House Energy and Commerce Subcommittee on Health
Questions for the Record from the Hearing on:
The Extenders Policies: What Are They and How Should They Continue Under a Permanent SGR Repeal Landscape?

Chairman Pitts Question: ACF provides technical assistance to grantees on a number of issues, but very little of that assistance includes how to encourage teens to choose abstinence or sexual risk avoidance. Please describe the technical assistance you provide on abstinence compared to other types of assistance, such as contraception.

Dr. Goldstein Answer:

ACF administers two Federal teen pregnancy prevention programs that provide formula grants to states – the Title V Abstinence Education Program, and the Personal Responsibility Education Program (PREP).

The legislation which established the Title V Abstinence Education Program did not provide funding for technical assistance activities. However, as part of routine grant administration, ACF does offer technical assistance to grantees and their sub-awardees. This assistance is frequently provided at the request of our grantees and often entails one-to-one guidance provided by ACF project officers to help grantees effectively administer their abstinence education programs.

Through these technical assistance conversations, ACF encourages Title V grantees to use evidence-based curricula that are medically accurate. Many of our grantees selected programs that HHS has identified as evidence-based, through the HHS Teen Pregnancy Prevention Evidence Review. The following three abstinence education programs have been identified by HHS as evidence-based, based on this evidence review:

1. *Heritage Keepers Abstinence Education*
   http://www.hhs.gov/ash/oah/oah-initiatives/teen_pregnancy/db/programs/heritage-keepers-v2.pdf

2. *Promoting Health Among Teens - Abstinence Only*
   http://www.hhs.gov/ash/oah/oah-initiatives/teen_pregnancy/db/programs/promoting_health.pdf

3. *Making a Difference*
   http://www.hhs.gov/ash/oah/oah-initiatives/teen_pregnancy/db/programs/making_a_difference.pdf

In addition, ACF provides information to Title V grantees through a variety of other methods, including conference trainings, webinars, and tip sheets. The following are examples of resources that are offered to Title V grantees:

- *AEGP Program Grant Administration Resource Guide*
  http://www.acf.hhs.gov/sites/default/files/fysb/sap_guidance.pdf

- *Title V State Abstinence Grantee Orientation Webinar, November 9, 2010*
  http://www.acf.hhs.gov/programs/fysb/resource/aegp-20101109

- *Abstinence Education Grant Program Medical Accuracy Guide*
  http://www.acf.hhs.gov/sites/default/files/fysb/medical_accuracy_aegp.pdf

Personal Responsibility Education Program (PREP) grantees are required by statute to emphasize both abstinence and contraception, so the technical assistance for these grantees emphasizes both. Unlike the Title V Abstinence Education Program, the PREP Program does provide funding for technical assistance activities. The following are examples of resources that are offered to PREP grantees:

- State PREP Adulthood Preparation Topics Webinar, May 4, 2011
  http://www.acf.hhs.gov/programs/fysb/resource/state-prep-adult-prep-110504

- Making the Connections: Reducing Teen Pregnancy Risk by Promoting Healthy Relationships (offered to all grantees)
  http://www.acf.hhs.gov/programs/fysb/resource/healthy-relationships-webinar-20130801

Chairman Pitts Question: The Committee published a report that analyzed abstinence or sexual risk avoidance programs; it describes over 22 peer reviewed studies that show statistically significant evidence of the positive impacts of these programs. Are you familiar with that report? Have you shared this with grantees as a part of the technical assistance?

Dr. Goldstein Answer:

HHS is familiar with the report. We encourage grantees to use evidence-based curricula that are medically accurate. Many of our grantees selected programs that HHS has identified as evidence-based, through the HHS Teen Pregnancy Prevention Evidence Review.

The evidence review was conducted in four steps, using standards that are consistent with review standards in other fields. First, multiple literature search strategies and a public call for studies were used to identify relevant studies released from 1989 through roughly January 2011. Second, all studies identified through the literature search were screened against pre-specified inclusion criteria. To be eligible for review, a study had to examine the impacts of an

intervention using quantitative data and statistical analysis and hypothesis testing. Both randomized controlled trials and quasi-experiments were eligible. A study had to measure program impacts on a least one measure of pregnancy, STIs, or associated sexual risk behaviors (sexual initiation, frequency of sexual activity, recent sexual activity, number of sexual partners, or contraceptive use). Third, studies that met the inclusion criteria were assessed by teams of two trained reviewers for the quality and execution of their research designs. Fourth, for studies that passed this quality assessment, the review team extracted and analyzed information on the research design, study sample, evaluation setting, and program impacts. Evidence-based interventions are defined as those with: (1) a high- or moderate- quality rating of the study design; and (2) a positive, statistically significant impact on one of the sexual behavior or reproductive health outcomes of interest (e.g., sexual activity, contraceptive use, sexually transmitted infections (STIs), pregnancy, or birth).

HHS shares materials with grantees about program models identified as evidence-based, based on this evidence review. The following three abstinence education programs have been identified by HHS as evidence-based:

1. *Heritage Keepers Abstinence Education*
   http://www.hhs.gov/ash/oah/oah-initiatives/teen_pregnancy/db/programs/heritage-keepers-v2.pdf

2. *Promoting Health Among Teens - Abstinence Only*
   http://www.hhs.gov/ash/oah/oah-initiatives/teen_pregnancy/db/programs/promoting_health.pdf

3. *Making a Difference*
   http://www.hhs.gov/ash/oah/oah-initiatives/teen_pregnancy/db/programs/making_a_difference.pdf

Additional Questions for the Record

The Honorable Joseph R. Pitts

1. Since the Subcommittee and ACF rely on the results of the evaluations conducted on the PREP program to make decisions about legislation and funding, it is important to understand how long these programs impact adolescent decision-making and behavior related to sexual activity over the long term. Would you provide a chart that includes the number and timing for the post tests for each of the evidence based PREP programs? For example, are the participants tested upon completion of the program or are there follow-up tests as well? If you do not do follow-up testing beyond six months, how do you measure the sustainability of the results?

Dr. Goldstein Answer:

Below we provide a chart that summarizes the evaluation findings for the 22 teen pregnancy prevention program models that: (1) met the Teen Pregnancy Prevention (TPP) Evidence Review criteria as showing evidence of effectiveness; and (2) are being implemented by PREP grantees[1]. The chart provides the findings for the longest follow-up period reported in the study. The length of follow-up in the evaluation study is conducted at the discretion of the program evaluator. At each study follow-up point, the evaluation had to demonstrate attrition rates within the acceptable range in order to meet the review criteria.

The current HHS criteria for evidence of program effectiveness have no requirement for evidence of sustained impact (for example, impacts on short-term contraceptive use versus longer-term impacts on pregnancy deterrence). It can be difficult to compare studies by follow-up period due to the length of the program. For example, findings from a three-year program with a follow-up survey at the end of the program (i.e. 36 months post-baseline) would be difficult to compare with those from a six-month program with a follow-up survey at the end of the program (i.e. 6 months post-baseline).

[1] The program models being implemented by PREP grantees – along with the number of youth expected to be served by each program model - are listed in a recent report by Mathematica Policy Research. See p. C.3 of the report, available here: http://www.acf.hhs.gov/programs/opre/resource/the-personal-responsibility-education-program-prep-launching-a

Program name	Length of Last Follow Up[2]	Behavioral Outcome Measures[3]						
		Sexual initiation or abstinence	Recent sexual activity	Number of sexual partners	Frequency of sexual activity	Contraceptive use and consistency	Sexually transmitted infections or HIV	Pregnancy or birth
Adult Identity Mentoring (Project AIM)	12 months post-intervention	Not measured	Yes	Not measured	Not measured	Not measured	Not measured	Not measured
All4You!	6 months post-baseline (4 to 5 months post-intervention)	No	Not measured	No	Yes	Yes	Not measured	Not measured
Be Proud! Be Responsible![4]	12 months post-intervention	Not measured	Not measured	Not measured	No	Yes	Not measured	Not measured
	3 months post-intervention	Not measured	Yes	Yes	Yes	Yes	Not measured	Not measured
	6 months post-intervention	Not measured	Yes	Yes	Not measured	Yes	Not measured	Not measured
Be Proud! Be Responsible! Be Protective!	12 months post-intervention	Not measured	Not measured	Yes	Not measured	No	Not measured	Not measured
Becoming a Responsible Teen (BART)	12 months post-intervention	Not measured	Yes (12 months post-intervention)	No	Not measured	Yes (6 months post-intervention)	Not measured	Not measured
¡Cuídate!	12 months post-intervention	Not measured	Yes	Yes	Not measured	Yes	Not measured	Not measured

[2] Length of last follow-up is the last follow-up period for which there are statistically significant positive findings that meet the TPP Evidence Review Criteria

[3] Yes = there was a positive, statistically significant finding on this measure; No = the outcome was measured and there was no positive, statistically significant finding; Not measured = the outcome was not measured or reported

[4] Three different studies of Be Proud! Be Responsible!, each with a separate sample and study design, meet the review criteria for demonstrating evidence of effectiveness. The results for each of the three studies are presented separately in the chart. None of the other program models have more than one study that meets the review criteria.

Program name	Length of Last Follow Up[2]	Behavioral Outcome Measures[3]						
		Sexual initiation or abstinence	Recent sexual activity	Number of sexual partners	Frequency of sexual activity	Contraceptive use and consistency	Sexually transmitted infections or HIV	Pregnancy or birth
Draw the Line/Respect the Line	At the program end (2.5 years after the baseline)	Yes	Yes	Yes	Yes	Not measured	Not measured	Not measured
FOCUS	11 months post-intervention	Not measured	Not measured	Yes	Not measured	No	Did not meet standards	Did not meet standards
HORIZONS	12 months post-intervention	Not measured	Not measured	Not measured	Not measured	Yes	Yes	Not measured
It's Your Game: Keep It Real (IYG)	12 months post-intervention	Yes	Not measured	Did not meet standards	Did not meet standards	Did not meet standards	Not measured	Not measured
Making a Difference!	3 months post-intervention	Not measured	Yes	Not measured	No	No	Not measured	Not measured
Making Proud Choices!	12 months post-intervention	Not measured	No	Not measured	No	Yes	Not measured	Not measured
Promoting Health Among Teens! Abstinence-Only Intervention	24 months post-intervention	Yes	Yes	No	Not measured	No	Not measured	Not measured
Promoting Health Among Teens! Comprehensive Abstinence and Safer Sex Intervention	24 months post-intervention	No	No	Yes	Not measured	No	Not measured	Not measured
Reducing the Risk	18 months post-intervention	No	No	Not measured	Did not meet standards	Yes	Not measured	No
Rikers Health Advocacy Program (RHAP)	10 months post-intervention	Not measured	Not measured	No	No	Yes	Not measured	Not measured

Program name	Length of Last Follow Up[2]	Behavioral Outcome Measures[3]						
		Sexual initiation or abstinence	Recent sexual activity	Number of sexual partners	Frequency of sexual activity	Contraceptive use and consistency	Sexually transmitted infections or HIV	Pregnancy or birth
Safer Choices	At the program end (1.5 years after the baseline)	No	No	No	Did not meet standards	Yes	Not measured	Not measured
Sexual Health and Adolescent Risk Prevention (SHARP)	12 months post-intervention	Not measured	Not measured	Not measured	Not measured	Yes	Not measured	Not measured
SiHLE	12 months post-intervention	Not measured	Not measured	Yes	Not measured	Yes	Yes	Yes (6 months post-intervention
Teen Health Project	12 months post-intervention	Yes	Not measured	Not measured	Not measured	Did not meet standards	Not measured	Not measured
Teen Outreach Program (TOP)	At the program end (9 months after the baseline)	No	Not measured	Not measured	Not measured	Not measured	Not measured	Yes
What Could You Do?	6 months post-intervention	Not measured	Yes (3 months post-intervention)	Not measured	Not measured	No	Yes	Not measured

The Honorable Henry A. Waxman

1. Chairman Pitts raised the topic of technical assistance (TA) provided to Administration for Children and Families (ACF) grantees during the hearing. How does ACF define TA and what types of TA activities does the agency engage in with PREP grantees?

Dr. Goldstein Answer:

ACF's PREP program defines Training and Technical Assistance as follows: "Significant planned and response-to-request training and other relevant subject matter expertise using a planning/ implementation/evaluation framework; site visits and virtual meetings (e.g., phone or video-

conference); efforts to reduce barriers to using evidence-based programs; the regular provision of technical or scientific information in user-friendly formats; and other proactive efforts to support State and Community-Based youth-serving organizations to use evidence-based approaches in their work. T&TA is provided over time and should include proactive follow-up support. T&TA will be provided to grantees through several methods, to include phone, email, written materials, and face-to-face consultation. Training will primarily be provided through webinars, annual meetings, and regional training."

ACF provides TA to PREP grantees through a variety of methods including: webinars, annual meetings, and regional trainings, phone calls, "cluster" phone calls, email, written materials, and face-to-face consultation. Online learning tools also available to assist grantees include: archived presentations, a web-based online community ("Community of Practice"), toolkits, tip sheets, and self-paced e-learning modules.

2. Chairman Pitts mentioned a July 2012 Energy and Commerce Majority Report that discusses "abstinence or sexual risk avoidance programs" and their impact. How does ACF define and make determinations regarding evidence-based programs? Do the programs cited in the July 2012 report meet ACF's evidence-based criteria?

Dr. Goldstein Answer:

The Teen Pregnancy Prevention (TPP) Evidence Review is a systematic process conducted by HHS through contract with Mathematica Policy Research and its partner, Child Trends. The purpose of the Evidence Review, and its periodic updates, is to identify program models that have demonstrated positive impacts on teen pregnancies or births, sexually transmitted infections (STIs), or associated sexual risk behaviors.

Overview of the TPP Evidence Review Methodology

The findings from the initial TPP Evidence Review were released in March 2010 and covered studies released from 1989 through roughly December 2009. A second round of review was released in April 2012 and added studies released from roughly December 2009 through January 2011. The review was conducted in four steps as outlined below. Evidence-based interventions are defined as those with: (1) a high- or moderate- quality rating of the study design; and (2) a positive, statistically significant impact on one of the sexual behavior or reproductive health outcomes of interest (e.g., sexual activity, contraceptive use, sexually transmitted infections (STIs), pregnancy, or birth).

Below we provide more information about the review process. More detailed information on the protocol used to conduct the review can be found at: http://www.hhs.gov/ash/oah/oah-initiatives/teen_pregnancy/db/eb-programs-review-v2.pdf. In addition, frequently asked questions (FAQs) about the review can be found at: http://www.hhs.gov/ash/oah/oah-initiatives/teen_pregnancy/db/db-faq.html.

Step 1: Study Identification

Studies were identified in four ways: (1) scanning the reference lists of prior systematic reviews and research syntheses (Advocates for Youth 2008; Ball and Moore 2008; Chin et al. 2012; Kim and Rector 2008; Kirby 2007; Oringanje et al. 2009; Scher et al. 2006); (2) searching the websites of relevant Federal agencies and research or policy organizations; (3) issuing a public call for studies to identify new or unpublished research; and (4) having a research librarian conduct a keyword search of electronic citation databases. For the first update to the review findings, the review team also conducted a hand search of 10 relevant research journals and scanned the conference proceedings of five professional associations. The search covered both published and unpublished studies.

Step 2: Study Screening

All studies identified through the literature search were screened against pre-specified inclusion criteria. To be eligible for review, a study had to examine the impacts of an intervention using quantitative data and statistical analysis and hypothesis testing. Both randomized controlled trials and quasi-experiments were eligible. A study had to measure program impacts on a least one measure of pregnancy, STIs, or associated sexual risk behaviors (sexual initiation, frequency of sexual activity, recent sexual activity, number of sexual partners, or contraceptive use).

Step 3: Study Quality Assessment

All studies that met the review inclusion criteria were assessed by teams of two trained reviewers for the quality and execution of their research designs. The reviewers made their assessments following a pre-specified set of standards documented in the review protocol. At the end of the assessment, each study was assigned a quality rating of *high, moderate,* or *low* according to the risk of bias in the study's impact estimates. In developing the scheme, Mathematica drew upon the evidence standards used by nine other evidence assessment projects or research and policy groups. The high study quality rating was reserved for randomized controlled trials with low rates of sample attrition, no reassignment of sample members, no systematic differences in data collection between the research groups, and at least one subject or group (school, classrooms, etc.) in both the treatment and control conditions. The moderate study quality rating was considered for studies using quasi-experimental designs and for randomized controlled trials that did not meet all the review criteria for a high quality rating. To meet the criteria for a moderate study quality rating, a study had to demonstrate equivalence of the intervention and comparison groups on race, age, and gender; report no systematic differences in data collection between the research groups; and have at least one subject or group (school, classroom, etc.) in both the intervention and comparison conditions. Studies based on samples of youth ages 14 or older also had to demonstrate equivalence of the intervention and comparison groups on at least one behavioral outcome measure.

Step 4: Assessment of Effectiveness of Interventions

All impact studies meeting the criteria for a high or moderate study quality rating are considered eligible for providing credible evidence of program impacts. Studies receiving a low rating are not subject to data collection and extraction, as the information provided in these studies is considered not to provide credible estimates of program impacts. To meet the HHS criteria, the program's supporting research study must show evidence of a positive, statistically significant impact on at least one priority outcome measure for either the full analytic sample or a subgroup defined by (1) gender, or (2) sexual experience at baseline. The priority outcome measures are sexual activity (initiation; frequency; rates of vaginal, oral and/or anal sex; number of sexual partners), contraceptive use (consistency of use or one-time use, for either condoms or another contraceptive method), STIs, and pregnancy or birth.

Review Findings

For the first two rounds of review, more than 1,900 citations were found through the literature search and call for studies. From this initial citation list, 1,438 (73 percent) did not meet the inclusion criteria listed in Step 2, above, based on a review of the study's title and abstract. Full text articles were obtained for 541 citations, and from these citations, the review team identified 452 unique studies. An additional 252 studies were found not to meet the inclusion criteria after a review of the full text, and 112 studies were dropped for failing to meet the review criteria for a high or moderate study quality rating. A total of 88 studies met the review criteria for a high or moderate rating and a total of 31 programs met the criteria for demonstrating evidence of program effectiveness in this round of review.

The table below indicates whether the programs cited in the July 2012 House Committee on Energy and Commerce report issued by Chairman Pitts met ACF's evidence-based criteria. For a list of all studies reviewed in the HHS TPP Evidence review and whether they were assessed as low, moderate, or high quality, please go to: http://www.hhs.gov/ash/oah/oah-initiatives/teen_pregnancy/db/all-studies-reviewed-v2.pdf.

Program Name	Evaluation Study Citation listed in the House Committee on Energy and Commerce Report	Reviewed in HHS TPP Evidence Review?	Study Quality	Evidence of Effectiveness
Jemmott Study of Inner City Youth	Jemmott, J. B., Jemmott L. S.,Fong G. T. (2010). Efficacy of a theory-based abstinence-only intervention over 24 months. Arch Pediatr Adolesc Med. 2010;164(2):152-159.	Yes	High Quality	Yes
Reasons of the Heart	Weed S., Ericksen I.H., Lewis A., Grant G.E., & Wibberly K.H. (2008). An abstinence program's impact on cognitive mediators and sexual initiation. American Journal Health Behavior, 32(1):60-73.	Yes	Low Quality	No
Game Plan/Aspire	Educational Evaluators, Inc. (2011) Evaluation Report of the Tesorosde Esperanza CBAE Evaluation report during 2008-09 project year. Program. -Impact Evaluation submitted to Department of Health and Human Services.	No	--	--
Choosing the Best	Weed, S.E., & Ericksen I.H., (2008) What kind of abstinence education works? Comparing outcomes of two approaches. Submitted for publication.	Yes	Low Quality	No
Heritage Keepers®: A Replication	Birch P. and Weed S. (2008). Effects of Heritage Keepers® Abstinence Education Program: A Replication. Salt Lake City: The Institute for Research & Evaluation.	No	--	--

Program Name	Evaluation Study Citation listed in the House Committee on Energy and Commerce Report	Reviewed in HHS TPP Evidence Review?	Study Quality	Evidence of Effectiveness
Choosing the Best/ STARS Georgia	Lieberman,LD,(December2010). Evaluation Report of the Choosing the Best, Inc./ STARS Georgia High School Abstinence Education Program, Submitted to HHS, ACYF under CBAE grant funding. Montclair, NJ: Montclair State University.	Under review[5]	--	--
L.I. Teen Freedom Program	Rue,L.A, Chandran,R., Pannu,A., Bruce,D., Singh,R.(2010). Estimate of Program Effects, L.I. Teen Freedom Program. Program Impact Evaluation submitted to Department of Health and Human Services.	Under review	--	--
The RIDGE Project, Inc.	Seufert, R.L. & Campbell,D.G. (2010).The RIDGE Project Evaluation 2008-2010. Program Impact Evaluation submitted to Department of Health and Human Services.	No	--	--
Earle School District	Rue, L. A., Rogers, J., Kinder, E., Bruce, D. (2009). Summative Evaluation: Abstinence Education Program Impact Evaluation submitted to Department of Health and Human Services, Grant # 90AE0219.	Yes	Low Quality	No
Arkansas Title V Funded Programs	Birch P. and Weed S. (2008). Phase V Final Report: Delivered to the Arkansas Department of Health. July 16, 2008. Salt Lake City: The Institute for Research & Evaluation.	Yes	Low Quality	No

[5] HHS is currently conducting a third round of the TPP Evidence Review and the findings are expected to be released later in 2014.

Program Name	Evaluation Study Citation listed in the House Committee on Energy and Commerce Report	Reviewed in HHS TPP Evidence Review?	Study Quality	Evidence of Effectiveness
Sex Can Wait	Denny, G., & Young, M. (2006). An evaluation of an abstinence-only sex education curriculum: An 18-month follow-up. Journal of School Health, 76 8): 414-422.	Yes	Low Quality	No
Heritage Keepers	Weed, S.E., Ericksen I.H., & Birch P.J. (2005). An evaluation of the Heritage Keepers Abstinence Education Program. Evaluating abstinence education programs: Improving implementation and assessing impact. Washington DC: DHHS, Office of Population Affairs and the Administration for Children & Families.	Yes	Low Quality	No
Best Friends	Lerner, R., (2004). Can abstinence work? An analysis of the Best Friends Program. Adolescent and Family Health, 3(4), 185-192.	Yes	Low Quality	No
Pure & Simple Lifestyle (PLS)	Wetta-Hall, R. (2010). Pure & Simple Lifestyle (PSL): Evaluation of Teen Participants of the Pure & Simple Choice Curriculum, Year Five Program Impact Evaluation submitted to HHS.	No	--	--
Not Me Not Now	Doniger, A., Adams, E., Utter, C. & Riley, J. (2001). Impact evaluation of the "Not Me, Not Now: Abstinence-oriented, adolescent pregnancy prevention communications program, Monroe County, New York. Journal of Health Communications. 6, 45-60.	Yes	Low Quality	No

Program Name	Evaluation Study Citation listed in the House Committee on Energy and Commerce Report	Reviewed in HHS TPP Evidence Review?	Study Quality	Evidence of Effectiveness
For Keeps	Borawski, E.A.,Trapl E.S., Lovegreen, L.D., Colabianchi, N., & Block T. (2005). Effectiveness of abstinence-only intervention in middle school teens. American Journal Health Behavior, 29 (5), 423-434.	Yes	Moderate Quality	No
Worth the Wait	Tanner Jr.,J.F., & Ladd, R.N. (2005). Saturation Abstinence Education: An application of social marketing In Golden A (Ed.) Evaluating Abstinence Education Programs: Improving Implementation and Assessing Impact. Washington DC: Office of Population Affairs and the Administration for Children and Families. Dept of Health and Human Services.	Similar Paper was reviewed	Low Quality	No
Abstinence By Choice	Weed, S.E. (2001, October 15). Title V abstinence education programs: Phase I interim evaluation report to Arkansas Department of Health. Salt Lake City: Institute for Research and Evaluation.	No	--	--
Stay SMART	St. Pierre, T.L., Mark, M.M., Kaltreider, D.L., & Aikin, K.J. (1995) A 27-month evaluation of sexual activity prevention program in Boys and Girls Clubs across the Nation. Family Relations. 44(1): 69-77.	Yes	Low Quality	No

Program Name	Evaluation Study Citation listed in the House Committee on Energy and Commerce Report	Reviewed in HHS TPP Evidence Review?	Study Quality	Evidence of Effectiveness
Facts	Weed, S.E. (1994). FACTS Project: Year-end evaluation report, 1993-1994. Prepared for the Office of the Adolescent Pregnancy Prevention Programs, U.S. Department of Health and Human Services.	No	--	--
Teen Aid/Sex Respect	Weed, S.E. (1992). Predicting and changing sexual activity rates: A comparison of three Title XX programs. Report submitted to OAPP, U.S. DHHS.	Yes	Low Quality	No
Teen Aid Family Life Education Project	Weed, S.E., Prigmore, J., Tenas, R. (1992). The Teen Aid FLE Project: 5th year evaluation report. Report submitted to HHS.	No	--	--

The Honorable Lois Capps

1. The Affordable Care Act established several new programs that you described in your testimonies: the Personal Responsibility Education Program; the Maternal, Infant, and Early Childhood Home Visiting Program; and the Health Workforce Demonstration Project for Low-Income Individuals. You mentioned that comprehensive evaluations of these programs are ongoing. From your testimony, even as we await results of the comprehensive evaluations, early indications are these programs have been successful. And, importantly, these programs are grounded in sound evidence. Would you please elaborate on the successes of these programs thus far and how these three programs are informed by available evidence?

Dr. Goldstein Answer:

Maternal, Infant and Early Childhood Home Visiting Program (MIECHV)

The MIECHV program is based on a large body of research on the effectiveness of home visiting for pregnant women and families with young children. Impacts have been seen across a broad range of outcomes, including maternal health, school readiness, parenting, prevention of child maltreatment, and family economic self-sufficiency. The statute requires the Secretary of

Health and Human Services (HHS) to establish criteria for evidence of effectiveness and to reserve the majority of program funding for home visiting models that meet those criteria.

Following an opportunity for public comment, in 2010 the Secretary established criteria for evidence of effectiveness of home visiting models. HHS has sponsored a thorough, transparent, systematic review of the evidence on models of home visiting, applying these criteria[6]. The review conducts an exhaustive literature search for impact studies, determines the quality of the studies based on their ability to produce unbiased impact estimates, and assesses whether the available evidence for particular home visiting models meets the HHS criteria. The project annually updates the evidence on models that have already been reviewed and considers emerging evidence on models not yet reviewed. To date, the review has examined 35 models and found 14 to have evidence of effectiveness.

The MIECHV program is being implemented on a national scale. There are three components to the program. First, funds are allocated by formula, based on child poverty rates, so that evidence-based home visiting services for high-risk families are supported in every state. Second, 19 states have received development grants through a competitive process. The development grants have helped these states build capacity in terms of workforce development, data infrastructure, and care coordination and referral systems in communities across the states. Third, 31 states have also received expansion grants which helped states build upon efforts they already had underway to expand services to more families and more communities.

States spent the first full year of the program conducting the statutorily required needs assessment to determine the eligible communities and priority populations to establish MIECHV home visiting programs and to select the visiting program models that would best meet the community needs. Families began to receive services at the end of 2011 and data from 2012 found that the program had provided more than 175,000 home visits to over 35,000 mothers and children in 544 communities across the country. These numbers account for mothers and children, but do not include other family members, including fathers, in the household who may also benefit from the home visit. Preliminary data for year 2013 indicate that the program is now serving more than 80,000 mothers and children, and the program has now expanded to 656 counties across the country, which is an increase from approximately 8 percent to 20 percent of all the counties in the United States, including 75 percent of the U.S. urban areas with a population of over a half million.

The Department has taken a number of steps to ensure MIECHV supported home visiting programs are implemented appropriately and states are making progress toward

[6] Information about the procedures and results of the review is available at http://homvee.acf.hhs.gov/

improvements in outcomes. HRSA and ACF provide ongoing technical assistance to grantees and encourage the dissemination of best practices, which accelerates collaborative learning across states. Additionally, HRSA and ACF closely monitor the states progress on the 37 outcome measures in the six MIECHV benchmark areas, such as improvements in developmental screening, parents' support of early learning and development, and reductions in emergency room visits. These data are collected on an annual basis, and by October 2014, states are expected to demonstrate improvement in at least four of the six benchmark areas.

Health Profession Opportunity Grant (HPOG) Program

The HPOG program builds on past research showing that a sectoral approach to vocational education and employment services can be effective.[7,8,9,10,11] The program uses a career pathways framework that links education, employment, and human services to help adults gain marketable skills and credentials in high-demand occupations in health care. This approach emphasizes a pathway so participants can pursue what are called stackable credentials – starting with shorter training programs that provide entry-level qualifications, and continuing along a path to gain more qualifications and advance to better jobs.

ACF has awarded five-year funding to 32 grantees in 23 states to carry out this program. Five of the grantees are tribal organizations. Grantees are post-secondary educational institutions; workforce investment boards (WIBs), state and local government agencies, and Community-Based organizations. Grantees have established partnerships with state and local WIBs, state and local TANF agencies and Federal and state offices of apprenticeship, among other partners.

As of December 2013, approximately 25,800 participants have enrolled in HPOG programs. Of the more than 12,000 participants who have completed an occupational or vocational training program, more than 10,000 participants have become employed since the program began. Among those who became employed, their average wage is $12.37 per hour.

The most common training among participants is preparation to become a nursing assistant, aide, orderly, or patient care attendant, generally short training courses that can be the first step in a longer career pathway. Other common trainings included instruction to be a licensed

[7] Bragg, D., Harmon, T., Kirby, C., & Kim, S. (2010, August). Bridge programs in Illinois: Summaries, outcomes, and cross-site findings. Champaign, IL: Office of Community College Research and Leadership, University of Illinois.

[8] Helmer, M., & Blair, A. (2011, February). Courses to employment: Initial education and employment outcomes findings for students enrolled in Carreras en Salud Healthcare Career Training 2005–2009. Washington, DC: The Aspen Institute. Retrieved from http://www.aspenwsi.org/WSIwork-HigherEdpubs.asp

[9] Barnett, E., Bork, R., Mayer, A., Pretlow, J., Wathington, H., & Weiss, M. (2012). Bridging the gap: An impact study of eight developmental summer bridge programs in Texas. New York, NY: National Center for Postsecondary Research.

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or vocational nurse, registered nurse, and medical assistant. HPOG participants also engaged in pre-training college study skills and basic skills education classes. Grantees provide a variety of support services including case management and counseling services; financial assistance for tuition, books, and fees; and social service supports, including assistance with transportation, child care and emergency assistance. Grantees also provide employment assistance in the form of job search workshops, career coaches, and placement and retention assistance.

More detailed information can be found on ACF's webpage. ACF is using a multi-pronged research and evaluation strategy to assess the success of the HPOG program. These research and evaluation activities examine outcomes and impacts for participants as well as program implementation and systems change resulting from HPOG programs. Reports published to date include:

- A report on HPOG implementation and outcomes after the first year (http://www.acf.hhs.gov/sites/default/files/opre/opre_report.pdf)
- The HPOG Year Two Annual Report (http://www.acf.hhs.gov/sites/default/files/opre/hpog_second_annual_report.pdf)
- Two briefs focusing on the Tribal HPOG Grantee programs and evaluation (http://www.acf.hhs.gov/sites/default/files/opre/tribal_health.pdf and http://www.acf.hhs.gov/sites/default/files/opre/hpog_practice_brief_supportive_services_june_2013_0.pdf).
- Two documents that the program office has produced: a compendium of success stories and of promising practices current HPOG grantees are using. (http://hpogcommunity.acf.hhs.gov/Resource%20Library/HPOG_SuccessStories_2013.pdf and http://hpogcommunity.acf.hhs.gov/Resource%20Library/HPOG_PromisingPractices2013.pdf)

The year three annual report and two interim outcomes reports (one focused on the tribal grantees and one on the non-tribal TANF and low Income grantees) will be issued in the spring of 2014.

Personal Responsibility Education Program (PREP)

The majority of funds in the PREP program are reserved by statute for services that replicate evidence-based models, or substantially incorporate elements of models found to be effective on the basis of rigorous scientific research. In addition, programs must be medically accurate and complete.

Beginning in 2010, HHS has sponsored a transparent, systematic review[12] of the teen pregnancy prevention evidence base, in order to independently identify teen pregnancy prevention programs with evidence of impacts on teen pregnancies or births, sexually transmitted infections, or associated sexual risk behaviors. The review identified, assessed, and rated the rigor of program impact studies and described the strength of evidence supporting different program models. Based on this review, HHS identified evidence-based programs, defined as those with: (1) studies with designs that have the best chance of finding unbiased impact estimates; and (2) a positive, statistically significant impact on sexual activity, contraceptive use, sexually transmitted infections, pregnancies, or births. So far 31 different program models have met the review criteria for evidence of program effectiveness. Most youth served through PREP formula funding (93 percent) will participate in one of these evidence-based programs. ACF released a report last fall on how states are scaling up these evidence-based programs. The report also highlights how some states are reaching their target populations.[13]

The report shows that the reach of the program is quite broad. States plan to serve a total of 300,000 youth through formula grant funding over the course of the five-year grant period. These youth are being reached through over 300 different program providers operating in over 1,300 different sites across the country. In addition, most state grantees are focusing on high-risk youth. Three-fourths of state program providers operate in high-need geographic areas. Finally, the report finds that state PREP grantees are creating an infrastructure to support successful replications of evidence-based programs through training, technical assistance, and monitoring.

On a Federal level, ACF/HHS is supporting grantees to successfully replicate the evidence-based programs through training, technical assistance, and monitoring. The agency has developed a range of resources, including webinars and online toolkits, to encourage grantees to draw on the best available research findings to inform the administration of their programs.

[12] Information about the review procedures and results is available at http://www.hhs.gov/ash/oah/oah-initiatives/teen_pregnancy/db/

[13] The report is available at http://www.acf.hhs.gov/programs/opre/resource/the-personal-responsibility-education-program-prep-launching-a