



David Heppel, MD
Director
Division of Child, Adolescent and Family
Health, Maternal and Child Health
Bureau, Health Resources and Services
Administration
U.S. Department of Health and Human
Services
5600 Fishers Lane, Room 18A-30
Rockville, MD 20857

Joan Lombardi, Ph.D.
Deputy Assistant Secretary and Inter-
Departmental
Liaison for Early Childhood Development
Administration for Children & Families
U.S. Department of Health and Human
Services
370 L'Enfant Promenade
Washington, DC 20447

March 31, 2010

Dear Dr. Heppel and Dr. Lombardi:

As you are aware, the newly-enacted Maternal, Infant, and Early Childhood Home Visiting Program (“Home Visiting Program”) of the Patient Protection and Affordable Care Act, Pub.L. No. 111-148 (2010), presents an historic opportunity to improve the lives of at-risk, vulnerable children and families with home visiting services that science and practice tell us work. This bold initiative is an important part of the President’s vision to support investments in programs proven by “evidence about what works and what does not and evidence that identifies the greatest needs and challenges.”¹ Nurse-Family Partnership (“NFP”) strongly supports the Administration’s goal to facilitate improvements in the evidentiary standards of early childhood interventions and to foster the development of a body of evidence that will guide future policy decisions.

As you begin implementation of the Home Visiting Program, NFP is grateful for the opportunity to provide the following recommendations, which we believe offer an effective federal framework to provide States and program models with the necessary guidance to provide home visitation services to vulnerable children and families. During the course of your implementation of this program, we invite you and your staff to visit our national headquarters in Denver, Colorado to observe our data collection and quality assurance systems, which ensure that NFP programs deliver measurable outcomes achieved in multiple randomized controlled trials of our program model. We also welcome you and your staff to tour one of our programs and attend a home visit to see first-hand the operational features of our program and its impact on children and families.

¹ See Analytical Perspectives, Budget of the United States Government, Fiscal Year 2011, p. 92, <http://www.whitehouse.gov/omb/budget/fy2011/assets/spec.pdf>

I. GUIDANCE TO STATES

NFP recognizes the limited time frame within which the Department of Health and Human Services (the “Department”) and States must implement the Home Visiting Program. In order to provide guidance to States, we recommend that the Department issue guidelines on program elements, such as the requirements of the needs assessment, benchmarks, and application process. We believe these guidelines will be needed by States to appropriately assess the needs of vulnerable communities and establish meaningful benchmarks to improve the health, development, education and well-being of children and families through the Home Visiting Program.

The Home Visiting Program statute also calls for guidance on the criteria to determine effectiveness of the program models participating in the Home Visiting Program. Because the success of the Home Visiting Program rests in large part on the criteria by which the program models will be deemed effective in improving the health, development, education and well-being of children and families, we hope the Secretary will define, prescribe and establish guidelines or rules regarding the participation of the program models.

II. CRITERIA OF EFFECTIVENESS

The Home Visiting Program identifies three types of program models that States may choose to deliver home visitation services, including program models with benchmark and participant outcomes proven through (1) randomized controlled research designs, the results of which have been published in peer reviewed journals; (2) quasi-experimental research designs; and (3) promising and new approaches that will be evaluated through rigorous testing. In establishing the criteria of effectiveness for the program models chosen by States to deliver home visitation services, NFP anticipates that the Secretary will provide guidance regarding the following:

- 1) The process by which home visiting program models will be determined eligible to participate in the Program;
- 2) The process by which home visiting program models will be determined to have outcomes proven through randomized controlled research designs, quasi-experimental research designs, or promising and new approaches to achieving benchmark and/or participant outcomes;
- 3) Definition of “significant, sustained, positive outcomes” with respect to programs proven through randomized controlled research designs;
- 4) Definition of “significant, positive outcomes” with respect to programs proven through quasi-experimental research designs;
- 5) Definition of a “well-designed and rigorous” research design;
- 6) The process by which promising programs will be determined to be eligible to participate in the Program;
- 7) The process by which promising programs will be evaluated to determine progress toward benchmark and participant outcomes;
- 8) The definition of “national organization” with which promising programs must be affiliated to participate in the Home Visiting Program.

NFP recommends that the Secretary designate the program models that meet the categories of evidence by establishing a process for home visiting program models to apply to the Department for certification to participate in the Home Visiting Program as models proven through randomized controlled trials, quasi-experimental studies or promising, innovative approaches.

For promising programs, NFP recommends that the Department create a framework to determine their likely effectiveness based on principles outlined by the National Academies.² These principles set forth the best scientific practices that should inform the initial development, testing, and implementation of unproven or new preventive interventions to increase the likelihood that they will produce measurable positive outcomes. The research process generally requires that new interventions undergo formative evaluations, followed by preliminary efficacy and effectiveness research to determine if they are reasonably likely to produce intended benefits. NFP recommends that promising programs meet these principles before they can be implemented by States as promising programs. In order to ensure that promising models improve outcomes in designated benchmark areas, NFP recommends that States' allocations for promising programs include the funds needed to support the requirement that they undergo "well-designed and rigorous evaluation."

III. GRANT PROGRAM SELECTION PROCESS AND ALLOCATION

A. Funds Should be Distributed Based on a Competitive Process

NFP believes that grant funding under the Home Visiting Program must be distributed based on a competitive process, rather than a formula distribution. Ample statutory evidence supports this conclusion. Congress specifically excluded the formula allocation for the Maternal and Child Health Block Grant as the applicable formula for the Home Visiting Program.³ In addition, nonprofit organizations may seek grant funding if the Secretary fails to approve a State's grant application by 2012, clearly anticipating the possibility that some States may not meet the applicable selection criteria to be awarded a grant. Allocating funding based on a competitive process also comports with the legislative intent to support States' implementation of effective programs that produce quantifiable improvements in child health, development and educational goals. A competitive process incentivizes States to develop quality home visiting programs that produce measurable, quantifiable results for children and families. In addition, we note that the Administration for Children and Families is currently administering a home visiting grant program that is based on a competitive process. We therefore recommend that the Department provide grants to States on a competitive basis.

² See O'Connell ME, Boat T, Warner KE. Preventing mental, emotional, and behavioral disorders among young people: progress and possibilities. Committee on the Prevention of Mental Disorders and Substance Abuse among Children, Youth, and Young Adults: Research Advances and Promising Interventions. Washington, D.C.: The National Academies Press 2009.

³ *Patient Protection and Affordable Care Act*, Section 2951 §511(4)(C)(i)(1) amending 42 U.S.C. 701 *et seq.* (Pub. L. No.111-148, March 23, 2010).

B. Criteria for Competitive Grant Awards

In the event the Department implements the Home Visiting Program for Eligible Entities on a competitive basis, NFP recommends that, in addition to the program requirements, successful grantees should demonstrate capability in the following areas:

1. Experience with and a clear plan for the selection of local organizations with the appropriate capabilities to conduct specific home-based programs in high-need communities;
2. A clear plan for providing, or whenever available contracting with the national office/university related to the selected home visiting program models to provide, the following:
 - community education about the home visiting model and planning support for local program implementation prior to or within the eligible entity's process for distributing funds;
 - guidance for home visitor and supervisor selection;
 - home visitor and supervisor training and coaching/practice consultation;
 - practice guidelines or curricula as required by the program models selected;
 - program implementation evaluation and quality improvement support;
 - reports that ascertain progress toward benchmark areas at year 3 and year 5; and
 - assurance from the national office/university affiliated with the selected model that the Eligible Entity's plans are acceptable and will provide adequate support to local implementing agencies to enable them to achieve implementation with fidelity to the model.

If the Eligible Entity intends to provide these services and resources directly, evidence of funding for personnel who are adequately trained and sufficiently available to conduct such activities should be required; and

3. Prior experience implementing the home visitation models selected or evidence of at least six months of preparatory work for implementing the selected program model in partnership with the national office/university affiliated with that model.

IV. AGENCY COLLABORATION AND COORDINATION

NFP strongly supports collaboration between the Maternal and Child Health Bureau and the Administration for Children and Families, both of which have considerable expertise in administering programs that promote the health and well-being of at-risk and vulnerable children and families. The leadership and work of both agencies will be critical to the success of the Home Visiting Program. NFP looks forward to serving as a resource to both the Maternal and Child Health Bureau and the Administration for Children and Families as this program is implemented.

V. NEEDS ASSESSMENTS

Because the needs assessments that Eligible Entities will conduct form the cornerstone of the design of home visiting initiatives, NFP recommends that the Department encourage Eligible Entities to select program models with strong evidence of effectiveness in attaining

particular desired outcomes with relevant populations and communities targeted by their needs assessment.. Given that different home visiting program models produce different outcomes, including stronger impacts for certain populations or settings, NFP recommends that the Department encourage Eligible Entities to select program models that produce specific outcomes based on the specific needs of the communities and populations served.

NFP also recommends that Eligible Entities be given flexibility to target and concentrate implementation of home visiting programs to specific high need communities identified in their needs assessment, rather than requiring them to offer services statewide. In NFP's experience, improving public health outcomes depends on making home visiting and other public health services widely available to a particular community in need. Small scale implementations rarely result in measurable public health improvements of the kind envisioned by the Home Visiting Program. NFP also recommends that, where appropriate, the Secretary give priority to applications from Eligible Entities that seek to offer home visiting services to the majority of eligible children and families in targeted high-needs communities in order to achieve measurable improvements in their health, development, education, and well-being.

VI. DEMONSTRATING PROGRESS IN BENCHMARK AREAS

A. Critical Issues for State Evaluation Design

Integration of Existing Evaluation Systems to Increase Efficiency and Reduce Burdens on Program Staff
We urge the Department to encourage States to integrate well-developed, established home visitation program evaluation systems into their plans for ascertaining progress in benchmark areas. For home visitation programs that already support such systems nationally and locally, this kind of integration will prevent duplication of effort and substantially reduce the burden on home visitation staff of participating in evaluation efforts. Keeping program implementation efficient and cost-effective will ensure effective use of program funds and maximize each program's ability to provide services to the largest number of eligible participants.

Initial Focus on Excellent Implementation and Limited Evaluation Results from Small Sample Sizes.
Similarly, we urge the Department to recognize the challenges of determining improvements in program participants' health and functioning when program implementations are new (within their first three years of operation) and when sample sizes are small. We urge a stronger evaluation focus on achieving excellent program implementation during the first three years, with assessment of participant impact in later years when home visitors have become competent in conducting the preventive intervention. We also urge caution in interpreting results from small programs (serving 100 families or less) due to the lower likelihood of detecting changes in infrequently occurring events or due to a very small number of families with extreme positive or negative outcomes, which may skew results.

B. Specific Suggestions for Guidance to States

In order to be able to demonstrate progress, Eligible Entities must make three important determinations with respect to each benchmark area, *and for each program model selected*:

- (1) determine the benchmark indicators and baseline information that are relevant to

the communities they seek to serve;
(2) determine how they will assess progress in achieving successful program implementation and adherence to the model(s) selected in each locality; and
(3) determine how to assess progress toward outcomes in each benchmark area using these indicators and baselines.
Additional information on each is provided below.

(1) Identifying Benchmark Indicators and Baselines

NFP suggests that Eligible Entities work with national organizations of home visiting program models to establish appropriate indicators and baselines for each benchmark area to assure that they are practical in replication settings and relevant to the model.

With respect to its program model, NFP offers suggested indicators and baselines to Eligible Entities that want to implement and/or expand its program in the attached Appendix 1. These benchmarks and indicators are examples of information that NFP may provide to Eligible Entities to fulfill the requirements of this Home Visiting Program.

We recommend that Eligible Entities select baselines from public health, education, or other readily available public data sources that are relevant to the population(s) served by the selected home visiting program models.

Alternatively, for any selected indicator pertinent to a benchmark area, Eligible Entities may use as a baseline the performance targets derived from research and set by the national office or university that developed the program model. A performance target sets out the rate or level of an indicator that should be considered as a standard for acceptable program implementation or outcomes. An example from Nurse-Family Partnership is: “Completion rates for all recommended immunizations are 90% or greater by the time the child is two years of age.” Performance targets for Nurse-Family Partnership are included as the baseline for small implementations in Table 1 in the Appendix. The use of such performance targets is advised for any implementation where change cannot be reliably detected due to the relatively small number of program participants in a local or state implementation or the unavailability or inaccessibility of appropriate baseline data for the indicator. Suggested Indicators for larger scale implementations in year 3 and 5 for NFP are provided in Table 2 in the Appendix.

(2) Assessing Program Implementation and Adherence to the Model Selected

During the first, second, and third years of program implementation under the Home Visiting Program, Eligible Entities should be encouraged to monitor critical aspects of program implementation and provide quality improvement support with the aim of assuring that by the end of year three, programs are being conducted well enough to contribute to improvements in each benchmark area. No program should be expected to face evaluation of its impact before the agencies and home visitation teams have become adept at conducting the program and its implementation processes are established in the community. In NFP’s experience, this requires about three years from the time nurses are hired in a new program.

Program implementation monitoring should be specific to each model selected. Each model should articulate basic requirements for successful implementation and model adherence such as:

- completion of an implementation planning process;
- initial education in the model for home visitors and supervisors;
- use of guidelines or curriculum to assure consistent practice relevant to program participants and program goals;
- evaluation of program implementation process; and
- consultation or other means to provide ongoing professional development and quality improvement for home visitation staff and programs;

In monitoring program implementation and model adherence, Eligible Entities might examine indicators based on that model's requirements, such as:

- Completion of staff education in the model within timeframes specified by the model;
- Whether or not each program is reaching the intended population;
- Degree to which each program attains recommended caseload limits within timeframes specified by the model;
- Degree to which each program retains an appropriate proportion of participants for recommended service duration; and
- How well home visit activities are adapted to participant needs and tied to program goals.

(3) Evaluation of Outcomes at Year Three and Year Five

The nature of program outcome evaluation conducted at year three and year five should be determined in light of three factors:

- Whether the home visiting program models selected by Eligible Entities have been proven in scientifically-sound studies;
- Whether the home visiting program model is operating well in targeted areas or communities; and
- Whether the home visiting program model is being implemented at sufficient scale to detect change in selected outcomes for each benchmark area relative to the baseline or performance standard.

If the program models chosen have been tested in replicated, randomized controlled trials and successfully implemented for at least three years with at least 1,000 participants, it is reasonable to conduct propensity matching studies or other quasi-experimental designs to gauge the Eligible Entity's progress toward achieving its targeted outcomes. Such evaluations would compare program participants with comparable non-participants using administrative data from public health, education, or other objective sources. Particular attention should be given to problems with ascertainment bias for outcomes that are likely to be identified more readily as a result of home-visitors' work with families. These studies would have to be funded adequately to assure large enough sample sizes, to complete data

collection from program participants and controls, and to conduct appropriate statistical analyses.

For smaller-scale implementations of well-tested models, progress should be assessed at year three and year five based on each local program's attainment of performance targets relevant to each benchmark area as set by the national organization or university guiding national program implementation. Examination of how participants in these smaller programs are faring in contrast to comparison groups not in the program may guide decisions related to program improvement or expansion. More definitive conclusions about program impact will be compromised by small sample sizes and possible inequality of comparison groups.

Programs selected on the basis of prior quasi-experimental research could use this time to lay the foundation for the program's being tested in well-designed randomized controlled trials. The focus of these evaluations would be on participant uptake and retention, indications that the programs are achieving behavioral change thought to lead to better outcomes, and perhaps, propensity matching or other quasi-experimental designs. The goal here would be to lay the groundwork for testing these programs in well-designed randomized controlled trials.

For promising programs that have not been proven in scientifically-sound studies, formative evaluations should also focus on implementation and outcome indicators to refine the model prior to testing it in randomized controlled studies. Once the effectiveness of these promising programs is better established, they may seek to qualify for higher levels of funding under this initiative.

VII. PLANNING PERIOD

We strongly recommend that the Secretary encourage States without experience in the home visiting program(s) to use the 6 month planning period to work with the national offices or universities related to approved program models and state and community organizations to develop the infrastructure needed to implement home visitation programs. In addition, we recommend that States be given flexibility to use the 6 month planning period for one or more program models as they see fit.

VIII. TECHNICAL ASSISTANCE

The Home Visiting Program requires the Secretary to provide technical assistance to Eligible Entities. Where a program model's national office has unique experience and knowledge of the model, and the demonstrated capacity to provide necessary training and consultation to States and local entities, NFP recommends that the Department contract with that national office to provide technical assistance. Training and consultation regarding program start-up, expansion, monitoring of performance, and the planning and management of statewide or multi-site initiatives can be more effectively provided by a national office with this capacity where available rather than by a technical assistance center or contractor lacking unique experience with the specific program model's implementation planning, support services, and evaluation.

IX. EXPERT ADVISORY PANELS

We urge the Department to include a representative of Nurse-Family Partnership National Service Office (and the national office or university related to each model proposed by states) on the Secretary's advisory panel on technical assistance.

We recommend that the Department consider the following individuals to serve on the Secretary's advisory panel on research and evaluation:

- Jeanne Brooks-Gunn, Columbia University
Professor of Pediatrics
College of Physicians and Surgeons, Columbia University
Teachers College
Columbia University
New York, New York 10027
P: (212) 678-3369
Brooks-gunn@columbia.edu

- C. Hendricks Brown, University of Miami
Professor
Department of Epidemiology and Public Health
Room 1064 Clinical Research Building
1120 NW 14th Street
Miami, FL 33136
P: (305) 243-4592
c.brown10@miami.edu

- Brian Flay, Oregon State University
College of Health and Human Services
Oregon State University
254 Waldo
Corvallis, OR 97331
P: (541) 737-3837
Brian.Flay@oregonstate.edu

- Mark Greenberg, Penn State University
Edna Peterson Bennett Endowed Chair in Prevention Research
Director, Prevention Research Center
Professor of Human Development and Psychology
Prevention Research Center
Pennsylvania State University
S109 Henderson Building
University Park, PA 16802
P: (814) 863-0112
mvg47@psu.edu

- Deborah Gross, The Johns Hopkins University
 Professor, Leonard and Helen Stulman Endowed Chair in Mental Health and
 Psychiatric Nursing
 Department of Acute and Chronic Care
 Johns Hopkins University
 School of Nursing
 525 N. Wolfe St.
 Baltimore, MD 21205
 P: (410) 614-5311
Dgross17@son.jhmi.edu

- David Olds, University of Colorado Denver
 Professor of Pediatrics and Director
 Prevention Research Center for Family and Child Health
 University of Colorado at Denver and Health Sciences Center
 Mail Stop 8410
 13121 East 17th Avenue
 PO Box 6511
 Aurora, CO 80045
 P: (303) 724-2892
david.olds@ucdenver.edu

- Sharon Ramey, Georgetown University
 Director
 Susan H. Mayer Professor for Child and Family Studies
 School of Nursing and Health Studies
 Georgetown Center on Health and Education
 Georgetown University
 3700 Reservoir Road NW
 Washington, D.C. 20057-1107
 P: (202) 687-1389
Sr222@georgetown.edu

X. APPROVAL OF FOUNDING ORGANIZATION

The Home Visiting Program requires States to provide an assurance that the entity will obtain and submit documentation or other appropriate evidence from the organization or entity that developed the model used under the program to verify that the program is implemented and services are delivered according to the model specifications.

NFP recommends that the Department allow the organization or entity that developed the model to delegate their verification authority to another entity with the specific capabilities to meet this objective. In the case of NFP, the Prevention Research Center for Family and Child Health at the University of Colorado at Denver would prefer to delegate this responsibility to the Nurse-Family Partnership National Service Office. The Nurse-Family Partnership National Service Office is the non-profit organization formed to assist states and

communities with program implementation and to assure program quality and effectiveness in the program's national replication.

XI. INDIVIDUALIZED FAMILY ASSESSMENTS

The Home Visiting Program requires program models to conduct family assessments to ensure that services delivered and outcomes achieved are appropriate to the needs of the children and family. NFP recommends that program models be allowed to meet this requirement by ensuring that children and families enrolled in a particular program model meet the model's requirements and would benefit from the outcomes that the program model has been proven to achieve. For NFP, family assessments at enrollment would document that women who enroll in the program are pregnant for the first time, at less than 28 weeks' gestation, and living in poverty. The outcomes the program helps participants achieve are related to those fundamental conditions, and service delivery is adapted to enable individual participants to build necessary competencies, rather than being based on more specific and ongoing individualized needs assessments. Other home visitation program models should determine individual and family assessment and service plans that are relevant to their model's requirements.

XII. MAINTENANCE OF EFFORT

We recommend that Maintenance of Effort should be based on State general fund commitments as of the date that the Home Visiting Program was enacted into law on March 23, 2010. NFP recommends that private funding not be included as part of States' maintenance of effort.

XIII. IDENTIFICATION OF STATE APPLICANT AGENCY

We recommend flexibility in the designation of the State agency charged with implementation of the program. The State's Governor or Tribal leadership should have the option to identify the applicant entity for the State or Tribe if one agency has greater capability for the implementation and management of the program than another.

XIV. USE OF HOME VISITING PROGRAM FUNDS FOR PRIOR GRANTEES OF THE EVIDENCE-BASED HOME VISITATION GRANT PROGRAM UNDER THE ADMINISTRATION FOR CHILDREN AND FAMILIES.

NFP is supportive of the grantees of the Evidence-Based Home Visitation Program currently administered by the Administration for Children and Families. Because grant funding for this program was eliminated in anticipation of the passage of the federal Home Visiting Program, NFP recommends that the Secretary fund existing grantees for the 2010 fiscal year to avoid the closure of programs and termination of services to children and families in need. NFP recommends defunding the existing national evaluation effort and any local grantee evaluation efforts, since they are not consistent with the program and evaluation requirements of the new Home Visiting Program. For example, current evaluation efforts do not include measuring specific program outcomes against defined benchmarks using relevant indicators and baselines.

XV. EVALUATION AND CONTINUOUS RESEARCH DESIGN

The Home Visiting Program is based on the belief that in order to meaningfully improve family health, education and economic sufficiency through home visitation, we must first ensure that rigorous evidentiary standards inform the formation, testing and implementation of these services. As the Secretary develops the evaluation and continuous research design for this pioneering effort, NFP suggests adopting the framework set forth by the National Academies' Committee on the Prevention of Mental Disorders and Substance Abuse among Children, Youth, and Young Adults in its publication, "Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities."⁴ In it, the National Academies identify a research protocol for interventions with the greatest likelihood of producing public health benefits. The protocol generally calls for formative evaluations of new programs to determine whether they hold promise in achieving desired outcomes. Following formative evaluations, the protocol recommends efficacy and effectiveness randomized controlled trials to determine whether the intervention is in fact effective in producing desired outcomes. While the National Academies report acknowledges that other study designs can substitute when randomized controlled trials are not feasible, the report emphasizes the unique value of randomized trials. Finally, the protocol recommends that programs found to be effective in replicated randomized trials in community settings conduct dissemination and replication research, which the National Academies refers to as the "new frontier" of prevention science. Dissemination and implementation research primarily focuses on determining whether proven programs are capable of reliable and adaptable replication in the field.

Given that the home visitation models likely to be selected by Eligible Entities to improve the benchmark areas are in different developmental phases, NFP recommends that the national evaluation and continuous improvement research recognize and support research and evaluation activities relevant to each individual program model's stage of development. Because multiple randomized controlled trials of the NFP model have shown it to be effective in multiple benchmark areas, NFP now focuses most of its research activities on dissemination and replication to ensure that its program model can be reliably replicated nationally. For these reasons, NFP does not anticipate that the Department will require its model to undergo additional randomized controlled trials as part of the evaluation and continuous research design. Instead, NFP recommends that evaluative efforts focus on the degree to which its program model is being replicated with fidelity to its model and the extent to which its programs are achieving the outcomes documented in multiple randomized controlled trials. NFP anticipates that this new body of research will guide continuous quality efforts focused on improving the NFP model and implementation.

NFP looks forward to being a resource to and working with the Department, its Advisory Panel and others in breaking new ground in the design of rigorous research and evaluation methods for prevention intervention programs.

⁴ O'Connell ME, Boat T, Warner KE. Preventing mental, emotional, and behavioral disorders among young people: progress and possibilities. Committee on the Prevention of Mental Disorders and Substance Abuse among Children, Youth, and Young Adults: Research Advances and Promising Interventions. Washington, D.C.: The National Academies Press 2009.

CONCLUSION

NFP is grateful for your leadership in implementing this important Program. Please feel free to call upon us with any questions regarding our recommendations. In addition, should you wish to meet with our program and research staff or Dr. David Olds, we would welcome the opportunity to further discuss the operation and implementation of this Program. Please do not hesitate to contact us.

Sincerely,

Tamar Bauer
Chief Policy & Government Affairs Officer

Karen S. Howard
Director of Policy & Government Affairs

Attachments:
Appendix

Cc:
Robert Gordon
Kathy Stack
Audrey Yowell

APPENDIX

Suggested Benchmark Indicators and Baselines Measures for the Nurse-Family Partnership Programs Serving Less Than 1,000 Families

TABLE 1

Nurse-Family Partnership (NFP) offers the following types of benchmark indicators and baselines for demonstrating improvements resulting from Nurse-Family Partnership implementations serving less than 1,000 families.

Benchmark Area	Indicator(s) for Nurse-Family Partnership	Recommended Performance Target for States
Improved maternal and newborn health	<p>Reduction in the percentage of women smoking from intake to 36 weeks pregnancy</p> <p>Reduced rates of low birth weight among women who smoke cigarettes at program registration.</p> <p>Rate of subsequent pregnancies</p>	<p>20% or greater reduction from intake to 36th week of gestation</p> <p>Low birth weight rate(s) is 25% lower than the population most similar to program participants and who smoke cigarettes in the first trimester of pregnancy.</p> <p>Rate of subsequent pregnancies within two years following birth of infant is 25% or less.</p>
Prevention of child injuries, child abuse, neglect, or maltreatment, and reduction of emergency department visits	Supervisors document that home visitors have received training on recognition and reporting of suspected child maltreatment consistent with state law.	100% of supervisors report completion of training within 6 months of nurse hire.
Improvement in school readiness and achievement	Early communication development in the normal range (fewer delays); and/or early detection and referral for delays.	Percent of toddlers who fall below the normal range for their age and gender on a standardized communication development screening is 25% or less.
Reduction in crime or domestic violence	Assessment for domestic violence is included in the program's content and education on available community resources is provided by each program supervisor.	100% of nurse home visitors are prepared to utilize domestic violence assessment questions and can refer to community support services where such resources are available.

Improvements in family economic self-sufficiency	Number of months of maternal employment and maternal attendance in educational programs in the second year of the child's life for program participants who were 18 years of age or older at registration.	Mother is employed for 8 of 12 months in the child's second year of life or in educational setting. Mothers less than 18 years of age at registration will have graduated from high school, completed GED or be in school or training by child's second birthday
Improvements in the coordination and referrals for other community resources and supports	Presence of a Community Advisory Council whose objectives include development and maintenance of referral sources and linkages for program participants based on staff assessment of participant needs and preferences.	80 % of program implementing agencies have a Community Advisory Council supporting their referral system by the time programs have been in operation for 3 years.

For large state program implementations, or in a national evaluation, it should be feasible to use propensity matching techniques to compare outcomes of program participants with baseline data from public health, education, or other sources that is relevant to program participants living in a particular community. These studies in states or nationally would have to be funded adequately to assure large enough sample sizes, complete data collection from program participants, collection of relevant comparison data, and appropriate analyses.

The nature of program evaluation conducted at Year Three and Year Five should be determined in light of two factors:

1. The degree to which the models selected by eligible entities have already been found to be effective in replicated randomized controlled trials versus being promising but not fully tested.
2. The maturity and extent of implementation in each eligible entity's targeted areas or population.

If mature programs that have been fully-tested in randomized controlled trials have been implemented widely and well with at least 1,000 participants, outcome studies using these techniques should be appropriate and feasible. For newer program implementations, the results at three years should be considered preliminary and provide focus and guidance for program improvement. At five years, if studies are financed well and conducted properly, the results of such outcome studies should be informative. Should such studies be funded, the following indicators and baselines would be appropriate for Nurse Family Partnership at the 5-year mark.

A randomized trial of such programs should be conducted once the implementation system has been developed and is functioning well (after the initial 5-year period covered by this phase).

Suggested Benchmark Indicators and Baselines Measures for the Nurse-Family Partnership Programs Serving More Than 1,000 Families at Year Three and Year Five

TABLE 2

Benchmark Area	Indicator(s) for Nurse-Family Partnership	Recommended Baseline for States
Improved maternal and newborn health	<p>Reduction in prenatal tobacco use among women enrolled in Nurse-Family Partnership</p> <p>Reduced rates of low birth weight among women who smoke cigarettes at program registration</p> <p>18 month or greater interval between birth of first child and start of subsequent pregnancy.*</p> <p>*Conde-Agudelo A, Rosas-Bermudez A, Kafury-Goeta AC. Birth spacing and risk of adverse perinatal outcomes: a meta-analysis. JAMA 2006 Apr 19;295(15):1809-23.</p>	<p>Rates of prenatal tobacco use among women who are similar to those to be enrolled in the NFP in the community in which program participants reside.*</p> <p>Rates of low birth weight among women who are similar to those to be enrolled in the NFP and who smoke in the community in which program participants reside.</p> <p>Percentage of women having a subsequent pregnancy less than 18 months after birth of previous child among women who are similar to those to be served by the program.</p> <p>Rates of inter-pregnancy intervals < 18 months among women who are similar to those to be enrolled in the NFP</p> <p>*Note that birth certificates include fairly extensive data on prenatal use of substances, obstetric complications and other predictors of poor pregnancy outcomes</p>
Prevention of child injuries, child abuse, neglect, or maltreatment, and reduction of emergency department visits	<p>Fewer child deaths due to SIDS, injuries, ingestions, or other preventable causes.* †</p> <p>*Detection of effects will depend on having a large enough sample size; states may have to combine program data across sites within the state</p> <p>† We strongly advise against the use</p>	<p>Rates of child death due to SIDS, injuries, ingestions, or other preventable causes among families who are similar to those to be enrolled in the NFP in the communities served by Nurse-Family Partnership.</p>

	<p>of child welfare administrative records of either child abuse and neglect reports or founded cases of child maltreatment due to the very high probability of introducing surveillance bias with a home-based program; and because the quality and availability of those data sets is extremely variable across states and communities.</p> <p>Similarly, not all state or local programs will have reliable or ready access to program participants' medical records to directly assess emergency department visits for injuries and ingestions.</p>	
Improvement in school readiness and achievement	Early language development in the normal range (fewer delays); and/or early detection and referral for delays.	Norms relevant to the population of children to be served by the program as established for the early language development screening tool.
Reduction in crime or domestic violence	Reduction in domestic violence	Rates of domestic violence among pregnant women in the community where program participants reside, especially among families similar to those who will be served by the NFP.
Improvements in family economic self-sufficiency	Number of months of maternal employment in the second year of the child's life for program participants who were 18 years of age or older at registration, or who are participating in educational programs.	Mother employed for 8 of 12 months in the child's second year of life or are participating in educational programs.
Improvements in the coordination and referrals for other community resources and supports	Presence of a Community Advisory Council whose objectives include development and maintenance of referral sources and linkages for program participants based on staff assessment of participant needs and preferences.	80% of program implementing agencies have a Community Advisory Council supporting their referral system by the time programs have been in operation for 3 years.