiting Program
- Section 7: Plan for Continuous Quality Improvement
- Section 8: Technical Assistance Needs

Attachments:

- Memorandum of Concurrence
- Budget

PART D: UPDATED STATE PLAN REVIEW

The Updated State Plan for a State Home Visiting Program will be reviewed internally by program staff for completeness and compliance with the requirements outlined in this document. The program review will include the State's response to the items described above and will also consider:

- The extent to which this Updated State Plan justifies selection of the targeted community(ies) at risk on the basis of the information reflected in Section 1, Identification of the States Targeted At-Risk Communities;
- The clarity of the State's explanation of the methodology used to select its model or models in order to address the specific needs of the targeted community(ies);
- The clarity of the State's plan for meeting benchmarks and collecting data to support its evidence-based home visiting program and to carry out CQI activities;
- The overall feasibility of the State's Implementation Plan for the proposed home visiting models and the administration of the program; and
- The level of commitment and concurrence of the required State partners for the program, as well as other collaborations and partnerships needed to successfully implement the program.

PART E: AGENCY CONTACTS

Applicants may obtain additional information regarding this Supplemental Information Request by contacting:

Audrey M. Yowell, PhD, MSSS
Health Resources and Services Administration
Maternal and Child Health Bureau
5600 Fishers Lane
16B-26
Rockville MD 20857
ayowell@hrsa.gov

Applicants may obtain additional information regarding business, administrative, or fiscal issues related to this SIR by contacting:

Mickey Reynolds
Grants Management Specialist
HRSA Division of Grants Management Operations, OFAM
Parklawn Building, Room 11A-02
5600 Fishers Lane
Rockville, MD 20857
Telephone: (301) 443-0724
Fax: (301) 443-6686
Email: mreynolds@hrsa.gov

Grantees desiring assistance when working online to submit information electronically through HRSA's Electronic Handbooks (EHBs) should contact the HRSA Call Center, Monday-Friday, 9:00 a.m. to 5:30 p.m. ET:

HRSA Call Center
Phone: (877) Go4-HRSA or (877) 464-4772
TTY: (877) 897-9910
Fax: (301) 998-7377
E-mail: CallCenter@HRSA.GOV

APPENDIX A. CRITERIA FOR EVIDENCE-BASED MODEL(S)

On July 23, 2010, a Federal Register Notice was published requesting comment on proposed evidence criteria for home visiting models⁷. Approximately 140 letters providing comments were received and considered in developing the final criteria to identify evidence-based home visiting models for the purposes of the MIECHV Program.

Taking into account the legislative requirements, the original criteria contained in the Federal Register Notice, and the comments received, HHS will consider a model eligible for evidence-based funding for the purposes of the Affordable Care Act MIECHV Program if it meets one of the two criteria below.⁸

A program is considered evidence-based and eligible for funding if it meets either of the following minimum criteria:

- At least one high-quality or moderate-quality impact study of the model has found favorable, statistically significant impacts in two or more of the eight outcome domains described below, or,
- At least two high-quality or moderate-quality impact studies using different samples of the program model have found one or more favorable, statistically significant impacts in the same domain.

For the purposes of the criteria, different samples are defined as non-overlapping participants in the analytic sample. To meet either criterion, the impacts must be found for the full sample or, if found for subgroups but not for the full sample, impacts must be replicated in the same domain in two or more studies using different samples. Isolated positive findings, and effects found only for a subgroup but not the full sample in a study, raise concerns about false positives that may be artifacts of multiple statistical tests rather than reflecting true results. The requirements for replication of positive findings across samples or for findings in two or more outcome domains are meant to guard against this problem. HHS recognizes the importance of subgroup findings for determining effects on subgroups of the population of interest, including specific racial or ethnic groups, the HomVEE website includes information on subgroup findings, whether replicated or not.

Additionally, per the legislation, if the model has met the above criteria based on findings from randomized control trial(s) only, then one or more impacts in an outcome domain must be sustained for at least one year after program enrollment, and one or more impacts in an outcome

⁷ Department of Health and Human Services, Health Resources and Services Administration, Administration for Children and Families, Maternal, Infant, and Early Childhood Home Visiting Program; Request for Public Comment, 75 Federal Register 141 (23 July 2010), pp. 43172-43177.

⁸ For the purposes of the MIECHV, home visiting models have been defined as programs or initiatives in which home visiting is a primary service delivery strategy and in which services are offered on a voluntary basis to pregnant women, expectant fathers, and parents and caregivers of children birth to kindergarten entry, targeting participant outcomes which may include improved maternal and child health; prevention of child injuries, child abuse, or maltreatment, and reduction of emergency department visits; improvement in school readiness and achievement; reduction in crime or domestic violence; improvements in family economic self-sufficiency; improvements in the coordination and referrals for other community resources and supports; or improvements in parenting skills related to child development.

domain must be reported in a peer-reviewed journal (as required under section 511(d)(3)(A)(i)(I) of the law).

The relevant outcome domains are:

- (1) Maternal health
- (2) Child health
- (3) Child development and school readiness, including improvements in cognitive, language, social-emotional, or physical development
- (4) Prevention of child injuries and maltreatment
- (5) Parenting skills
- (6) Reductions in crime or domestic violence
- (7) Improvements in family economic self-sufficiency
- (8) Improvements in the coordination and referrals for other community resources and supports

HRSA and ACF acknowledge that there is not a one-size-fits-all program for any individual grantee and therefore encourage States to consider more than one model to adopt for their home visitation needs.

Detailed information about the systematic review undertaken by HHS, the definitions of high-quality and moderate-quality impact studies, and the available evidence of effectiveness is posted on the HomVEE website (<http://www.acf.hhs.gov/programs/opre/homvee>). The HomVEE website contains reports of evidence available by model, across models within a domain, and implementation information. The reports include available information on: target population, target outcomes, program intensity and length, replication of findings, unfavorable or ambiguous findings, null findings, magnitude of impacts, quality of the measures, duration of impacts, independence of the evaluator, prerequisites for implementation, training requirements, materials, and estimated costs. States should carefully weigh the range in the strength of evidence available for each home visiting model using the information provided.

APPENDIX B: MODELS THAT MEET THE CRITERIA FOR EVIDENCE BASE

As of the date of release of this SIR, the following models meet the criteria for evidence of effectiveness for the MIECHV (as described in Appendix A). HHS intends to continue to review the available evidence of effectiveness for other home visiting models.

Early Head Start – Home-Based Option

Population served: Early Head Start (EHS) targets low-income pregnant women and families with children birth to age three years, most of whom are at or below the Federal poverty level or who are eligible for Part C services under the Individuals with Disabilities Education Act in their State.

Program focus: The program focuses on providing high quality, flexible, and culturally competent child development and parent support services with an emphasis on the role of the parent as the child's first, and most important, relationship. EHS programs include home- or center-based services, a combination of home- and center-based programs, and family child care services (services provided in family child care homes).

Family Check Up

Population served: Family Check-Up is designed as a preventative program to help parents address typical challenges that arise with young children before these challenges become more serious or problematic. The target population for this program includes families with risk factors including: socioeconomic; family and child risk factors for child conduct problems; academic failure; depression; and risk for early substance use. Families with children age 2 to 17 years old are eligible for Family Check-Up.

Program focus: The program focuses on the following outcomes: (1) child development and school readiness and (2) positive parenting practices.

Healthy Families America (HFA)

Population served: HFA is designed for parents facing challenges such as single parenthood, low income, childhood history of abuse, substance abuse, mental health issues, and/or domestic violence. Individual programs select the specific characteristics of the target population they plan to serve. Families must be enrolled prenatally or within the first three months after a child's birth. Once enrolled, services are provided to families until the child enters kindergarten.

Program focus: HFA aims to (1) reduce child maltreatment; (2) increase use of prenatal care; (3) improve parent-child interactions and school readiness; (4) ensure healthy child development; (5) promote positive parenting; (6) promote family self-sufficiency and decrease dependency on welfare and other social services; (7) increase access to primary care medical services; and (8) increase immunization rates.

Healthy Steps

Population served: Healthy Steps is designed for parents with children from birth to age 5. Healthy Steps can be implemented by any pediatric or family medicine practice. Residency training programs can also implement Healthy Steps. Community health organizations, private practices, hospital based clinics, child health development organizations, and other types of clinics can also become Healthy Steps sites if a health care clinician is involved and the site is based in or linked to a primary health care practice. Any family served by the participating practice or organization can be enrolled in Healthy Steps.

Program focus: The program focuses on the following outcomes: (1) child development and school readiness and (2) positive parenting practices.

Home Instruction Program for Preschool Youngsters (HIPPY)

Population served: The Home Instruction Program for Preschool Youngsters (HIPPY) program aims to promote preschoolers' school readiness by supporting parents in the instruction provided in the home. The program is designed for parents who lack confidence in their ability to prepare their children for school, including parents with past negative school experiences or limited financial resources. The HIPPY program offers weekly activities for 30 weeks of the year, alternating between home visits and group meetings (two one-on-one home visits per month and two group meetings per month). HIPPY sites are encouraged to offer the three-year program serving three to five year olds, but may offer the two-year program for four to five year olds. The home visiting paraprofessionals are typically drawn from the same population that is served by a HIPPY site, and each site is staffed by a professional program coordinator who oversees training and supervision of the home visitors.

Program focus: The Home Instruction Program for Preschool Youngsters (HIPPY) program aims to promote preschoolers' school readiness.

Nurse-Family Partnership (NFP)

Population served: The Nurse-Family Partnership (NFP) is designed for first-time, low-income mothers and their children. It includes one-on-one home visits by a trained public health nurse to participating clients. The visits begin early in the woman's pregnancy (with program enrollment no later than the 28th week of gestation) and conclude when the woman's child turns two years old. During visits, nurses work to reinforce maternal behaviors that are consistent with program goals and that encourage positive behaviors and accomplishments. Topics of the visits include prenatal care; caring for an infant; and encouraging the emotional, physical, and cognitive development of young children.

Program focus: The Nurse-Family Partnership program aims to improve maternal health and child health; improve pregnancy outcomes; improve child development; and improve economic self-sufficiency of the family.

Parents as Teachers

Population served: The goal of the Parents as Teachers (PAT) program is to provide parents with child development knowledge and parenting support. The PAT model includes home visiting for families and professional development for home visiting. The home visiting component of PAT

provides one-on-one home visits, group meetings, developmental screenings, and a resource network for families. Parent educators conduct the home visits, using the Born to Learn curriculum. Local sites decide on the intensity of home visits, ranging from weekly to monthly and the duration during which home visitation is offered. PAT may serve families from pregnancy to kindergarten entry.

Program focus: The Parents as Teachers aims to provide parents with child development knowledge; and improve parenting practices.

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APPENDIX C: PROMISING APPROACHES

HRSA and ACF expect that a promising approach funded under this grant will develop a knowledge base around successful strategies for the effectiveness, implementation, adoption and sustainability of evidence-based home visiting programs. The legislation does not require the States to conduct implementation or impact evaluation other than research on promising approaches.⁹

HRSA and ACF have a particular interest in promising approaches that develop knowledge about:

- Efficacy in achieving improvements in the benchmark areas and participant outcomes specified in the legislation.
- Factors associated with developing or enhancing the State's capacity to support and monitor the quality of evidence-based programs; and
- Effective strategies for adopting, implementing and sustaining evidence-based home visitation programs.

Furthermore, HRSA and ACF are especially interested in the use of evaluation strategies that emphasize the use of research to help guide program planning and implementation (e.g., participatory or empowerment evaluation¹⁰). To support the State's evaluation efforts around promising programs, States must allocate an appropriate level of funds for a rigorous evaluation in all years of the grant.

HRSA and ACF expect States to engage in an evaluation of sufficient rigor to demonstrate potential linkages between project activities and improved outcomes. Rigorous research incorporates the four following criteria:

Credibility: Ensuring what is intended to be evaluated is actually what is being evaluated; making sure that descriptions of the phenomena or experience being studied are accurate and recognizable to others; ensuring that the method used is the most definitive and compelling approach that is available and feasible for the question being addressed. If conclusions about program efficacy are being examined, the study design should include a comparison group (i.e., randomized control trial or quasi-experimental design; see the HomVEE website for standards for study design in estimating program impacts:

<http://www.acf.hhs.gov/programs/opre/Homvee>)

Applicability: Generalizability of findings beyond current project (i.e., when findings "fit" into contexts outside the study situation). Ensuring the population being studied represents one or more of the population being served by the program.

⁹ States provided assurances in the initial Funding Opportunity Announcement about participation in any national evaluation activities. It is the Secretary's intent to fund and carry out the national evaluation. However, HRSA and ACF would not prohibit a State from conducting research and evaluation outside of the national evaluation and other ongoing Federal research .

¹⁰ Participatory evaluation engages stakeholders in the development, implementation and interpretation of evaluation results to maximize the usefulness of the results for stakeholders. Empowerment evaluation supports stakeholders to learn the tools on conducting effective evaluation to foster inquiry and self-evaluation or installation of continuous quality improvement.

Consistency: When processes and methods are consistently followed and clearly described, someone else could replicate the approach, and other studies can confirm what is found.

Neutrality: Producing results that are as objective as possible and acknowledge the bias brought to the collection, analysis and interpretation of the results.

The State Plan should provide a narrative addressing how the evaluation of the promising approach will be conducted. The Plan should address the proposed evaluation methods, measurement, data collection, sample and sampling (if appropriate), plan for securing IRB review, and analysis. If the research is measuring the impact of the promising or new home visiting model on participant outcomes, an appropriate comparison condition should be utilized. The Plan should also include a logic model or conceptual framework that shows the linkages between the proposed planning and implementation activities and the outcomes that these are designed to achieve. For assistance in developing a logic model, see <http://toolkit.childwelfare.gov/toolkit/>. HHS has already initiated a contract for the provision of technical assistance for evaluation of promising programs and will be providing information about the technical assistance available to States.

If the State does not have the in-house capacity to conduct an objective, comprehensive evaluation of the promising approach, then HRSA and ACF advise that the State contract with an institution of higher education, or a third-party evaluator specializing in social sciences research and evaluation, to conduct the evaluation. In either case, it is important that the evaluators have the necessary independence from the project to assure objectivity. A skilled evaluator can help develop a logic model and assist in designing an evaluation strategy that is rigorous and appropriate given the goals and objectives of the proposed project.

Additional assistance may be found in a document titled "Program Manager's Guide to Evaluation." A copy of this document can be accessed at: http://www.acf.hhs.gov/programs/opre/other_resrch/pm_guide_eval/reports/pmguide/pmguide_toc.html.

APPENDIX D: SPECIFIC GUIDANCE REGARDING INDIVIDUAL BENCHMARK AREAS

States will be required to report to the Secretary data on all benchmark areas in a format to be specified at a later date. At this time States are required to collect data on all constructs listed below each benchmark area. . It should be noted that one benchmark requires collection of data for “reduction in crime or domestic violence.” Given this language, States are not required to report on both domains, but may elect one or the other. For all other benchmark areas, the States must collect data for all benchmark areas and for all constructs listed under each benchmark area. In order to capture quantifiable, measurable improvement, grantees must collect, at a minimum, data for each benchmark area and construct when the family enters the program and at one year post-program enrollment.

Technical assistance related to the benchmark requirement will be available to the State during the process of preparing for and submitting the Updated State Plan. Requests for technical assistance should be made to the State’s Project Officer, indentified in Appendix F.

I. Improved Maternal and Newborn Health

A. Constructs that must be reported for this benchmark area (all constructs must be measured that are relevant for the population served; if newborns are not being served, constructs related to birth outcomes will not need to be reported):

- (i) Prenatal care
- (ii) Parental use of alcohol, tobacco, or illicit drugs
- (iii) Inter-birth intervals
- (iv) Screening for maternal depressive symptoms
- (v) Breastfeeding
- (vi) Well-child visits
- (vii) Maternal and child health insurance status (note: some of these data may also be utilized for family economic self-sufficiency benchmark area)

B. Definition of quantifiable, measurable improvement:

- For prenatal care, inter-birth intervals, screening of maternal depression, breastfeeding, adequacy of well-child visits, and health insurance coverage, improvement is defined as changes over time for mothers and infants;
- For pre- and post-natal parental use of alcohol, tobacco, or illicit drugs improvement is defined as rate decreases over time.

C. Sources of data:

- Data can be collected from interviews and surveys with families or through administrative data, if available, at the individual and family level.

D. Format to report data

- Depending on the measure used and the grantee’s plan for data utilization, the format of the data should include rates for each relevant construct. For example, the percentage of children birth to age five in families participating in the program who receive the recommended schedule of well-child visits; the percentage of mothers enrolled in the program prenatally who breastfeed their infants at six months of age.

II. Child Injuries, Child Abuse, Neglect, or Maltreatment and Reduction of Emergency Department Visits

A. Constructs that must be reported for this benchmark area (all constructs must be measured):

- Visits for children to the emergency department from all causes
- Visits of mothers to the emergency department from all causes
- Information provided or training of participants on prevention of child injuries including topics such as safe sleeping, shaken baby syndrome or traumatic brain injury, child passenger safety, poisonings, fire safety (including scalds), water safety (i.e. drowning), and playground safety
- Incidence of child injuries requiring medical treatment.
- Reported suspected maltreatment for children in the program (allegations that were screened in but not necessarily substantiated)
- Reported substantiated maltreatment (substantiated/indicated/alternative response victim) for children in the program
- First-time victims of maltreatment for children in the program

B. Definition of quantifiable, measurable improvement:

- Decreases over time for identified constructs other than information provided or training on preventing child injuries, for which increases are considered improvement.

C. Specifying source of data:

- For reductions in emergency department visits and child injury prevention: Data can be collected through participant report, medical records, emergency department patient records or hospital discharge systems. Injury-related medical treatment includes ambulatory care, ED visits and hospitalizations due to injury or ingestions.
- For child abuse, neglect and maltreatment: It is preferred that data be collected through administrative data provided by the State and local child welfare agencies. Grantees may propose collecting the data through self-report or direct measurement if it utilizes a valid and reliable tool.

For more information see:

- A list of the State contacts for National Child Abuse and Neglect Data System collection are available at: <http://www.acf.hhs.gov/programs/cb/pubs/cm08/appendd.htm>
- Child Maltreatment: <http://www.acf.hhs.gov/programs/cb/pubs/cm08>
- National Data Archive on Child Abuse and Neglect (NDACAN): <http://www.ndacan.cornell.edu>.
- Centers for Disease Control Injury Prevention: http://apps.nccd.cdc.gov/NCIPC_SII/Default/Default.aspx?pid=2
- National Health Survey: ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/Survey_Questionnaires/NHIS/2010/english
- Children’s Safety Network and Child Death Review Resource Center’s Best Practices website: www.childinjuryprevention.org
- State Injury Prevention Profiles; <http://www.childrenssafetynetwork.org/stateprofiles/state.asp>

D. Format to report data:

- For reductions in emergency department visits: The data format should include emergency department visits divided by the number of children or mothers participating in the program.
- For child injuries training or information: The construct can be reported as the percentage of participants who receive information or training on injury prevention by the total number of families participating in the program.
- For reduction of incidence of child injuries: The construct should be reported as the rate of child injuries requiring medical treatment (i.e., ambulatory care, emergency department visits or hospitalizations) for children participating in the program.
- For child abuse, neglect and maltreatment: Each construct can be reported as a rate for children prior to kindergarten entry participating in the program.
 - The rate for **suspected maltreatment** is the number of cases of suspected maltreatment of children in the program, divided by the number of children in the program.
 - The rate for **substantiated maltreatment** would be calculated by counting the number of cases of substantiated maltreatment of children in the program and dividing by the number of children in the program.
 - To calculate the rate of **first-time victims**: Count the number of children in the program who are first-time victims divided by the number of children in the program. A first time victim is defined as a child who:
 - had a maltreatment disposition of “victim” and
 - never had a prior disposition of victim

- Data should be reported overall for a program and also should be broken down for each construct by:
 - i. Age category (0-12 months, 13-36 months, and 37-84 months, as appropriate given population served by the home visiting program)
 - ii. For child abuse, neglect or maltreatment only: maltreatment type (i.e., neglect, physical abuse, sexual abuse, emotional maltreatment, other).

III. Improvements in School Readiness and Achievement.

A. Constructs that must be reported for this benchmark area (all constructs must be measured):

- Parent support for children's learning and development (e.g., having appropriate toys available, talking and reading with their child)
- Parent knowledge of child development and of their child's developmental progress
- Parenting behaviors and parent-child relationship (e.g., discipline strategies, play interactions)
- Parent emotional well-being or parenting stress (note: some of these data may also be captured for maternal health under that benchmark area).
- Child's communication, language and emergent literacy
- Child's general cognitive skills
- Child's positive approaches to learning including attention
- Child's social behavior, emotion regulation, and emotional well-being

Child's physical health and development. For more information see:

- o http://www.acf.hhs.gov/programs/opre/ehs/perf_measures/index.html
- o http://eclkc.ohs.acf.hhs.gov/hslc/ecdh/eecd/Assessment/Child%20Outcomes/edudev_art_00090_080905.html
- o Kagan, S. L., Moore, E., & Bradekamp, S. (1995). Reconsidering children's early development and learning: Toward common views and vocabulary. Washington, DC: National Education Goals Panel, Goal 1 Technical Planning Group. (See Child Trends summary here: http://www.childtrends.org/schoolreadiness/testsr.htm#_Toc502715209)

B. Definition of quantifiable, measurable improvement:

- Increases over time in the developmental progress of children between entry to the program and one year after enrollment.
- C. Specifying source of data: Data can be collected from a variety of sources including observation (teacher or an independent observer), direct assessment,

administrative data or health records (e.g. program-specific clinical information systems), parent-report, teacher-report or samples of children’s work. The grantee must collect and report data from the source appropriate to the method and measurement of the construct proposed.

D. Format to report data:

- Depending on the measure used and the grantee plan for using the data, the data reported should be either one or both of the following:
 - Scale scores. When they are available, scores should be the calculated score for individual scales in the measure. Individual item-level data should not be reported. The scale scores should be calculated as instructed in the manual or other documentation provided by the measure developer; and,
 - Rates of children in a particular risk category (e.g. rates of children at risk for language delay).

The following are some suggested ideas or sources for measures within the area of “Improvements in School Readiness and Achievement:”

- http://www.acf.hhs.gov/programs/opre/ehs/perf_measures/reports/resources_measuring/res_meas_title.html
- http://www.casel.org/downloads/Compendium_SELTools.pdf
- <http://journal.naeyc.org/btj/200401/Maxwell.pdf>
- <http://www.earlylearning.ubc.ca/research/initiatives/early-development-instrument/>

IV. Crime or Domestic Violence

The legislation includes a requirement for States to report on reduction in “crime or domestic violence.” Given this language, States are not required to report on both domains.

Crime

A. If the grantee chooses to report crime, constructs that must be reported for this benchmark area (all constructs must be measured) for caregivers served by the home visiting program:

- Arrests
- Convictions

B. Definition of quantifiable, measurable improvement:

- For family level crime rates, improvement shall be defined as rate decreases over time in the identified constructs.

C. Sources of data:

- Data can be collected from interviews and surveys with families (i.e. with validated and reliable instruments) or through administrative data if available at the individual level.

D. Format to report data:

- Data can be reported as annual aggregate rates for parents participating in the program. Data should be reported broken down by reason for the arrest or conviction.

Domestic Violence

A. If the grantee chooses to report on domestic violence, constructs that must be reported for this benchmark area (all constructs must be measured) include:

- Screening for domestic violence
- Of families identified for the presence of domestic violence, number of referrals made to relevant domestic violence services (e.g., shelters, food pantries);
- Of families identified for the presence of domestic violence, number of families for which a safety plan was completed.

B. Definition of quantifiable, measurable improvement:

- For screenings, improvement shall be defined as increases in the rate compared to the population served completed over time.
- For referrals and completion of safety plans related to domestic violence, improvement shall be defined as an increase over time.

C. Sources of data:

- For family-level data, data can be collected from interviews and surveys with families using either administrative data or reliable and valid measures.

For more information see:

- o http://www.cdc.gov/ncipc/dvp/Compendium/Measuring_IPV_Victimization_and_Perpetration.htm
- o <http://www.cdc.gov/ViolencePrevention/intimatepartnerviolence/datasources.html>

D. Format to report data:

- Depending on the measure used for each construct and the grantee plan for using the data, the data reported should be either one or both of the following:
 - o Percentage of screenings for domestic violence of program participants.

- o Referrals and safety plans should be reported as a rate of appropriate services identified and referrals and safety plans made by the total number of identified participants in need of these services.

V. Family Economic Self-Sufficiency.

A. Constructs that must be reported for this benchmark area (all constructs must be measured):

- Family Income
- Employment and Education
- Health insurance status

B. Definition of quantifiable, measurable improvement:

- For family income, improvement shall be defined as an increase in family income over time.
- For employment, education, and health insurance status, improvement shall be defined as an increase in each construct over time among families participating in the program.

C. Specifying source of data:

- Data shall come from interviews or surveys with families. For employment, family-level data may also be gathered (or verified) using Unemployment Insurance data or the ACF's National Directory of New Hires.

D. Format to report data:

- Annual measures of:
 - a. Family income;
 - b. Number of days at least one adult family member is employed, hours per day, and wage/salary OR Time spent by at least one adult family member in educational programs and educational benchmarks achieved (e.g., program completion, degree attainment); and,
 - c. Health insurance status of all family members.

The following are suggested ideas or sources for measures within the area of "Family Self-Sufficiency:"

- "Observations from the Interagency Technical Working Group on Developing a Supplemental Poverty Measure," March 2010, http://www.census.gov/hhes/www/povmeas/SPM_TWGObservations.pdf.
- "National Directory of New Hires," <http://www.acf.hhs.gov/programs/cse/newhire/ndnh/ndnh.htm>
- Evaluation Data Coordination Project http://www.acf.hhs.gov/programs/opre/other_resrch/eval_data/index.html.

VI. Coordination and Referrals for Other Community Resources and Supports

For the purposes of the home visiting benchmarks, referrals include both internal referrals (to other services provided by the local agency) and external referrals (to services provided in the community but outside of the local agency). As part of their initial and ongoing needs assessments, grantees should track the number of services available and appropriate for the participants in the program. The construct of coordination includes capturing linkages at the agency and the individual family level.

A. Constructs that must be reported for this benchmark area (all constructs must be measured):

- Number of families identified for necessary services
- Number of families that required services and received a referral to available community resources
- MOUs: Number of Memoranda of Understanding or other formal agreements with other social service agencies in the community
- Information sharing: Number of agencies with which the home visiting provider has a clear point of contact in the collaborating community agency that includes regular sharing of information between agencies
- Number of completed referrals (i.e., the home visiting provider is able to track individual family referrals and assess their completion, e.g., by obtaining a report of the service provided).

B. Definition of quantifiable, measurable improvement:

- Increase in the proportion of families screened for needs, particularly those relevant for affecting participant outcomes.
- Increase in the proportion of families identified with a need who receive an appropriate referral, when there are services available in the communities.
- MOU: Increase in the number of formal agreements with other social service agencies.
- Information sharing: Increase in the number of social service agencies that engage in regular communication with the home visiting provider.
- Number of completed referrals: Increase in the percentage of families with referrals for which receipt of services can be confirmed.

C. Specifying source of data:

- Data for each of the constructs can be collected through direct measurement by the home visitors and/or administrative data provided by the local agency.

The Secretary of HHS will provide technical assistance specifically around measuring this domain.

D. Format to report data:

- Number of screenings and number of referrals provided divided by the total number of participating families.
- Total number of social service agencies with an MOU and/or regular communication.
- Proportion of referrals of participating families with identified needs whose receipt of service was verified divided by the total number of participating families with identified needs.

DRAFT

APPENDIX E: CONTINUOUS QUALITY IMPROVEMENT

Continuous Quality Improvement (CQI) has been defined as “a systematic approach to improving processes and outcomes through regular data collection, examination of performance relative to pre-determined targets, review of practices that promote or impede improvement, and application of changes in practices that may lead to improvements in performance. The foundation of CQI is the collection and regular use of data in an ongoing fashion. Through regular monitoring, organizations can identify and rectify impediments to effective performance, and document changes and improvements.”¹¹

CQI methods in the MIECHV Program are likely to result in more effective program implementation and participant outcomes. Widespread use of the CQI approach in the prevention field is encouraged for several reasons: CQI provides a means for community-based programs to benchmark their processes and outcomes and thus document results in the absence of comparison groups; CQI methods can provide site-specific data to inform the adaptation of home visiting models to the unique community settings in which they reside; CQI can inform programs about training and technical assistance needs, monitor fidelity of program implementation, and strengthen referral networks to support families; and, CQI empowers home visitors and agencies to seek information about their own performance through the provision of regular reports which summarize their performance on a variety of quality indicators associated with their processes and outcomes.¹²

The State Plan should discuss how the State will comply with the legislative requirement around CQI for evidence-based home visiting models.¹³ States are strongly encouraged to utilize CQI for any proposed promising home visiting model.

¹¹ Ammerman et al: “Development and Implementation of a Quality Assurance Infrastructure in a Multisite Home Visitation Program in Ohio and Kentucky.” *Journal of Prevention and Intervention in the Community*. Vol 34. No.1/2. 2007.

¹² *Ibid.*

¹³ Section 511 (d)(3)(B)(i)(I).

**APPENDIX F: MATERNAL, INFANT, AND EARLY CHILD HOME VISITING PROGRAM
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APPENDIX G: RESPONSE TO PUBLIC COMMENTS ON FEDERAL REGISTER NOTICE ON CRITERIA FOR EVIDENCE OF EFFECTIVENESS OF HOME VISITING MODELS

Background

The legislation establishing the Maternal, Infant, and Early Childhood Home Visiting Program reserves the majority of funds for models that are “evidence-based” according to criteria to be established by the Secretary. On July 23, 2010, in compliance with a legislative requirement, HHS published a Federal Register Notice (FRN) requesting public comment on proposed criteria for evidence of effectiveness. The comment period closed August 17, 2010. One hundred and forty letters were received, most containing multiple comments. Comments were received from legislators, program developers, advocacy organizations, researchers, and program administrators. This Appendix describes HHS’s decisions in seven areas where significant comments were received.

1. Requests for reconsideration of evidence determinations
2. Comments regarding the criteria
3. Factors for consideration
4. Outcome domains
5. Study design, and
6. Promising programs and adaptations

1. Requests for reconsideration of evidence determinations.

A number of comments requested a mechanism for reconsiderations of the evidence determinations.

HHS RESPONSE: In response to these comments, HHS has established a transparent procedure for re-reviews, described in the Supplemental Information Request.

2. Comments regarding the criteria.

Numerous comments suggested different ways to conceptualize criteria for evidence of effectiveness. Many of the comments were mutually inconsistent. Comments covered ratings of study design, program models vs. critical elements of programs, and consideration of findings for subgroups.

- **Distinguishing between “high” and “moderate” quality impact study designs.**

Many comments received criticized the hierarchical rankings of RCTs over QEDs and advocated that the two designs be equally acceptable as evidence. Many of the comments argued that distinguishing these two designs did not follow the legislative intent. Some comments appeared to confuse the ratings of study design and quality with the assessment of the strength of evidence for home visiting models.

As discussed further in (5) below, some commenters recommended including certain types of non-RCT study design in the high-quality category.

HHS RESPONSE: The SIR lists alphabetically the models that meet the evidence criteria and provides the final HHS criteria for evidence of effectiveness. The list does not draw distinctions among the models meeting the evidence criteria, either on the basis of study design or quality. The HomVEE website reports the study design and quality as one of the factors for consideration in weighing the available evidence of effectiveness for each model. In response to comments received, HHS has revised the evidence standards to place certain types of QEDs (single-case-study designs and regression discontinuity designs) in the high-quality category if they meet specific requirements relevant to each design, as suggested by commenters (see (5) below).

- **Program models vs. critical elements.** Two comments were received requesting a focus on elements that make evidence-based programs effective rather than focusing on entire program models.

HHS RESPONSE: The language of the legislation focuses on program models rather than elements of evidence-based practices. Thus, the evidence criteria in the SIR continue to focus on program models. However, HHS hopes to address the task of identifying critical elements of effective programs in the national evaluation or other components of the ongoing research agenda.

- **Subgroups.** One commenter suggested that the proposed criteria for dealing with subgroups be altered depending on the study and outcome domain.

HHS RESPONSE: The SIR retains the proposed approach for considering subgroup findings consistent across all of the home visiting research to keep the review procedures and application of criteria as simple, transparent and straightforward as possible for States.

3. Factors for consideration.

Many of the comments recommended including additional factors when reviewing home visiting research. Examples include measurement quality, cost/affordability of the program, and fidelity of implementation in the study. Other factors recommended for consideration in the comments were related to external validity (e.g., whether the program has been implemented in the “real world,” or recency of the research). Some comments suggested considering factors related to study design, such as power to detect effects.

HHS RESPONSE: HHS has not added factors to the evidence criteria. The HomVEE review reports information on some of the recommended factors concerning outcomes or implementation, but does not consider them when rating a program’s evidence of effectiveness. When feasible, HHS has added information on suggested factors to the HomVEE website. The HomVEE website reports the available information on factors related to external validity in order to inform State or local assessments about the applicability of a program model to the implementation context. The factors recommended by commenters are listed below, along with the recommended response:

- Objectivity or independence of researcher conducting impact study.
 - Based on comments received, information on the independence of the research has been added to the HomVEE website, including information on the program developer’s authorship of the research and the funding

source. HHS has not added this factor to the criteria for evidence of effectiveness because of the lack of clear criteria in determining “independence.”

- Statistical power to detect effects.
 - The HomVEE website already reports sample size. Further, power to detect effects is implicit in whether the study found significant findings.
- Study recruitment process and refusal rates.
 - This information is generally not available in adequate detail.
- Study duration.
 - This is already reported on the HomVEE website and considered in the criteria related to sustained findings.
- Process for selecting study sites and participants.
 - This is related to external validity and should be left for States to weigh in their assessment of the available evidence. This information is already included in the HomVEE website, though not considered in rating program effectiveness.
- Research indicating the model has been implemented successfully in real-world situations.
 - The HomVEE evidence review prioritized programs in wide use. This information is already included in the HomVEE website, though not considered in rating program effectiveness.
- Age of participants.
 - This information is already included in the HomVEE website, though not considered in rating program effectiveness.
- Cost of implementation.
 - This information is already included in the HomVEE website, though not considered in rating program effectiveness.
- Past success of collaboration with other organizations.
 - This information is generally not available.

4. Outcome domains.

A number of the comments received recommended considering specific outcome variables within the domains included in the proposed criteria. A few of the comments requested adding other domains in determining evidence of effectiveness visiting, including child protective and domestic violence services; protective factors; and economic, housing, education and health system deficits. Of the 18 recommended outcome variables, only three were not already included in the HomVEE review. These three were prevention of subsequent pregnancies, expulsions from preschool, and vision and eye health.

HHS RESPONSE: HHS has not added outcome domains or specific outcomes within domains to the evidence criteria. Regarding outcome domains, given time and fiscal limitations and the legislation’s explicit focus on eight domains, the evidence criteria continue to focus only on those outcome domains specifically stated in the legislation. Regarding the three outcome variables not already included in the review:

- Prevention of subsequent pregnancies was not included since this may not be an appropriate goal for all participants.

- Expulsions from preschool settings were not measured in any of the home visiting literature reviewed. This variable could be considered as a measure of socio-emotional outcomes if it is measured in any future studies reviewed.
- Vision and eye health would be included in the health domain if measured in any studies.

5. Study design.

A number of comments requested clarification of the definition of QED. Some commenters recommended that specific non-experimental designs be considered for the high- or moderate-quality study design categories.

HHS RESPONSE: The HomVEE website includes a specific definition of QED. Specifically, HomVEE defines a QED as “a study design in which sample members (children, parents, or families) are selected for the program and comparison in a nonrandom way.”

Commenters suggested including retrospective designs. Retrospective designs may qualify as QEDs and be rated as moderate quality studies if specific standards are met. Based on commenters’ suggestions to include regression discontinuity designs and single-case study designs, HHS has included these types of QEDs in the high- or moderate-quality study design categories, if specific standards relevant to each type of design are met.

6. Promising programs and adaptations.

Some commenters requested clarification on the process for reviewing States’ proposed hybrid or adapted models of home visiting services. Other comments requested a definition of promising programs.

HHS RESPONSE: Though research on program adaptation is in its infancy, there is some literature available around adaptation of evidence-based programs. This literature refers to “adaptation” as changing a model to make it better fit the population or conditions without altering core elements. In contrast, “drift” refers to changes made to the core elements of a model that undermine program effectiveness. Literature around adaptation of evidence-based programs consistently recommends that implementing agencies should discuss proposed adaptations with the program developers prior to implementation to ensure changes do not alter core components. The SIR asks States to include documentation that the program can be implemented as planned and support from the program developers for any adaptations proposed.

The SIR defines a promising program as: A promising approach is one in which there little to no evidence of effectiveness; one with evidence that does not meet the criteria for an evidence-based model; or a modified version of an evidence-based model that *includes significant alterations to core components*. The promising approach should be grounded in relevant empirical work and have an articulated theory of change. The promising approach must have been developed by or identifies with a national organization or institution of higher education, and States must agree to evaluate this approach through a well-designed and rigorous process.

APPENDIX H: GLOSSARY

Adaptation	In some cases, the State may wish to adapt an existing model that has been identified as evidence-based in order to meet the needs of targeted at-risk communities. For the purposes of the MIECHV, an acceptable adaptation of an evidence-based model includes changes to the model that have not been tested with rigorous impact research but are determined by the model developer <i>not to alter the core components related to program impacts</i> . Literature around adaptation of evidence-based programs consistently recommends that implementing agencies should discuss proposed adaptations with the program developers prior to implementation to ensure that changes do not alter core components. Changes to an evidence-based model that alter the core elements related to program outcomes undermine the program’s effectiveness. Such changes (otherwise known as “drift”) will not be allowed under the funding allocated for evidence-based models.
Administration for Children and Families	The Administration for Children and Families (ACF), within the Department of Health and Human Services (HHS) is responsible for federal programs that promote the economic and social well-being of families, children, individuals, and communities.
Aggregate Data	Data combined from multiple measures and/or across multiple subjects.
Alternative Evidence-Based Home Visiting Model	A home visiting model, proposed by a State, that has not already been identified as meeting the criteria for as evidence-based.
At-Risk Community	An <i>At-Risk Community</i> is defined as a community 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 dropouts; substance abuse; unemployment; or child maltreatment. <i>See Section 511 (b)(1)(A)</i> .
Benchmark Data	Data collected for the purposes of measuring progress towards an intended goal.
Community Involvement	“ <i>Community Involvement</i> is a State’s effort to establish two-way communication with the public to create understanding of the MIECHV program and related actions, to ensure public input into decision-making processes related to affected communities, and to make certain that the State is aware of and responsive to public concerns.” Adapted from the Environmental Protection Agency’s

definition of ‘community involvement:’

http://www.epa.gov/waste/hazard/correctiveaction/training/key_terms.htm.

Continuous Quality Improvement

Continuous Quality Improvement (CQI) has been defined as “a systematic approach to improving processes and outcomes through regular data collection, examination of performance relative to pre-determined targets, review of practices that promote or impede improvement, and application of changes in practices that may lead to improvements in performance.

Early Childhood System

An *Early Childhood System* is an “integrate(d) early childhood service systems that address the critical components of access to comprehensive health services and medical homes; social-emotional development and mental health of young children; early care and education; parenting education, and family support.”

<http://eccs.hrsa.gov/About/index.htm>

EPSDT

Early and Periodic Screening, Diagnosis and Treatment - a program for medical assistance recipients under the age of 21, including those who are parents. The program has a Medical Protocol and Periodicity Schedule for well-child screening that provides for regular health check-ups, vision/hearing/dental screenings, immunizations and treatment for health problems. (Title V glossary <ftp://ftp.hrsa.gov/mchb/blockgrant/bgguideforms.pdf>)

Evidence of Effectiveness

After completing all study reviews for a program, the HomVEE team evaluated the evidence across all studies of that program that received a high or moderate rating to answer seven questions:

1. Did the program have at least one high- or moderate-quality impact study?
2. Do the high- or moderate-quality studies show any favorable impacts on primary outcome measures?
3. Do the high- or moderate-quality studies show any favorable impacts on secondary outcome measures?
4. Were any of these favorable impacts sustained for at least one year after program services ended?
5. Were any of these favorable impacts replicated in two or more studies using different samples?
6. Were favorable impacts limited to acceptable subgroup findings,¹ or were they observed on the full sample?
7. Do the high- or moderate-quality studies show any unfavorable impacts?

¹ Acceptable subgroup findings have been replicated in at least two studies using different samples.

Evidence-Based Home Visiting Model

HHS will consider a model eligible for evidence-based funding for the purposes of the Affordable Care Act Maternal, Infant, and Early Childhood Home Visiting Program if it meets the following minimum criteria:

- At least one high-quality or moderate-quality impact study of the model has found favorable, statistically significant impacts in two or more of the eight outcome domains below; or,
- At least two high-quality or moderate-quality impact studies using different samples of the program model have found one or more favorable, statistically significant impacts in the same domain.

Federal Education Rights and Privacy Act (FERPA)

FERPA is a “Federal law that protects the privacy of student education records. The law applies to all schools that receive funds under an applicable program of the U.S. Department of Education.” See <http://www2.ed.gov/policy/gen/guid/fpco/ferpa/index.html>.

Health Resources and Services Administration

The Health Resources and Services Administration (HRSA), an agency of the U.S. Department of Health and Human Services, is the primary Federal agency for improving access to health care services for people who are uninsured, isolated or medically vulnerable.

Home Visiting Evidence of Effectiveness Review (HomVEE) Study

The Office of Research, Planning and Evaluation, Administration for Child and Families (OPRE/ACF) launched Home Visiting Evidence of Effectiveness (HomVEE) to conduct a thorough and transparent review of the home visiting research literature and provide an assessment of the evidence of effectiveness for home visiting programs that target families with pregnant women and children ages birth to 5. To carry out the HomVEE review, Mathematica Policy Research conducted a thorough search of the research literature on home visiting, issued a call for studies to identify additional research, reviewed the literature, assessed the quality of research studies, and evaluated the strength of evidence for specific home visiting program models.

Home Visiting Models

For the purposes of the MIECHV, *home visiting models* have been defined as programs or initiatives in which home visiting is a primary service delivery strategy and in which services are offered on a voluntary basis to pregnant women, expectant fathers, and parents and caregivers of children birth to kindergarten entry, targeting participant outcomes which may include improved maternal and child health;

prevention of child injuries, child abuse, or maltreatment, and reduction of emergency department visits; improvement in school readiness and achievement; reduction in crime or domestic violence; improvements in family economic self-sufficiency; improvements in the coordination and referrals for other community resources and supports; or improvements in parenting skills related to child development.

Infants

Children less than one year of age not included in any other class of individuals. (Title V glossary <ftp://ftp.hrsa.gov/mchb/blockgrant/bgguideforms.pdf>)

Institutional Review Board

An **institutional review board (IRB)** is “a specially constituted review body established or designated by an entity to protect the welfare of human subjects recruited to participate in biomedical or behavioral research.” http://www.hhs.gov/ohrp/irb/irb_glossary.htm

Key Positions

A **Key Position** is any position that is vital to the planning, implementation, administration and evaluation of the home visiting program.

Legislatively Mandated Benchmarks

The **Legislatively Mandated Benchmarks** for the MIECHV program include: Improved maternal and newborn health; Prevention of child injuries, child abuse, neglect, or maltreatment, and reduction of emergency department visits; Improvement in school readiness and achievement; Reduction in crime or domestic violence; Improvements in family economic self-sufficiency; and, Improvements in the coordination and referrals for other community resources and supports. *See Section 511 (d) (1)(A).*

Legislatively Mandated Outcomes

The **Legislatively Mandated Outcomes** refer to the “improvements in outcomes for individual families.” These outcomes include: (i) improvements in prenatal, maternal, and new born health, including improved pregnancy outcomes; (ii) improvements in child health and development, including the prevention of child injuries and maltreatment and improvements in cognitive, language, social-emotional, and physical developmental indicators; (iii) improvement in parenting skills; (iv) improvements in school readiness and child academic achievement; (v) reduction in crime or domestic violence; (vi) improvements in family economic self-sufficiency; (vii) improvements in the coordination of referrals for, and the provision of, other community resources and supports for eligible families, consistent with State child welfare agency training. *See Section 511 (d) (2)(B).*

Life Course Development

Life course development points to broad social, economic, and environmental factors as contributors to poor and favorable health and development outcomes for children, as well as to persistent

inequalities in the health and well-being of children and families.

Logic Model	A logic model is “a map or simple illustration of what you do, why you do it, what you hope to achieve, and how you will measure achievement. It includes the anticipated outcomes of your services, indicators of those outcomes, and measurement tools to evaluate the outcomes.” http://toolkit.childwelfare.gov/toolkit/
Low Income	An individual or family with an income determined to be below the income official poverty line defined by the Office of Management and Budget and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981. [Title V, Sec. 501 (b) (2)]
Memorandum of Concurrence	This requirement is made to ensure agreement among State agencies on the Updated State Plan for a State Home Visiting Program. The purpose is to demonstrate that these agencies are committed to collaboration and are in agreement with implementation of the program, as well as to ensure that home visiting is part of a continuum of early childhood services within the State.
Patient Protection and Affordable Care Act of 2010	On March 23, 2010, the President signed into law the Patient Protection and Affordable Care Act of 2010 (Affordable Care Act) (P.L. 111-148), historic and transformative legislation designed to make quality, affordable health care available to all Americans, reduce costs, improve health care quality, enhance disease prevention, and strengthen the health care workforce. Through a provision authorizing the creation of the Affordable Care Act Maternal, Infant and Early Childhood Home Visiting Program, the Act responds to the diverse needs of children and families in communities at risk and provides an unprecedented opportunity for collaboration and partnership at the Federal, State, and community levels to improve health and development outcomes for at-risk children through evidence-based home visiting programs.
Perinatal	Period from gestation of 28 weeks or more to 7 days or less after birth. (Title V glossary ftp://ftp.hrsa.gov/mchb/blockgrant/bgguideforms.pdf)
Pregnant Woman	A female from the time that she conceives to 60 days after birth, delivery, or expulsion of fetus. (Title V glossary ftp://ftp.hrsa.gov/mchb/blockgrant/bgguideforms.pdf)
Promising and New Approach	A promising and new approach is one in which there is little to no evidence of effectiveness; one with evidence that does not meet the criteria for an evidence-based model, or a modified version of an evidence-based model that <i>includes significant alterations to core</i>

components.

Reflective Practice	<p>Reflective practice is “the process of continuous learning through thoughtful examination of one’s work.” From Mentoring, Coaching, and Reflective Practice: An Annotated Resource List http://nitcci.nccic.acf.hhs.gov/resources/final_resources_for_mentorin_g.pdf.</p>
Reliability of Measurement	<p>Consistency of a measure to capture the intended construct (e.g., a person answer the questionnaire will most likely answer in a similar way both today and tomorrow). It is most frequently quantified through inter-rater reliability, test-retest reliability or internal consistency.</p>
Risk Factors	<p>Risk factors are scientifically established direct causes of, and contributors to, morbidity and mortality . Changes in behavior or physiological conditions are the indicators of achievement of risk factor results. Results focused on risk factors tend to be intermediate term. Risk factor results should answer the question, —Why should the State address this risk factor (i.e., what health outcome will this result support)?</p>
Sampling	<p>Selecting a group of participants that are representative of the population to which the data is intended to generalize. Sampling is used in instances where it is not feasible or appropriate to measure every single member of a specific population.</p>
Socio-Ecological Perspective	<p>The socio-ecological perspective emphasizes that children develop within families, families exist within a community, and the community is surrounded by the larger society.</p>
Statewide Needs Assessment	<p>In completing the FY 2010 Affordable Care Act Maternal, Infant, and Early Childhood Home Visiting Program application, states were required to complete three steps, the second of which was submission of a statewide needs assessment as a condition for receiving FY 2011 Title V Block Grant allotments. The needs assessment included an identification of 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; identification of the quality and capacity of existing programs or initiatives for early childhood home visiting in the State; and a discussion of the State’s capacity for providing substance abuse treatment and counseling services to individuals and families in need of such treatment or services.</p>
Technical Assistance	<p>Technical Assistance is the process of providing recipients with expert assistance of specific health related or administrative services.</p>

Title V	The authorizing legislation for the Maternal and Child Health Block Grant to States program, which is found in Title V of the Social Security Act. (Title V glossary ftp://ftp.hrsa.gov/mchb/blockgrant/bgguideforms.pdf)
Updated State Plan	In completing the FY 2010 Affordable Care Act Maternal, Infant, and Early Childhood Home Visiting Program application, states were required to complete three steps, the third of which is submission of an Updated State Plan for a State Home Visiting Program. The Updated State Plan includes identification of the community(ies) at risk where home visiting services are to be provided, a detailed assessment of the particular needs of that community(ies) in terms of risk factors and existing services, identification of home visiting services proposed to be implemented to meet identified needs in that community(ies), a description of the State and local infrastructure available to support the program, specification of any additional infrastructure support necessary to achieve program success, and a plan for collecting benchmark data, conducting continuous quality improvement and performing any required research or evaluation.
Validity of Measurement	The degree to which a measure is capturing the construct it is intending to capture (e.g. the measure is capturing depressive symptoms and not anxiety). It is frequently expressed as construct validity, content validity or criterion validity.