Child Welfare League of America Comments on the Affordable Care Act Home Visiting Program Model Criteria for Evidence of Effectiveness

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August 17, 2010

Re: **Request for public comment on criteria for evidence of effectiveness of home visiting program models FR Doc. 2010-18013 Filed 7-22-10**

Dear Administrator Wakefield and Assistant Secretaries Nazario and Hansell:

The Child Welfare League of America (CWLA), on behalf of hundreds of public and private agencies serving children and families would like to thank you for the opportunity to participate in the comment process. We welcome the proposed criteria as a guide to the implementation of the Maternal, Infant, and Early Childhood Home Visiting Program created in the Affordable Care Act (ACA). However, states will need ample time and clear guidelines from the Administration to be able to improve service coordination and provide comprehensive evidence-based home visiting programs. We acknowledge the proposed criteria as a good starting point for laying the foundation for criteria of evidence of effectiveness in a transparent manner. Our concerns focus mainly on the future allocation structures indicated in the Request for Public Comment. We are pleased to provide the following comments.

Section 2: Background

Section 2.1 states:

> "HHS intends that the home visiting program will result in a coordinated system of early childhood home visiting in every State that has the capacity to provide infrastructure and supports to assure high-quality, evidence-based practice."

CWLA appreciates that HHS intends for the Maternal, Infant, and Early Childhood Home Visiting Program to result in a coordinated system of home visiting that provides the infrastructure and

supports to assure high-quality evidence-based practice, and in keeping with the spirit of the statute, we agree that this should be the fundamental goal in every state.

Section 2.2 states:

> "It is expected that eligible entities will also have an opportunity to present documentation in their application for the grant program to demonstrate that additional home visiting models meet the final criteria. Such documentation will be reviewed by HHS using the same procedures applied in the HHS systematic review."

CWLA supports the opportunity that HHS is providing for states to submit additional documentation to demonstrate that a model is eligible even if it is not included in the initial Mathematica review, that has been called for by HHS. Since the review has yet to be finalized, states face the uncertainty of not knowing whether or not their model(s) will be eligible or screened out. Therefore, we suggest that states should only be required to submit additional documentation for qualifying their given model(s) based on the criteria outlined in sections 3.1 and 3.2.2.

Section 3: Proposed Criteria for Evidence of Effectiveness

Section 3.1 states:

> "The two types of impact study designs that have the potential to be both well designed and rigorous are Randomized Controlled Trials (RCT) and Quasi-Experimental Designs (QED). HHS proposes to define RCT as a study design in which sample members are assigned to the program and comparison groups by chance. HHS proposes to define QED as a study design in which sample members are selected for the program and comparison groups in a non random way."

CWLA appreciates that in HHS' attempt to determine what type of study designs would be accepted as well-designed and rigorous, that they kept with the intent of the legislation by including both RCT and QED studies.

Section 3.1 states:

> "QED's are considered weaker than RCT's because characteristics that may be related to outcomes may also influence whether someone is in the program or comparison group."

CWLA agrees that from a research perspective QED's and RCT's are not equal. In distinguishing between the two, it is important to remember that RCT's are useful for isolating a variable and conclusively determining impact on the variable. Nonetheless, QED's take into account the complex nature of programs and communities and are often more appropriate in direct practice settings. Therefore, we urge HHS to maintain the intent of the statute by continuing to recognize the value of both RCT and QED study designs by allowing for both to qualify as well-designed and rigorous.

Section 3.2.2 states:

> "Based on the legislative statute and the rating scheme, HHS proposes to consider a program model eligible for evidence-based funding if it meets the following criteria:
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> - At least one high or moderate quality impact study of the program model finds favorable, statistically significant impacts in two or more of the eight outcome domains (established in statute); or

- At least two high or moderate quality impact studies using different samples of the program model finds one or more favorable, statistically significant impacts in the same domain."

CWLA applauds the criteria mentioned above as it allows for range of models to be deemed eligible, thereby allowing states the flexibility needed to implement a continuum of models to meet the needs of their respective population. While the foundation is set by the aforementioned criteria, technical assistance will be needed for states to successfully implement the most appropriate model and/or bring to scale multiple models, depending on their varying needs.

Section 4: Proposed Methods for HHS' Systematic Review of Evidence of Effectiveness

Section 4.0 states:

> "The review will be completed after comments on this notice are received and considered."

CWLA commends the transparency HHS provides in allowing the public to comment on the rating and assessment steps of the review process being carried out by Mathematica. However, we are concerned that the limited time in which states are being given to submit their needs assessment and application is restricting their ability to meet the final eligibility criteria. We would recommend that HHS provide states with a clear and realistic timeline for all requirements under the ACA Home Visiting Grant Program, including time to challenge the Mathematica review if necessary. The guidance is strong in setting up a system for states to apply what works. However the guidance is undermined if there is not enough time allowed for states to pick the best models that best meet their vulnerable population's particular needs.

Section 5: Implementation Reviews

Section 5.0 states:

> "To assist in implementation of the ACA Maternal, Infant and Early Childhood Home Visiting Program, the project plans to collect and publish information about implementation of the prioritized program models."

In order to scale up and replicate evidence-based programs, it is indeed critical to account for proper implementation. From our experience communicating with agencies and programs, CWLA strongly recommends ensuring that model developers have the capacity to provide the supports and technical assistance for (1) exploring the appropriateness of the model to the potential service population, (2) adapting the model to the needs of the particular service population and (3) ensuring model fidelity. While we believe it would be more prudent to screen for this capacity before a model is deemed eligible, we strongly urge all Administration implementation publications to clearly indicate if the model developer has the aforementioned implementation capacity that is key to successful replication.

Section 7: Future Allocations Based on Application Strength

Section 7.0 states:

> "To encourage exemplary programs and direct Federal funds where they can have the greatest impact, HHS plans to allocate the grant funding available in future years that exceeds funding available in FY 2010 competitively based upon states' capacity and commitment to improve child outcomes specified in the statute through improvements in service coordination and the implementation of programs with fidelity to the model."

CWLA is concerned about allocating funds competitively before the end of the five year grant program as it is not feasible or consistent with the intent of the statute. The amount of time needed to demonstrate positive outcomes will heavily depend on the outcomes measured, noting that data collection times vary. In addition, the statute does not propose any incentives for states meeting the outcomes after the first year. Rather it requires states who cannot demonstrate improvements in four outcome areas at three years to develop and implement a corrective action plan. Ultimately, commitment to innovation is compromised by this competitive grant program due to the limited time states will have to demonstrate improvements in the specified outcomes.

Section 7.0 states:

> "HHS plans to evaluate applications based on multiple criteria and invites comments on what criteria are appropriate. Among the criteria, HHS proposes to give significant weight to the strength of the available evidence of effectiveness of the model(s) employed by the state. In this context, the use of program models satisfying the criteria outlined in Section 3.2.2 would be a minimal requirement, but HHS would consider additional criteria that further distinguish models with greater and lesser support in evidence. HHS is committed to ensuring that these criteria are transparent, methodologically sound, and increase the likelihood that federal funds will contribute to improved outcomes for at-risk children and families."

CWLA believes it is important not to place significant weight on any one factor/variable as there are multiple factors that could contribute to the outcomes a model(s) can demonstrate, including participant engagement, community systems, organizational capacity, efficient use of resources, data collection, demographics, etc. For example, a model with strong evidence could have poor outcomes when brought to scale in the context of a community where it does not fit the needs of the given population. As quoted above from the first sentence in section 7.0, improvements in service coordination and implementation fidelity are important criteria, and they require advanced guidance on how to strive for and measure success. If HHS is going to remain committed to innovation, placing disproportionate emphasis on the strength of model evidence is a disincentive for states to invest in promising, and potentially more appropriate, models.

In the end, if a competitive funding process is established after the first year, it should prioritize demonstrated improvements in outcomes.

Section 8: Future Considerations

Section 8.0 states:

> "HHS anticipates the criteria for evidence-based models will likely need to be altered over time as the state of the field changes. If HHS believes the criteria need to be changed in the future years, it is anticipated the public will have an opportunity to comment on the proposed revisions. HHS intends to review the evidence base for home visiting models on an ongoing basis to ensure that new evidence is incorporated."

Again, CWLA commends the efforts of HHS to provide transparency with respect to any changes that may be made to the criteria over time. We would only ask that as the Administration and others continue to push the field towards a more evidence-based approach, HHS ensure that as new evidence is required, models are given the opportunity to build up the quality of both their service and research. Following, states should have ample time to enact program improvements based on advancements in research and to gather and submit additional documentation to demonstrate the improvements with the help of HHS technical assistance.

Again CWLA thanks you for the opportunity to provide our insight on the proposed criteria of evidence of effectiveness as well as the Mathematica Review process. We look forward to working with you to provide eligible entities the resources they need to ultimately keep children and families safe.

Sincerely,

Christine James-Brown
President/CEO
Child Welfare League of America