Synthesis of Stakeholder Feedback Regarding MIECHV Statutory Changes for the Assessment of Awardee Improvement in Benchmark Areas

Kerensa Nagle, Lauren Supplee, & Jessica Goldberg

Introduction

As a part of the reauthorization of the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program, the Bipartisan Budget Act of 2018[1] (BBA) introduced several new requirements related to needs assessments, demonstrating improvement in benchmark areas, pay for outcomes initiatives, and data exchange standards. This report focuses on the changes related to demonstrating improvement in benchmark areas.

In the original 2010 authorizing statute, awardees were required to demonstrate improvement on four of six MIECHV benchmark areas[2] within three years of their award. In 2016, HRSA revised the performance reporting requirements. Since this update, the assessment of improvement has only occurred once. One change the BBA introduced is the requirement that awardees conduct regular and ongoing assessments to ensure that they are demonstrating improvement in four of the six MIECHV benchmark areas every three years. (Similar to the original statutory requirement, if awardees cannot demonstrate improvement in four of the six benchmark areas, they must develop and implement a corrective action plan to improve home visiting outcomes.) Second, the statute requires awardees to report information on the benchmark areas that the home visiting model(s) they implement were intended to improve. Third, the statute added language about the use of comparison data in the context of a corrective action plan. The Health Resources and Services Administration (HRSA) is seeking to develop guidance operationalizing these new requirements for the MIECHV Program awards to states and territories. Specifically, HRSA seeks to develop the following:

- A method for assessing improvement using the revised MIECHV performance measurement system
- A method to determine alignment between models and the benchmarks they were intended to improve
- Guidance for developing and monitoring corrective action plans

To guide the operationalization of assessing improvement in four of the six benchmark areas and aligning models with the benchmark areas, HRSA, in partnership with the Administration for Children and Families (ACF), conducted two meetings with stakeholders and experts in the home visiting field: 1) a listening session at the MIECHV All Grantee Meeting (AGM), and 2) a stakeholder and expert roundtable. Each meeting is briefly described below.

Listening session at MIECHV All Grantee Meeting

On February 26, 2019, as a part of the MIECHV AGM, HRSA and ACF conducted the *Statutory Change: Assessment of Awardee Improvement in Benchmarks* listening session. The session was held to present HRSA's preliminary thinking on methods to assess improvement and give awardees an opportunity to share their

HRSA Maternal & Child Health

feedback on the challenges and opportunities of the proposed approach. The approximately 200 attendees, who included researchers, state administrators, program providers, and HRSA staff, were presented with HRSA's proposed definition of improvement, which is shown below. Note that this draft definition is provided only as context for the listening session discussion; it does not represent HRSA's official guidance or the direction of future guidance.

Proposed definition of improvement

- **Measure-level improvement:** At the measure level, awardees must demonstrate any change in the intended direction of the measure between the baseline and comparison period *or* must meet a minimum performance threshold that would be defined and communicated in advance and may be different for each measure.
- **Improvement in benchmark areas:** At the benchmark level, awardees must demonstrate improvement in 50 percent or more of the measures in a benchmark area. The baseline would be fiscal year (FY) 2018, and the comparison would be FY 2020.

Attendees were asked a series of questions to elicit feedback about the HRSA proposed definition of improvement; these questions covered topics including weighting of measures, issues related to performance indicators and systems outcomes, and benchmark domains with few measures. Participants also shared feedback about how they use the benchmark data in addition to assessing improvement, and whether they prioritized some measures over others. Both large-group discussion and facilitated written comments were used to gather attendees' feedback.

Stakeholder and expert roundtable

HRSA and ACF convened a full-day roundtable of home visiting researchers, home visiting model representatives, and MIECHV awardees on April 24, 2019. Federal staff were invited to observe the roundtable. In the period between the AGM listening session and the roundtable, HRSA revised and expanded on their proposed definition to reflect comments made at the listening session, and to provide more specific points for roundtable attendees to respond to. The revised definition is as follows, with the changes/additions from the AGM that were applied to the roundtable version shown in italics. Like the proposed definition presented at the listening session, this draft definition of improvement is provided only as context for the roundtable discussion, and does not represent HRSA's official guidance.

Revised definition of improvement

- **Measure-level improvement:** To meet measure-level improvement criteria, awardees may demonstrate change in the intended direction between the baseline period of the *preceding two fiscal years* and the *current comparison fiscal year* OR *by meeting or exceeding an established threshold (a computed mean across all awardees for the preceding two reporting years*).
- **Improvement in benchmark areas:** To demonstrate improvement in a benchmark area, awardees must meet measure-level improvement criteria in at least 50 percent of the measures in that benchmark area. *If there is only one measure in the benchmark, the awardee must meet measure-level improvement criteria for that measure.*
- **Reconciliation phase:** *Awardees who do not demonstrate improvement in at least four of the six benchmark areas will move on to a reconciliation phase that will be used to determine if a corrective action plan is needed.*

The goals of the roundtable were to elicit feedback on the above proposal, and to discuss alignment between the home visiting models and the benchmarks they were intended to improve. Participants engaged in large-group discussions, breakout discussions organized by role (i.e., state or local implementing agency, model, or researcher), and mixed-role breakout discussions to elicit a range of feedback. The names of the roundtable attendees are included in Appendix A.

Synthesis

Feedback from the listening session and roundtable is synthesized below. While this brief incorporates feedback from both meetings, most is drawn from the roundtable, where attendees responded to HRSA's most recent thinking on the definition of improvement. The synthesis is presented in three sections: 1) definition of improvement, 2) alignment between the MIECHV benchmark areas and the home visiting models, and 3) recommendations for HRSA.

Participants in the listening session and roundtable provided varied feedback on HRSA's proposal. Although they agreed on some topics, participants in both meetings represented diverse experiences within the home visiting field that sometimes generated conflicting feedback. The synthesis below presents these multiple viewpoints, highlighting the complex issues HRSA is tackling as they operationalize the new requirements.

Definition of improvement

Several key themes emerged during the discussions of how best to measure benchmark improvement. These themes are presented below, organized as feedback about 1) improvement in benchmark areas, 2) measure-level improvement, and 3) the reconciliation phase. For each of these three areas we offer a synthesis of proposed solutions.

A. Benchmark improvement: For accountability or learning opportunity

Attendees of both the listening session and the roundtable confirmed that performance measurement serves multiple purposes for multiple stakeholders: These include accountability to HRSA, accountability to state legislatures and other funding sources, and learning/continuous quality improvement (CQI) opportunities for awardees and local implementing agencies (LIAs). These multiple purposes create an inherent tension between the view that performance measurement is a high-stakes set of obstacles that programs must overcome to continue receiving funding, and the view that it is an opportunity to learn and improve. Throughout both sessions, attendees articulated a definition of improvement that tried to balance both perspectives.

Discussions about benchmark improvement focused on the distribution of measures across benchmark domains, the differences between performance indicators and systems outcomes, and the potential unintended consequences of the proposed definition, as summarized below.

1. Uneven distribution of measures across benchmark domains

- **Problems of de facto weighting.** Participants in the roundtable noted that, under the working benchmark definition of improvement, benchmark areas with fewer measures (such as Crime or Domestic Violence, which only has one measure) are more heavily weighted than benchmark areas with more measures. While participants felt weighting systems may be appropriate in other areas of the definition of improvement, they felt that weighting by number of measures within a benchmark does not accurately reflect the value of each benchmark area. For example, one participant shared that home visiting can have large impacts on the School Readiness and Achievement benchmark area, but because it has four measures, the working definition unintentionally places less weight on measures within that benchmark area.
- **Pros and cons of proactive weighting.** One option to counter the de facto weighting is for awardees to instead show improvement in one measure within a benchmark area. Although this definition of benchmark approval may be easier for awardees to meet, one participant noted that this definition allows awardees to choose "the lowest hanging fruit," which may be a less compelling standard for policymakers. This option would not support the goal of using the measures as a learning opportunity.

2. Performance indicators versus systems outcome measures

Currently the benchmarks include measures designated as performance indicators and systems outcomes. According to HRSA, "performance indicators are relatively proximal to the home visiting intervention or shown to be sensitive to home visiting alone. Systems outcome measures are more distal to the home visiting intervention and/or are less sensitive to change due to home visiting alone due to many factors, including confounding influences or differences in available system infrastructure at the state- or community-level."[2] Awardees shared feedback on how they view the performance indicators versus systems outcome measures when measuring improvement within their communities.

- **Systems measures and level of a program's control.** Participants in both meetings expressed that they did not want to be held accountable for demonstrating improvement within measures that are out of awardees' control. Listening session participants suggested that awardees have less control over systems outcomes versus performance indicators. Some participants suggested that awardees should only be responsible for demonstrating improvement in performance indicators, and that performance indicators should be weighted over systems outcomes. Others noted that one of the goals of MIECHV is early childhood systems change, and so it was still important to measure the outcomes, even if they are more distal from local home visiting programs' control.
- **Systems/performance distinctions that are ambiguous for awardees and may vary from state to state.** Awardees shared that the distinction between performance indicators and systems outcomes may not be as clear within specific communities. For example, continuity of health insurance is considered a systems measure. In a state with near-universal health insurance, however, health insurance could act as a performance measure because of the active role that home visitors are able to play in making sure participants stay enrolled. The distinction between the two groups of measures is only relevant should the two categories be weighted differently in the final assessment.

3. Unintended consequences

In both the listening session and the roundtable meeting, participants shared various unintended consequences that could result from the new definition of improvement. Across discussions, participants were most concerned that changes made to the MIECHV definition of improvement may discourage positive practices that risk awardees' not meeting the definitions of improvement. Specific examples provided in the listening session and roundtable include the following:

- **Disincentive to take program risks.** Programs may be discouraged from expanding to new communities that would benefit from home visiting because serving new communities may put awardees at risk for not demonstrating improvement within the year of expansion, and in subsequent years, as the program builds infrastructure and trust within the community.
- **Disincentive to enroll high-need participants.** Programs may be discouraged from enrolling higher-risk families or encouraged to shift enrollment to lower-risk families that would be more likely to meet improvement requirements.
- **Disincentive to improve data documentation and reporting.** Programs may be discouraged from improving their data systems to reduce missing data. Participants disagreed on how reducing missing data would affect the reported numbers. While some awardees who worked to improve their data quality noted that they demonstrated improvement in their benchmarks, other awardees shared that their efforts to improve data quality resulted in the measures' not appearing to show improvement.

4. Solutions

- **Importance of providing context.** One overarching solution that attendees recommended was having the ability to contextualize data prior to determining the need for a corrective action plan during the reconciliation phase, as is currently proposed. Participants in both meetings suggested that qualitative data should be incorporated into the regular reporting process by providing awardees with the ability to

annotate their data. Incorporating qualitative data into regular reporting will help awardees develop their home visiting story and provide the ability to accurately capture the complete story of home visiting programs over long periods of time.

- **Selective measurement by LIA.** Participants in the roundtable suggested that, instead of awardees demonstrating improvement across their population, they could show improvement within specific LIAs selected on the basis on their ability to innovate and support technical assistance (TA) and CQI processes. These LIAs could be used as pilot sites to guide future improvement across the awardee's population. The discussion raised a concern that awardees would need to allocate funding to do this, and thus this proposal may be less feasible for awardees with more limited funding and resources.

B. Measurement-level improvement: Concerns about proposed comparisons

Attendees expressed several concerns about their ability to demonstrate measure-level improvement using the definition of improvement HRSA proposed at the listening session and roundtable.

1. Insufficient baseline period

Participants from both meetings expressed concern that the two-year time period for the baseline measurement was insufficient. They shared that two years is not enough time to demonstrate a trend and would not be able to account for changes in outcomes caused by events outside of an awardee's control within a specific reporting year. This could include decisions made by a state's legislation over which awardees do not have control.

2. Threshold option privileges better-resourced states

Participants in the roundtable felt that it would be inappropriate to set a single threshold for all awardees, since a single threshold that does not account for differences among awardees would dramatically affect their ability to meet the threshold. Awardees with more resources could consistently meet the set threshold and raise the mean, while low-resource awardees could have more difficulty meeting it. Participants noted the significant differences in population, geographic layout, economic resources, and infrastructure among tribes, territories, and states.[a] Specifically, they noted concerns over holding tribes and territories accountable for state standards if the definition of improvement sets a single threshold. The discussion raised the need to potentially have different thresholds for certain awardees, such as territories.

3. Confusion about different measure-level criteria

Although roundtable participants appreciated being provided with multiple options to demonstrate measure-level improvement, they predicted that it could be confusing for awardees to report on measures within and across benchmarks using two separate measure-level improvement criteria.

4. Solutions

- **More flexibility in baseline measurement.** To address the concern about an insufficient baseline, listening session participants suggested using rolling comparisons within the three-year baseline and comparison period instead of the set baseline/comparison method. However, due to the recent changes to the MIECHV benchmarks, awardees will not have enough data to use three-year rolling comparisons for the first assessment in FY 2020. Roundtable participants suggested that as time goes on, HRSA should add years to the baseline measurement instead of choosing the two most recent years. To support this suggestion, one participant noted that it takes seven datapoints to develop a trend.

---

[a] While some of the discussion included the tribal awardees, the discussion at the listening sessions focused on the state and territory awardees.

Allowing the baseline period to grow would reduce the sensitivity of yearly means and more accurately demonstrate whether program outcomes are not improving or the awardee was experiencing a noisy year[b].

In the awardee breakout group, a tribal awardee shared that, due to the 2016 changes to the MIECHV benchmarks, the awardee will not have two years of data on the new benchmarks and measures to be used for baseline data for FY 2020. This awardee estimated that they will have about 15 months of data. Tribal awardees were not able to begin data collection based on the updated measures on the same timeline as states and territories were able to. The tribal awardee worried about meeting improvement standards compared to a reduced baseline period.

- **Thresholds relative to similar awardees.** To address the concern of having one threshold across states and territories, attendees discussed the possibility of using a system that takes into account where awardees fall relative to other similar awardees, perhaps by assigning thresholds to groups of awardees based on quintiles or region, for example.

C. Reconciliation phase

Discussion about the reconciliation phase was based on the assumption that this process would be used prior to awardees' being place on a corrective action plan. Participants appreciated that the reconciliation phase could offer the opportunity to engage with HRSA instead of immediately going onto a corrective action plan. Attendees emphasized that they would like to experience reconciliation as positive learning opportunity, instead of a punitive formality before being placed on a corrective action plan.

Participants also noted that the reconciliation phase should be used as an opportunity for awardees to provide context to their quantitative data. Although quantitative data serves as the main criterion for defining improvement, it excludes important information that contributes to the awardee's story and the national story of home visiting. Context or qualitative data could provide some explanation for why awardees might not meet improvement standards. Examples covered within various roundtable discussions include:

- Awardees are experiencing changes outside of their control, such as statewide policy changes.
- Awardees are working to engage new communities.
- Awardees are focusing CQI efforts on a specific measure or benchmark area. Lack of improvement within a measure may be a result of an awardee's improved measurement instead of a reduction in positive outcomes. One awardee provided an example of their CQI work to improve safe sleep outcomes. Based on their quantitative data, the awardee saw a reduction in safe sleep outcomes; however, this reduction actually captured differences between home visitor and family definitions of soft bedding before and after their CQI effort.

Most participant feedback on the importance of context was shared in relation to the reconciliation phase; however, as noted above, the ability to contextualize data was emphasized throughout all of the feedback.

Alignment of benchmarks and models

While the listening session only focused on the development of a method to assess improvement, the roundtable also elicited feedback on the new legislative language specifying that awardees are only required to report information on the benchmark areas that the home visiting model(s) they implement were intended to improve.

[b] Participants referred to years during which uncontrollable events caused changes in their data as "noisy years."

To operationalize this new requirement, the roundtable facilitators proposed two methods of alignment, and participants identified various pros and cons of both methods.

- **Method 1**: Align models with benchmarks based on the outcomes the models are *intended to improve*. For the purpose of this meeting, model developers' logic models were used.
- **Method 2**: Align models with benchmarks based on *available evidence* of what the models are improving. For the purpose of this meeting, ACF's Home Visiting Evidence of Effectiveness review (HomVEE)[c] for each model was used.

A. Feedback on Method 1: Intent to improve

Participants noted that models are designed based on the outcomes they are intended to improve, which would suggest that aligning measurement more precisely with model-specific outcomes is a good option. One option presented for determining the outcomes the model is intended to improve was the model's logic model. However, attendees raised two concerns related to this proposal.

1. Logic models are not consistent in level of specificity or relevancy.

Logic models may face some challenges as guides for specifying the outcomes the model is intended to improve. Roundtable participants pointed out that logic models are not designed to provide this level of guidance; as such, logic models vary greatly in their specificity across models, making it difficult to use them as a method of alignment across the various models. Furthermore, none of the home visiting models were designed based on the MIECHV benchmark areas and measures, so additional work is needed to map models onto the MIECHV benchmark areas.

Additionally, participants noted that logic models change over time, and that the current logic models may not have been updated recently; therefore, they may not reflect the model's current service delivery. In fact, at the time of the roundtable, some models were in the process of updating their logic models. When representatives from models were asked how central logic models are to a model's work, they noted that logic models are not being used to guide a model's services on a daily basis.

2. Benchmarks may have evidence within a domain that is not captured by the current measure(s).

For a model to be considered aligned with a MIECHV benchmark, it must demonstrate improvement for the specific measures within that benchmark. However, these measures do not fully capture all outcomes within the topic areas the MIECHV benchmarks represent. A model may work to improve outcomes within benchmark areas that are not represented by any of the MIECHV measures. For example, a model may work to help families access welfare benefits, such as Temporary Assistance to Needy Families. These supports would fit under the topic area of Family Economic Self-Sufficiency, but the Family Economic Self-Sufficiency MIECHV benchmark area does not include a measure related to accessing welfare benefits.

B. Feedback on Method 2: Evidence base

Participants also explored the option to align MIECHV benchmarks with models based on evidence of what the models are improving. HomVEE has already compiled and reviewed much of the home visiting research literature by model. Therefore, HomVEE could be used to determine the model's intended outcomes. Participants noted three concerns about using this method to map benchmark alignment across models:

[c] https://homvee.acf.hhs.gov/

1. Some models have a larger evidence base than others.

Some newer models have not had enough time to develop large evidence bases and may not have had as many chances as older models to test their effects on some outcomes. The chances that the model will find effects in different benchmark areas increases as researchers conduct more studies on the model.

2. Models change over time.

Some older evidence available on HomVEE may not apply to the current version of a model because the model (and implementation context) has changed over time. HomVEE collects research on models going as far back as 1979.[3] While not all models have been in existence since 1979, all models have changed over time, and research that dates from 10 to 30 years ago, or earlier, may not have much relevance for the current versions of models.

3. Should evidence from a specific subgroup be used inform alignment?

Participants considered how to address effects that have only been observed within a specific subpopulation. They wondered whether evidence from subpopulations should be used to map model and benchmark alignment across populations. In addition, participants discussed whether evidence from only a subpopulation should be applied to the population served by that model as a whole.

C. General feedback on alignment of benchmarks and models

Attendees had several concerns related to the general idea of aligning measures and benchmarks.

1. Awardees implementing only one model may have limited measures on which to demonstrate improvement.

Fifteen awardees currently use a single model across their communities, which may cause problems for these awardees when they are required to report performance measures only for those benchmarks that align with their chosen model. Depending on the implemented model, awardees using one model may be more likely to cover four or fewer benchmarks, which puts them at a disadvantage compared to awardees that use multiple models to cover five or six benchmarks. Awardees using a model that covers four benchmark areas would have to show improvement in all four benchmark areas their selected model was intended to improve. Awardees using a model that covers fewer than four benchmark areas may face significant difficulties in demonstrating improvement. Awardees may have to add another model, or replace their current model if it does not align with four or more benchmark areas. A participant noted that it takes two to three years to implement and stabilize a new model, which would make it impossible for awardees to report data from the new model according to the established reporting schedule (i.e., awardees must submit their home visiting data within 30 days following the end of FY 2020).

2. Both logic models and research are moving targets.

Participants described logic models and evidence bases as “moving targets,” noting that both may change frequently to reflect updates within the model and within the home visiting field. Although these updates are necessary for models to remain relevant and responsive to family needs, reporting systems based on moving targets require a level of mutability that may not be feasible, or may cause additional stress to awardees in the data collection and reporting processes. Strategies to manage the effect of model changes on awardee data reporting must be incorporated into the operationalization of alignment.

3. Aligning models with benchmarks may have unintended consequences.

Similar to their feedback on the definition of improvement, roundtable attendees noted potential unintended consequences of the effort to align models with the MIECHV benchmarks. Participants raised the following concerns:

- **Alignment between models and benchmarks provides an opportunity to more clearly differentiate between models but may be challenging to implement.** The model developers noted that models are meant to complement each other. Participants noted changes that the models have already made over the last 10 years to address all of the MIECHV benchmarks and measures. The statutory language was described as an opportunity for models to focus their efforts on the benchmarks and measures they aimed to improve. However, the current proposal requires awardees to collect and report on all benchmark areas and measures and only take into account model differentiation in the reconciliation phase. One attendee felt that the proposed system did not leverage the opportunity to align MIECHV with precision home visiting, which calls for more model specificity. Implementing differential data collection by model would be challenging for these reasons:
  - **Awardees have built state systems around consistent data collection across models.** For many states with more than one model, expecting consistency of benchmark measurement across LIAs and models has been a way to create cohesion among disparate models. There was some concern expressed that tailoring benchmarks to models may not only have a negative impact on cohesiveness of state home visiting systems, but may also herald a return to the competitiveness between models that marked the years preceding MIECHV.
  - **Awardees will likely require sites to collect and report on all benchmarks.** Participants noted that in previous conversations with awardees, many awardees shared that they do not intend to change their data collection practices, and they intend to continue collecting data on all MIECHV measures from all families and LIAs. Awardees felt that changing the data collection system would be unnecessarily complicated and place an additional burden on LIAs that already spend significant time doing paperwork and entering data. Additionally, awardees receive funding from multiple sources with different reporting standards. Making changes in their system to accommodate changes to MIECHV reporting when they are also responsible for reporting to other funders would be counterproductive for awardees. Ideally, funding sources would require the same reporting practices, using the same home visiting outcomes or measures, that also reflect what is important to the awardees and their communities. However, this streamlined system does not exist and awardees must work within their programs to simplify their reporting systems.
- **Awardees may select models to meet benchmark improvement standards rather than to address population needs.** If data reporting were different across models, awardees might select models that allow them to assess improvement in areas where they can easily demonstrate improvement, instead of selecting models based on best fit with their communities' needs.

4. Solutions

Instead of using logic models, some participants suggested that models could identify the MIECHV measures they are intended to improve. Participants noted that HRSA would need to develop a framework for model selection of intended MIECHV measures. In response to this proposal, some model developers noted that they would be hesitant to name specific measures over others. One participant suggested that, instead of selecting measures in an either/or framework, models could select primary and secondary measures to allow for additional flexibility.

Participants noted that both methods of identifying outcomes—using logic models and using HomVEE evidence—have strengths and weaknesses. They felt that a combination of both methods would be a more effective method of alignment. Defining the alignment between models and the MIECHV benchmarks, using one specific methodology increases the potential for unintended consequences and ignores the benefits and drawbacks of both methods.

Recommendations

Some key themes emerged throughout the total body of participant feedback:

- **Importance of context.** Every awardee has a unique set of circumstances and would value having the ability to provide context to their data. This was one of the strongest themes over the two listening sessions.
- **Support for individualized situations.** Awardees expressed that the adopted process should not inadvertently influence model selection, such that the implemented model no longer supports family and community needs. Awardees also wanted the ability to add new communities or try new innovations or models. There was a clear theme that awardees wanted the process of assessing improvement to support these efforts without causing fear that the awardee would be placed on a corrective action plan.
- **Fairness.** Across several topics, awardees' feedback reflected an underlying theme of fairness. This emerged with respect to awardees' concerns about what they would be compared to in the definition of improvement. The theme of fairness also emerged in discussions about the models and the issue of ensuring that all of the evidenced-based models were treated the same with regard to benchmarks.

Overall, participants reflected that change is difficult and expensive to implement. They appreciated that the proposal did not include changes to the current benchmark system but would like the ability to add context to their quantitative data.

---

[1] Bipartisan Budget Act of 2018, Pub. L. No 115-123, 138 Stat. 228 (2018).

[2] HRSA: Maternal & Child Health (2016). MIECHV performance indicators and systems outcomes. Washington, DC: Author. Retrieved from: https://mchb.hrsa.gov/sites/default/files/mchb/MaternalChildHealthInitiatives/HomeVisiting/Federal_Home_Visiting_Program_Performance_Indicators_and_Systems_Outcomes_Summary.pdf

[3] Home Visiting Evidence of Effectiveness (n.d.). Review process: Screening studies. Retrieved from https://homvee.acf.hhs.gov/Review-Process/4/Screening-Studies/19/3