

# Federal Advisory Committee on the Home Visiting Program

## Evaluation

MCHB / DECHD Webcast, March 23, 2011

PETER VAN DYCK: Good morning, everybody. Welcome to the first meeting of the secretary's advisory council for Home Visiting. I'm Peter van Dyck. One of the co-chairs is sitting across the table from me is the other co-chair, Naomi Goldstein. We will introduce ourselves and go through the motions of beginning the committee but the first order of business is the swearing in. Welcome to the members of the committee on the phone. And to do the swearing in as the first order of business, we have Beverly Jackson from the health resources. A human resources specialist. Beverly, would you perform the swearing in?

BEVERLY JACKSON: Okay. Let's perform the oath of office. I just ask everyone to raise their right hand. Repeat after me. I, repeat your name. Do solemnly swear that I will support and defend the Constitution of the United States against all enemies, foreign and domestic, that I will bear true faith and allegiance to the same, that I take this obligation freely without any mental reservation or purpose of evasion, and that I will and faithfully discharge the duties of the office on which I am about to enter so help me God. Welcome to the federal government.

PETER VAN DYCK: Thank you, Beverly. Carlos?

CARLOS CANO: Good morning. I'm Dr. Carlos Cano. I'm the federal officer along with my colleague Dr. T'Pring Westbrook from the Administration for Children and Families designated to provide staff support for the advisory committee on the evaluation of the Maternal, Infant and Early Childhood Home Visiting programs. I'd like to welcome all of you to this webcast and bring to your attention a few housekeeping items before I turn the floor over to Dr. Terry Adirim who will welcome you on behalf of the Health Resources & Services Administration, HRSA, where this first meeting of the committee is taking place today.

First, a few technical points on the webcast. For the segment involving the slide presentation, the slides will appear in the central window and will advance automatically. Synchronized with remarks. You do not need to advance the slide. Members of the audience may need to adjust the timing of the slide changes to match up with the audio by using the slide delay control as the message appears in the window, the lower right part of your screen. We have been advised that setting the change to 12 seconds works best. On the left of the screen is a window for the video. You can adjust the volume using the volume control slider, which can be accessed by clicking on the loud speaker icon. Those of you that selected the accessibility feature during registration will see text captioning underneath the window of the video. At the end of the broadcast, the interface will close automatically and you will be asked to fill out an online evaluation. Please take a couple minutes to do so. Your response will help us to plan future webcasts and improve our technical support.

It's my pleasure to introduce Dr. Terry Adirim, who is the Director of the Office of Special Health Affairs here in HRSA, and is the lead HRSA official for the Home Visiting program. Dr. Adirim comes to our agency from the office of health affairs at the Department of Homeland Security, where she served as Senior Advisor for science and public health. While at Homeland Security, she also served as the vice chair of the FEMA children's work group which focused on incorporating the needs of children and families in disaster preparedness, response, and recovery.

TERRY ADIRIM: Good morning. I bring greetings from the HRSA administrator, Dr. Mary Wakefield. Your recommendations are critical for the design and planning of the program evaluation activities of this program. I also want to bring to your attention today is the one-year anniversary of the Patient Protection and Affordable Care Act. So this committee meeting takes on even more importance or significance. We at HRSA and ACF are committed to the development and implementation of home visiting programs at the highest quality and we depend on all of you, the experts, for assistance.

CARLOS CANO: Let me turn it over to one of the two co-chairs of the meeting today, Dr. Peter van Dyck.

PETER VAN DYCK: Thank you, Terry. Thanks for being here. George Askew from the Administration of Children and Families would like to say a few words.

GEORGE ASKEW: Good morning, this is George Askew from ACF. We're very excited to be kicking off this meeting today. I bring you greetings from the deputy assistant secretary for early childhood development, Joan Lombardi, who is also very excited about this as we look at the intersection of education, health, and family support as critical to our work. This Home Visiting program is a key element in establishing that very important intersection. We look forward to participating in our role as Tribal -- the tribal home visiting support and coordinator as well as our role in the technical assistance through our administration for children, youth and families, where Brian Samuels is a commissioner and also sends his greetings and his great commitment to the program. Thank you for all the work that you're doing for us and for our country and for all of our children and families.

PETER VAN DYCK: Thank you, George. Well, welcome to the first meeting of the Maternal, Infant and Early Childhood home visiting program evaluation. For those of you on the phone, you are committee members. Those of you watching on the internet, you are public visitors and we welcome both of you and all of you to the call. For those on the phone, can you hear? Just doing a check here. Someone talk back to me.

>> Can you hear us? We can't hear you

PETER VAN DYCK: I can hear you fine.

>> Just now. You just beeped on.

PETER VAN DYCK: Okay. Fine. Thank you for your willingness to serve on behalf of the high risk families, infants and children. Thanks for not being upset with us for bugging you to complete your forms so we could meet today. I'm so impressed with the expertise of the committee. I know a number of you personally and I want to personally thank you for meeting with us and for coming in future to a next meeting where we can all meet you personally.

Let me describe the authority and purpose of the committee. The authority for the advisory committee on maternal, infant and early childhood home visiting evaluation is authorized by Section 5.11 from Title V in the Social Security Act. To the extent that its provisions do not conflict with those requirements, the committee is governed by FACA which sets forth the standards for the formation and use of advisory committees. The purpose of the advisory committee on the maternal, infant and early childhood home visiting program evaluation is to advise the Secretary of Health and Human Services on the design, plan, and progress, and findings of the evaluation as required under the act. The committee will advise the Secretary regarding the design, plan, progress and results of the evaluation. The evaluation will provide a state by state analysis of the results and needs assessment and state actions in response to those assessments. Finally, the evaluation will provide an assessment of the potential for the activities conducted under the home visiting programs is scaled broadly to include healthcare practices, eliminate health disparities and improve health care system quality,

efficiencies and reduce costs. The committee reports to the Secretary of Health and Human Services.

The purpose of today's meeting is to briefly bring you up to speed on the Home Visiting program, number 1. Number 2, to get your comments and recommendations on a design for the national evaluation of the home visiting program. A few housekeeping things. If you have to walk away from your phone for a few minutes, don't hang up. Stay connected. During the question and answer period and there will be after every presentation a question and answer period, please try not to interrupt during the presentations. Save your questions for the question and answer period. We will try, I think, to have free form questions just spontaneously to ask your question. If that doesn't work very well, we'll go through a list and ask you specifically by person. I'll chair the first half of the meeting. Naomi will chair the second half. Naomi, any comments?

NAOMI GOLDSTEIN: I just -- well, first, actually, let me ask one more time if members of the committee can hear us.

>> Yes

>> Yes , we can hear you now.

NAOMI GOLDSTEIN: Okay. Good. I want to add my welcome and speaking for myself, I'm delighted to be here. I'm grateful for you giving your time and expertise. I appreciate the efforts of our staff and contractors whom we'll introduce in more detail as we move through the agenda. And particularly thank you to Carlos Cano for all his efforts to make this meeting come off. If we can find out who is on the phone?

PETER VAN DYCK: Let's go around and take roll of the committee. I'll call names. If you're there, please answer and say a few words about yourself so everybody knows who you are. Portincia Camari

>> Yes , I'm here. I'm a professor at Northeastern University . My background has been research related to [Inaudible] and minority populations.

PETER VAN DYCK: Thank you, Portincia. Mark.

>> Yes. I'm primarily a quantitative psychologist who works largely in longitudinal develop mental work with children and co-authored with one of my graduate students, one of them that works on home visiting.

PETER VAN DYCK: Thank you, Mark. Robert Bradley. Hendricks Brown. Greg Duncan? Katherine Gallagher?

>> Yes. Hi. I'm Katherine Gallagher. I'm a professor at George Mason University. My research focuses on health services, research for high risk needs, particularly those involved in the juvenile justice system where children are being incarcerated.

PETER VAN DYCK: Thank you, Katherine. Rob Grimwald.

>> Good morning. I conduct reviews of benefit analyses of the children program and have been involved in a couple visiting programs here in the Minnesota area.

PETER VAN DYCK: Have you had snow lately, Rob?

>> Yeah. I was calling in a little late because of our snow and ice from last night. Surprise surprise.

PETER VAN DYCK: So we've heard. Thank you for braving it.

>> You're welcome.

PETER VAN DYCK: Bette Keltner Jacobs.

>> Yes. This is Bette Jacobs. I'm presently distinguished professor at the O'Neal health law institute at Georgetown University. I served for almost a decade as dean for the School of Nursing and Health Studies. My work has been in public health for over

30 years dealing particularly with the environmental risk with health systems and with marginalized and vulnerable populations.

PETER VAN DYCK: Thank you, Bette. Sharon Kagan? Marie McCormick?

>> Hi. I am a pediatrician. I'm professor of maternal and child health at the Harvard School of Public Health and professor of pediatrics at the medical school. I've been involved in both issues of the outcomes of very low birth weight infants as well as the evaluation of programs to improve infant outcomes and I am the past immediate principal investigator of the health and development program, a randomized clinical control trial of early childhood intervention.

PETER VAN DYCK: Thanks, Marie. Frank Putnam.

>> Hi. I'm a professor of pediatrics and child psychiatry at Cincinnati Children's Hospital. I've been primarily working in the area of child abuse and neglect. But working in the home visiting field for about 12 years and primarily focused on the impact of maternal depression.

PETER VAN DYCK: Thanks, Frank. Ed Shore?

>> Good morning, Peter, this is Ed Shore. I'm Vice President for the Commonwealth Fund in New York City, where I direct a program on child development and preventive

care. I have doctoral training in behavioral and social sciences and spent a number of years in public health where one of my responsibilities was leading a state program of home visiting.

PETER VAN DYCK: Thank you, Ed. Paul Spicer?

>> Hi. I'm professor of anthropology at the University of Oklahoma and been involved in research of early childhood since the program started. I was founding director of the American Indian and Alaska Natives head start center, which we now run jointly with our colleagues in Colorado. And I've spent my recent years I've been developing modules for home visiting and cognitive development, obesity prevention, and early childhood care for American Indians.

PETER VAN DYCK: Thank you, Paul. Heather Weiss? Thank you. Did any other committee member join during the roll call that I didn't call on?

>> Yes. This is Hendricks Browne.

>> Good morning.

>> Good morning.

PETER VAN DYCK: Can you say a few words about yourself?

>> Yes. I'm a biostatistician by training. I work in the prevention field around large scale prevention trials and implementation. I'm director of the prevention science and methodology group at the University of Miami.

PETER VAN DYCK: Thank you, Hendricks. Anybody else? Well, good. Welcome to the committee. I think we'll move right ahead into the introduction of the maternal, infant and early childhood home visiting program. Audrey will give that presentation. She's the national coordinator for the Home Visiting Program here at HRSA. Welcome and good morning, Audrey.

AUDREY YOWELL: Good morning. I'm really honored to be here with all of you. Such an impressive group. We're very appreciative of your willingness to do this. We know that like the passage of the law that has come about rather suddenly and especially appreciative of your willingness to work with us under those circumstances. Could I have the next slide, please. The overview of the presentation will be clear to you very quickly. We'll move on to the next slide.

Many of you I'm certain are familiar with the legislative authority of the home visiting program. And this is part of the Affordable Care Act. And this particular part of the Affordable Care Act amends Title V of the Social Security Act, which is the maternal, infant and early childhood home visiting program. As you may know, this is a \$1.5 million program with escalating funding over the course of five years starting with \$100

million in fiscal 10, which has already been awarded to 56 eligible entities and ending up at \$400 million for FY 13 and FY 14. This program is for grant states with 3% set aside for Tribal organizations and urban Indian organizations and 3% set aside for research evaluation and technical assistance. It's under this 3% that your committee is now being convened. There's also a requirement for collaborative implementation by HRSA and ACF. You can see from the folks that are participating in this meeting today. This is an on going collaboration.

We included this slide on legislative purpose because you can see it's easy for us to forget the actual purposes of the legislation. Easy to get caught up in which models are going to be implemented where. But really the purpose of the legislation is to strengthen and improve the title -- programs and activities under Title V, which is maternal and child health. Number 2, to improve coordination of services for at-risk communities and three, to identify and provide comprehensive services to improve outcomes for the families in these communities. We're emphasizing that because we believe that the home visiting program is one strategy and part of an overall early childhood system and that we really think that in order for home visiting to succeed, we have to be able to improve the infrastructure that supports it. Next slide, please.

Of course, we're all aware that one of the objects of this particular legislation is to implement evidence-based home visiting programs. And that they are targeted to pregnant women, expectant fathers and parents of children birth to kindergarten in at-risk communities. The purpose is to promote the six items that are listed there, which

are actually found in the benchmark areas that we'll be talking about in a few moments and that you'll be talking about in greater detail. Next slide, please.

As I mentioned, in addition to implementing evidence-based home visiting programs, we'd like to encourage the support and development of statewide childhood systems in every state. Establishing home visiting is one of the key services, but as one of the services in a comprehensive statewide system. We're also trying to promote collaboration among all the different state and local agencies and interest groups that would like to promote maternal and child health because we believe that only through partnerships through the state and community level, that includes government and non government organizations, can these programs really be successful. Next slide, please.

One of the key components of this legislation is that the program implemented and be evidence based. Grantees are required to implement these evidence-based home visiting programs. First we had to determine what the criteria would be for establishing the evidence-base and this summer we published a federal register notice with the proposed elements for determining the evidence-base. And we received comments back in August. We also would note, however, that while 75% at least of these entities, home visiting programs need to be evidence-based as determined by the program. The legislation does allow for up to 25% of funding to be used for promising approaches that will be rigorously evaluated. Next slide, please.

As Dr. Askew indicating, there's a tribal program supported by 3% set aside that I mentioned before. This is for discretionary grants to the tribes and including consortia of tribes and urban Indian organizations. 13 of those awards have been made already. Those are five year cooperative agreements. We're expecting five more to be awarded in the near future in FY 2011. These grants are to the greatest extent practical and consistent with the grants to the state. We're aware because of the special circumstances among the tribes and among the research findings on tribes and home visiting programs that are effective there, we can't always tailor the two to be exactly the same. Next slide, please.

Because of the time in which the legislation was passed, March 23, a year ago, we had six months basically to obligate FY 10 money and to collect the statewide needs assessments that were required by every state and eligible jurisdiction as a condition for receiving their 2011 block grant funds under the Maternal & Child block grant. So what we did was issue the FY 10 funding in three steps.

Number 1, states had to apply in response to the funding announcement and at that time they indicated their interest and willingness to apply for home visiting funding. And they were required to have sign off among all of the state agencies that were going to be involved in early childhood. So it wasn't just the lead agency appointed by the governor but those that we thought should be in the Home Visiting program.

The second step was to get the statewide needs assessments from all 56 of the entities. All 56 did apply for grant funding. All 56 did get their needs assessments in time for the end of FY 10 and therefore received their block grant funding. We now find ourselves in stage three. Because the 56 entities are all grantees now, we have been issuing our guidances to them in the form of supplemental information requests. The current one that has been issued includes guidelines for completing states, updated state plans, which are more than updated. This is where the details come in about how they're going to narrow down their communities at risk. I would say as an aside that nearly every single eligible entity identified, many more communities at risk than they could possibly serve with their FY 10 funding. So they're having to drill down for FY 10 and probably throughout the course of the project to decide which of their communities at risk they're going to be implementing these programs in. Then they have to determine which models that are among the seven that we've identified that we'll get to presently. Really fit the needs of those communities they have identified. So they don't take a model and shoehorn it into someplace.

They're supposed to find out what the needs are of the community and figure out which are the models, all of which serve different target audiences for different purposes, how that's going to fit. And they're supposed to identify how they're going to structure this within the state and within the community so that it has the proper supports, the proper infrastructure, to support their home visiting program. Those are due on a rolling basis to us, between 90 and 120 days after issuance. Which means that the 90 days falls on May 9 and the 120 days falls on June 8. So we are looking

forward to getting those updated state plans and in the meantime, our project officers who are located out in the ten regions are working very intens ively with the state and jurisdiction to support them and developing a plan. So it's our hope that by the time the plans come in, they will know what's in them, will know they're approvable and will get them rolling.

When we issued the funding this summer for FY 10, the funds were allocated by formula. We used the Title V formula, a proportion for children 5 and under that fall below the poverty line. However, the states were only able to spend \$500,000 of their initial funding for planning and for the needs assessment. The rest of the funding is restricted pending their updated plans. I'm sure the states are looking forward to and we're looking forward to the final release of those funds, which in many cases are substantially more than \$500,000. Next slide, please.

Because of the way the funding fell and the passage of the law, states have 27 months to obligate their FY 10 funds. So these are FY 10 funds only, they do have 27 months to obligate their funds. They're going to be receiving their FY 11 funds by the end of this fiscal year, which is of course is 9-30, 2011. Each state will be continuing to receive at least their level of funding received in FY 10. There's going to be some competition. We're not sure how much will be available for increase in formula and how much is going to be available for competition. Next slide, please.

As I mentioned, each entity was required to conduct a needs assessment within six months of enactment. The slides that you already got identify exactly what they had to include in the needs assessment. I'm not going to go through that with you. Next slide, please.

And the updated state plan that I just mentioned is described in this slide . It includes the guidance for making final designation of the communities at risk and the models, how they're going to go about implementing those. Next slide, please.

This slide and the next are outlining the different sections of the guidance that we provide in the supplemental information request to the states. They had to identify the at-risk communities. They had to identify a plan for meeting the legislatively mandated benchmarks that we'll be getting into in greater detail later, and which is going to be a focus of much of your attention. They had to have their plan for the administration of the state program, which is part of the infrastructure support that we've been talking about. We also asked them specifically to provide a plan for continuous quality improvement. Because we don't see this as, "Let's implement this one way and these fail or succeed," we would like to see this information used as not only a measure of success, but also as a management tool to continuously improve the quality.

We asked for technical assistance needs. We're going to be providing ongoing technical assistance, and to the extent some states already know what TA they're going to need. We talk to them about their reporting requirements. We have expanded

the number of agencies that are required to sign a memorandum of concurrence at the state level. We really believe this should be a systematic effort within the state. We're also requiring that the states develop their plans in concert with the local communities in which these programs will be implemented. Next slide, please.

As mentioned previously, we had advertised our proposed criteria for the evidence-base for the home visiting programs. Comments were due in August. And 130 letters of comment were received. These were not letters that addressed just simply one element. Many of these letters, most of them, address the number of different aspects of the research. An analysis was done. In our supplement information request, Appendix A provides a summary of all the comments that we received. The responses to these comments also appear in Appendix F of supplemental information request. Next slide, please.

Appendix B of the supplemental information request included a listing of all of the seven models that were identified as evidence-based. We think that a much more interesting aspect to look at these by going to the website identified here, [the HomVEE website](#), which is named after the study that was conducted to identify them. And Naomi will probably be talking about that in greater detail later. The HomVee website really provides detailed information about the way the research was conducted and the way conclusions were drawn about which models were evidence-based. Next slide, please.

This slide identifies the seven programs that were found to meet the criteria for evidence-based. Of course, we're going to be continuing our analysis of research as it develops. So we're hopeful that in the future there will be more than just these seven identified. Next slide, please.

This slide repeats some things I've said before. The states may request implementation of models from among the seven that have been identified as evidence-based. They may propose another model that our study team did not review. They may request reconsideration of a model that was reviewed that people may feel we had missed research or there's other reasons that they would like to request reconsideration. And of course, states can propose to use up to 25% of their funds for promising programs. Next slide, please.

Of course, states are going to have to describe to us how the models meet the needs of communities as I said before. And when they are talking about which models they want to implement, they are supposed to provide to us within 45 days approval by developers of those models. The model developers feel they're appropriate and the plans are going forward in such a way that they feel they can work closely with the states. Next slide, please.

The state also has to provide a plan for data collection for each of the six benchmark areas that are listed here and we're going to be discussing in greater detail later. And this involves their discussion of data collection systems which as you can imagine can

be rather problematic for a number of these states. There's such a variation in the experience among the states in terms of data collection, in terms of home visiting programs that this will be challenging for many. Next slide, please.

The major requirements as set forth in the legislation and as we are implementing through this program requires the states collect data on all six benchmark areas. They must collect data for all of the constructs under each benchmark area. To demonstrate improvement by year three, the state has to show improvement in at least half of the constructs on each benchmark area and they have to show progress in four of these benchmarks at year three. We are recommending that programs use these and other data for continuous quality improvement as I mentioned before. Next slide, please.

These updated state plans, because the states are already grantees, their plans will be reviewed by federal staff from both HRSA and ACF. And there's specific review criteria of course. And it has to do with their justification of target communities. Can't just be this is where the governor's family lives or something like that that we're all familiar with. You have to have a real rationale for why this community is at risk. And why you believe there's a local infrastructure that will support the success of that program. You have to talk about how the model is going to address these needs, of course. What the plan is for meeting the benchmarks and collecting the data. The feasibility of the implementation plan and the level of commitment and concurrence among the required partners, which we consider to be a really essential part of this program. Next slide, please.

Now we come to you. The secretary is to appoint the advisory panel consisting of experts in program evaluation, research, education and early childhood development. This morning we have the representation on the panel and we're very proud to have you with us. Next slide, please.

The charges of your panel are to review and make recommendations on this design and plan for the evaluation. To maintain and advise the secretary regarding progress of the evaluation and to comment should you so desire on the report that is to be submitted to Congress. Next slide, please.

The committee is also charged to conduct an analysis on a state by state basis of the results of their statewide needs assessment, including indicators of maternal and prenatal health, infant health and mortality. The state's proposed actions in response to those assessments in their updated state plans. Next slide, please.

And has already been said , the components of the evaluation are listed here. Basically it's the effectiveness of these programs overall and on different populations and their potential for scaling up to improve health care practices and eliminate disparities. Next slide, please.

The secretary is required no later than March 31, 2015 to provide a report to Congress. The report should be made public. As mentioned before, we will look forward to your input on that report. Next slide, please.

If you have any questions now or after this, this is my contact information. Anybody should feel free to contact me by e-mail. It's simple. It's my first initial, last name, [ayowell@hrsa.gov](mailto:ayowell@hrsa.gov). We're looking forward to working with you. Thanks.

PETER VAN DYCK: Thank you, Audrey. Let me ask the committee members, can you hear all right?

>> Yes.

PETER VAN DYCK: Wonderful. We can hear you. Thank you. I'd like to open up the committee to questions for Audrey. Please ask your questions. Be polite of your other committee members.

>> Can you say something about the resources available to the committee in terms of reports and the evaluation?

PETER VAN DYCK: You want to say your name to help everybody on the phone first?

>> Yes. This is Frank Putnam. I just wanted to know about the resource as available to the committee for reports and evaluation.

AUDREY YOWELL: Actually I'm going to turn this question over to Carlos Cano, who is the research purpose on the HRSA team and to Naomi Goldstein who is the research lead on the ACF team.

CARLOS CANO: I'm not sure the question has to do with the resources the committees have been allocated to their functioning or the other resources which might include the contract and the administration for children and families has currently within MDRC. And MDRC is a contract or that is working on developing the evaluation design and will be presenting shortly. So I don't know if Naomi has anything to add. Perhaps defining the question might help.

NAOMI GOLDSTEIN: Frank, were you focussing on one or other of those aspects or both?

>> Actually, I didn't know there was a distinction there. I'm interested in both.

NAOMI GOLDSTEIN: So committee is not expected to design or carry out the evaluation. The committee is to advise us on the evaluation. I can speak to the resources available for the evaluation in the legislation, there's a reservation of 3% of funds each year for the purposes of the national evaluation and an ongoing portfolio of

research and evaluation and technical assistance around corrective action plans that states put forward. So 3% of fiscal 10 is \$4.5 million for those three purposes. 3% obviously will increase as the funds increase. But technical assistance needs will also increase. I can't say precisely what will be available for the national evaluation but that will give you a sense of the ballpark.

AUDREY YOWELL: I can also add to that that we do have staff people available. I think you been working with Dr. Cano and with Billy Butler on the team. We can provide you with any kind of logistical or other kinds of support that you would like to have. Please feel free to get in touch with us about that.

CARLOS CANO: Essentially the committee has a financial operating plan with resources allocated to support the meetings, some in-person meetings, this one today, and then there's devoted time from federal officials to staff and support the committee's activities.

>> Other questions?

>> Yeah. This is -- I want to ask about the function of the committee. So can you give us a sense of how often and what points the committee will meet? Will we have longer term process on advising?

NAOMI GOLDSTEIN: Who asked the question?

>> This is Hortencia.

CARLOS CANO: Right now there's a second in-person meeting scheduled for perhaps the first week in May. The charter of the committee indicates that we will have up to four meetings every year. The resources are allocated to that effect. It's not clear what the exact timing of any future meeting also be. It will depend on the timing of a contract to be let for implementing the evaluation for which you'll give us recommendations later in the year.

NAOMI GOLDSTEIN: And this is Naomi. In a few minutes I'll speak a little bit about the timing of the step to move toward an evaluation contract and that will give you more in sight to roll out the activities the next year or so.

>> Any more questions for Audrey?

>> This is Rob. Audrey you mentioned on slide 26 about the benchmark that the states are using. Have you given them guidance on specific measures that they're using to measure those benchmarks?

>> Yes. In fact, I'm going to turn this over to Naomi and to Lawrence who have been working extensively on this along with Carlos.

>> And I introduce Lauren Supplee. She'll see more in a minute. But for now please speak to the question. Thank you.

>> Sure. So in the supplemental information request that Audrey mentioned in her comments provided detailed framework for the benchmark. That included identifying subconstructs under each of those very broad benchmark areas. Each of the grantees meets a measure, each of the subcontract within the benchmark domain and we are providing those flexibility on the exact measures to capture those constructs. This was done to recognize that we're encouraging states to use the benchmark data for quality improvement. We want measures that are useful for reporting benchmarks and for problematic decision making and information. We also recognize that many of the home visiting models that were on the other lists have required measures already. And so we also wanted to minimize burdens on programs and on participants. And I believe that we haven't already provided the SIR, we can do so to the committee. You can see those subconstructs. We're also providing technical assistance through the grantees around benchmarks. That includes providing information such as the measures compendium that gives us suggestions on possible measures to collect. One other important thing about the benchmark, the law is clear that the benchmarks need to be reported on individual families participating in the program. Not community level benchmarks.

>> Thank you. Just one other question about the 25% that is available. You said something about a model. Can you tell us about rigorous evaluation would mean and how the funds –

NAOMI GOLDSTEIN: This is Naomi . I can say a couple words about that. So first, states are required to conduct evaluations of the promising models. Second, I think it will be -- it's clear to the state s that it's in their interest to conduct an evaluation that can meet the standards for high er studies that were establish ed for judging which models are evidence-based. If they can evaluate a program in such a way that it meets those standards, then that program model would become eligible for the 75% of funds that are re serve d for evidence-based programs. I could take a moment to review what those criteria are, if that would be helpful.

>> Yes , it is. Maybe briefly, yes. That would be great.

>> Okay. So in order to be considered evidence-based, a program model has to have conduct ed on at least one high er moderate impact study. I'll come back to that. That study must have shown favor able impact in two or more of the eight legislative out come domains. Or two high er moderate quality impact studies with non over lapping an alytic studies. So there has to be stud ies that meet certain quality standards and those studies have to show -- if there's one study with positive impact, it has to show impact in two or more domains. If there were impacts only in one domain, there has to be two or more studies. Impacts had to be found for the pool sample or if they were

found for sub groups only, they had to be replicated in the same domain in two or more studies with non overlapping samples. And a little quirk following the legislation. If the evidence was from random controlled trials only, then there might be at least one significant favorable impact sustained for at least the year-after enrollment program and there must be one impact that's been reported in peer review journal. So briefly favorable impacts either in two or more domains or in two or more studies. And the impact had to be for the full sample or a sub group only had to be replicated. To go back for a moment and explain what was considered high or moderate studies. A high quality study would be a random controlled trial with no substantial problems. That is no re assignment, low attrition, no confounding issues between the controlling treatment group. In addition, single case study designs and regression designs that met certain standards could be considered high quality. A moderate quality study would be a random control trial with some problems such as attrition or criminal designs that had comparison groups matched at baseline or single case subject designs that met certain standards. Any study that didn't meet the standards would be low quality and findings from low quality studies were not considered in determining which models were evidence-based. Lauren, go ahead.

>> Going to add one more thing about the definition of rigor. In the appendix, there's a broad definition of rigor. We put three priority areas. You know, we do want people to test efficacy but we also recognize some programs are not at the point with nonappropriate questions. We have a couple points they can address in those evaluation plans. Again, if we provide you the SIR, you can look at that appendices.

>> And I believe the legislation mentioned randomized trials where feasible.

>> Under the ongoing research agenda.

>> Sorry. Not in the context of the model.

>> Right.

>> So I think as the questions are beginning to move towards the evaluation itself, I think we ought to move ahead

>> I can I ask one question? This is Marie McCormick. Are children with special healthcare needs one of the target groups?

>> The target group is determined by each state. So we would certainly -- since we are concerned with children with healthcare needs, we hope other populations would be included. One of the key aspects of the implementation of the program is we would like this to be state and community driven. And while we will certainly be providing technical assistance and encouragement to include those groups and be taking a look at any particular supports that they may need in addressing these groups, we are going to allow the state and communities to select their targeting communities.

>> Thank you.

PETER VAN DYCK: So Naomi Goldstein serves as co-chair of the committee a long with myself. Naomi is the director of the office of planning research and evaluation at ACF. And will talk to us about the legislative requirements for the evaluation. Naomi?

NAOMI GOLDSTEIN: Thank you, Peter. I'm going to give a brief introduction to the requirements for the evaluation, the context, where we are in the planning process before introducing the contractor staff and saying more about the ACF staff that worked on this.

Most of the questions so far have been related to the evaluation. As we get deeper into the evaluation, you'll begin to see how some of the complexities of the program structure are also important to understand and very much inform the thinking about the evaluation. So just briefly to recap the legislative requirements about the evaluation.

Evaluation is required to include an analysis of the state needs assessments. An assessment of the effect of the home visiting program on child and parent outcomes. Assessments of the effectiveness of the program on different populations and the potential for activities, if scaled broadly, to improve healthcare practices, eliminate health disparities, and improve healthcare system efficiencies and reduce costs. And as Audrey mentioned, and as you'll see shortly, it's very challenging, the evaluations that the legislation requires a report to be submitted to Congress March 31 of 2015,

which basically means we should be putting that reporting into place right now. It's a very short time line.

I just wanted to highlight for a minute the legislation talks about research and evaluation throughout in addition to the requirements for a national evaluation the legislation states the Secretary shall carry out a continuous program of research and evaluation activities to increase knowledge about the implementation and effectiveness of home visiting programs using random assignment designs to the maximum extent feasible.

There's a lot in that paragraph there. And today we are going to be focusing on the national evaluation, not the continuous program of research and evaluation. I just wanted the committee to be aware that we don't expect the national evaluation to answer all questions and there will be other research as well. This paragraph also specifically mentions implementation. That is a priority for us in the national evaluation in general because we think it's very important, not just to answer how much but why and how. Next slide, please.

The secretary is also to ensure that an evaluation of a specific program is conducted by people not directly involved in the operation of that program. So there's a plug for independence. And a specific requirement for consultation with independent researchers, state officials and developers and providers of home visiting programs. Those are all requirements that we take very seriously.

And legislation also requires an inter agency federal work group to coordinate and collaborate on research and I won't go into any details but just to assure you that we have been following that requirement in addition to the basic collaboration that is occurring between HRSA and ACF. We've reached out to other agencies as well. Next slide, please.

And as I mentioned, the legislation reserves 3% of funding for the purposes of the national evaluation, ongoing research and evaluation, and technical assistance and the -- and for fiscal 10 funds where there were \$150 million overall, 3% is \$4.5 million. So where we are and where we're going. Next slide, please.

In September of 2010, we awarded a contract to MDRC, several contractors, Cincinnati children's hospital and a number of academic consultants for developing design options for the home visiting evaluation. The co-principal investigators are here today. Ginger Knox from MDRC, Charles, known as Chuck, Michalopoulos from MDRC and Anne Duggan from John Hopkins University. So this contract is developing design options. Ginger will speak more about that in a moment. This is all through the contract providing technical assistance to grantees, namely states and other entities around the evaluation of promising models, around benchmarks, continuous quality improvement, and management information systems.

So next steps, we will be awarding a contract to carry out the evaluation by September 30<sup>th</sup>, 2011, and that is an unforgiving deadline. We have to award the contract by September 30<sup>th</sup> in order to obligate fiscal 11 funds. If we don't do that, we simply lose those funds. That's not an option. Working backwards, that means we have to issue a request for proposals for that contract by June 1 at the latest. So today as Peter and Audrey have mentioned, it's really an introduction, an overview to the program context and some of the challenges in the evaluation design. We plan to -- we have some specific big picture questions to pose to the committee. We welcome advice on other topics as well. So we want to get some broad advice from this committee today and then we'll provide more detail on the evaluation design at a second meeting we hope to schedule in early May.

To say more about future schedules. I think we won't seriously consider a schedule for future meetings of the committee until after the design -- after the evaluation contract is awarded. Although of course we welcome the committee's thoughts about what would be most useful, but basically from June to September will be proposal writing and proposal review and we won't really be in a position to make refinements in the design at that point. So this committee will probably take a hiatus during that period.

So I did want to introduce a few people. I had one more thought before I do that. Again, a plug just for keeping in mind the program context. It is a program with a pretty complicated structure and many legislative requirements. The national evaluation is to evaluate the program as a whole. And that is different from most evaluations in the

home visiting arena to date, which have typically focused on a specific model. The legislation is very focused on models. Grantees are to implement evidence-based models. So clearly the research to date is very apropos. The national evaluation has a slightly different cast and Ginger will be talking more about that. So I've already introduced or mentioned Ginger and Chuck. We're also joined by Jill Fileen from MDRC, who is part of the design contract team and from ACF, we have Katie Beckman, George Askew, T'Pring Westbrook, who is the co-designated federal official along with Carlos Cano, responsible for –

Ah! "Tell Naomi to stop talking. We have a problem!" [Laughter]. Can you hear me?

>> We have music in the background. Somebody put us on hold and they're playing jazzy music.

>> Okay.

>> Mostly your talk was drowned out unfortunately.

>> How sad!

>> One of the committee members have their phone on hold?

>> Probably did and couldn't hear you.

NAOMI GOLDSTEIN: Okay. So Mike in Chicago, can you mute the committee members? Okay. I believe the committee members have been muted. Of course now they can't tell us whether their situation is better. [Laughter]

>> Maybe they can identify which line it is or –

>> yeah.

NAOMI GOLDSTEIN: Okay. So maybe we should -- we can go around the committee members and identify who it isn't. Could you un mute the committee members?

>> I can tell you what cell phone number it was.

NAOMI GOLDSTEIN: Okay. That's great.

>> The area code.

>> 617-432-3787.

>> Oh, Boston.

NAOMI GOLDSTEIN: Marie?

>> Not Hortencia.

>> Is it cleared up now?

>> She muted the line.

>> Great.

>> Thank you.

>> Okay.

>> For the rest of us, if you go away, don't put it on hold.

>> I think we missed a bunch of it. I don't know if you can go back over it a bit or –

>> most of it is on the slide.

>> So I think we'll back up and have Naomi give her presentation again.

>> This is Hortencia. I had another thing I wanted to add. I was noticing that -- I'm using the powerpoint sent to us. But it didn't seem to have all the information that was being discussed –

>> the first one seemed complete. The second didn't

>> That's right.

>> Naomi had an introduction to her talk.

>> I said a few things that were not on the slide.

>> That's fine. So you're not missing any slides.

PETER VAN DYCK: So Naomi, why don't you –

NAOMI GOLDSTEIN: okay. Pardon?

>> So we're going back to the beginning? Are we going to go back to the beginning of Naomi's talk? So keep the slides where they should be?

NAOMI GOLDSTEIN: Yes. Please go to slide 30. Which is actually at the end of Audrey's talk.

>> Okay. For those of us that get the new one, that's 34.

>> Yes.

>> Okay.

>> 35 I guess. Yeah, 34.

NAOMI GOLDSTEIN: It says "evaluations component A." I'm going back to the end of Audrey's talk because I recapped a little bit. Can our technical folks in Chicago go back to slide 30. Thank you. Can I just say there's several people in the room who are monitoring their e-mails. If you have problems, maybe I'll read somebody's e-mail. Katie, you want to be it?

>> Sure.

>> Can you spell out your e-mail loudly?

>> [Inaudible]

NAOMI GOLDSTEIN: So for any committee members, if you're having difficulty, technical difficulty, e-mail Katie.

PETER VAN DYCK: We're break in on the line and let us know.

NAOMI GOLDSTEIN: Yes. Break in on the line. Although that may be challenged.

>> Yes. You control it.

PETER VAN DYCK: Okay , Naomi.

NAOMI GOLDSTEIN: Okay. So I just started by briefly recapping the last few slides from Audrey's pre citation on the legislative requirements for the evaluation. The evaluation is required to include an analysis of the state needs assessment. Next slide.

An assessment of the effect of the home visiting program on child and parent outcomes in the legislatively benchmark areas. An assessment of the effect of the program on different populations, and the potential for these activities if scaled up to include healthcare practices, eliminate health disparities, and improve healthcare system qualities, efficiencies and reduce costs. A report is due to Congress March 21, 2015, which is very, very soon in federal time. And as Ginger goes through the design, you'll see how truly soon that is. And that report will be made publicly available. If you can go to slide 35.

I mentioned -- although we're not focusing on it today, I did want the committee to be aware that the legislation talked about research and evaluation throughout in addition to requirements for a national evaluation, there's a requirement for continuous program and research evaluation activity that specifically mentions not only effectiveness but implementation and calls out random assignment as being desirable and feasible. We take that implementation language seriously. We're interested in learning not just how much but how and why programs are effective. In addition there are requirements for independence as well as consultation with researchers, state officials and model developers.

And then on the next slide, there's a requirement for an inter agency federal work group. In addition to the basic collaboration between ACF on every aspect, we also have involved many other federal officials pursuant to that requirement. Having mentioned the ongoing program of research and evaluation, I just want to make a point about the national evaluation. That it is an evaluation of the home visiting program in contrast with the body of visiting research to date, which has primarily been evaluations of specific models. The national evaluation is focused on the program as a whole. The home visiting program is centralized around the model. States are required to implement evidence-based models. The legislation reserves 3% of funding every year for the national evaluation for the ongoing portfolio of research and evaluation and for certain kinds of technical assistance. In fiscal 10, which is the money that states have already, there were \$150 million appropriated for the program as a whole. So 3% would be \$4.5 million for those three purposes. As the funding goes up, the

funding available for those three purposes increases. All the technical and assistance needs around the corrective action plan begin to kick in. So that gives you a sense of the ballpark of money that's available for the evaluation. We don't know the specific amounts.

So where we are now and where we'll be the next several months. In September of 2010, we awarded a contract to MVR C to develop design options. It's called the DOHVE contract. This includes Cincinnati children's hospital and a number of academic consultants. The co-principal investigators are here with us today and includes Ginger Knox, Chuck Michalopoulos and Anne Duggan from Johns Hopkins. We have Jill Filene who is a member of the contract team and we have several staff members from ACF, including Katie Beckman, who has volunteered to monitor your distress e-mails. We have the co-designated official as long with Carlos Cano. And I have to special give special mention to Lauren Supplee. She's from the DOHVE contract and the home review. [ Audio Difficulties ] you'll notice that I have already started deferring questions to Lauren [Inaudible]. The purpose of the contract that we've awarded is to design the national evaluation following the specifications in the legislation. This contract is also providing [Inaudible] and other grantees on evaluation-related issues such as the evaluation of promising models, developing a benchmark, continuous quality improvement and management information systems. So we will be awarding a new contract for carrying out a national evaluation by September 30th 2011. That's a hard deadline. If we don't award it by then, we will lose

the opportunity to use fiscal 11 money for that evaluation. We don't get that back. So we will be awarding our contract by September 30th.

Working backwards, that means that we'll be issuing a request for proposals for the national evaluation by June 1 at the latest. So it's clear today we'll be scratching the service into an introduction of the nature of the program. It's a broad level introduction to the features of the design we're considering. We have some specific big picture questions that we'll pose to committees. We of course welcome your thoughts and ideas on other topics as well. But given that this is the first meeting and it's relatively limited time to -- for a lot of information, we are not expecting that this is our chance to delve in depth. So we do plan another meeting in early May in which we will present a proposed design in more detail and then we'll take your advice at that meeting into account before we request proposals. From June through September, bidders will be writing proposals. We'll be completing the procurement process. Most likely that will be a hiatus for the committee. We wouldn't be in a position to act on advice. So probably we will reconvene the meeting after the contract is awarded. And I think that is everything that I wanted to say. Lauren says there's something else important but I can't read her handwriting so I'm going to give it back to her.

>> I just thought -- this program is very complicated and can be overwhelming at times. We mentioned evaluation and research mull time times this morning. I thought it might be helpful to specify, there's five specific times that it's mentioned in the program. And the legislation and how those are different. We talked about the criteria for the

program, we talked about the benchmark for the grantees to collect. We talked about the ongoing portfolio of research and evaluation, which will be over time. We talked about the evaluation of promising models by states that the states will be in charge of those evaluations and then we have the evaluation that is a focus of state meetings, which is the evaluation of the home visiting program. I recognize that can be very confusing. I want to be sure we're focusing on just that last piece in our discussion today.

>> Thank you, Lauren. That is very hopeful. I never enumerated it out like that. I'm going to turn it over to Ginger and the design team for a presentation. Ginger will be pausing at certain points for comments. I would suggest we not interrupt the presentation except at those points. We're ahead of schedule and have more time than anticipated for discussion, questions and advice. So I'm delighted about that. So I will turn it -- let me pause now for some questions, if there are any. Although I suspect most of them will be after Ginger's presentation.

>> This is Hortencia. I have a couple of questions. One is -- I know the meeting in May we'll have access to the design options. Didn't know if it was anything that might be ready for a preliminary look at. With respect to that, that's my first question. And the other is I think I recognize this is -- our committee is focused on the national evaluation but it would be useful to know what constitutes research and evaluation so that we can have that kind of in the background as information.

>> Sure. So in answer to your first question, no, there's not a design ready for you yet. We hope to get your big picture guidance in today's discussion and incorporate it into a design that will present at the next meeting. And there is not yet an on going portfolio of research and evaluation. So although we want particularly want and need your advice on the national evaluation, if you have thoughts on other topics or are if you're recommending for the national evaluation that we think are feasible within that scope, we will put that in our thinking for the other evaluation and research activities.

>> Okay. My third question was, I was wondering if the designs that are being considered are going to include multi level models for looking at neighborhood level factors on the impact of home visiting programs.

>> I think I'm going to take that not as a yes or no question, but as a proposal for a topic to discuss.

>> Other questions? Has anybody joined, any committee members joined since we took roll first thing this morning?

>> Yes. Lynn Kagan.

>> Welcome.

>> Hi.

>> Welcome. Sharon, do you want to say a few words about yourself like the other committee members did?

>> I'm a professor at teacher's college, Columbia University. I've been long interested in home visiting family support and early child hood intervention programs.

>> Thank you. Anybody else joined?

>> Ginger, I'm going to suggest you come over here.

>> If anybody has trouble hearing during the presentation or a problem, please just un mute your phone and say something. We'll correct it as it happens.

>> Hello. I'm ginger Knox from MDRC.

>> I'm sorry.

>> We were schedule d to take a break at 10:30. Shall we just go through ginger's present ation and then break?

>> Does anyone object to going through the presentation, which will be about 45 minutes?

>> Including the discussion, it will be longer.

>> Okay.

>> Are we go for about an hour or anyone think we should take a break?

>> No. That's fine.

>> All right. Whoever that was, you're speaking for the committee. Thank you.

VIRGINIA KNOX: As Naomi mentioned, I'm here with with Chuck Michalopoulos and Anne Dugan of Johns Hopkins. We're happy to be here to share with members of the secretary's advisory committee. Some of our initial thinking about the national evaluation for the MIECHV program and to get input for you as we think further about the design options. I want to talk about some other team members that are not presenting but working on other parts of the design. They're available to address those topics, even though some of them may not be on yet. Jill Filene is here with us in person James and Erica are also available. So if you can turn to slide 44.

This slide gives a preview of what we'll be covering. We'll be talking about the seven evidence-based programs and some unanswered questions that the evaluation can be helpful in addressing. We'll discuss HHS's goal. We'll introduce some challenges and

trade-offs that we think need to be thought about as we set priorities for the evaluation. We'll talk about the opportunities that the evaluation presents to increase the home visiting field's knowledge about what works for whom as well as how and why. We'll talk about the timeline for the study, which is not just a housekeeping issue as name mentioned as one of the challenges that we need to hear some input about from the committee. Most important, we want to use this time to get your feedback on these and other issues.

Now we're slide 45. The next few slides give you some information about the seven evidence-based programs that we'll be talking about. We don't have time to describe each program in depth. What we wanted to do is highlight some aspects of the programs that have implications for the design of the national evaluation. So the seven programs that you see on this slide all met the criteria laid out in the ACA legislation for voluntary evidence-based early childhood home visitation programs. They all have things in common. They use home visiting as a primary service delivery strategy. They provide services to pregnant mothers, fathers and care givers. And they all target one or more of the specific out comes. There's substantial differences in the content of the models and how the offices support the implementation at the local level. You'll hear throughout our session that these differences between the programs make it challenging to include them all in one national evaluation. But also the program might have an un usual opportunity to provide information to the field. We'll talk more about that. I should also mentioned that these slides that show characteristics of the different programs, most of the information is drawn from the HomVEE web site. Home visiting

effect and effectiveness website, which was mentioned. And there's more details there about each program if you're interested. So first, each program has somewhat different goals and emphasis. Some have a significant emphasis on improving newborn and pre natal health. Some have a more significant focus on working with parents of infants or young children to prevent child maltreatment or promote effective parenting. Some are more explicitly aimed at promoting school readiness or pre cursors. Some also work with parents on longer term goal settings for the future. While the program varies in the goals, but you can see in the chart most of them have goals that cut across more than one of those domains.

Target population. You can see that most of the programs target families that have either low income or some indication of developmental risks. Two of the programs, Healthy Steps and Parents and Teachers, do not target families of risk per se but simply enroll families with young children and Healthy Steps focuses on families enrolled in a particular medical practice or another organization where the program can be admitted.

We're on slide 47 now. Also relevant to the diversity of possible enrollees in the national evaluation is the target age at which children typically enroll in each program. So these range from pregnant women who can be enrolled by Early Head Start, Healthy Families America, Nurse Family Partnership, and Parents as Teachers, to newborns who are enrolled by the Healthy Steps program as well as some of the other programs that enroll pregnant women. Some programs focus on toddlers or older

children, which would be HIPPI and Family Checkup. Even within the programs that serve pregnant women, Nurse Family Partnership serves only first-time mothers, while the other three programs do not have that requirement.

We're on slide 48. The seven programs also vary along the line of dimensions that describe how they operate, such as the qualifications that home visitors are expected to have when they're hired. Some of the models specify areas of knowledge or work experience that programs should look for, rather than specific educational credentials. And some of them place a high priority on home visitors coming from the communities that they're working with. Three of the programs do have educational requirements. One asks for a bachelors degree, another asks for a masters degree, one requires a nursing degree. The different qualifications can be expected to effect how the home visitors deliver services to families.

Now we're on slide 47. To be classified as evidence-based under the MIECHV program, the programs needed to have some kind of central office that could support dissemination of the program in the national initiative. Some of these are relatively small offices and universities or programs -- for programs that have not been as widely disseminated. And others are independent non profits. And then there's the case of Early Head Start, which is overseen by the Department of Health and Human Services. So these different central offices can play a big role in structuring how the programs are implemented in their local sights. For example, they each decide how closely the local programs need to adhere to their staff qualifications, training or other aspects of

the model in order to be an official affiliate of the program. Some of them provide support for fairly strict fidelity to a highly structured program model while others allow more discretion by local offices or even individual home visitors.

Now we're on slide 50. Most of the programs have specified training modules that home visitors have to undergo outside of their job. Only some of them have additional training that home visitors are expected to take throughout their time working with families. So there's quite a bit of variability in the kinds of on going professional development that local sites provide to their staff. And training can differ even between sites that are implementing the same program model.

We're now on slide 51. And finally the seven program models vary on the kinds of concrete supports that they offer. Sometimes require sites to use when implementing their program. Three of the programs have developed specific MIS systems, Management Information Systems, for tracking progress and for monitoring the program's performance in aggregate. These three models require the local sites to use their program's specific MIS systems. Other central offices provide advice about how programs can operate effectively but don't require any particular MIS.

This is an example of the variations in MIS systems that have a very real effect on the resources needed for the national evaluation from a practical point of view. The evaluation would benefit from access to automated data about enrollees' participation in the services and would be much easier to use data from programs that use one MIS

system across all their different sites around the country. To the extent that each local site uses a different system for tracking participation, that would make participation data less consistent and probably more expensive to collect. So as you can tell from the different examples the programs differ in their goals and the requirements and supports that come from the central program offices. As we go along, we'll talk about some implications for these variations in how we think about the evaluation design.

So we're now on slide 52. What do we know from prior research in home visiting? This is a thumbnail sketch. We're not going to go into reviewing the evidence for each program but we wanted a few general points about the evaluation design. Each of these have an effects of one of the relevant domains in at least one rigorous study. So we know that no single model has been shown to improve outcomes in all of the benchmark areas or domains that were laid out in the legislation. Nearly all of the programs have shown effects in child development, school readiness and parenting practices. Three have had positive effects on child health and one has affected maternal health, child maltreatment and family economic self-sufficiency. These are all using the criteria that were used in the HomVEE evidence review. In addition, no one model has shown impacts for all of the high priority subgroups listed in the legislation. There's been findings in the home visiting literature that suggests these programs may have different effects for families who have different levels of risk or disadvantage. So we know that targeting is a really important issue. In many cases, the sample sizes from individual studies have been too small to allow for analysis of subgroup effects.

So this is one of the areas in which a large scale national evaluation could make a substantial contribution to the field.

There's other limitations of the prior research as well. First, several studies in the evidence review were conducted by the developers of the program models rather than an independent evaluator. Second, the results have varied across studies even often for the same program model which makes it difficult to confidently predict what impacts these programs will have as they expand. Third because different studies use different outcome measures, it's been very difficult to compare the results for programs with different characteristics and to learn from the differences in their results. Fourth, most evaluations of home visiting programs have provided very little information about program implementation, which Anne will be talking more about in a few minutes. One final limitation of the existing research is that we know that many local home visiting programs adapt to the program models while they're implementing them. Now, some adaptations are aimed at tailoring the program to the needs of the local population and might be expected to improve program impacts compared to the results of prior studies. The local service delivery can also diverge from the intended model in a much less deliberate way, which could be seen as diluting the expected effects and undermining the benefits for families. So this adaptation at the local level [Inaudible] that will study the effectiveness of this new program in real time as it unfolds in its current context.

We're now on slide 53. So taking all of this into account, there's several unanswered questions that we think the national evaluation will be able to inform. First as I just suggested, we would want the evaluation to ask, What are the impacts of home visiting programs as operated with the MIECHV funding so that the assessment of effectiveness reflects any local adaptations and the specific operational context at the federal, state and local levels for this new initiative. Second, what are the impacts of the home visiting programs when the outcomes of interest are measured consistently across the programs and domains of interest by an independent evaluator, which would address some of the limitations of the prior studies I've just talked about. Third, what is the variation in effects for different groups of families for whom home visiting is extended in MIECHV. That's the subgroup question. And fourth, what are the relationships between features of the service model and the implementation system. The services that are actually delivered to families and the impacts of the program. This is a question that has been very difficult to answer by studying one program model at a time. We think the national evaluation could make progress on since it will span multiple program models in a variety of operation contexts. So I'm going to turn it over to Chuck Michalopoulos to continue.

CHUCK MICHALOPOULOS: Thanks, Ginger. So moving from the past prior research to thinking about the national evaluation. Let's move to the next slide.

We're going to talk about some of the goals for the evaluation and some of the challenges that are faced in designing the evaluation and elaborate on the goals and

challenges over the remainder of the presentation. This slide lists some broad goals that HHS has for the national evaluation starting with using a rigorous design for assessing the effectiveness of the program overall and for key populations.

[Gap in transcription]

provide credible evidence of the respective program.

[Gap in transcription]

Moving to the next slide, here are a few of the challenges we're facing in designing the evaluation. As Ginger noted there are seven very different models that have been considered evidence-based. That may go up in the future over time, so there may be more than seven. It can be, you know, there are complications involved in trying to think about how to do an evaluation that encompasses all the different models and approaches and interpreting the results. A second challenge is that already there are thousands of home visiting programs being run all around the country and that's probably only going to increase with the new funding coming out of the legislation. So that will really further complicate interpretation of findings and also raises issues of whether the evaluation should be studying a program that comes into existence because of the new funding or focus more on programs that currently exist that will be expanded with the funding. Related to that is just a very highly decentralized nature of the home visiting services as they currently operate. That raises a number of

challenges that we'll talk about more later in doing an evaluation. And fourth, the evaluation has to collect data across all of the domains. That is again raises challenges about how to collect information for different age groups of children and maybe different types of data that are needed for different types of outcomes. We'll talk more about that as well.

The final two challenges relate to [Gap in transcription]

The states will be submitting plans the next couple months in May and June. We don't know what they're currently thinking about in terms of which program models might be using, in communities to target and families to target. That is based on a number of assumptions about those things. The final challenge that Naomi pointed out is just thinking about what it means to have a report in progress and what information can be [Inaudible] Moving to the next slide. We'll be talking more about the goals for the evaluation and what some of the implications are. First goal as we mentioned [Inaudible] [ Audio Difficulties ] we know that there are a lot of un certainties in the environment. There [Inaudible] doesn't mean the evaluat or [ Audio Difficulties ]

Moving to the next slide. The second part of the first goal, to learn about the overall the effectiveness of the new funding, of the home visiting programs. Ginger mentioned seven different programs. The number of the program release targets pregnant women before they have given birth. Others work with mothers after they have given birth. So there's programs that focus on pregnant women versus those that have not. Is that

because the home delivering services started earlier in the life of the child or is it [Inaudible] another example is that the types of information that are appropriate to collect for 5-year-old children are different for 1-year-old children. So taking that into account has some implications for the evaluation. Although the diversity in the kinds of programs that will be out there is a challenge, we also think of it as an opportunity as ginger mentioned to learn about what the relationship is about the program features and the impacts [Inaudible]. One way of trying to summarize the information through a cost-effectiveness analysis, how much does it cost to gain a particular outcome. For example, how much is spent for each case of child maltreatment. That can be used to prepare programs [Inaudible] and other programs designed to achieve the same kind of outcomes. [ Audio Difficulties ] the second goal listed was to learn about the impact open all of the HCA domains. And as ginger talked about, some are briefly -- the evidence-based programs have information you'd like to collect. The evaluation would be collecting information across all of those domains, even if the legislation required you to [Inaudible]. Data will be collected in a different [ Audio Difficulties ] for example, if some of the programs are serving 35-year-old infants and some collecting infants, [ Audio Difficulties ] moving to the next slide. I'm going to jump ahead to the last goal that was listed on the previous slide and then Anne will return to talk about the last goal. The last is community of populations programs that are in the [Inaudible] program. There's thousands of communities in existence and the evaluation should reflect that diversity. You know, including not only community but lots of different types of [Inaudible] the main person is to learn from a broad set of program models and families and not have one type or small set of types of those really dominate the

results of the evaluation. [ Audio Difficulties ] turning to the next slide. The next three slides will present three options for achieving geographic diversity. [Inaudible] the first option is to choose sites throughout the country. Could be putting the names in a hat and picking it out randomly I could be sites from all 50 states and beyond potentially in an evaluation like that. One of the strengths of that kind of evaluation is that the impact of it would really provide a pretty good answer to what is being gained for the additional funding for home visiting in the program. Like-wise, such an evaluation would probably be closely reflect the diversity of programs of families being served nationally. Some sites might be serving two families to really contribute a lot of information to effectiveness study for the cost of the site and also in our experience, the evaluator has to work closely with local sites to make sure they understand the study, make sure they can implement procedures related to the study if there are any and that would just increase the difficulty and expense of the evaluation. The next slide has a second option for achieving geographic diversity. That's where they concentrate on the [Inaudible] this may mean the evaluation is done in 10 or 12 states. So even with that kind of concentration, we think [Inaudible] local programs in those states to make sure that there is some diversity of program types [Inaudible] in the national evaluation. The main goal of the benefit of this kind of concentrating [ Audio Difficulties ] in addition to the programs that are chosen purposefully. Do [Inaudible] [ Audio Difficulties ] we do recognize an evaluation that would [Inaudible] may lose some of that and possible to a chief diversity as well. The next slide talks about the third option, the eighth option for achieving [Inaudible] this is focused on programs in major cities. [ Audio Difficulties ] at this point we want to stop and get some input from

the staff members on the three options for geographic diversity. And any other questions you'd like to raise such as should we focus on existing programs sites rather than measuring impacts for new programs. Anything else to raise in terms of diversity of programs.

>> And just before we launch into that discussion, I wanted to add one comment. So the comment is that this presentation has emphasized the diversity among the seven models that have been determined to be evidence-based. Chuck alluded to the fact that that might increase. States have an option to propose additional models and HHS has arranged for a review of any models to determine whether they're evidence based in addition, models that have been reviewed and determined not to be evidence-based have the option to request a re review. So it's possible that that number of seven will increase and that only underlines points that Chuck is making. Second, can I ask our technical support in Chicago to please unmute Marie McCormick, if she's still muted. Marie, are you there? Chicago, are you there?

>> I think Marie told me that she had to be gone for an hour. She had a meeting she couldn't move.

>> Okay. Well, Chicago, is she muted? I just don't want her to come back to the phone and find that she's been black-listed. Mike? Okay. Somebody there, who is moving the slides. Okay. In that case, let's move ahead. Okay.

>> Hello? Anybody there?

>> Okay. We do want committee members to be able to speak now. Is the committee there?

>> Could someone catch us up on what is happening right now?

>> Hortencia, are you there?

>> I'm here. I was going to ask a question, but I'm not sure –

>> Mark, are you there?

>> Yes.

>> Any committee member, please speak up.

>> Bette Jacobs. I'm here.

>> Hortencia is here.

>> Chicago, you need to un mute the committee members. We can't hear them.

>> I think we're detached from them.

>> We hear you. This is frank in Cincinnati. I hear you fine.

>> Yeah, we hear you fine on our end. This is Bob.

>> I think we've been muted.

>> This is the committee.

>> We lost them again.

>> Sounds like you have us o mute.

>> We can hear you now.

>> Why don't you tell us what it is you'd like from us and we will know what to do.

>> We want the committee members to be able to speak so that we can hear them and they can hear each other.

>> I think we're at that state right now.

>> I can hear everyone.

>> Okay. I think we're good now. Okay. So the question on the floor is comments about the three options proposed for ensuring geographic diversity. We'll try again just to have a discussion. If that appears chaotic, we'll go member by member. The floor is open.

>> This is Hortencia. I'm not sure I'm ready to make recommendations about that specific issue. I wasn't sure how the evaluation was supposed to look at that. I know diversity in these slides is used in a rather general way because it refers to many types of diversity. In specific, the thoughts that this contract group has on how the questions about addressing health disparity will be integrated into the evaluation. Maybe they can [Inaudible].

>> I mean, yeah, the issue of that -- you know, the potential [Inaudible] is something we're thinking about in the evaluation. I don't think we're getting into a lot of detail about the thinking on the evaluation today. But there will certainly be a lot of information collected about how services are received and that will understand the effect on the visiting program on those aspects. And you know, how they have effect on sociostatus and so on. And to do an analysis to compare those to some benchmarks to see how disparities have been reduced. But those are issues that we're still working out. I think will be part of a May presentation.

>> And we'll also be talking a little more about our conceptual model for the evaluation, so that will be coming in a few minutes. We're starting with sampling issues as a foundation for the rest of the discussions.

>> Hi, this is Paul Spicer.

>> Paul, go ahead.

>> I guess I'm particularly concerned about option three. Given what I know about rural health disparities, I think a focus solely on metropolitan areas would do an injustice to the ability of home visiting programs to engage and address rural health disparities, and especially those in tribal communities. I don't really have a strong opinion between one and two, but three seems suspect in that regard. I think, especially as we learn more about urban American Indian, Alaskan native communities look like in contrast to rural communities.

>> This is Bob Bradley. I'm gonna strongly echo what Paul just said. I think my knowledge in Arizona and Arkansas, places where these programs have been implemented, I think we would make the kind of decision processes and providers and all of that, can sometimes be quite different in their capacities for implementing various kinds of programs can be quite different. So I really think it would be a mistake to go for option three as well.

>> This is Bette Jacobs. Along the same line, I think you have good voices that indicate the distinctiveness of tribal communities and you've shown considerable astuteness in having that as a designated carve-out for funding and representation. That's going to be very useful for the evaluation. There are, in fact, some similarities as well as differences in rural, and it's always important that you not get so romantic and exotic that you don't realize the fullness of living in places like I've lived in. I'm from Wyoming. There are, as you will, experience with all of your data analysis within group and between group variation. In making these distinctions among the tribes are great deal of differences, and because decisions will have to made, it's going to be important that a cluster of a couple of tribes don't represent the totality of that particular experience and the same can be true for Latina experiences in various regions historically as well as currently.

>> This is Greg Duncan. You know, 70 years ago the sampling people developed or perfected, I guess, stratified clustered selection models and I think that's a good kind of framework to think about here. Sounds like there are definite dimensions, strata, that you want represented, rural areas, tribe tribes and certain ethnic groups. And if you identify the most important strata and then order your possible program selection according to that, you can ensure that you have representation across those strata. Clustering is a separate dimension where geographically you do tend to take programs that are close to one another geographically to minimize interviewer costs. There are obvious tradeoffs here. You don't want to cluster too much, because then you miss some of the representation. But clustering substantially to optimize interview costs is a

good thing. You need to balance the competing goals, I think, for representation and it may be -- the other kind of overarching representation issue is that you don't so want to over sample certain subgroups, small subgroups that may be of interest that you end up with a pretty inefficient sample for making sort of national--

>> I agree with that, yes.

>> The other thing that I would just mention with regard to whether to select the programs that are up and running and really going strong versus brand-new programs, you know, I think it's a mistake to evaluate quite immature programs. They might have proven to be effective but they have just gotten a year or two under their belt. On the other hand, I think it will be a big mistake to select just the programs that appear to be the most effective or appear to be the best run. So I would think it's probably not a good idea to select programs that -- and evaluate the programs in their first operating year but once you get beyond the initial kind of startup phase, I think you want as representative a selection as possible.

>> Mark Appelbaum here, I would strongly, strongly agree with Greg. The one thing I am unclear on and I think it may have some influence on your whole sampling strategy is early on you said that random assignment is your kind of preferred way of doing this. But what are you thinking -- what are the units that are supposed to be randomized to watch?

>> Good question.

>> We've been working on the assumption that families would be the unit that is randomized and randomized to either a home visiting program or to a control group that would have access to other services in the community but not the MIECHV home visiting program.

>> But are you -- I mean, most families, even though they agree to be in the study, don't passively sit there and say oh heck, you know, I didn't get into what I wanted but, you know, I don't think my kids are going to be very well off this way but I'm gonna stick with the randomization. They don't do that. And you also have communities and Doug and I -- Greg and I were just at a meeting last week on the L.A. first five thing where home visiting is a determined key part of their overall county-wide strategy. So, for instance, in the -- probably the Latino communities in Los Angeles County, you're not going to have many families that you could even get to who will not have had the option not duty -- your randomization but due to prior selection of home visiting versus not home visiting. So I think as you think about how you're going to sample, you've got to figure out if you're going to really try to go with a quasi random indication strategy.

>> We're talking about units of analysis and we have programs that are already in place and new programs that are coming through as part of this funding so to me one of the main questions is to what extent do you have a national sampling roster and do you have any ability to give us some of the estimates on the number of programs, the

number of new programs and how easily or how difficult will it be to identify all of these different units so then you can maximize all your statistical power and diversity in the most efficient way?

>> Briefly to that direct question when the state plans come in in May and June they have to delineate where they're going to operate the programs and describe both the program models they're choosing and the ways of implementing them and who they are targeting and we're hopeful that the evaluator will have a pretty nice roster before doing this sampling of what states are doing what and which populations each one of them is planning to target. So unlike some other efforts, it feels like this one will have kind of a list to start from, at least. Does that sound right to you?

>> Yes. I was just going to add that one of the -- the states have agreed they'll be able to participate in the evaluation if they're selected and that they are responsible for ensuring that their programs do cooperate.

>> This is Ed shore. I'm a little confused. One was the option is focus on well-operated programs but I thought the seven options were chosen because they have been documented as being effective. So what I'm hearing described is kind of Greg's question raised it for me again and that was, well, is it necessary to evaluate well-operating programs if those programs have been selected because they have already been evaluated? But that relates to a larger question then to what extent is this supposed to -- someone listed earlier five different kinds of evaluations that are

supposed to happen. And my question around that is to what extent is this an evaluation of the Federal program and its effectiveness so the effectiveness that's putting out money to various states, to establish and operate home visiting program, is a different level than the effectiveness of programs at individual sites. So are we doing both, are we doing one or the other? What's the focus?

>> Well, this is Naomi. These models have evidence of effectiveness. When we talk about a well-operated program, that refers to a local entity that is operating a model. Second, you asked -- a couple of things. You asked what are the benefits of evaluating models that already have evidence of effectiveness and I think I will turn to ginger on that one because I know she has some develop talking points about what it is we hope to learn about this evaluation and lastly you asked to what extent is it an evaluation of the Federal program as opposed to the effectiveness of programs operating on the ground, and I would say that our hope is for this to be an evaluation of the Federal program that will inform -- set in and inform multiple levels. It's an evaluation of the Federal program and we think the diversity of models and of implementation around the country provides an opportunity to learn about the elements of models and the features of implementation at the local level that are associated with impacts. As Ginger so—

>> We've interpreted our general charge or the evaluation's general charge as understanding the effectiveness of this new Federal program meaning -- but with the meaning of what benefits does it bring to families? And so -- I think actually the

legislation says under the domains specified in the legislation. We've interpreted that to be asking for an evaluation design that does examine effectiveness for individual families in these particular domains of this new program. And so we see that as really asking, you know, given the requirements states are being given to have particular infrastructure in place to operate these programs and given the way that this is being supported and structured over the next few years, what are the effects of these programs in that context and in that Federal funding stream? So does that answer your question?

>> It does but it still leaves open the question of the various levels that you would want being evaluated.

>> We'd be happy to hear. You can definitely provide input on what do you see as the different levels. We've been thinking about implementation research and what you would want to learn about how -- you know, how states make the decisions to choose particular communities or how, you know, the individual sites are interacting with the program developers, you know, all kinds of different aspects of implementation would be important to document.

>> Yes.

>> This is Frank. A couple of things. I think all of the evaluations of standard models, including the ones, have found very strong site effects. So that a program may work

very well at one site and not work very well at another site. It is implicit in the number of the evaluations, explicit in a couple ones like Dave Rubin's evaluation of the family partnership in Pennsylvania so that a model isn't the same everywhere. And there are also differences between urban and rural. Even with urban data for example shows big differences between north and south Philadelphia. So you have to look beyond the model to really a lot of site effects and what are the variables associated there. I think the -- so the other thing is that I think we should keep sight of our implementation sort of responsibilities because if these programs are effective, they're going to be implemented more widely and therefore we should know much more about the early implementation. While I understand the wish to look at more mature programs, I think we should be clearly in the evaluation thinking about looking at some representative implementations and understanding what works and what doesn't.

>> I'm gonna suggest that we continue with the presentation. We're going to have plenty of time for discussion later. Some of the issues that are being raised will be touched on in the remainder of the presentation. So is anybody on the committee want to get something in now before we continue? Let me also ask, has anybody besides Greg Duncan joined and not yet introduced themselves?

>> Bradley, I haven't introduced Phil. I don't know what all you want to say than sorry I couldn't join earlier. [Laughter]

>> The apology wasn't necessary. We're glad to have you. Each person who at the beginning just briefly said who they are, where they work. So Greg and Bob, if you want to just say a word.

>> Sure. Greg Duncan, University of California at Irvine in the Department of education here.

>> Bob Bradley at Arizona state university and I'm in the Department of psychology and social and family dynamics.

>> Great, welcome. You've figured out we're ahead of schedule and actually in the session that was supposed to begin after lunch so we'll continue with the presentation by the design options team and I think that we will probably just go right through until about noon and then break for lunch and that will leave us plenty of time for discussion this afternoon.

>> I just had one suggestion in here when the speakers are talking, if they can tune us to what the number of the slide is, it would be helpful.

>> Will do, thank you.

>> We'll try to identify the number consistently and when it seems helpful we'll also use the title of the slides.

>> Two more slides to go through and I'll turn it over to Anne Duncan. I don't have the correct number. The next slide is called analysis of state needs assessment and it's 564. As was mentioned by a couple other speakers, one of the requirements of the evaluation is to analyze the state needs assessments that have been already filed and will be filed in the next few months. They talked about the three sets for getting funding. I mention it here because as Ginger noted this could be a place where the evaluator could learn where the states are planning to operate home visiting programs, what models they're planning to use, how they're going to -- what families they'll be targeting and that's where we could -- the evaluator could get information to help ensure the diversity of programs either using stratified methods or using other methods.

Moving to slide 65, just wanted to touch upon one of the challenges we mentioned earlier, home visiting services are highly descent ralized and what that means to the evaluation. One thing it means that eligibility procedures and criteria for receiving home visiting programs will vary from place to place. You know, and from state to state and for sites using the same national model there may be different criteria for getting into the home visiting program in a particular location and all that just has to be taken into account by the evaluator in negotiating and talking with local sites about study procedures and also in thinking about how the results can be interpreted and compared from site to site at different types of families are coming into the studies and coming in through different means that may affect the impact. Then another

consequence of a highly decentralized nature. Negotiating with more places to think about possibly collecting data, talking to home visitors, local staff, visiting the local places, costs associated with figuring out the procedures for getting families into a study and getting informed consent and that sort of thing and also each site in part because of the decentralized nature and another set of challenges the evaluation will have to tackle. I'll turn it over to Anne Duggan, the rest of the presentation on the evaluation and the importance of implementation research and some of the other challenges.

ANNE DUGGAN: Now we're on slide 66 and we're able to move to discussion of the third and fourth HHS goals for the national evaluation and you see here at the top the fourth goal, HHS intends for the evaluation to inform ways to strengthen home visiting as a preventive intervention and this can be accomplished by meeting the third HHS goal, which is to systematically study implementation and to link it with program data. As noted earlier home visiting is complex with many defining features or dimensions. Programs vary in how they specify their service model and in how they decide their implementation system. A key evaluation question is to identify the service model and the implementation system features associated with larger effect sizes for outcomes in each domain. The evaluation must measure those features in each program site. There is good reason to believe that even when adopting the same evidence-based models, program sites will vary in how they specify their service model and how they establish their implementation system. However, relatively few home visiting studies have reported actual service delivery and how it links back to specification of the

service model and the adequacy of the implementation system. Furthermore, different measures of implementation have been used by different investigators making it hard, if not impossible, to draw generalization. Because of this, existing meta-analytic studies of home visiting such as that by Sweet and Appelbaum have been limited in the program features they were able to relate to affect sites.

Slide 67 illustrates the conceptual model in very basic terms for the national evaluation. This model calls for a systematic study of implementation across program sites tied to assessment of actual service delivery and tied in turn to assessment of program impact in order to inform the strengthening of home visiting in the future. It uses a basic logic model framework of inputs, outputs and outcomes. If we start at the right we see outcomes fall into three main categories. Family health and functioning. Child health and government. Family health and functioning have direct effects on child outcomes and also have indirect effects through its effect on parenting capacity and behavior. Outcomes are influenced by services that families receive. Not specified in this diagram, the services include both home visiting per se, the content of home visiting, participant responsiveness and so on, and it also includes other community services to which families are linked by home visiting and with which services are coordinated. Now moving to the left half of the figure we see the inputs that are hypothesized to influence service delivery. First we'll look in the upper left-hand corner, the service model, which directly influences actual service delivery. Now, service model is defined by many things. These include intended goals and outcomes, the families who are to be targeted and intended service dosage and content and the roles, responsibilities

and required competencies of program staff. But that link between the service model and actual service delivery is moderated by the con -- the length between the service model is moderated by the adequacy of the implementation system. The implementation system is a set of resources that are used to bring a service model to life. To take it from paper to actual service delivery. And the implementation system includes, for example, policies and procedures for staff recruitment, training, supervision, evaluation. It includes screening and assessment tools that are used, protocols and curricula. It includes whether there is a management information system and how that system is actually used to monitor and promote fidelity to the service model. And it includes formal and informal agreements between the home visiting program and other resources in the community with an eye to referral and coordination of resources. Now if we look in the lower left-hand corner, we see that multiple organizations actually influence the definition of the service model and the adequacy of the implementation system. These organizations are not limited to the program developer and purveyor and the important role played by the agency itself. National, state and local and public agency that play a role in many ways including funding, regulation, articulation of state or local goals and objectives in addition to those at the national level. And other organizations in the early childhood system of care. Finally, the model shows that at the individual level, families and staff influence how services are delivered. And lastly, the model shows that those -- the family and staff attributes actually interact as influences on service delivery.

We can go to the next slide. 68. So what this slide notes, the model I just presented is derived from lessons learned in implementation science as it's been applied to a broad range of preventive and therapeutic interventions. The first lesson is that program impact is determined not only by model efficacy but also by fidelity of implementation. In short, fidelity matters. The second lesson is that fidelity is influenced by both the service model and the implementation system. Thus as the coherence and clarity of the service model increase, so does fidelity. And within the implementation system as organizational capacity increases, so does fidelity. Also within the implementation system as staff are provided access to consultation and as they are given relevant and timely feedback on their performance, fidelity increases. And then finally, as organizations assure that staff develop and maintain the competencies that they need to carry out their roles and responsibilities, fidelity increases.

Slide 69. As this slide notes the conceptual model we presented is also derived from implementation science that has focused specifically on home visiting. First there is empirical evidence that aspects of actual service delivery, dosage, content, quality, influence home visiting impact. Second, some studies have looked at how staff and family characteristics influence service delivery. For example, staff and family members understanding of the service model and their specific roles in it influence how services are delivered. Their willingness to fulfill their roles and their ability to do so also influence how services are delivered. It's important to note that the service model and implementation system themselves influence staff and family characteristics. Staff and families are better able to carry out their roles if these are made clear to them. The

implementation system determines how families are recruited and part of that determines how the program model is explained to the families. What their understanding is of the benefits they're likely to derive and their understanding the model, the program theory of change for example. And the implementation system also determines how staff are motivated, reinforced and enabled in carrying out their intended role.

So let's go to slide 70 now to touch on the opportunities that we see being provided by the national evaluation. First, we cannot only learn whether there are impacts for each domain, we can learn which families benefit most and we can deepen our understanding of how and why benefits vary by family sub group and across outcomes domains. Second, we can use this deepened understanding in shaping policy and practice around how best to target families, how to adapt and enhance service models, and how to strengthen home visiting implementation systems. But in order to reach this potential, we need to measure how services are actually delivered and to explain identified variations in service delivery. With these important aspects of the study in mind, we wish to ask the committee members if there are specific aspects of program implementation that they think the national evaluation must certainly focus on and so do we want to break here to discuss that?

>> Yes, let's take a break to focus on that question. Is the committee unmuted?

>> I did want to make a couple comments that have to do with the logic model that was presented that pertains to the issue involving the community level factors that need to be considered that are not in the model. First I just want to go back to my previous comment about the design approach and the selection of sites. I asked the question regarding health disparities because I think that we don't look at that first and decide on a sampling or a design that will be -- we may be later not be able to address the issue of health disparities or certainly the way we choose to look at how a sampling will be done. Has direct implications for the ability later to look at health disparities. I think the subsequent discussion highlighted that. Regarding the logic model, in addition to the things that are there and the individual level factors that -- that identify we currently know that community-level factors impact child well-being and specifically characteristics of neighborhoods. For example, within the framework of communities of opportunity, have an important -- play an important role outside of individual level factors. I think these are going to be confounders. It would be really important to consider in the framework as well as in the analytic approach. That refers to my earlier question about multi-level analysis. We know that things like racial segregation have -- a set of consequences related to resources, living environment, etc., that play -- have an independent impact on child well-being and outcomes. So I think it would be important at minimum to include in the models some population level measures, for example, by census tract of where children live to look at how those may be impacting the outcomes of the study. So they certainly I would think would be moderators. So I wanted to just say that because I felt like the model really doesn't acknowledge that kids live in certain environments that will vary across communities in the level that they

may present risk or protection and I think that the neighborhood opportunity index developed by the Kerwin Institute might be one way of looking at that. There could be others but something I felt was missing.

>> What you're talking about really is community capacity.

>> No, no. Neighborhood opportunity framework is broader than that. It includes -- it may include some of that but there are three basic domains within that. For example, the Institute index that says -- the index creates a measure that is able to classify neighborhoods by -- on a spectrum from low to high opportunity, characteristics of neighborhoods. Capacity, certain aspects may be part of that but it goes beyond that.

>> Okay.

>> This is Hendricks Brown and I wanted to reinforce that in a slightly different way, too. And maybe this goes a little bit opposite of what Greg and Mark have been talking about a little bit earlier there, too. I do think that this is a really unique time. It is a roll-out of a major Federal program, and because of this point I think we have a great opportunity to understand the implementation process and what communities are able to work closely and be effective in adopting these programs and I say that word adoption because I think that would be a really useful thing to study. I do know that there are other Federal programs out there that have some very high restrictions on getting into these programs. For example, in prevent-ready communities, I think what

that will be doing is really making it very difficult for many minority communities to be able to participate. Because they just haven't got the resources available. And I do think we do not want to take a major role out of a huge program like this and put the bar so high that some communities can't really be able to effectively use that program. I do think that the first year of a program is a very useful time in which to study adoption. It is a terrible time to study the effectiveness of it.

>> This is Greg. I'm not sure what I said that contradicted that. I think it's important to think about clustering and a community cluster is an interesting one for the reasons that several people have talked about. When I talked about wanting a mature program to evaluate I was talking about the outcomes and not the roll-out. As we talk, it seems to me that it is going to be important to have some sort of reliable on the ground view of how the program is not only rolling out in the community but also is perceived by the families themselves, the participating families. One of the best evaluation experiences I've had is with the new hope program where we had a genuine mixed method design where we randomly selected from both the treatment and control group a subset of families for a qualitative -- a systematic, qualitative sub study where people would be visiting every couple months and with -- not with a structured interview but with a semi structured conversation and what we learned from that about how participants were perceiving the program, using the program, it was just invaluable for getting an understanding of what the quantitative results were saying. It's expensive to do that. You don't want to -- you want to balance off the costs and benefits in qualitative versus quantitative. One of the elements of the visitation programs is the kind of credibility that

parents are attaching to the people delivering the services and at least some people think that the old model is -- has its effect because of the credibility of the nurses. That kind of thing is an absolutely vital el -- you might be able to get some of that in conventional surveys but having some kind of on-the-ground parallel system of information gathering in at least a subset of the community I think would be very valuable.

>> This is Paul. I would love to echo what Greg said. I think that's very valuable from the perspective of the people receiving the services but I think one of the lasting findings in the national evaluation of early Head Start was derived from qualitative work on implementation and site visits to the programs evaluating it to understand the quality of the implementation there. The finding as I've followed the results and left the evaluation stood the test of time and I think is a key component of what you're after here as well and that would allow you also to capture, I think, the predicaments and challenges those programs confront in trying to implement the services and I think we're not in a state where we have all the measures with want for that and I think some inductive and exploratory work is certainly indicated on the program side as well.

>> This is Ed. First, Anne, I like your conceptual model. I was coming up with questions and you were answering them. Two comments, though. One is I would expect that the extent to which this program is linked to other programs and in fact imbedded in other programs may be an important factor in its effectiveness in communities and your implementation system piece is, I think, where that would sit.

But I would think that the bureau, for example, would be really interested in having this kind of work embedded in the ECCS program and the extent to which that embedding linkages takes place I think would be important thing to examine. My second is a much bigger policy question really. That is, who is the audience or who are the audiences for this evaluation and what questions is it that they would want answered in order to make some decision five years down the road? One hunch I have in the current political climate which may or may not persist, the likelihood of continuing large Federal funding for home visiting in this way is probably not likely. And so if this seems to be a valuable program, valuable service to the families, in fact responsibilities for sustaining the program is going to have to rest with states. And I would think that state legislators particularly would be having perhaps a different set of questions than we have been discussing so far today. And it might be useful to think about the evaluation in part as providing the kinds of information it would take to make the decisions to sustain this with public dollars both at the Federal and state level and wondering what those questions might be.

>> This is Lynn. With the prior speakers, it seems to me that we need to hold this overall evaluation accountable to the program goals in the slides specified in 10 and 11 and I am not sure, much as I like the logic model, I'm not sure that all of those outcome goals are reflected in the indicators under either the outputs or the outcomes. In particular, I am interested in those -- I'm interested in all of them but the goals that talk about how these programs will be the development of statewide systems doesn't seem to find expression and I raise that as a concern with that of my colleagues. This seems

to be very focused on human outcomes as opposed to systemic outcomes. That's a decision point but I raise it for consideration.

>> Lots of good thoughts and questions. I'm keeping a list and I -- let me ask if there is anybody on the committee. Especially anybody who hasn't spoken much to wants to get a word in before we finish the presentation, take a break and come back for more discussion?

>> This is Frank and just a couple of points echoing some is I think community capacity is very important. Many of these programs are supposed to link people to services and if those services don't exist, that is a real barrier for them. I think we should also be paying attention to issues like dose. Most of these programs are predicated on the idea that people have to please the program to benefit from it but what we know is the retention rates are very poor in these programs and doesn't mean that the outcomes are necessarily poor but we have to look at that certainly people who drop out of these programs and understand more about do they get what they needed, what was the adequate dose. Are there critical windows around some of these outcomes that we're interested in. I also like the fact that Anne put in that organizational driver way down in the left-hand corner, these programs are implemented in communities and they have national organizations, but there is an enormous amount of community input through organizations like united way and various kinds of councils and things like that that have a lot of effect at the local level. And I think trying to capture and understand that is going to be important because they

ultimately are sort of what many of these programs answer to locally in terms of their success and so those are, I think, a hidden factor. I also think that we should have some kind of base rate measures for some of these outcomes which are going to vary dramatically across some of the communities, I think. And we have to understand the environments the programs are operating in if they're expected to reduce domestic violence and crime and child maltreatment. What are the rates in those communities that they're up against? So those are just some additional thoughts.

>> Mark Appelbaum here. If possible, I would really like to emphasize the importance of that output box in distinguishing the outputs from the outcomes. In the metaanalyses we did, largely published studies, one thing we got clear in the ghost literature there was within programs, no matter what their stated goals were, that in many, many cases they're working with fairly chaotic families and what ends up happening is that there are things that kind of demands it happen in the individual home visit that may be totally unrelated to what the mission goal is. And so to actually kind of be able to trace what the actual services are versus what those theoretical services are is extremely important to try to understand the very large variability that you are likely to see. And given the implementation schedule, all of this is going to hit just as in many states, California certainly, that the usual services that people have relied on are going to be vanishing. So you are going to be looking at the ability of these organizations to be able to provide services that lead to these outcomes in an even more impoverished environment and we need to look at those actual services.

>> This is Rob. In talking about implementation and this maybe I'm building on Lynn's comments just a bit. Considering you were putting the implementation at the state level as part of your implementation analysis and the states are structured so differently around on the provision of health services and early childhood services and the lessons learned about how those states absorb these resources and how well they get disseminated to the actual home visiting program.

>> Okay. Any other thoughts or questions before we conclude the presentation, have lunch, and come back? Okay. Let's continue.

ANNE DUGGAN: Okay. So then going on to slide 71, we're going to shift from addressing two of the goals that the evaluation is intended to address to focusing on the challenges. It's important to comment on the dynamic nature of the national home visiting program itself as another challenge in designing its evaluation. States have not yet submitted their updated home visiting plan. This means that several key pieces of information are not yet known. First, we don't know how states will distribute in their choice of models. Second, we don't know which population subgroup they'll choose to target and finally we can't characterize the communities of they will focus. The evaluation design must be based on many assumptions and it's possible that aspects of the design will need to be modified once the details of the state plans are made known.

Now going to slide 72 and the last challenge, which relates to the ACA stipulation that a report from the national evaluation must be made to Congress in 2015. This slide gives a partial time line to the national evaluation with that report as the last endpoint. As shown, states will be implementing ACA home visiting programs in the second quarter of 2011 and the evaluation contract will be awarded the following quarter. OMD must review and approve all study protocols and instruments and realistically, we expect that will take about nine months. As a result, site selection is unlikely to be completed until the last quarter of 2012. Realistically, it will take about six quarters to recruit the study sample and collect baseline data on program service models, implementation systems and participants. And concurrent with this, the evaluator will be able to collect very short term data on actual service delivery. So if we go to the next slide we'll see the ramifications of these time constraints on the content of the 2015 report to Congress. First let's consider what could be included in that 2015 report. It would be possible to characterize home visitors, family and program service models and implementation system features at baseline. It would also be possible to describe early service delivery. But it's important to note that family outcomes could not be included in the 2015 report but could be reported after the initial report of 2015. It would be possible to report outcomes at 12 months post program enrollment or when children -- 12 months post program enrollment in 2017. And it will be possible to report outcomes at 24 months post program enrollment in 2018. This assumes that site selection and family enrollment are carried out per the time line of the preceding slide. We would like to pose our third question for the committee which is, given that the impact analysis could not be included in the 2015 report, we would like to hear the

committee members' views on the value of having the national evaluation extend beyond what can be included in the 2015 report.

>> Is the Committee on mute?

>> Silent. Can I -- this is Greg. If you stop with 2015 you won't have any outcomes, is that true?

>> Looks that way to us.

>> We're supposed to endorse—

>> Well, I would add a question to Anne's question. When we looked at this time line and realized the implications, my reaction at the time was it is what it is. We can't do the impossible. We can't make kids, you know, achieve 12 months of age any quicker than they can. We can't make programs start up any quicker than they can start up and we can't make OMB move. So it seemed important to raise that to the committee if you see some other way to think about it. We'd be happy to take that advice and so if you see another way to sort of think about this broad time line we can try to move quicker on some of these pieces. We don't really think it's feasible but again we welcome your thoughts. If you see some other way to think about the 2015 report, we would welcome that. You know, one could imagine a shorter follow-up. We didn't think

that was very advisable or possibly some kind of interim report with a small sample. We didn't think that was very appealing either but we're interested in your views.

>> I think -- this is Paul. What I also heard Anne ask is our opinion about the value of extending the evaluation so you actually could collect outcomes, is that correct as well? Sound like we're adamant on that.

>> Yes, right.

>> This is Frank and certainly I would vote for extending the evaluation but here is where maybe the mature programs would be useful to pick up samples graduating and graduates and match them in some fashion and use those outcomes.

>> This is Hendricks. I have a question. What happens -- what's the process between the last dot on this one, which is dated looks like it's done in 2014, second quarter of 2014 and then March 2015. What is going on that 10 months?

>> After 2014? We were just informed that in order for a report to be cleared and delivered to Congress, the report has to be done six months earlier than its actual due date. Is that your question?

>> Yes. That is the process.

>> You're talking about the very last line? Yeah.

>> It needs to--

>> There is also analysis and writing.

>> Right. But it looks like you're finalizing the report but that's not true, right? You're working on that report at that time.

>> I'm not sure which time you're referring to. You said it but I lost it.

>> September.

>> We do need several months to clear the report within HHS.

>> It's due in March of 2015.

>> So to complete that, September of 2014, is that what you're saying, correct?

>> Correct.

>> Okay, thanks.

>> I had a question about the implications of recommending that the study be extended so are we talking about requesting additional funds or are we talking about sort of carrying over funds and extending the appropriated funds for use for a longer period of time through 2018?

>> I think I understand your question. The study will be funded out of annual appropriations. So we'll be putting funds in each year. I think if we were to extend the study beyond 2015 we wouldn't be stretching out the same amount of money.

>> We're also up for reauthorization in 2015 and this is assuming.

>> If the program goes away and evaluation funding goes away we close up shop and go home. We can't predict that.

>> I just want to make sure what the fiscal implications are of that recommendation. So the extension of the evaluation through 2018 would be dependent on reauthorization and as a result the evaluation dollars that would flow from that.

>> Yes. But we're not -- we wouldn't be compromising the early years of the study in order to extend it.

>> It's kind of a double edged sword, isn't it? You have these time restrictions but yet at the same time you aren't going to be able to put a lot of meat in terms of what they

were hoping to get by 2015, which might discourage further funding in addition to the fact that considering the fiscal climate, we don't know how feasible it will be to get reauthorization, right? Unless somebody has a reading on that.

>> The only thing that I would say, I think even if we managed to deliver the report on time, if reauthorization is on time it's probably too late to inform reauthorization anyway. Chances are they'll both be delayed.

>> Are you also imagining the benchmarks will be examined by Congress in addition to the evaluation results?

>> There is a report to conference on the benchmark data that is also due in 2015.

>> So Congress is going to want to see the benchmark data at 2015 so is that saying that you are going to have to give them some kind of outcome measures in terms of the benchmarks?

>> For the benchmarks, yes, which will be reported by states outside of the national evaluation. That's a separate reporting structure.

>> That report comes a little later. It is due, I think, in December.

>> This is Audrey again. I just had noticed that whenever we talk about this in various arenas, the confusion arises between the benchmarks that have to be collected programmatically and the national evaluation which is really conducted on a sample. So there are two separate purposes to that dataset.

>> I would venture to say, you know, tell me if I'm wrong, that whatever those benchmark data reported by states indicate, might influence Congress's decision regarding reauthorization for the whole program and for the national evaluation?

>> I think that's fair to say.

>> Carlos. I just wanted to let you know that our staff has been able to get ahold of the SIR and emailed it to all the committee members so at your pleasure you can print it out and take a look at it. It has a lot of material about the benchmarks themselves just to let you know.

>> A fine way to spend your lunch break. So we skipped our 15-minute break in the middle of the morning. I'll suggest we break now instead of at 12:15 and take a full hour for lunch break and we'll be back at 1:00 for then two hours of discussion. You can put your phone on mute and unmute it at 1:00 or hang up and dial in again. We ask that you not put your phone on hold because sometimes that leads to music. So any questions before we break?

>> No. This is Lynn. I won't be able to join you in the afternoon because of prior commitments. I'm really sorry. It was a wonderful discussion and I want to congratulate our presenters on being very clear and thorough. The fact that I can't participate this afternoon leads me to make one additional request, I'm sorry. The degree to which you could give us lead time for future meetings would be very much appreciated.

>> Yes, we all agree and we will try to provide substantial lead time for the next meeting, which we plan for early May. Lynn, if you want to send us further comments we'd be glad to hear them and look forward to talking with you at the next meeting. Thank you.

>> Thanks so much.

NAOMI GOLDSTEIN: Okay, we will hear you all again at 1:00. Mike in Chicago, can you take us in Washington off line please and let us know when that happens? Please stand by.

[ MID-DAY BREAK ]

>> Committee, can you hear me?

NAOMI GOLDSTEIN: I'm Naomi Goldstein along with Peter van Dyck and we'll continue our discussion. Let me just check, committee, can you hear me?

>> Yes, we can.

NAOMI GOLDSTEIN: Okay. Thanks. So this how I propose to proceed this afternoon. First off I'll propose to give you back a half hour of your life and adjourn at 2:30 instead of 3:00 if the discussion is rolling along and we want to continue we can decide to do so at that point. I wanted to just reiterate a couple of points. Those of you who joined a little late may or may not have heard this this morning. So today's meeting has been an introduction to the program and to some of the design challenges. Kind of a broad brush discussion and we have very much appreciated the advice you've xwifn -- given us so far. We plan to convene in May for an in-person meeting for a more detailed discussion and we expect to give you more notice about that May meeting. We are not hoping for consensus at this meeting or perhaps ever. We would rather spend our time as we have so far today on our rich discussion drawing on your range of expertise than spend our time agonizing towards consensus recommendations.

I must say I am very pleasantly surprised at how well this phone mechanism is working. It seems that people are able to get their comments in. We're not speaking over each other. I very much appreciate your patience with this approach. And the discussion so far today has been really terrific. I am going to propose that we have

about 45 minutes of open discussion and then that would take us to about 1:50 at which point we would switch to a round Robin and go to each member of the committee and ask you to make whatever final comments you want to make. That will probably use up most of the remainder of our time and then we would adjourn until our next meeting. Before we move to open discussion, I wanted to list a few points that we identified from this morning's discussion as -- that we would find particularly valuable to focus on in the afternoon and obviously if you have other suggestions, please toss them out. This is a mix of things that we touched on this morning that we thought could bear more discussion as well as some things that we didn't touch on. So in -- not in any particular order, we talked about site selection. We would like to draw you out a bit more about what features of site particularly features that are likely to be described in state plans you would suggest we focus on in site selection and those features presumably would also be features that we would want to use in forming analytic subgroups based on site features. That's one topic.

Another topic that came up this morning is what kind of services control group members might receive. This is not entirely within our control. But it is potentially relevant to site selection, to measurement and to analytic issues and we would like to draw you out a bit more on that topic. We just touched on Sharon's parting comments, does she go by Sharon or Lynn's comment this morning about measuring systems as an outcome and systems at the local and state level we would love to get further advice on how to approach the measurement of systems. We have not talked about fathers but that is a topic of particular interest and we welcome your thoughts about

how best to incorporate fathers in our measurement and then lastly, there are a couple of issues related to how to structure the design depending on state choices about models.

If there are models that are adopted by relatively few states or in few locations, how should we think about incorporating them into the design. Does it make sense under some circumstances not to include all models in the design, assuming that they're taken up at all. And then that question overlaps with the model's features, for example, if it turns out that there is only one model that is not adopted very widely, serving older kids, say 2 to 5-year-olds, how should we think about that? You know, we've thought under some circumstances it might make sense to exclude models that are not widely adopted and it has implications, again, for sampling and the adequacy of our sample size for different groups. So those are some issues that I wanted to toss out. And with that, I think I will just open it up for open discussion until about 1:50 unless it gets chaotic in which case we'll go to alphabetical discussion.

>> This is Greg. Can I ask an information question?

>> You may.

>> You may have covered this before I got on the phone. You are going to start data collection toward the end of 2012 and I guess I don't have -- we talked before about to what extent programs were just starting up to what extent programs had been in

operation for at least some period of time. I know that a number of states have programs and operations. To what extent at the beginning of the actual data collection do you expect the programs that you'll be collecting data from to have been in operation for significant amounts of time, say a year or more or two years or more?

>> I think that's a question that is part of the sampling plan. So I mean a lot of states already have some version of some of these programs running and the question is, how many of them are going to opt to expand those programs as opposed to starting up new ones they've never run before. And so it's a question we don't know the answer to yet. We don't know how many will do these two different things and then we also just need to think through whether to include states in the sample who really are only starting up brand-new programs or whether to go with places that have already been operating for a year or two and are just expanding on what they're already doing.

>> That sort of goes to one of my more general questions. I think you all know that states tend to differ in terms of the prevalence rate of programs already there of the various models you've identified and perhaps others. The fact is in some states there is a very well-established infrastructure for certain particular programs which has implications from sampling but it may also have implications for things that need to be asked in terms of supports for the program's implementation and other such kinds of issues. It wasn't clear to me how that might be considered, the fact that in a given state you may have a very well-established infrastructure and mechanism for certain kind of programs and either less for others or certainly or maybe none at all that might even

be considering operating brand-new models, etc. Part of this also goes, I think, in terms of how within a state communities or providers or etc., might think about what they want to put in place. That is, the history that the state has had of implementing particular models.

>> This is Peter. I wonder, does the evaluation evaluate only programs that have ACA money in them?

>> Yes.

>> But not restricting to participants. Not restricting to the slots opened up by the ACA funding. They have to have the infrastructure as part of the ACA funding so if they expand an existing program they have to build all the requirements and infrastructure that the ACA funding requires but we could draw from participants in that program that are not necessarily specifically funded by ACA.

>> Or were in the program previous to ACA funding as individuals?

>> Well, we're anticipating that we would be studying new enrollees.

>> Okay.

>> So I think one way to think about your question is, you know, there are different levels of sampling that would probably go on. So if we ended up, for example, in that middle group of doing some geographic clustering but still trying to think about diversity across the country, we might end up in, you know, say 15 states or something, which would be chosen based on some criteria but then inside those states we also would have to think about which communities or how many communities are operating the program. So the state might have some diversity in the sense that given one of these states might have some new programs and some expanding programs, and that would have to be another sampling decision is whether to include all of those or whether to just include, you know, a subset.

>> I would say this. Differences within states in various features such as whether there is a well-established infrastructure, different models operating within the same state, that kind of variation is an opportunity to learn about variations so that, you know, the more that different features of the programs are not confounded with state or site, the more that we can try to understand how those features are associated with impacts. And so, Bob, actually both of these comments are related to site selection. If we stick with that for a bit can we draw you out a bit further or other members about what features of sites or programs you would urge us to consider in developing the range of sites and then later in analysis?

>> One thing I'm aware of, and I don't know precisely how you can incorporate absolutely everything in site selection. Even in situations where let's say there has

been a pretty long history within a State of implementing a program, the truth is, the characteristics of communities that might not have used that before but now may be considering adopting, I think you would know the consideration of the differences that might come in a community where a program has long been established, maybe is well-accepted and well-connected to the community versus the same exact model presumably again the same state infrastructure but a brand-new community where the actual program and what it means is not as well understood. So something about, you know, the novelty at the community level seems to me important because this goes back to comments that several have made way back I remember Greg making it, among others, that the acceptance of people and what they expect of something which connects typically to the history of that program and an area thoroughly has an impact on the likely access of the program at many levels. I just think in site selection, you might need to consider the extent to which it's somewhat new within a community and it might be a different community versus a very well-established situation as a factor in site selection.

>> This is Paul. I mean, I think that relates as well to your ability to do random assignment. You certainly grappled with this issue. If you have a state like Oklahoma that has implemented a program statewide your ability to do random assignment is compromised.

>> Absolutely.

>> This is Ed. One of the site selection criteria that I alluded to before but I still think it's important is the extent to which a new program or even an existing program is independent versus embedded within some larger program or programs, whether it's the ACS program the bureau has or other established entities. I expect that an independent new program is going to have much less success than one that's able to build on and link to infrastructures. And from a pediatric point of view, one of the things that I would hope would happen but isn't necessarily there is the extent to which a home visiting program has relationships with the child's source of medical care. Because I think that's a way to reinforce some of the messages, and so I would expect that where you have that linkage, you'll have a stronger effect.

>> This is Greg. I want to get back to a point I tried to make earlier about the importance of this as a national study. I think the--

>> I'm sorry, Greg, you broke up a little bit. Can you repeat that?

>> I want to get back to the idea of the importance of thinking about this as a national study. So I would think that the single number that Congress and policymakers most want is for this collection of programs that they funded, what is the impact on the parents and the kids who are receiving the services? Now, in most evaluation studies, we don't have the luxury of thinking about some sort of national sampling frame. With the national historic grid and there was a nice representative sample of Head Start centers that was drawn for that, outward bound also did a national sampling scheme.

Here I think you do have an opportunity to think of enumerating the qualifying programs and to think about, as I was saying, this list of programs according to the site selection that we're talking about, new versus existing program models. And--

>> Excuse me, Greg. Can people who are not speaking mute their phones?

Something is interfering. Thanks.

>> Okay. Is this better now?

>> Yes, it is.

>> Okay. So anyway just to finish off the thought, you do want representation by program model. You do want representation by new versus existing, urban versus rural. And to think about that systematically in kind of a sampling perspective will get you not only the variation that you want, but it will also get you, when you add everything up together, the national picture that I think would be valuable to present to Congress. Now, you may well end up selecting a subset of states. I would imagine that will be the most efficient way to think about this. But it becomes then an efficiency question of data collection balanced against the kind of representation across the different dimensions of new versus existing and so forth that you want.

>> This is Appelbaum. Can I ask a question? I can't get my head quite around a bunch of this stuff. Since home visiting, the unit of observation, as I understand you saying

before, is in the home. That's where the program is delivered and if you're looking at what do people actually get, it's going to have to be observations in the home.

Knowing that there are all sorts of things that influence the cost of doing these, but just as a ballpark, how many -- roughly how many homes do you envision your being able to go and actually observe? And are you planning to do it as a one-time go in, see what's happening that day, or are you thinking about multiple observations to kind of get some more stable picture?

>> I just have a clarification question and then we'll dive into that. Are you talking about for the impact study or more part of the implementation study to know what's going on in the actual service delivery?

>> I'm actually thinking of both. All of these sampling issues and how many things you build into it in the final analysis kind of depends on, you know, in general, on how many cases, how many situations do you think you can observe and whether you're doing one-time observation or multiple observations in the same unit.

>> Those questions interact. How many we can observe.

>> Right. I'm trying to get a ballpark. I don't know--

>> We have given it some thought.

>> In order of magnitude sort of thing. Are you talking about 10,000 homes being visited in the course of this, 5,000 homes being visited? Just ballpark.

>> The latest -- current thinking is with random assignments the study would have about 7,000 families. Home visiting have control and that each of them would get observed once with the home visit. Home visitors. Plus we're having discussions with the team about whether you want to do fewer families but multiple times per family to get a better sense of what is happening with the family.

>> The 7,000 is what we estimate in order to be able to do sub group analyses and other impact work that would examine the features of program versus the impact. That was the ballpark of what we needed for the impact analysis, and then if -- the question of going into people's homes to look at the actual service delivery, you can decide whether you're gonna do the implementation study literally for every single family or whether it makes more sense to do multiple observations of a smaller subset. There are certainly arguments in different directions. So any thoughts people have.

>> And just to reiterate, of course, you know, that number is kind of one fixed estimate but it is what it actually turns out to be depends on cost, it depends on how many states we end up going to. It depends on a lot of other things. That gives you a sense of the kind of magnitude.

>> The one thing that I think we did pretty well establish is if you're trying to get any idea of what happens in the course of this home visiting, a single observation just doesn't work. At least for most of the studies that were historical studies on home visiting, the families are fairly distressed and fairly disorganized and the person who is delivering the service is often responding to the situation of the day as opposed to the planned service to deliver. So you may want to think about at least in the subset to take multiple observations. Once you get into the house, it's less difficult to get back into the house. But to get yourself some idea of the stability.

>> This is Kathryn Gallagher. I'm wondering, maybe I missed this or maybe it's been part of a prior discussion, but it seems like we're talking about, you know, a single type of evaluation when in fact maybe we could have multiple tiers of it. It seems like, you know, there are many available and freely and easily accessible indicators that might be able to speak to -- one, the descriptive state of the universe right now but the descriptive state of the universe in a few years but also give us an indication if any natural experience have been able to be observed through this program. I guess what I'm saying is for example, I don't mean this as any real idea but throwing things out there. But one tier of the evaluation could be descriptive where we look at indicators nationally of the magnitude of eligible kids and all the different mechanisms in terms of infrastructure available to serve them. And various indicators of the need and the family makeup and the setting. And then another level where we can't do this now, I guess, until the states come back with their revised plans, but capitalize on any potential natural experiments that evolve from their plans and then third, do a very

focused and much more detailed random assignment evaluation and implementation study. I'm wondering if that's conceivable or did I -- or maybe you've already addressed this.

>> I think, as I've done before, I'll take this not as a yes or no question but as food for thought.

>> This is Bette Jacobs. I'm sorry if I chimed in late. Appropriate to the granularity of understanding some within group variations and experiences, one of the methodologies that I have used has been cell phone data collection. And while it takes a certain amount of structure to set that up, the responseivity and the nature of the data that one can obtain on the factors we're interested in are some other methods to consider in what it is we want to look at for outcomes.

>> Can you give an example of -- can you give an example of what you have collected in that way?

>> Yes. We had a six-site study for predicting and preventing child neglect both an assessment as well as intervention and we were able to collect experience data. Some of the things we sometimes wonder about in terms of families responding to the crisis of the moment is, is it the same crisis every day? Are children experiencing some regularity in even their physical presence, are they mostly with the mother and by doing a true repeated measures, that is you can call every other day and check on

very particular concrete variables that are not highly subjective, whereas your child right now, what has happened in the last 24 hours, something very brief, and that in a fairly effective way gives you enough feedback to what has troubled some of these fields of study and that is knowing the continuous landscape of experience.

>> Can I just ask if committee members have any further thoughts about the features of sites to consider in site selection?

>> This is Kathryn again. The one thing that I haven't heard anything about. We talked about the neighborhood context and the larger community context but one consideration I might have would be the rates of incarceration and the mobility in and out of the home for -- [inaudible]

>> Mobility in and out of the home of the parents? The stability of the household membership?

>> Well, both. You could have mobility levels within certain communities, even if you're able to go to the neighborhood or household level all the better. But some neighborhoods, as you know, are more affected by parental removal from the home for incarceration reasons and we find that is deeply affecting the child's development especially in the early, early years. So you can do it at a community level. Do it at the household level. Especially the father or whatever guardians or even familial members.

I think that's a harder one to catch when there are so many very specific things but just to put it out for their consideration.

>> This is Frank. I would echo that. We've tracked home composition over multiple years and thousands of people in home visiting programs and there are some often very dramatic shifts in home composition, as well as multiple moves. And that are very common in this population and do have a significant impact on sort of the uptake of services. The other thing I just want to say is I like the idea of the phone. We've used that also. The issue is that the moms don't like you to use up their minutes. Texting is more acceptable because it doesn't use up the same kinds of minutes. But the other thing we found is that they go through cell phones like crazy so the numbers are always changing. So there is a lot of tracking there.

>> This is Rob and I've been looking across the seven models and we discussed program features we would like to study in terms of understanding the impact of duration of these programs or the professional nature of the home visitor and seeing if some of the programs look similar enough that if you were selecting sites that you would have a sample large enough at the end of the day so that there would be some information about the impact of professional level home visitors, duration of home visits, age of the child and so on. And at the end of the day I don't think there is a lot of similarities between these programs.

>> I think the plan is to be able to do that. I think duration is a tricky one if you have one year of follow-up, a number of of the programs go beyond the year. That's the goal to try to understand that kind of variation.

>> Sure.

>> I'm going to suggest that we switch focus a little bit and one of the questions on the table was Lynn's parting question or parting advice to be sure that we address the program's broad goals related to systems both local and state systems and we welcome the committee's thoughts about how best to conceptualize and measure system level outcomes. We thought that was a hard one, too.

>> Rob. I was thinking about that, too, as we were in the other discussion and it does seem difficult. One aspect might be to see how families as they are being served, how well they are connected to other parts of the early childhood system. That they are connected to other parts of the support. Some of it -- some of the observations to the implementation might be able to observe how timely the resources are distributed once the state receives them and they're able to be able to reach families through their programs. So maybe some data around that.

>> I'm wondering, this is Kathryn, if anyone can speak to the lines of deployment. Are they marked by geographical boundaries or further service areas, for example, county service areas or multi-county service areas, or community hospital service areas? Is

there any definitive thing that is equivalent across these states in terms of service area or are they going to be vastly different?

>> They're likely to be different.

>> I think they're going to be quite different. We even discovered that in the statewide needs assessment the units of measurement were quite different depending on what state it was. We are asking that they have a geographic area identified but the characteristics of that geographic area and, in fact, the services that may be associated with that geographic area I would suspect are going to differ.

>> Might be able to -- this is Peter.

>> Sorry, we have two people speaking. Frank, can I ask you to hold for a moment?

Peter, go ahead.

>> I was just thinking when we talk about link to community services, link to a medical home or presence of a medical home might be an important systemic measure.

>> I should note that one of the benchmark areas and participant outcomes is increasing coordination in linking to resources and referrals and how to measure that and we also recognize that's also a very difficult area to measure and there is very little consensus from what we can tell about how to measure those things.

>> Frank, thanks for waiting, go ahead.

>> I was going to make two small points. One is I work with home visiting in four different states and they all have different geographic ways of dividing things up. So I don't think you're going to find a lot of commonality. Secondly, not only what we've seen is that home visiting programs often make referrals but the actual follow through and connection with those services is generally pretty low. And we need to really track how many of these people actually get into these services if we're going to look at that feature.

>> I think given the lack of any sort of common denominator in a service area or at least a level of government in which the service might occur if it were publicly operated, I would be interested in seeing some sort of objective indicator and this is just throw it out there and I'll never speak of it again unless someone is interested, but it would be interesting to see some sort of objective indicator of distance from the service so you could do evaluation would be the geographic information system to see how difficult it is to get services or how long does it take to get to a service even if the distance isn't great?

>> But there are other barriers besides that, particularly transportation, childcare, those sorts of barriers. They may be relatively proximal to the service geographically but they still can't get there.

>> Are you all referring to other services that you're trying to link folks to, is that what you mean by which services they're distant from?

>> Yes. I mean, one of the theories of home visiting is that it identifies and connects families to services that they need. In addition to providing in-home services.

>> Right. And then it would just be interesting, again, throw it out there I agree totally there are thousands of other obstacles besides distance. Travel, distance, babysitter, time. The extent you can create a simple objective indicator, for example, if you were asking them to keep diaries for a period of time, that would be one I would want to see in there as well.

>> This is Paul. Back to the question about estimating the impact on the sis emotion. I'm concerned about mark's comment earlier today that this program will be unrolled at a time when states are cutting back in often massive ways on existing services. That makes it particularly difficult to understand what impact this program has had on existing services because those will be in such a State of rescission.

>> Okay. Let me switch topics again and ask for views about fathers. I think it doesn't seem especially useful to ask you whether you think it's important to measure things about fathers. We think it's important. We also think it's difficult and expensive. So -- because they tend to be hard to reach. So how much we're able to do will depend in

some measure on resources and, of course, on setting priorities since we don't have a design that would provide you any context to compare this element with other elements. I don't think we just want to ask you that basic question but rather assuming that we do want to include and measure fathers, we would welcome your advice, either practical level advice about cell phones or other ways to reach them and then more conceptual questions like who counts as a father, are we looking at the biological father, the social father. How do we think about father presence, father absence? How do we measure features of father behavior that may, for example, be relevant if the father is present but not if the father is absent? How do we account for that in our analytic study and that's plenty for me to toss out and ask you to think about and comment on.

>> This is Greg. The fragile family study I think had to address a lot of these issues in the context of a survey that began with sampling births in hospitals and practical bit of experience from that study is that if you actually want to interview fathers, that contacting them in the hospital or shortly thereafter is by far the best strategy and you can actually get a pretty decent response rate at that time. As the months pass, it becomes harder and harder to find them and to persuade them to consent to interview. And non-response problem not only grows because you've got your interviews but the obvious selectivity of who becomes hard to reach was very difficult and it is not uncommon to get 25% response rates or 30% response rates among absent fathers, which is really a deathly low response rate. But in terms of guides to what questions to ask especially moms about the absent fathers, how to treat social fathers versus

biological fathers, I think the experience of someone like Sara would be helpful to frame the practical questions of collecting information.

>> I was going to say, we struggle with some things in the early Head Start national evaluation study. I think there are some folks there that might be worth chatting with and I'd be glad to provide further information on that, but kind of to follow up with what Greg said, I think we used multiple strategies. He did try to get somewhat we hoped would be useful information from others. I would say that I think if we only try to get information from biological fathers, we probably create some difficulties at that process knowing some of the instability in family structure that are sure to happen with these families. I would be concerned limiting whatever might be done to biological fathers and I would defer to some of the others here in this committee that maybe one possible thing to consider that given how much money might be required to try to get information from fathers, maybe some -- a very careful sample selection, maybe if we could try harder, even if that meant with fewer fathers but to try to get a little more certain information and a little deeper information from fewer fathers might be a better strategy than trying to get, you know, a lot of fathers involved in this just from a strategic standpoint. The other group that struggled with this that might be worth chatting with because they have incorporated a father study component into some of the ECLS data collection. Those folks might have some wisdom to offer, too, about what success they've had and what they've tried to do that might be informative to this effort as well.

>> I would also add there are probably some indicators from formal records that might be very useful. Death certificates and even court orders and things like this. To supplement what you get.

>> Who was that speaking?

>> This is Kathryn. I think that what we find when we're looking at fathers in our high risk very young kids and actually young fathers themselves, if there is any justice involvement on their part or involvement within their household, they tend to suffer earlier mortality from most causes and that obviously -- that would be an important descriptor part of this. It wouldn't necessarily something that you could evaluate in the short-term outcomes but something that really hasn't been examined in terms of its magnitude affecting these kids. I could be wrong about that. But it would also be interesting to see if there are other court records and things available where you actually wouldn't have to track the father, you could just track public records. For the social father as well.

>> Okay. Let me shift focus again and ask for comments about how to think about the design, if it turns out that some models have very little take-out and the related question or the subquestion if, for example, the models that serve the older young children have little take-up again, how to think about whether to include those older kids and those scarce models or not. We would welcome your thoughts.

>> This is Kathryn again. I'm getting awfully chatty here, sorry. It seems like you may just want to select a non-priority cut-off point so that before you know what -- how many states, if the committee and the people who have been working on this had a thought of what proportion would be a reasonable investment for evaluation given the overall numbers and money spent, because I think once you surpass a certain threshold, that it seems worth the money and you can set that priority. It's not so hard once the numbers come in. You know, then it would be mostly a cost/benefit ratio, I think.

>> Wouldn't the fact that they weren't chosen be an important thing to document? Seems like if we're looking at the higher level evaluating the Federal program, the fact that some models were not selected is important information in and of itself.

>> And I think we will collect that information. And I want to remind people to tell us your name before you speak.

>> Can you hear okay? Can you hear me?

>> I can although I was speaking at the same time. Just tell us your name. We recognize some voices but not always.

>> Yeah, Hendricks Brown. It seems to me that, you know, going back to the other point at the beginning in here, it seems to me that it's important to measure this in

multiple levels and I think that the framework of, you know, does this program work for a specific families is a very valuable part in here but I think if we only did that in this project I think we would not be able to get a sufficient information that we could get. And I would suggest that we include things where the state programs have said that they are going to be using program A and really do a good job of trying to evaluate whether those programs actually got adopted. Did they get in the front door in these communities? And I think one of the major issues of, you know, it's sort of the same kind of thing. If we're going to have a population effect, it needs to go into communities, you know, at the front end of the process, not only just whether it gets in the community or not but eventually down to the point of what is the reach into that community of, you know, what are the numbers of families that are served? And I just suggest that we try and make sure that we, you know, hit the key dimensions around implementation, including that adoption early phase part of it. Can you get people in the front door?

>> Okay, one last question for open discussion and then I want to move to a round Robin where everybody can have a chance to give us your last thoughts and the last question that I had identified as of particular interest was about the services that control group members might receive. So as I mentioned earlier, this is relevant to site selection. We may want to pick sites where we think control group members are not likely to get extensive services. We want to measure the services that they receive. How to measure consistently across treatment and control is a challenge. And then obviously there are implications for the analysis plan. So have at it.

>> This is Kathryn, again. So, you know, the services as usual is something we always come up with and systematic reviews and meta-analysis. Given you're talking across all the states and all these different locality and different service providers \*r providers I think it would be really hard to impose the services that the control comparison groups get in terms of -- I think it would be easy enough and by easy, you know, several months of work at least, but coming up with ways to classify the services as usual so that it doesn't come off as an imposition on these systems. Just my own off the cuff remark.

>> This is Frank. I think what--

>> What?

>> I didn't understand Kathryn's comment. Are you suggesting -- is that about the extent to which we try to embargo control group members from receiving services?

>> I was saying that I would personally -- this is based on my experience -- not try to embargo control group members from receiving services because, one, that's really hard to do and two, it may detract from the program and from the implementation of the actual treatment. Especially because you'll be doing it at so many localities. It doesn't mean it's not possibly and there are certainly good cases the make for it. I would argue just in my initial response against, you know, dictating what or if none or

what services the control group can get. I think that on the analysis side once the data come in from these evaluations it is easy enough to classify what services they did get into meaningful comparisons and contrasts so you get something that looks like apples and oranges across the different deployment areas so you can actually say when you go to the eval -- evaluation. I wouldn't impose about the different areas but I can see arguments for doing it. It's not fully a both guns firing statement.

>> Frank, please go ahead.

>> I think what you're gonna find is that there is gonna be an overlap between services received by your controls and by your home visited populations since the home visiting is meant to also link people to local community services so you'll need to track those also and maybe even some dose-related way and secondly, having tried a number of, you know, control trials and home visiting as usual and home visiting with augmented services, etc., many of your stakeholders just are in communities which is that organizational piece that is in Anne's model, are very hostile to withholding of any services and so I think it's going to be a case of tracking what people received than embargoing services.

>> Other thoughts on this point?

>> This is Hendricks again. I hate to -- I agree with this one. You know, the negotiations behind the scenes about what actually are going to be these alternative

comparison groups, I guess I don't know exactly how the states and the individual communities are going to come up with it. I could easily see, you know, many of the communities refusing to hold back and not delivering services. And I don't know what kind of experiences people are going to have with that one. I mean, it goes back to this issue of, you know, how much intensity about randomizing at the individual family level do you really want to have in this study? And I think that also comes back to, you know, what is the balance between the kinds of questions that were on the earlier pages of coming in here about evaluating programs as they get delivered in here on the seven outcomes for the families versus those that talk about what happens more at the community level in terms of implementation.

>> This is Peter. Has there been some thought given to using controls from within the community? As well as similar communities, choosing a similar community as a control and comparing it to the intervention community?

>> I just also want to put out there that we've talked about only going to communities where there is overenrollment. Most home visiting programs have a waiting list and don't have the capacity to serve all families that qualify. The randomization would be in those circumstances.

>> Appelbaum here. Maybe I'm really extreme on this but I think it's extraordinarily unethical to do anything that would in some way restrain people who need services from getting them to start with. Secondly, in many communities, the agencies that

provide services compete with each other for clients. I mean, their own success and their ability to, you know, gain funds and gain status is dependent upon their getting people in for service. That's what they have to report and what have you. So within the community I just don't see any way that you could either ethically or practically keep people not randomized into home visiting from getting those same services so as has been said before minimally what you have to is carefully track what people who you think are control subjects are actually getting. I should drop my voice at the end of that.

>> Other thoughts on this point? Okay. Let's shift gears now and move to a closing round Robin. I am going to start go alphabetically for no particular reason start in the middle of the alphabet. Which I'm going to interpret as meaning Bette Jacobs. If I can ask each person to speak for two or three minutes and either reiterate something you said before or raise a new topic or question as a reminder, we will be meeting again. So it's fair to raise questions as well as making comments.

>> All right. I'm happy to kick off. I think you've got some useful input and I want to thank you for being so well-organized with our time for a long day. I would point to a couple of overriding issues that have been mentioned that must be considered for this particular evaluation project. And one is the precision and importance of the health disparity data. As we look at the historic period, and all research is conducted in the historic period, but this one is going to certainly speak about the value the public invests in support programs and there I think we have a real responsibility to look at the efficacy of programs that give good value and hence I would emphasize selection

of disparity data. A lot of money spent on not always very good improvement on a large scale. That would be my second point. The ability of demonstration projects. Even multi-site fairly large demonstration projects should have positive effects has just existed for decades, and the ability to scale them up is just difficult. Sometimes it's history, sometimes it is the magnitude or our own desire for what we want interventions and outcomes to produce. And sometimes it is, as has been observed, the characteristics of people themselves in particular projects and so what we usually look at the intervention, I always think it's helpful to look at the attributes of people involved with the interventions that are successful because in my experience that often does make a big difference. And then I would say that an advisory committee should be helpful for more than four times a year and I would hope that we would have an internal system for the kind of communication and input that would be most useful for the people who will be moving forward with this.

>> Thank you. Marie McCormick. Frank Putnam.

>> Okay. I have a couple of things that I just want to touch on again. I think our partner. One is that I raised earlier this issue of very high attrition rates in people -- in programs in terms of people retained and yet we don't really know what the outcomes are for people who have one year of home visiting versus three years of home visiting. Tracking something about those and follow-up of people who leave this programs and understanding maybe not only why they leave these programs but what are their outcomes relatively? I think another one is this the issue that many of the outcomes

that Congress wants, the benchmarks are fairly distal kinds of things particularly to home visiting. If you're providing services to infants and toddlers and you want to look at school readiness, you really don't know about that for several years and so some kind of thinking about the design, as I suggested earlier, of maybe looking at graduates of programs and mature programs that we think are up and running and have some evidence to see what those are in some ways. Also, tracking community baselines. If you look at the number of the outcomes. Reduction in crime and violence and all those things are community capacity and parameters as other people have mentioned and we need to contextualize how the programs are operating. Something that may not look great in one community but may be dramatic changes because of the baseline. Site variability. Over and over again if you look there is enormous amount of site variability for the same model. I think that much of that variability has to do with leadership factors, supervision and training and some way to track those if particularly important as we look at those implementation issues.

>> Thank you. Ed Shore.

>> Okay. Rather than reiterate let me just make two points. I think one is there was a lot of discussion in the -- a lot of -- in the introduction to today's meeting on continuous quality improvement, which to me means that an aspect of the evaluation is that it's a formative evaluation. And we haven't discussed that at all. I think it's really important. I think CMS has moved this direction in a lot of its Medicare demonstration projects that they're moving off of terminal outcomes and really focusing on measuring along the

way in ways that are likely to improve the outcomes of the various interventions. So it's different than what we've been discussing but I would strongly encourage some consideration of it. Another is there is an aspect of an application process where states are presenting what their needs assessment is the basis for getting funding and presumably making the choices that they are going to make in terms of setting up programs. And I think some of the evaluation ought to focus on assessing the extent to which those needs that were idiosyncrasies to each state. It is fine for us to come out with universal generic outcomes we'd like to see and what Congress has listed but what's likely to change are the things that the state and the implementers want to change. I would use the state needs assessment as a guide to part of the evaluation effort.

>> Thank you. Paul. Peter, would you like to comment?

>> I'm sorry, I was muted, I'm sorry. I was talking and no one was hearing me. This is Paul, I'm still here. Hello?

>> Yes, we hear you.

>> Okay. Sorry about that. So I would just start by echoing Greg's comment about the importance of capitalizing on the opportunity you have to do a national study. I think that's particularly exciting and important and significant and I think there are two comments I would make about the work the states are already doing that build on the

comment that Ed just made about the needs assessment but give you an opportunity to think beyond the 7,000 families you'll enroll in the trials. The benchmarks and the assessments of the benchmark data that they're developing currently or may have already developed. I couldn't locate that in the time line just in the time that I was listening to folks talk but if we could -- if that information could be collected statewide if it's true that all states are serving far fewer of the families than they'd like to, you have the opportunity to do this before the states start providing -- they have the opportunity to collect this data before they start providing home visiting services they could conduct trials themselves even independent of the evaluation if they were persuaded to do that. And I think the second thing and I forget who made this comment earlier. Obviously this is -- there will be some naturally occurring experiments here. All states are participating and making different choices and you may be able to exploit. The data systems independent of the valuations and required in program participation you may be able to exploit those for interesting analyses and I would just close by reiterating the suggestion I made earlier about the importance of -- I wish we knew everything we need to know about implementation science. I think there is an opportunity to learn a lot about program implementation in the context of the trial and to devote resources to very detailed close and somewhat open-ended attention to what the programs are doing and how they're doing it.

>> Thank you. Peter.

>> I think it is important to measure systems. And I think it's important to measure implementation and these are things that are -- can be evaluated early in the evaluation time period. So you may be able to be further along in these kinds of measurements than waiting for outcomes. And I think the suggestion somebody else made about measuring elements proximal to the outcomes that we have some idea affect outcomes but measuring these, some of these proximal things to outcomes can give early indication that maybe our outcome measurements will be positive and then I think also the neighborhood and community characteristics play an important role in the implementation success and in the success of the outcomes as well. So I think it is important to measure neighborhood and community characteristics. If it's possible to do multi-level analysis, I think that's important.

>> Thanks. That brings us to the end of the alphabet so back to the beginning.

>> I've been quiet for so long I had to clear my throat. Okay. I have a number of issues that I want to go back to and talk about. One is the issue of health disparities I brought up before and others have brought up since either directly or indirectly. While I know that you know you mentioned that you're thinking and you're planning to address this, I really think it needs to be addressed early on because it has implications for research design and sampling, etc., otherwise once all that is done we may find that we don't have the adequate sample size for the various groups we want to look at. So I really think it needs to be up front as we think about the research, the design and the sampling approach. That was number one. The issue of multi-level analysis and

neighborhood effects I want to go back again to my suggestion of looking at not only the family characteristics but the neighborhood characteristics and perhaps you might be interested if looking at the Kerwin Institute Neighborhood Opportunity Index because it includes a number of measures, they've mapped cities by census tracts using these -- this index. So if you have that for a particular -- that index or particular family member or community, it could provide you a good summary index for neighborhood level factors that are known to impact health more broadly but also health -- so I think if that could be used it would be a powerful way of looking at neighborhood level impacts and facilitate looking at using analysis approach. Related to the other programs in addition to home visiting -- other home visiting programs, the dissemination of home visiting programs and their availability in these communities to randomize people even if they don't get home visiting there are many other initiatives that are being funded. For example, in some of the same communities like Project LAUNCH and my child, etc. Many of these families are participating in these and that use some integrate home visiting into their strategies but also provide a number of other services that are likely to impact both children's outcomes so even then the comparison group is going to be -- those services are even services as usual group. So I think it is unrealistic to think that we can get a comparison group that doesn't have a level of exposure that might confound the design. So I agree that measuring exposure to these programs would be important. I wondered about -- we haven't talked at all about language. In, if fact, you're collecting from data from people how are you going to handle -- I assume you're planning to do these measures in different languages which is in and of itself a very direct measures to be taken from families. That's an issue I did think about and wanted

to mention at least. The other issue about home observations. I came from lunch 15 minutes late that conversation had started and I didn't know if this is a required element but it seemed like a huge undertaking with a lot of the problems that were mentioned and it doesn't seem realistic to me as much as one could really get great data and you could observe families over time. It doesn't sound like that will be the situation here. I wanted to say that. Then the last comment is about the outcomes. I think I agree with other comments we have to choose realistic outcomes that are more immediate or proximal to intervention. Potential intervention impacts and choosing ones we know are associated with the child outcomes, the more long range child outcomes that Congress is interested in. So it's clear that this is an incredibly complex undertaking. Put a lot of information -- so those are just some of the items that I wanted to mention.

>> Thank you. Mark Appelbaum.

>> This is amazingly complicated undertaking you have here. Probably the one thing I would like to say is it doesn't sound to me like a single experiment, a single design can get at the various things that people think are important for you to be able to report back to make some sort of reasonable, meaningful and reasonably succinct statement about what these programs do. And it may just be simply better to think of several studies, each of which does some component of it well. Give up some things that would be nice in a kind of a complete academic study, and to concentrate on those things that you can do well without confounding the various questions with each other.

I would also like to emphasize that there are strategies, for instance the ones that Greg has talked about, where you can do sampling by using cluster sampling methods that actually can be worked very efficiently with surprisingly small numbers of cases in each of the clusters. And with that I think I'll just shut up.

>> Thank you. Rob Bradley.

>> Mark anticipated the tack I was -- the discussions we've had today and Frankly the studies that any number of us have been involved in have always had this dilemma of we want to measure many things and we want to measure many things that are simply impossible. Therefore, before we sort of come up with a study design that's one size fits all, whatever the iterations are, I think some consideration ought to be given to multiple studies or at least some new structured substudies within this which might take on particular questions where we feel like we've got to have greater depth on some issues but a smaller sample or a cluster sample will in fact give us some very, very useful, more penetrating information. So I would certainly suggest that, you know, before we come up with a sort of one design that fits all that we really not foreclose the option of some sort of structural -- structured way of getting some sub studies that take advantage of some of the opportunistic things which are going to occur, as many people have said. Maybe there is a way to grab that in a purposeful and doable way as well. Some of the other issues, which simply we could not possibly go into as much depth but we could very carefully gather a sample, which would do a good enough job

to allow us to penetrate more deeply basically following mark's comments. The issue that I wanted to talk about.

>> Thank you. Hendrick Brown.

>> Yeah, I wanted to just go back to the points about the time line on page 78 for -- that we did talk about earlier about the report to Congress based on a small amount of data and what would be available at that time. I do think we have to take that seriously. You know, I think if we try to balance is kinds of value that we'll get out of this study by that report that is going to come out in 2015, I do think we need to be careful about balancing the importance of different research questions in here. And the way it was written on that particular slide or the next slide was that it really was emphasize the question around implementation. I do think that there really are some novel, interesting ideas about sophisticated intervention designs or implementation designs that could get to both the implementation questions and also start to do something about evaluation. The effectiveness as well and I think that we could pair these with techniques for -- this is a roll-out study and what I would call it and as a roll-out study there is a major opportunity to randomize at the level of communities as it gets rolled out and there are a number of examples that we've been working with on those on suicide prevention and other places as well. And I think that those are useful to consider. I just would stop there.

>> Thank you, Greg Duncan.

>> Thank you. So the effort is very impressive. The scope of it is overwhelming. I guess I would think of following Mark and Rob advice kicking and screaming to the extent that you can pull off a kind of a uniform design and come up with a coherent aggregate estimate of impacts. I think that's a prize to be valued. But I certainly recognize the complications that lead to their kind of consideration. I am very worried by -- I think we all are and you are, too, by the short timetable here and I'm -- I've been trying to think of ways of getting around that timetable. You know, if I were just sitting back as an academic that I am and not worry about following the letter of the law, I would worry a lot about measuring child outcomes. We know that programs can affect parenting beliefs pretty readily and practices are more difficult and the hardest thing but the most valuable thing is to have an impact on child outcome. And again, ignoring the constraints, if I were to do two follow-ups I'd probably pick something like age two and age five for the child outcomes. Only by age two can you start to measure outcomes like cognitive ability in a reasonably reliable way. That holds for other child outcomes, too. At age five you've got school readiness measured pretty well. I keep thinking of the kind of model that the moving opportunity experiment in HUD adopted for their long-run follow-up where HUD put up only a fraction -- I don't know, certainly less than half and may not even have been a quarter of the money, and the evaluators, NBR, I'm part of the follow-up team, raised most of the money from NIH from IES from private foundation. So it might be possible to actually pull off these longer run evaluations to get the child outcomes that I think we value the most with some kind of partnership where there is just a limited amount of funding from your agency coupled

with tapping into these other funding sources. I wanted to also endorse the use of administrative records to the extent possible. Not really -- not counting on the local people to think about all the possible sources that might be brought to bear here, the more consistently across the site you can pull together the child protective service information, hospital information about child injuries, you know, all the different kind of sources that you might be able to draw both before and after these programs are rolled out. The more of a chance you have to take advantage of some of the natural experiments that people have talked about, the more leverage you have to characterize the non-response to your survey if you have the administrative data and that's a huge resource that should be tapped systematically. Another point we haven't really talked about cost data. And the different program models are likely to carry very different price tags. And I think being systematic across all the data collection sites in getting very good cost for family information is vital because then you can do the kind of cost effectiveness studies that are really the kind of things that policymakers ought to value the most and it could be that you will get smaller effect sizes for weaker programs but perhaps their costs are proportionally less than the affect sizes are. Unless you have the cost data you really don't have the basis for making these kind of policy decisions. And finally I want to get back to this idea of how important it is to understand how families are actually perceiving these programs. People offering the programs think they have a great set of services, they can't imagine why families wouldn't want to take them up and profit from them. If you get inside the families and their lives, you often get a very different view and that different view often has a lot of

implications for how to better design the service delivery package so that they can be more effective in carrying out their goals.

>> Thank you. Kathryn Gallagher.

>> Well, I agree with all the sentiments and I really am appreciative of the really good work you all did laying out all the complexities that we're considering and also the scope of the project. I'll keep my comments really brief, I hope. I'm still back at the question of is it possible to use this opportunity for evaluation to do instead of one study of one evaluation study but rather a multi-tiered multi-method approach where a number of questions could be answered and so I'm personally going back in the flip-flop between it would be nice to have a very fantastically strong evaluation design but on the other hand if I were Congress and I bought the evaluation I would want something to tell my constituents and how I was going to use my resources going forward. So I would be inclined to kind of write out my most important questions and I think cost is one of them. I think how it affects the individuals and the families is another one. Another one is just how states are -- how they're making the decisions about what they'll go after and what kind of programs they're going on use and what kind of infrastructure they already have. I would have looking for descriptive for the health services research studies. I'd be looking for administrative data studies and natural experiments and I'd be looking for the observational and experimental design study. Not all of those can be done or should they all be done under this mechanism so I think moving into a phase where I would just like to think about all this and I think

you all have already given it a lot of thought as you prepared for this meeting. The organizers. And so going through the prioritization are and what questions and what populations. That's where I'm at right now. A lot of thinking.

>> Thank you, and the last word, Rob.

>> Okay. I get the last word. I would first like to underscore Greg's comments about cost effectiveness analysis as a way to normalize the different amount of resources that each model brings to bear in home visiting. And also Greg had mentioned the ideally being able to provide child outcomes at age two and five but in the very near term for those programs that are evaluating pre-natal programs that we'd be able to get birth outcomes fairly near term. Also immunization rates and other access to healthcare such as well babies. That data that seem to be available a lot earlier. One comment I would like to make. Earlier we talked about the benchmark data as it comes to Congress may be used to consider reauthorization for home visiting and to what extent that data as it's presented and brought forward to a Congressional members is their role for this committee to be commenting on that document, is that outside of our scope. Which is food for thought. That data may end up trumping our 2015 report in some way. Enjoy the discussion.

>> Okay. Thank you all very much. Just a couple of brief concluding remarks. First, to thank everybody for your stamina. This was a little challenging to do by phone but we think remanaged to get a very rich and helpful discussion. We plan to reconvene the

committee in early May to further inform the development of the request for proposals for the contract to carry out the evaluation. At that time we'll present to you a more detailed -- we haven't presented a design. At that time we'll present to you a proposed design that I hope you will find incorporates many of your suggestions and some choices about those areas where you have suggested that we've either got to do A or B and we'll have to figure that out and very much welcome your feedback at that point. Peter, did you want to make any closing comments?

>> I think this has been really good and the comments have been wonderful. And I think the structure has worked well. I didn't get a chance to thank the people on our staff that have been here most of the day. Terry and David and Audrey and Carlos and Bonnie, they have a lot to do with making this all work and the programmatic efforts work and I want to offer my thanks to them and the collaboration between HRSA and ACS.

>> Unless there are any closing comments or questions, we will adjourn and be in touch shortly about our next meeting. Any last words?

>> Good luck.

>> Good luck, yeah. [Laughter]

>> Thank you, thank you to all the members.

>> Thank you, bye.