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Briefing Report to the Ranking Minority Member, Select Committee on Children, Youth, and Families, House of Representatives

August 1988

CHILDREN'S PROGRAMS

A Comparative Evaluation Framework and Five Illustrations

Released

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The Honorable Dan Coats, Ranking Minority Member
Select Committee on Children, Youth, and Families
House of Representatives

Dear Mr. Coats:

As you know, judging fairly the value of a program can be fraught with pitfalls. One is that both advocates and adversaries can attempt to draw exclusive attention to relatively unimportant aspects the program does well or poorly. Another is that the areas where information is lacking may not be distinguished clearly from areas where the information is quite clear that the program is or is not working well. Further, alternatives may not be considered at all as decisions are made whether to allocate more, the same, or fewer resources to a program.

Objectives, Scope, and Methodology

Our work, which was undertaken in response to your request, addresses the pitfall of not adequately examining a broad range of criteria on which a program's value should properly be based. To respond to your request, we developed an evaluation framework, one that we believe could be applied to all or most of the very diverse programs of interest to the Committee.

We developed the framework from a review of literature on program evaluation methods and their use, our own experience in evaluating federal programs, and consideration of the types of information required to make a variety of program decisions. This general framework would, of course, have to be particularized. That is, the specific details that would differentiate expectations for the Head Start program from those for the Special Supplemental Food Program for Women, Infants, and Children (WIC), for example, would have to be spelled out for each criterion. To test the applicability of our framework, and also to illustrate what it would look like when particularized, we applied it to five federal programs. We present the results of this application in this report. Our next step, to be reported later, will be to examine the research and evaluation evidence appropriate to the criteria for one program, providing the "bottom line" in terms of the criteria and the framework.

The Framework

The framework consists of two components: descriptive and evaluative. The first component is a standard format for describing (1) the problem

the program is designed to address, (2) the program's purpose and goals, (3) program operations, (4) the administrative structure, (5) the program's relationships with other programs, and (6) recent funding and participation levels. The second component is a set of 10 general criteria to assess the need for the program (problem magnitude, problem seriousness, and duplication), implementation of the program (interrelationships, program fidelity, and administrative efficiency), and effects of the program (targeting success, achievement of intended objectives, cost-effectiveness, and other effects). The framework is intended as a way to formulate questions about a program and organize evidence on it. These questions could address decisions about whether to terminate, reduce, expand, or modify an existing program or to initiate a new one.

To illustrate the use of the framework, we prepared brief program descriptions and lists of indicators of the evaluation criteria for five specific federal programs selected after consultation with your staff. These programs are Head Start, the Special Supplemental Food Program for Women, Infants, and Children, the extension of Medicaid eligibility to children and pregnant women, Child Welfare Services, and the Juvenile Justice and Delinquency Prevention grants. The lists of program-specific evaluative criteria are intended to demonstrate how each of the general criteria would apply to each of these programs, and perhaps to other similar programs. We developed these lists by identifying evaluation issues from selected agency and congressional documents, rephrasing those issues, and generating others as needed. Taken together, the lists serve as possible indicators of the program's merit on a given criterion.

To test the comprehensiveness of the framework, we asked experts to review drafts of the framework, the program descriptions, and evaluation criteria illustrations. Nine to fourteen experts were selected for each program to represent a wide variety of interests and perspectives, including those of congressional and executive agencies, organizations representing program providers or recipients, as well as researchers previously engaged in policy discussions.

Generally, we found that the framework, after an initial revision, successfully captured the types of issues raised in reviews of these varied programs. The majority of experts surveyed for each program agreed that the framework and its illustration reflected the evaluation issues in that program. Most of their suggested revisions were to add specific indicators under the existing criteria.

Using the framework to evaluate a program will require both policy-making and technical expertise in order to set the purpose and scope of the review, select and collect the relevant evidence, judge the technical adequacy of that evidence, and synthesize the results to form judgments of the program's merit. We believe this framework could serve as a way to structure hearings or to synthesize the results of research on existing programs, to assess the promise of proposed program changes, or to compare programs with different scopes, purposes, and goals.

Agency Comments

As you requested, we did not seek formal agency comments on the final draft, but we did ask the executive agencies responsible for the five programs to provide informal comments on draft illustrations of the framework for their program. Agency officials expressed two general concerns. They felt that some criteria are clearly more important than others, and they indicated that the cost of answering some of these questions could exceed the value of the information provided. We agree that priorities will need to be established and that some information may be costly to collect. Our purpose was to enumerate the indicators implied by questions or issues that have been raised. Use of this framework will inevitably require priority setting if new data are to be collected. It is also valuable to learn where relevant data are lacking, rather than to curtail the criteria to fit the data.

As agreed with your office, unless you publicly announce its contents earlier, we plan no further distribution of this briefing report until 30 days after its issue date. At that time, we will send copies to the Attorney General, Secretary of Agriculture and Secretary of Health and Human Services and other interested parties and make copies available to others upon request. Further information on this briefing report can be obtained by calling me on 275-1854 or Lois-ellin Datta on 275-1370.

Sincerely yours,

Eleanor Chelimsky
Director

Contents

Abbreviations

ACYF	Administration for Children, Youth, and Families
AFDC	Aid to Families With Dependent Children
CDC	Centers for Disease Control
DOJ	Department of Justice
EPSDT	Early and periodic screening, diagnosis, and treatment
GAO	General Accounting Office
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
NIJJDP	National Institute of Juvenile Justice and Delinquency Prevention
OJJDP	Office of Juvenile Justice and Delinquency Prevention
SSI	Supplemental Security Income
USDA	Department of Agriculture
WIC	Special Supplemental Food Program for Women, Infants, and Children

Introduction

Background

As part of its normal authorization, appropriation, and oversight processes, and especially in the current difficult budget situation, the Congress needs to determine the public's return on investments in federal human service programs. It is, however, difficult to judge fairly the value of a program. Pitfalls include looking at too few, or perhaps not the most important, aspects of a program; not distinguishing a program that is convincingly shown not to work from one where information is lacking; and considering only how well a program is doing, rather than considering also whether a better—perhaps much better—approach exists.

Further, people differ in what they believe is most important about a program—childrens' test scores? their progress in school? impact on the family? how well parents like it? jobs it brings to the community? In the face of a potentially large number of issues they could consider, people choose some and exclude others for reasons that are not always very systematic or explicit. Self-interest may be involved in these decisions in legitimate ways, such as concerns by program operators and recipients about how the program operates locally and concerns by federal officials about its effects on the federal budget. Additionally, the full range of evidence on a program might be suppressed or simply not provided to congressional decisionmakers by persons advocating a particular position.

While there are, to date, many sources of sound guidance on the technical aspects of evaluating a program, there are no broad frameworks readily available to help ensure that a fair—comprehensive and balanced—assessment will be made. Thus, up to now, the risk exists that valuation of a program will be flawed because of insufficient attention to what criteria are used to judge a program's worth. The general evaluation framework presented in this report is intended to resolve this problem and assist in developing fair program reviews.

Objectives and Scope

The House Select Committee on Children, Youth, and Families is concerned with the operation, effectiveness, and cost-effectiveness of over 70 federal programs and has reviewed or commissioned reviews of the evidence available on some of these programs. The Committee's Ranking Minority Member, Representative Dan Coats, noted that these reviews have employed extremely diverse criteria because each program serves potentially distinct segments of the citizenry and each has different purposes and goals. He expressed his concern that this diversity of potential criteria makes it very difficult to know whether a given program review

is sufficiently comprehensive. Therefore, he asked that we develop a framework of general criteria for ensuring a comprehensive review of the operations and effectiveness of the many programs serving children and families. This report describes the development and initial test of the framework. A later report will present the results of applying it to evaluate a program.

Methodology

We developed and assessed the framework of general evaluation criteria through a three-step process: (1) literature review, (2) application of the framework to case examples, and (3) expert review of both the framework and the case examples.

Development of the Framework

First, we synthesized a draft list of evaluation criteria from a search of the literature on program evaluation methods and their use, our own experience in evaluating federal programs, and consideration of the types of information required to make a variety of program decisions. Our review of the evaluation literature revealed no single list of questions or criteria that would yield a comprehensive review of the overall merit or worth of all types of programs.

We then reviewed selected agency and congressional documents to identify the issues posed, questions raised, and claims made about three federal programs: Head Start, the Special Supplemental Food Program for Women, Infants, and Children (WIC), and the Juvenile Justice and Delinquency Prevention grants. (A full bibliography of the materials reviewed is available upon request.) After sorting the issues identified for these programs into an initial draft framework, we sent it to three evaluation methodologists with extensive experience in designing and conducting national evaluations of federal programs. These methodologists, listed in appendix I, reviewed this version of our framework and made suggestions for improving its structure.

Illustrations

To illustrate the use of the framework and conduct an initial assessment of its utility for a range of programs, we developed program descriptions and lists of indicators of the evaluation criteria for five federal programs. This particularization is necessary for using the framework to assess a given program. The lists demonstrate how each of the general criteria would apply to these programs, and perhaps to other similar programs. These five programs included the three used to develop the initial set of general criteria, as well as two others: the recent extensions

of Medicaid eligibility to young children and pregnant women and the Child Welfare Services grants. For each program, we rephrased the issues identified in the literature into possible indicators of the program's merit on each criterion, and we added other indicators as needed for illustrative purposes.

Assessment of Comprehensiveness

We tested the accuracy and comprehensiveness of the revised framework and the five illustrations by asking additional outside experts to review draft program descriptions and lists of program-specific criteria for each of the five programs. We selected 9 to 14 content area experts for each program to gain some consensus on the appropriateness and completeness of the general criteria of our framework and to acquire a comprehensive list of indicators specific to each program. We identified these experts based on our discussions with executive and congressional agency staff and our review of hearings and other materials. To include a wide variety of perspectives, we chose experts from congressional and executive agencies and organizations representing program providers or recipients, as well as researchers previously engaged in policy discussions. (Appendix I includes a listing of the experts who provided comments on the program illustrations.)

Based on their comments, we revised both the five program illustrations and the general framework, adding a general criterion to reflect issues commonly suggested across all five groups of experts. This briefing report includes most of the suggestions made by reviewers.

Explanation of the Framework and the Criteria

The framework has two components: a description of the program and a set of 10 general evaluation criteria. The descriptive component identifies what the program is intended to do, how activities are organized to accomplish program goals, what other programs are explicitly linked with the program, and what common purposes or activities they share. The evaluative component addresses whether a need for the program exists, whether resources are well directed, and whether the program's purposes have been achieved.

Program Description

The descriptive component provides the background for the evaluative component. We developed a standardized format which identifies the authorizing legislation; the problem the program is intended to address; the program's purpose and goals; program operations—including eligibility requirements, if relevant; the administrative structure; the program's relationships with other programs; and recent funding and participation levels for the program.

The purpose of the program and the problem it is intended to address are both derived from the authorizing legislation and related legislative history. The word "problem" refers to the explicit reasons for authorizing the program. For example, poor or inadequate nutrition and health care for many pregnant women and young children are cited in the authorizing legislation for the WIC program. The word "problem" should not be understood, however, as restricting this framework to ameliorative programs; instead we intend it to apply to programs with an essentially preventive purpose as well.

In some cases the program operations may not appear to match well with the stated purpose for the program. Rather than attempt to reconcile them, our approach is to describe each in terms that are as close as possible to the legislation and regulations. Then, when assessing the program, one can review the extent of mismatch between purpose and program design as a potential explanation for any difficulties that may be observed in the program's achieving its purposes. For example, a program aimed at coordinating existing day-care services to expand their availability may fail to reach more eligible children if the regulations are so loosely formed and monitoring so lax as to permit funds to be used for starting up new, and possibly duplicative, services.

Another application of the framework is prospective, as the Congress considers proposed changes to a program. When applying the framework prospectively, describing the proposed change and examining cascading consequences in the other descriptive items and in the evaluative component can help identify both probable benefits and pitfalls.

Ten General Evaluation Criteria

The evaluative component of the framework is expressed as 10 general criteria in a three-part structure that represents: (1) the need for the program, (2) its implementation, and (3) its effects (see table 2.1).

Table 2.1: Ten General Evaluation Criteria

Class	Criteria
Need for the program	Problem magnitude
	Problem seriousness
	Duplication
Implementation of the program	Interrelationships
	Program fidelity
	Administrative efficiency
Effects of the program	Targeting success
	Achievement of intended objectives
	Cost-effectiveness
	Other effects

This structure reflects our belief that an adequate assessment of a given program must consider its purpose, the nature of the problem it was designed to address, the context in which the program operates, as well as its success in addressing that problem. The 10 criteria were developed to categorize the types of issues raised about certain federal programs. We make no claim that this represents the only categorization scheme possible or that these criteria incorporate all the issues that could be raised about all federal programs.

Need for the Program

The first three criteria examine the need for the program: whether an important and sizable problem exists (problem magnitude); the possible consequences for children, families, and society of not addressing it (problem seriousness); and whether other available resources—public or private—are sufficient to adequately address it (duplication). A congressional committee or executive branch agency could use the answers to these questions in making decisions on expanding, terminating, or initiating a program.

By problem magnitude we mean the current size, intensity, and geographic distribution of the actual or anticipated problem that this program (or proposed program) is designed to address. Problem magnitude also includes recent trends and future projections regarding the extent of the problem. It may also involve concentration of the problem by age, socioeconomic status, or urban or rural location.

Generally, problem magnitude is measured by the size of the problem as defined in the program description. Attention must be paid to the different operational definitions of the problem that may exist and to the clusters of problems that may have been specified. For example, nutritional risk can be defined in the WIC program through diet or medical conditions related to diet. Each type of definition could yield a different estimate of the extent of nutritional risk.

For a service delivery program such as Head Start, problem magnitude can be measured most simply by the size of the population meeting the program's eligibility requirements, that is, the number of children from age 3 to the age of compulsory school attendance whose family income is below the poverty line. However, not all those eligible may actually need the program. For programs that provide general assistance to state and local governments to correct system weaknesses, this criterion is indexed by the extent of undesirable practices. One example under the Child Welfare Services grant program would be a high incidence of children experiencing several temporary foster care placements within a year.

Problem seriousness refers to what social, economic, and human consequences are anticipated if the problem is not addressed. It can be defined as the extent to which the problem is perceived as a threat to the welfare of society. For example, for the WIC program, experts agree that poor nutrition during pregnancy often results in low birthweight, which in turn is associated with lower cognitive functioning in later years.

Problem seriousness generally examines the anticipated effects of not providing services. Where the "problem" defined in the legislation is a condition that is not in itself a problem (for example, lack of health insurance is the basis for extending Medicaid eligibility to certain groups), this criterion refers to the strength of the link between that condition and more serious conditions (such as not receiving needed health care). Thus, in judging the seriousness of the problem creating a need for the eligibility extensions, one would examine how often lacking

health insurance results in not receiving needed care. Alternatively, one could assess the strength of the links between the multiple problems identified. This criterion also specifies the need to examine whether the problem has more serious consequences for some groups (for example, the poor) than for others.

Duplication is defined as whether other public or private resources are sufficient to adequately address this problem. The extent of duplication between these efforts and the program under study would be assessed by examining the actual availability of other public or private programs, services, or strategies that address this problem at the federal, state, and local levels and the adequacy of these resources.

Under duplication, the objective is to identify the federal and nonfederal programs and resources that are aimed at the same problem—perhaps only tangentially—and to determine whether there is indeed duplication between these efforts. This determination involves distinguishing program goals and activities "on paper" from those that really are available to people in all areas of the country. For example, although it may be permissible to use block grant funds for a similar purpose as the program under study, states may choose not to use those funds for that purpose. It is necessary to examine whether, in fact, the services are sufficiently similar and whether, in practice, the other programs actually serve the same population targeted by the program under study. In another example, Head Start would not be considered duplicative unless other preschool programs were found to provide the same broad range of additional health and social services and serve substantial numbers of low-income families.

Implementation of the Program

The second group of criteria examines how the program is carried out. Implementation includes the nature and extent of relationships between this program and others, and what constraints or advantages are created for program operations (interrelationships). It also involves whether the program has been implemented as Congress and the responsible federal agency intended (program fidelity) and in a cost-efficient manner (administrative efficiency). Answers to these questions could be used by oversight committees and agency program managers as sources of suggestions for program improvement.

Interrelationships addresses the extent to which this program relies on (or is relied upon by) another program, institution, or facility; how well they interrelate (including the success of any required coordination);

and how changes in one program might affect the other. For example, congressional committees might find it useful to know in detail the relationship between employment training programs and AFDC (Aid to Families With Dependent Children) program work requirements.

Interrelationships between programs could either have been intended initially or have developed over the years. Congressional committees can expect that cooperation will exist at the local level, as service providers share resources with other providers and agencies and serve the same children and families. For example, Head Start centers may gain in-kind support from parent volunteers, schools, and other local institutions. The Department of Health and Human Services (HHS) reports that, in addition, centers rely on the Department of Agriculture (USDA) Child Care Food Program to fund their food and food service costs. Both kinds of interrelationships are part of our definition. Assessing a program on this criterion would also require determining whether the services to which eligible participants are referred actually exist.

Interrelationships refers to relationships not only between programs, but also among the components of a single program. For example, extending Medicaid eligibility to more children would not provide them with access to recommended health care if reimbursement rates are so low that families could not find a participating physician. Coordination among programs and agencies could be considered either under this criterion or under program fidelity. If such coordination is required at the case level, it is probably best addressed under program fidelity.

Program fidelity is defined as whether the program has been implemented at all levels of government as currently intended by the Congress and responsible federal agency; whether the program as implemented conforms to the intended program model; and the nature and causes of the deviations, if any, from the legislative intent and implementing regulations.

Examination of program fidelity begins with assessing the appropriateness of the interpretations of legislative and regulatory intent, but also includes how well program activities reflect that intent. In Head Start, for example, one might examine the quality of opportunities provided for parent participation in program decision-making: Are these little more than occasional notes sent home with the children, inviting comment on the lunch menus? Or is there active outreach to involve parents in what their children are learning? Important to this criterion is determining whether state and local practices follow the federal rules both in

letter and spirit and whether the executive agencies meet their responsibilities. One also examines the program's conformance with accepted professional standards where such standards exist. And this criterion can be applied to interacting components of the same program, to determine, for example, if state-set limitations on Medicaid benefits prevent participants from receiving the recommended amount or frequency of service.

Administrative efficiency refers to the extent to which program resources are efficiently managed or expended. This includes assessing management performance, standards and controls, and accountability for and ability to control program costs, as well as quality control. For example, it may be of considerable interest to an oversight committee to learn if, in the Juvenile Justice and Delinquency Prevention grants program, a large share of some state grants is absorbed in administrative expenses, if contractors cannot account for their use of the discretionary grants, or if the program has been relatively free of such problems.

Administrative efficiency also addresses the advantages and disadvantages of different service delivery strategies—such as delivering WIC foods directly or through grocery store coupons. To assess this, one should consider possible interactions of the efficiency of a strategy for different types of recipients or service settings. For programs basing individual eligibility on need, the criterion includes the accuracy of eligibility and benefit determinations, for example, the rates of awards to ineligible families as well as inappropriate denials of benefits. For a program like the Juvenile Justice grants, this includes the adequacy of the federal agency's monitoring of grantees, for example, for the timeliness of reports, relevance and quality of training provided to local agency officials, or participants' actual receipt of services.

Effects of the Program

The last four criteria address the effects of the program, including whether the program has reached its intended target groups (targeting success), whether it has achieved its intended purposes and outcomes (achievement of intended objectives), how the value of these effects relate to costs (cost-effectiveness), and whether the program has had effects—desirable or not—on other congressional concerns (other effects). This is where congressional committees and agency policymakers can gain answers that speak to a program's effectiveness as currently configured.

Although we focus here on evaluation criteria rather than the technical details of evaluation design, application of the framework requires an understanding of evaluation designs that permit different degrees of certainty about program effects. In particular, information collected on the criteria achievement of intended objectives, cost-effectiveness, and other effects should first be reviewed by persons thoroughly familiar with evaluation design strengths and weaknesses before being used as evidence on these criteria. Of special concern prior to congressional or agency use is that the designs permit concluding that the program, rather than some other factor, was responsible for any changes observed in the outcomes measured. For example, to confidently ascribe changes in birthweight to the WIC program, the evaluation design must be capable of showing that other factors, such as expanded access to prenatal health care or a decrease in the rate of births to very young mothers, are implausible rival explanations. Similarly, claims about cost-effectiveness require solid evidence that the program, and not other factors, caused an increase in birthweights.

Targeting success assesses whether the program is effectively reaching its intended recipients, whether it is appropriately focused on the problem addressed, and whether its resources are effectively distributed among prioritized groups and across areas of the country.

For programs with individual eligibility requirements, this criterion is frequently measured by the percent of the population meeting those requirements who are actually served. But a full review should consider characteristics such as ethnicity and rural residence that may indicate potential barriers to access. When programs are funded at a level substantially below universal coverage, there is usually a concern to direct resources toward those individuals with the greatest need. Targeting success at the federal level can be assessed by determining whether the grant allocation formula directs program resources to the states or local entities with the greatest need. In some cases, for example the Juvenile Justice grants program, one should also consider whether giving more resources to states with the poorest performance might generate unintended disincentives to achieving program goals.

Achievement of intended objectives is defined as the program's effectiveness in reaching its intended or stated objectives. Assessing a program on this criterion includes determining whether each component of the program is effective and whether some populations benefit more, or some objectives are met more effectively, than others.

Generally, program-specific objectives are found by returning to the problem, purpose, and goals (short-term and long-term) for the program. For example, the most general purpose of the Child Welfare Services program is to protect and promote the welfare of children. More specific goals include preventing and remedying the abuse and neglect of children, as well as ensuring their adequate care and preventing their unnecessary placement in foster care. To judge the program fairly, progress in each of these areas should be examined.

Some long-term goals may be more appropriately included under the "other effects" criterion because either (1) the program is known to be only one of several important influences on that problem or (2) several intermediate steps or links are posited between the immediate goals of that program and those long-term goals. For example, two purposes originally outlined for Head Start were to improve the preparation of low-income children for school and to improve their chances of attaining their full potential. In this case, we would characterize the first outcome as an "intended objective" and the latter as an "other effect" because of the large number of other factors influencing whether a preschool child will attain his or her full potential.

Cost-effectiveness refers to an assessment of the effects of a program relative to the costs (e.g., resources or ingredients) associated with producing those effects. In contrast to cost-benefit analysis, cost-effectiveness analysis measures program effects in units other than dollars and is useful in comparing programs where the effects, such as reduced infant mortality, are difficult to measure in dollar terms.

Cost-effectiveness comparisons can be made of alternative strategies for achieving the same goals or objectives. For example, one could ask whether spending additional funds on outreach to high-risk pregnant women would yield a cost-effective improvement in enrollees' health status, compared to serving the full range of eligible pregnant women who apply. Alternatively, if the goal is improving children's health during the preschool years, one could ask whether WIC or Head Start has the greatest benefits, relative to the costs of services per child.

Other effects deals with how the program influences other congressional interests that are not explicitly stated intentions of the program. These include unforeseen effects—desirable or not—on the problem at hand or other social problems, goals, or objectives. For example, extending Medicaid eligibility to children of the working poor may, by breaking the prior link between welfare receipt and access to health insurance,

remove unintended disincentives to employment that does not provide insurance coverage.

This criterion also recognizes that we expect more from the program than efficiency of operations and achievement of objectives. This is where congressional committees and executive branch agencies can learn whether the program is having an impact on the long-term goals posed in the legislative intent, such as Head Start's effect on children achieving their full potential and breaking the cycle of poverty. They can learn the impact on general societal goals, such as equitable treatment of individuals with similar circumstances who live in different areas of the country. And they may also want to consider recipient satisfaction with the program under this criterion.

Where a program provides services to individuals, it may also have concomitant effects on their families and communities, such as encouraging families to make more or better use of available resources. This in turn places greater demand on those other community resources. Additionally, the role the government plays in an area may affect private sector activities in that area, either by supplanting them or by providing a standard for comparison. For example, by promoting the purchase of nutrient-enriched foods, the WIC Program could contribute to the visibility and, thereby, wider popularity of such foods among the general population. Some effects may be positive; others might be negative. For example, delaying children's entry into foster care might exacerbate problems for some families resulting in continued abuse or neglect.

To determine the full effects of a program, a broad perspective is critical. Program effects that appear as cost savings, for example, to other federal programs would naturally be important to the Congress. Yet, if the program's effects were examined in isolation from these programs, those effects might not be apparent. For example, nutritional improvements for pregnant women financed through the WIC Program may be reducing Medicaid costs for complicated pregnancies and neonatal intensive care.

Results of Testing the Framework

We illustrated our framework by developing descriptions of five federal programs and indicators of the criteria for each. These illustrations for Head Start, WIC, extending Medicaid eligibility to children and pregnant women, Child Welfare Services, and the Juvenile Justice and Delinquency Prevention grants are in appendixes II through VI. Our next step in testing the framework, to be reported separately, will be to apply it to one program, using available information to answer the questions.

From our examination of only five programs, we have not established that the framework applies to all of the more than 70 federal programs that the Committee has identified as serving children, youth, and families. However, the five illustrations reveal how flexible the framework is. We found that it was applicable to programs in a relatively wide variety of content areas: early childhood development, health care, nutrition, family social services, and administration of justice. Specific indicators of the criteria could be generated for a clearly defined component of a program, as well, demonstrating how the framework might be applied to assess a proposed program change. We also demonstrated in these illustrations how the criteria can be applied to different governmental units according to their specific roles and to such different program activities as information development, service delivery, and technical assistance. Perhaps most importantly, most reviewers of each program illustration said that they thought the framework captured the main issues of that program.

The framework was designed for assessing a program or program component that has a specific, defined problem and purpose or set of purposes. In our five illustrations, we found the framework applied to programs with multiple, broad goals and to those programs that allowed substantial state flexibility in program structure and content. But we encountered greater difficulty in generating indicators of the evaluation criteria for those program purposes and goals that were less concretely defined in their authorizing legislation than others. We expect that the framework will not be as useful where the explicit purpose of the program is as broad as, for example, revenue sharing, or where states are free to choose among a wide variety of explicit purposes, as for example, in many of the block grants. These types of programs are known to be difficult to evaluate.

Use of the Framework

In this section, we describe how to use the framework and who needs to do what. Using the framework involves both priority setting, in terms of where to focus, and technical analysis of evidence. Table 4.1 summarizes the three major steps in applying the framework and indicates for each step whether it requires a policy decision to agree on the priorities and the focus or requires technical analysis in examining actual data.

Table 4.1: Expertise Needed to Apply the Framework

	Expertise	
Application step	**Policymaking**	**Technical**
Reach agreement on purpose and scope of review	X	
Decide on and collect relevant sources of information	X	X
Judge technical adequacy of information and synthesize results		X

Several steps are required to use the framework to evaluate a program. The first is to reach agreement on the purpose and scope of the review. For example, to evaluate a proposed program change, one should describe that change following our format for program description. Then one should prioritize the general criteria and select the relevant indicators for each to match the purpose of the review.

For example, before deciding to expand appropriations for a service program to enroll additional participants, the need for that expansion should be assessed. Are there, indeed, a large number of eligible persons unserved? What other services are they receiving, and how adequate are those services for addressing the problem? Alternatively, before deciding to terminate an apparently ineffective program, its implementation should be examined to ensure that the program was faithfully tried, but found to be ineffective. Where program effects are of primary concern, agreement needs to be reached on which outcomes are considered of primary importance: direct benefits to child health, safety, or education? increased jobs for the community? or family strengthening?

The second step is deciding on sources of information and collecting them. Generally, information on each criterion should be drawn from as wide a set of sources as possible and be reviewed for its relevance and methodological quality. As noted above, application of the framework requires an understanding of evaluation methodology. An anecdotal report of difficulty with one contractor, for example, is not sufficient to imply that an entire grant program is riddled with fraud and abuse. Both methodological and substantive expertise are required to ensure

that the information collected applies to the current situation. For example, the results of implementation studies conducted prior to major changes in program operations would probably not be applicable to the current program. Similarly, the results of an impact evaluation of a demonstration project may not be generalizable to typical program operations because they may not be as carefully monitored and controlled as the prototype.

Reviewers noted that the information needed to address each criterion may not be readily available. We do not imply from our listing of illustrative indicators that we recommend engaging in new data collection to answer all of these questions. Rather, the purpose for conducting such a program review should guide the determination of which questions are most relevant. Then, before undertaking new data collection, one should weigh the value of that information for decision-making purposes against the costs of acquiring it. It is important to note where information is not available because that may raise questions about whether certain assumptions about program operations or influence are, in fact, well-founded.

The third step is assessing and synthesizing the information. Rules for judging the quality of information are somewhat easier to specify than those for judging relevance, but both require professional judgment. Our methods paper, The Evaluation Synthesis, describes the standard considerations for judging the quality of program evaluations.[1] Analogous considerations can be generated for judging the quality of administrative data on program operations.

This report does not address how to combine information on one criterion to reach a judgment, or how to combine judgments on several criteria in order to form an overall assessment of the program. Several options are possible, and The Evaluation Synthesis describes a number of methods for combining evidence across evaluations. Which method is the most appropriate depends on both the quality and volume of relevant evidence available, as well as the type of program decision contemplated. For example, if several studies of good quality provide quantitative estimates of effects, then quantitative synthesis methods may be appropriate. Other situations may require the analyst's best professional judgment or a review of the evidence by a panel of substantive experts. Forming an overall assessment of the merit of a program across

[1]Program Evaluation and Methodology Division, The Evaluation Synthesis, Methods Paper No. 1, accession no. 088890, GAO, Apr. 1983.

these criteria is inherently a judgmental process which should be guided by the initial prioritization of the criteria.

In summary, the framework can help answer a variety of questions about a program from the information gathered on the separate components. For example, troubleshooting reasons for low participation could involve questions about the appropriateness of a program's design and comparison of evaluative information on the problem's magnitude with descriptive information on the program's operations. The framework also could be applied to assess the promise of a specific proposed change to a program. In that instance, all the criteria may not be relevant, and the user need only select indicators for each of the pertinent criteria.

The primary value of the framework is to provide a comprehensive list of criteria for judging a program's merit. The framework can help decisionmakers with different perspectives list their concerns about a program and focus on the same set of program issues. It could serve, for example, as a way to structure hearings or to synthesize the results of research. Depending on the quality and quantity of existing information, it could be used retrospectively to yield conclusions from the available evidence or prospectively to focus future research and evaluation. Additionally, the general nature of the criteria permits making comparisons across programs with different scopes, purposes, and goals.

The framework we have developed has not previously been available. It provides a new tool to help reach agreement on the criteria needed to judge a program fairly. And it provides a means for systematically assembling what can—and cannot—be said with confidence about what works for programs for children, youth, and families.

Expert Reviewers of the Framework and Program Illustrations

Thomas D. Cook, Northwestern University; Peter Rossi, University of Massachusetts; and Lee Sechrest, University of Arizona, reviewed an earlier draft evaluation framework.

The Head Start illustration of the framework was reviewed by Bettye Caldwell, University of Arkansas; Richard Darlington, Cornell University; Ellen Galinsky, Bank Street College of Education; Gary Gottfredson, Johns Hopkins University; J. Ronald Lally, Far West Laboratory for Educational Research and Development; Irving Lazar, Cornell University; Michael Namian, Congressional Budget Office; Lawrence Schweinhart, High Scope Foundation; Sharon Stephan, Congressional Research Service; Edward Zigler, Yale University; Jim Matlack, National Head Start Association; and the presidents of the National Associations of Head Start—Directors, Larry Siroshton; Staff, Lawanna Dowden; Parents, Willie Simmons.

The Special Supplemental Food Program for Women, Infants, and Children illustration was reviewed by Kathy Allen, National Commission on Infant Mortality; Julie Isaacs, Congressional Budget Office; Jean Jones, Congressional Research Service; Milton Kotelchuk, Harvard University; Richard Narkowitz, Donald Schiff, and James Strain of the American Academy of Pediatrics; David Rush, Albert Einstein Medical College; and Sandra Scarr, University of Virginia.

The illustration for the Medicaid eligibility extensions was reviewed by Kathy Allen, National Commission on Infant Mortality; Annalise Anderson, Hoover Institution; Barbara Blum, Foundation for Child Development; Joseph Cislowski, Congressional Research Service; Alan Fairbank, Congressional Budget Office; Irene Fraser, American Hospital Association; Ian Hill, National Governors' Association; Constance Horgan, Brandeis University; Arlene Liebowitz, Rand Corporation; Peggy McManus, McManus Health Policy, Inc.; Jack Meyer, New Directions for Policy, Inc.; Sara Rosenbaum, Children's Defense Fund; and Judith Wagner, Office of Technology Assessment.

The Child Welfare Services illustration was reviewed by Douglas Besharov, American Enterprise Institute; Ronna Cook, Westat, Inc.; David Fanshel, Columbia University; Charles Gershenson, Center for the Study of Social Policy; Sheila Kamerman, Columbia University; Roland Kulla, University of Chicago; Penny Maza, Child Welfare League;

Michael Namian, Congressional Budget Office; Patricia Schene, American Association for the Protection of Children; Sharon Stephan, Congressional Research Service; Toshi Tatara, American Public Welfare Association; and Rachel Warren, University of Iowa.

The Juvenile Justice and Delinquency Prevention illustration was reviewed by Jack Calhoun, National Crime Prevention Council; A. L. Carlisle and Marian Mattingly, National Coalition of State Juvenile Justice Advisory Groups; Peter Greenwood, Rand Corporation; E. Hunter Hurst, National Center for Juvenile Justice; Barry Krisberg, National Council on Crime and Delinquency; Michael Sieverts, Congressional Budget Office; Joseph Thome, Community Research Associates; and William Woldman, Congressional Research Service.

Head Start

Program Description

Authorization

The Head Start program originated in 1965 as part of the Urban and Rural Community Action Programs, which were established under Public Law 88-452 (Economic Opportunity Act). It was reauthorized by Public Law 97-35 in 1981 (Head Start Act) and is currently authorized through fiscal year 1990 by Public Law 99-425.

Problem

Economically disadvantaged children exhibit poor nutrition, health status, and educational performance and enter school less prepared than their more advantaged peers. In turn, these problems reduce these children's chances to break the cycle of poverty.

Purpose and Goals

Head Start aims to provide comprehensive services to low-income and handicapped preschool children and their families to improve the children's learning and social skills and their health and nutrition so these preschoolers may begin school better equipped to learn and with greater chances of attaining their full potential. Head Start also aims to promote parental involvement in the development, conduct, and direction of the program at the local level.

Program Operation

The Head Start program provides a wide range of services to low-income children and their families, at no cost, in the context of a preschool child development program. Services include comprehensive nutritional services (identification of nutritional needs and problems, daily meals, and nutritional education), educational services (activities and programs for children, parent training, and staff career development), medical services (preventive services, education, early detection, screening, and comprehensive services, including medical, dental, mental health, and nutritional), and social and other services (emergency assistance and information about, referral to, and cooperation with existing community services).

Parental involvement is intended to be extensive, through both decision-making about the services their children receive and volunteer participation and employment of parents as Head Start staff. Head Start primarily serves children between the ages of 3 and 5 (eligibility is limited to children below the age of compulsory school attendance) and their

families. While there are no federally required individual income eligibility standards for participation, 90 percent of a center's enrollment must come from families with income at or below the federal poverty line and at least 10 percent of the children must be handicapped.

Since April 1973, Head Start centers may select the program option, from five available, that they determine is best suited to meet the needs of the children served and the capabilities and resources of the program staff. Program options are

1. Standard Head Start Model—5-day center-based classroom format

2. Variations in Center Attendance—attendance is less than 5 days a week; for instance (a) 4 days of center-based activities plus an additional day for staff to perform special activities, (b) split-session schedule, for example, two regular enrolled groups, each meeting 2 days a week, with the fifth day set aside for staff to perform special activities

3. Double Sessions—two regularly enrolled groups, one meeting in the morning, the other in the afternoon

4. Home-Based Model—family home is the central facility

5. Locally Designed Variations—other approved program options that meet the needs of individual children and their families

In fiscal year 1986, only about one-fifth of the participating children were in full-day programs, about 8 percent received home-based services, and the remainder were served through half-day programs.

Administrative Structure

The Administration for Children, Youth, and Families (ACYF) of the Department of Health and Human Services (HHS), through Washington and regional offices, is responsible for the administration of Head Start, including selecting Head Start grantees and monitoring their compliance with program regulations.

Head Start funds are allocated by state through a formula that takes into account a state's fiscal year 1981 allocation, the number of children under age 6 living in poverty, and the number of children receiving Aid to Families With Dependent Children (AFDC). HHS distributes funds as grants directly to eligible local Head Start agencies, and with certain exceptions, funds are limited to 80 percent of total program costs (i.e.,

there is a 20-percent matching requirement). Thirteen percent of Head Start appropriations are reserved for Indian and Migrant Head Start programs, services for handicapped children, payments to the territories, training and technical assistance, and discretionary payments (including research and evaluation).

Relationships With Other Programs

Twenty percent of total Head Start center costs must come from nonfederal sources, which can include in-kind contributions of services or use of facilities. A significant amount of in-kind contributions is generated through affiliations with local institutions (such as schools) as well as through the use of parents as volunteers. Through use of existing community services, centers also gain indirect support from such federal programs as Medicaid, the Job Training Partnership Act, the Community Services Block Grant, and educational programs. Most Head Start centers use the Department of Agriculture (USDA) Child Care Food Program to fund food and certain food service costs.

As noted, local Head Start agencies are expected to provide information, referral, and coordination services to make Head Start children and their families aware, and facilitate their use, of available community resources.

Recent Funding and Participation Levels

In fiscal year 1986, approximately 450,000 children—about 18 percent of 3- to 5-year-old children living in low-income families—were served in full-year Head Start programs, at a total federal cost of about $1 billion. For fiscal year 1987, $1.1 billion was appropriated, and for 1988, $1.2 billion. For fiscal year 1989, $1.3 billion was authorized, and for 1990, $1.4 billion.

Illustrations of the Criteria

Tables II.1-II.3 provide illustrative indicators of the evaluation criteria for Head Start as well as suggested measures and analyses, where these seemed to be indicated.

Table II.1: Head Start Indicators—Need for the Program

Evaluation criterion	Indicators	Measures and analyses
Problem magnitude	Extent of the gap between low-income and non-low-income children's school performance	Educational achievement for grade level and age
		Frequency of special education placement
		Frequency of compensatory education placement
		Frequency of grade retention
		Educational attainment, high school completion
		Trends over time
	Number of children from age 3 to the age of compulsory school attendance in families with special needs	Income below the poverty level
		Teenaged parent, single parent
		Prolonged unemployment or reliance on public assistance
	Extent of below-age-level development among low-income preschoolers	Cognitive ability and achievement
		Fine and gross motor development
		Social competence or skills
		Self-help skills (dressing self)
	Extent of health risks among low-income preschoolers	Frequency of dietary deficiencies
		Frequency of chronic and acute medical conditions
		Frequency of tooth decay
	Concentration of below-age-level development and health risks	Family income
		Family structure (one or two parents, teenaged parent)
		State and local area

(continued)

Evaluation criterion	Indicators	Measures and analyses
Problem seriousness	Relationship of family income to parents' characteristics	Educational achievement and literacy
		Social competency
		Parenting skills
		Encouragement of school performance
	Relationship of family income to children's later social difficulties	Poor school achievement or performance
		Dropping out of school
		Teenage pregnancy
		Juvenile delinquency
		Lack of vocational skills and employment
		Receipt of public assistance as young adults
	Relationship of below-age-level development among low-income preschoolers to their later school performance	Achievement for grade level and age
		Frequency of special education placement
		Frequency of compensatory education placement
		Frequency of grade retention
		Educational attainment
		Self-esteem and self-concept
	Relationship of poor school performance among low-income children to later social difficulties	Dropping out of school
		Teenage pregnancy
		Juvenile delinquency and substance abuse
		Lack of vocational skills and employment
		Receipt of public assistance as young adults
		Poor self-concept and unrealistic expectations
	Relationship of poor nutrition and health in early childhood to later difficulties	Chronic and acute medical conditions
		Schooldays lost to illness
		Delays in cognitive development
		Poor school achievement

(continued)

Evaluation criterion	Indicators	Measures and analyses
Duplication	Extent to which other programs for low-income preschoolers provide similar services	Educational activities for children
		Social skills development
		Health screening, services, and education
		Nutritional screening and meals
		Social service referrals for parents
		Parenting education
		Opportunities for mainstreaming handicapped preschoolers
		Education and job opportunities for parents
	Availability of other comprehensive programs for low-income preschoolers, by state and local area	Catchment area overlap with Head Start program sites
		Free or reduced prices
		Location near target population
		Schedule meets parents' needs
		Full-day versus part-day or part-week availability
		Enrollment of low-income preschoolers
	Extent to which the Medicaid EPSDT[a] and Maternal and Child Health Block Grant programs meet children's ongoing health care needs, by state and local area	Health and support services actually provided
		Enrollment of low-income preschoolers
	Extent to which the WIC program meets children's nutritional and long-term nutrition education needs, by state and local area	Enrollment of low-income preschoolers

[a]Early and periodic screening, diagnosis, and treatment.

Table II.2: Head Start Indicators—Implementation of the Program

Evaluation criterion	Indicators	Measures and analyses
Interrelationships	Extent of federal, state, and local coordination with other educational, health, and social services	Co-location
		Cooperative outreach efforts to target population
		Advisory board representation
		Routine referral and follow-up processes
		Extent of shared or contributed resources
		Identification and adoption of promising activities and materials provided by and to other programs
	Extent of transition efforts made to the next educational provider (kindergartens, local schools)	Efforts to coordinate curriculums
		Preparation of children and parents for the local schools' procedures and expectations
	Availability of health care and social services to enable referral of program recipients	Stability and adequacy of funding for providers of free or reduced-price services
		Ratio of program recipients to health care providers who serve low-income children and accept Medicaid and local indigent health care benefits as full payment
		Percent of Head Start children with Medicaid coverage
	Stability and adequacy of funding for programs that provide material or staff resources to Head Start centers	Education for All Handicapped Children Act funds
		USDA's Child Care Food Program

(continued)

Evaluation criterion	Indicators	Measures and analyses
Program fidelity	Extent of approved program plans' compliance with legislation and regulations	Types and amounts of proposed services, activities, and materials
		Required coordination and cooperative agreements with other public and private entities
		Financial management
		Parental involvement and training arrangements
		Staff selection and training arrangements
		Outreach to and enrollment of target groups
		Demonstration that program option selected meets local needs and provider capabilities and resources
	Extent of local program compliance with approved plan	Percent of participants receiving daily meals; full set of immunizations; and medical, nutritional, and dental screening and follow-up
		Extent of, and opportunities for, parent participation in classroom and in decision-making
		Adherence to requirement for two home visits a year per child
		Adherence to approved description and schedule of proposed activities and materials for children
		Adequate staff-to-child ratios and staff qualifications
		Adequate amount and quality of training provided to staff
		Referrals routinely made to services proposed to be coordinated
		Non-low-income enrollment not exceeding 10 percent of participants
	Ability to meet Head Start performance standards	Type of program option (full-day, part-day)
		Type of sponsoring agency (school or other)
	Adequacy of community needs assessment and correlation with actual programming	Choice of center program option
	Adequacy of accommodations for special needs groups	Handicapped children (mental, emotional, and physical handicaps and learning disabilities)
		Indians
		Migrant families
		Non-English-speaking children
		Homeless families
		Children in rural areas
	Adequacy of individualized educational plans for handicapped children	Parent involvement in plan design
		Follow-up
	Program quality beyond minimum for compliance	Staff salaries and amount of early childhood training
		Number of classrooms assessed as having high-quality programs
		Number of centers with accreditation from the National Association for the Education of Young Children

(continued)

Evaluation criterion	Indicators	Measures and analyses
Administrative efficiency	Stability of program funding at federal and local levels	Extent of continuity in program planning and operations across fiscal years
	Federal costs, direct and indirect	Funding food and allowable food service costs through the USDA Child Care Food Program instead of directly from HHS
		Administering the Indian and migrant programs separately from the rest of the program
	Ability to control local program administrative costs, measured comparatively	Variations across programs by sponsoring organization and availability of supportive services
		School-based centers versus other sites, by state and local area
		Home-based versus center-based programs, by urban, suburban, and rural residence
	Limitations on hours of service and number of enrollees	Center versus home-based programs
		School-based centers versus other sites
	Per-child costs	Actual enrollment compared to potential level
		Average daily attendance compared to number of enrollees
		Receipt of sliding-scale fees from non-low-income enrollees

Table II.3: Head Start Indicators—Effects of the Program

Evaluation criterion	Indicators	Measures and analyses
Targeting success	Coverage of eligible population	Low-income children aged 3 to 6
		State and local area
		Mild, moderate, and severe handicap
		Special group membership (Indian, migrant)
		Ethnicity
	Geographic coverage	Distribution of centers to areas most in need
	Concentration of resources on highest risk eligibles	Mild, moderate, and severe handicap
		Enrollees receiving public assistance
		Families not previously participating
Achievement of intended objectives	Improvement in children's health	Dental health
		Incidence of chronic and acute medical conditions
		Receipt of full immunizations
		Link parents with ongoing health care providers and ensure involvement in children's health needs
	Improvement in children's preparation for school	Cognitive skills (language understanding, recognition of numbers and letters, understanding of concepts)
		Competence in social relationships
		Positive self-concept
		Perceptual development, language development, and cognitive abilities of handicapped
		Positive attitudes toward learning, school, and teachers
		Self-help skills (dressing self)
	Improvement in educational performance relative to low-income non-Head Start, low-income nonpreschool, and non-low-income children	Achievement for grade level and age
		Frequency of special education placement
		Frequency of compensatory education placement
		Frequency of grade retention
		Social adjustment, emotional problems
	Breadth of parent involvement	Representation in planning groups
		Satisfaction with the program
		Proportion volunteering in classroom
	Improvement in parents' status and skills	Self-confidence
		Child-rearing practices
		Knowledge of child health, nutrition, and development
		Awareness and use of community resources
		Skills development
		Attitude toward children's potential and importance of education

(continued)

Evaluation criterion	Indicators	Measures and analyses
Cost-effectiveness	Full costs and effects of different program delivery strategies for improvement in preparation for school	School-based centers versus other sites
		Program options (full-day versus half-day)
		Children continuing for a second year versus maximizing enrollment of children
	Full costs and effects of using parents as volunteer staff	Cost savings
		Quality of staff training
		Benefits of parent involvement and training to children
		Job training benefits for parents
	Costs of ACYF regional office monitoring of centers relative to effects on program performance	Centers meeting ACYF performance standards
		Children's preparation for school
	Additional effects, compared to the cost, of each program component	Social skills development
		Health screening and services (versus enrollment in Medicaid EPSDT program)
		Nutritional screening and meals
		Parenting education
		Mainstreaming handicapped preschoolers
	Cost-effectiveness in the short term, compared to other preschool programs	School performance
	Cost-effectiveness in the long term, for avoiding later difficulties, compared to programs that deal more directly with older youth's concerns	Juvenile delinquency
		Teenage pregnancy
		Lack of employment

(continued)

Evaluation criterion	Indicators	Measures and analyses
Other effects	Improvement in life chances of economically disadvantaged youth	Increased educational attainment
		Lowered teen pregnancy rates
		Improved employment skills
		Lowered costs of public assistance to young adults
		Lowered delinquency and substance abuse rates
		Improved self-esteem and realistic expectations
	Improvement in parents' status	Education
		Employment
		Economic status
		Job performance and attendance
	Community development	Increase in jobs and services in the community
	Improved coordination	Improvement in local social service and health agency coordination
		Coordination with child-care providers for employed mothers
	Improvement in local schools	Sensitivity to developmental needs of low-income children
		Awareness of early childhood education practices
	Increase in parents' involvement in community	Local schools and other community organizations
	Increase in parents' participation in children's education	Help with homework
	Stimulating the private sector	Degree of private sector's provision of low-price preschool opportunities

WIC Program

Program Description

Authorization

The Special Supplemental Food Program for Women, Infants, and Children (WIC) was authorized by Public Law 92-433 in 1972 as section 17 of the Child Nutrition Act of 1966. The current program is authorized through fiscal year 1989 by Public Law 99-661.

Problem

The physical and mental health of a great number of low-income pregnant, postpartum, and breast-feeding women, infants, and young children are at special risk because of poor nutrition or health care or both.

Purposes and Goals

The WIC Program is designed to provide supplemental foods and nutrition education and to serve as an adjunct to good health care during critical times of growth and development. It aims to prevent the occurrence of health problems and to improve health status.

Program Operation

The WIC Program provides, at no cost to participants, nutrition education and supplemental foods to low-income pregnant, postpartum, and breast-feeding women, infants, and children under age 5 who have been determined to be at "nutritional risk." Recipients are also provided access to health care through referral to and coordination with local providers. Supplemental foods are provided monthly through direct distribution of food items by the WIC Program, contracted home delivery, or vouchers for exchange at authorized grocery stores. Food supplements are tailored to the specific needs of eligibility groups. The nutrition education component of the program is designed to improve the health status of participants, achieve positive change in their dietary habits, and emphasize the relationships between nutrition and health.

Nutritional risk is defined as dietary deficiencies or other nutritionally-related medical conditions that impair or endanger health, including alcoholism and drug addiction. The administering states, territories, and tribal organizations may tie income-eligibility guidelines to state or local health care guidelines, provided such guidelines fall between 100 and 185 percent of federal poverty income guidelines, or set income eligibility at 185 percent of the federal poverty level.

Program regulations define seven priority groups at nutritional risk. The three considered most in need of WIC services include pregnant and breast-feeding women and infants meeting the medically-based risk criteria; infants of women who were in WIC during their pregnancy, or who would have been eligible; and children meeting the medically-based criteria, and at the state's option, some high-risk postpartum women. October 1987 program data reveal that 84 percent of recipients were in these groups. Three other groups include pregnant and breast-feeding women and infants at risk because of an inadequate diet, children at risk because of an inadequate diet, and postpartum women at nutritional risk. The state agency may include a seventh group: previously certified participants who might regress in nutritional status without continued participation. Additional special target populations include women in the early months of pregnancy and eligible migrants and Indians.

Administrative Structure

The Supplemental Food Program Division of the USDA Food and Nutrition Service provides grants-in-aid to states, territories, and tribal organizations that distribute funds to local WIC agencies to carry out the program. Factors considered in the allocation of funds include the need within a state (income and rates of low birthweight and infant mortality), the level of prior state participation, and food costs.

The Food and Nutrition Service develops the formula for state allocations, determines the compliance of state and local agencies, and evaluates program performance and health benefits. The agency prepares a biennial program participation report, provides technical assistance to help improve state agency administrative systems, and administers pilot projects. The purpose of these pilot projects includes addressing the special needs of migrants, Indians, and rural populations.

The National Advisory Council on Maternal, Infant and Fetal Nutrition is responsible for studying WIC and related programs to determine how they may be improved and provides a biennial report to the Congress and the President. The Council includes state and local WIC and USDA Commodity Supplemental Food program directors and fiscal and health officers, representatives of organizations serving migrants, parent participants, and other representatives of USDA and HHS.

Relationships With Other Programs

State and local agencies are to announce and distribute information on the availability of program benefits (eligibility criteria and location of local agency) to offices and organizations that deal with significant

numbers of potential participants. They must also coordinate program operations with such special counseling services as the food and nutrition education program, immunization programs, prenatal care, well-child care, family planning, alcohol and drug abuse counseling, child abuse counseling, and with the AFDC, Food Stamp, and maternal and child health care programs. Other related federal programs include Medicaid; the Maternal and Child Health Block Grant; the Commodity Supplemental Food, Community Health Center, and Migrant Health Center programs and federal research on maternal and child health.

Recent Funding and Participation Levels

For fiscal year 1986, $1.6 billion was appropriated; for 1987, $1.7 billion; and for 1988, $1.8 billion. For fiscal year 1989, $1.8 billion is authorized. Costs for nutrition services and administration are limited to 20 percent of appropriations, while no less than one-sixth of state administrative funds are to be spent on nutrition education. One-half of 1 percent of appropriated funds (not to exceed $3 million) are reserved for USDA's evaluation, reporting, and technical assistance responsibilities and for administering demonstration projects. In addition, nine-tenths of 1 percent of appropriations are reserved for services to families of migrant workers. Average monthly participation for fiscal year 1987 was 3.4 million women, infants, and children. The Food and Nutrition Service estimates that the 3.4 million served represent 40 to 50 percent of the total eligible population.

Illustrations of the Criteria

Tables III.1-III.3 provide illustrative indicators of the evaluation criteria for the WIC Program as well as suggested measures and analyses, where these seemed to be indicated.

Table III.1: WIC Program Indicators—Need for the Program

Evaluation criterion	Indicators	Measures and analyses
Problem magnitude	Extent of nutritional risk	Number of pregnant, postpartum, and breast-feeding women, infants, and children both income-eligible and at nutritional risk because of dietary and nutritional problems or medical conditions
		General population's health status and food consumption patterns
		Trends over time in extent of nutritional risk or related medical conditions
	Concentration of nutritional risk	Relation of family income to poverty level
		Maternal age
		State and local (urban and rural) area
		Children's age
	Rates of preterm and low-birthweight babies and of infant mortality, trends over time and concentration	Family income
		State and local area
Problem seriousness	Extent of co-occurrence of dietary-based and medically-based nutritional risk criteria	Women, infants, and children
		Relationship of family income to poverty level
	Relationship to adverse health outcomes of nutritional risk	Excess, inadequate, or imbalanced nutrition
		Inattention to health risks (substance abuse and smoking)
		Nutrition-related medical conditions
		Prior problem pregnancies
	Relationship of maternal nutritional status to health status	Poor pregnancy outcomes (preterm birth)
		Low birthweight
		Infant mortality
		Delayed infant and fetal development
	Relationship of infant nutritional status to health status	Delayed mental and physical development
		Medical conditions
	Relationship of children's nutritional status to health and other outcomes	Delayed mental and physical development
		Medical conditions
		School achievement
	Extent to which adverse health effects of poor nutrition are exacerbated by other factors	Low family income
		Maternal age
		Infant's or child's age
	Relationship of nutritional risk to poverty	

(continued)

Evaluation criterion	Indicators	Measures and analyses
Duplication	Extent to which Food Stamp program meets special nutritional needs of WIC-eligible groups	Adequacy of Food Stamp benefits for WIC-eligible groups
		Enrollment of women and children at nutritional risk in Food Stamp program
	Extent to which AFDC program meets special nutritional needs of WIC-eligible groups	Adequacy of AFDC benefits for WIC-eligible groups, by state
		Enrollment of women and children at nutritional risk in AFDC program, by state
	Extent to which WIC-eligible groups also eligible for food stamps and AFDC are enrolled only in WIC	
	Extent to which state and local public assistance programs meet special nutritional needs of WIC-eligible groups	Adequacy of benefits for WIC-eligible groups, by state
		Enrollment of women and children at nutritional risk, by state
	Extent to which AFDC, Medicaid, and Maternal and Child Health Block Grant programs provide access to health care	Extent of recommended perinatal, infant, and child health care services received by Medicaid participants
		Enrollment of women and children at nutritional risk in the Medicaid program, among eligibles, by state
	Extent to which available perinatal, infant, and child health care meets nutritional education and screening needs of WIC-eligible groups	Extent of nutritional screening, education, and services received by maternal and child health care recipients from public and private health agencies and other providers outside WIC
		Coverage of women and children at nutritional risk by these health providers, among eligibles and enrollees
	Extent to which Commodity Supplemental Food program meets special nutritional needs of WIC-eligible groups	Extent of nutrition problems among supplemental food recipients
		Enrollment of WIC-eligible women and children in program, by local area
		Relative effectiveness of supplemental food program versus WIC

Table III.2: WIC Program Indicators—Implementation of the Program

Evaluation criterion	Indicators	Measures and analyses
Interrelationships	Extent of federal, state, and local coordination with public assistance programs	Public announcement of WIC benefits availability
		Co-location with public assistance offices
		Coordination with HHS
		Automatic WIC income-certification provided to AFDC, Food Stamp, and Medicaid enrollees; percent enrolled in WIC
		State AFDC and Medicaid eligibility provided to WIC recipients; percent enrolled in these programs
		State and local indigent health care program eligibility provided to WIC recipients; percent enrolled
		Agreement between programs' definition of income
	Extent of federal, state, and local coordination with health care providers	Coordination with HHS
		Co-location
		Cooperative outreach efforts to target population
		Outreach to private physicians, and community and migrant health centers
		Identification and adoption of promising activities and materials provided by and to other federal, state, and local health-promotion programs
		Referral of WIC participants to related federal, state, and local programs
		Physicians' input into program design and operations
	Availability of health care services for program participants, by state and local (urban and rural) area	Proximity to health care providers (referral, follow-up)
		Ratio of program recipients to health care providers who serve low-income women and children and accept Medicaid and local indigent health care funds as full payment

(continued)

Evaluation criterion	Indicators	Measures and analyses
Program fidelity	Adequacy of USDA recipient priority system	Concordance with published professional standards
	Concordance of state practices among the states and with USDA guidelines and published professional standards	Nutritional risk criteria and screening and waiting list systems
	Receipt of nutrition education	Method, content, and frequency of receipt
		Extent of services received in programs using home delivery and local distribution centers
	Receipt of nutritional package	Accessibility of local distribution centers and clinics
		Redemption rates for grocery store vouchers
	Adequacy of nutritional content of food packages, by type of food delivery system	Prescribed by a competent professional
		Tailored to individuals
		Proper supplement to diets of program enrollees, compared to national diet surveys
	Adequacy of nutrition supplementation	Extent of food-sharing among families of participants
		Decrease in family food expenditures
		Displacement or substitution of food otherwise consumed
		Improved dietary intake
	Referral to health care services	Degree of automatic enrollment
		Extent of co-location with health care providers
		Frequency and duration of prenatal care
		Weeks of pregnancy before first doctor visit
		Child's receipt of full set of immunizations
		Frequency and duration of well-baby and well-child care
	Maintenance of adequate length of participation	Continuous participation, particularly for those at highest risk such as migrants

(continued)

Evaluation criterion	Indicators	Measures and analyses
Administrative efficiency	Direct and indirect costs of direct distribution versus voucher food delivery systems, by local area	
	Cost of quality control procedures relative to costs of inappropriate expenditures	Cost of determining recipient eligibility
		Costs of monitoring, investigating, and taking enforcement action on vendors
	Control of food costs per recipient, relative to inflation increases	Category of recipient
		Urban or rural residence
		Type of food delivery system
		Extent of food package tailoring
	Effectiveness of cost-containment strategies such as rebates and competitive bidding on purchases of commodities	Savings incurred
		New participants served
	Control of administrative costs per recipient	Type of food delivery system
		Size of state, local agency
		Quality of services provided
	Frequency of nutrition education contacts, by cost per recipient	Type of food delivery system
		Size of state, local agency
		Number and length of contacts
	Accuracy of eligibility determinations	Risk certified by competent professional
		Reliability of "regression to risk" certifications and measures of nutritional risk (anthropometric, biochemical, dietary intake)
		Time available for certification
		Extent of income misreporting
		Adequacy of income documentation requirements
		Frequency of erroneous certifications, denials
	Efficiency of caseload management	Clinic patient flow
		Fluctuations in caseload size over year
		Length of application approval process
		Use of prioritized waiting lists
		Timeliness of certifications
		Extent of automatic income certification of recipients of other means-tested public assistance programs

Table III.3: WIC Program Indicators—Effects of the Program

Evaluation criterion	Indicators	Measures and analyses
Targeting success	Coverage of eligible population, percentage of eligible population enrolled	Relation of family income to poverty level
		Eligibility and priority group categories
		State and local area
		Urban and rural residence
		Type of food delivery system
		Special group membership (Indians, migrants)
	Concentration of resources on highest risk eligibles	Relation of family income to poverty level
		Eligibility and priority group categories
		Special group membership (Indians, migrants)
	Prioritized enrollment	Trends over time in coverage and concentration of resources
		Location of program sites in areas of greater nutritional risk
		Waiting lists of eligibles by priority group
	Extent to which allocations to states reflect differences in need	Extent of nutritional risk, how widespread and how serious
		Food costs and increases in costs
		Delivery systems for food supplements and nutrition education

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Evaluation criterion	Indicators	Measures and analyses
Achievement of intended objectives	Improved nutritional intake	Dietary intake, while on WIC and afterward
		Household food and nutrient consumption
	Improved knowledge, attitudes, and behavior regarding nutrition and diet	Types and quantities of foods purchased, prepared, and consumed
		Nutritional soundness of food preparation activities
		Tailoring meals to the special nutritional needs of pregnant and breast-feeding women, infants, or children
		Increased incidence and duration of breast-feeding
	Improved nutritional status	Anthropometric measures (skin-fold thickness)
		Biochemical measures (hematocrit and hemoglobin levels)
		Children's appropriate growth rates
	Improved health care access	Weeks of pregnancy before first prenatal care visit
		Frequency and duration of prenatal care
		Full set of immunizations
		Frequency and duration of well-baby and well-child care
		Regular source of health care
	Improved pregnancy outcomes	Duration of gestation and rate of preterm birth
		Incidence of preeclampsia and other complications
		Birthweight above 500, 1,500, 2,500 grams
		Perinatal and other infant mortality rates
		Incidence of nutrition-related birth defects
		Incidence and duration of neonatal intensive care
	Improved child health	Dietary intake
		Appropriate growth and weight gain
		Incidence of mental retardation
		Incidence of nutrition-related medical conditions
	Differential effects on nutritional intake and status and on pregnancy outcomes	Length of participation
		Eligibility and priority group categories
		Program components
		State and local (urban or rural) areas

(continued)

Evaluation criterion	Indicators	Measures and analyses
Cost-effectiveness	Effects and costs added by the nutritional education component of the program	Improved family purchase, preparation, and consumption of food
		Improved recipient nutritional status and health
		Reduction in rates of infant low birthweight and preterm birth
	Full costs and effects of direct distribution versus voucher systems, by urban or rural area	Costs of food storage and vendor monitoring
		Recipients' receipt and consumption of supplemental foods
		Recipients' receipt of nutrition education
	Costs and effects associated with serving different categorical and priority groups	Reducing rate of neonatal intensive care required for infants of pregnant women at nutritional risk
		Reducing rate of rehospitalization for infants at nutritional risk
	Costs and effects associated with expanding coverage of highest risk priority groups versus serving as many eligibles as possible	Additional costs of outreach
		Differential effects, by risk category
	Long-term cost-effectiveness	Cost-effectiveness of early intervention on long-term medical expenses

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Evaluation criterion	Indicators	Measures and analyses
Other effects	Supplementation of family income	Maintaining at least the same level of family food expenditures
		Substitution of WIC foods and nutrients for purchases otherwise made
		Food sharing with other family members
		Reduction in hours worked by mothers of older children
	More efficient and nutritious food purchasing	Nutrients per dollar spent
		Better balanced diet for entire family
		Reduction in purchase of junk food
	Reduced Medicaid and indigent health care expenditures for enrollees	Neonatal intensive care
		Predelivery hospitalizations
		Complicated deliveries
		Infant rehospitalizations within a year
	Equitable treatment	Equal access among categorically eligible, by priority group, within and across states
	Influence on prenatal care delivered outside the program	Extent to which providers routinely include nutritional screening, education, and supplements
	Improved knowledge base for nutrition	Improved accuracy and cost of methods for screening nutritional risk
		Better understanding of how income and nutrition affect health status, in order to improve program design
	Effects on retail markets	Displacement of retail purchases (with home and direct delivery)
		Reduced shelf price of infant formula and other commodities to non-WIC consumers
		Increased availability of nutrient-enriched food products in the retail market
		Increased sales of infant formula and nutrient-enriched foods to other consumers
	Societal goals	Contribution to the nation's progress toward the Surgeon General's goals for reducing rates of infant mortality and low birthweight
	Unanticipated effects	Decrease in breast-feeding in states getting rebates on infant formula

Medicaid Eligibility Extensions

Program Description

Authorization

The Medicaid program was permanently authorized in 1966 as title XIX of the Social Security Act. Public Law 98-369 (DEFRA-84), Public Law 99-272 (COBRA-85), Public Law 99-509 (OBRA-86), and Public Law 100-203 (OBRA-87) amended title XIX to make more pregnant women and young children eligible for Medicaid.

Problem

Some poor women and children lack health insurance and therefore are not receiving the health care they require to prevent and treat serious health problems, such as low birthweight and associated infant morbidity and mortality and chronic medical conditions.

Purposes and Goals

The Medicaid program was created to provide low-income families with dependent children and low-income aged, blind, and disabled individuals with access to health care. Prior to 1984, the program also covered some pregnant women and other children. Program eligibility for pregnant women has since been expanded to ensure that more low-income pregnant women receive quality prenatal care and to thereby reduce the incidence of low-birthweight infants and infant mortality. Eligibility for children was expanded to provide continued coverage of certain low-income children, regardless of their family's eligibility for AFDC. Additionally, the federal ceiling on income standards for pregnant women and infants was raised to that of the WIC Program to permit the states to better coordinate the financing and delivery of health and nutrition services to low-income, high-risk pregnant women and their infants.

Eligibility

The Medicaid program is an entitlement program that pays for medical assistance for certain low-income families and aged, blind, and disabled persons. States and territories must cover certain eligibility groups, for example Aid to Families With Dependent Children program recipients and Supplemental Security Income (SSI) recipients. States have the option to cover the "medically needy"—persons who generally are ineligible under other eligibility groups because of too much income. Such persons may become eligible by incurring medical expenses such that their adjusted income falls below a state's medically needy income level. (In 1986, these levels were below the federal poverty level in all but one

state.) Prior to 1984, states could also include other groups such as children up to age 18-21 who meet states' AFDC income and resource requirements.

The eligibility extensions since October 1984 require states to cover children up to age 5 (and effective October 1, 1988, children up to age 7 born after October 1, 1983, and at state option up to age 8) and pregnant women who meet states' AFDC income and resource requirements.[1] States have the option also to cover pregnant women and children under age 5 who have family incomes up to a state-established income standard that does not exceed the federal poverty level (or effective July 1, 1988, pregnant women and infants up to 185 percent of the federal poverty level, and as of October 1, 1988, children up to age 8 on a phased-in basis). If states include the medically needy, they must include certain children under age 18 and pregnant women.

Program Operation

Medicaid, like private health insurance, authorizes payments to medical vendors for covered services. All participating states are required to provide inpatient and outpatient hospital services; laboratory and X-ray services; skilled nursing facility services for individuals aged 21 or older; family planning services and supplies; rural health clinic services; physician services; certified nurse midwife services; and early and periodic screening, diagnosis, and treatment (EPSDT) for those under age 21.

States may also choose to cover such additional services as home and community-based services; inpatient psychiatric services (for those under 21); services in intermediate care facilities; physical therapy; private duty nursing services; care provided by other licensed practitioners; dental care (outside of the EPSDT program); and prescribed drugs, dentures, and eyeglasses.

States may also limit the number of days or visits covered, require participants to obtain prior authorization before using certain services, or require nominal copayments for optional services. Although copayments are not permitted for services to children under age 18, pregnancy-related services, and family planning services and supplies, monthly

[1]The Medicare Catastrophic Coverage Act of 1988 (Public Law 100-360), enacted on June 30, 1988, further extends this mandated coverage. Effective July 1, 1989, states must cover pregnant women and infants with family income at or below 75 percent of the federal poverty level and, effective July 1, 1990, those with incomes at the poverty level. States that already offer coverage to pregnant women and infants with incomes between 75 and 100 percent of the poverty level must continue to do so.

premiums may be charged to infants and pregnant women whose family income equals or exceeds 150 percent of the federal poverty level. Coverage for pregnant women eligible under state option is limited to pregnancy-related medical services, including family planning services and treatment of conditions that could complicate the pregnancy. Pregnancy-related and postpartum services continue to be available for 60 days following the end of the month in which the pregnancy ends.

The EPSDT program was authorized to begin in 1969. States may provide services directly or through referral, but must inform eligible participants of available services and provide or arrange for examinations and evaluations of mental and physical health and treatment for problems identified if the state ordinarily covers such treatment.

Administrative Structure

The Health Care Financing Administration (HCFA) of the Department of Health and Human Services provides matching grants to states, which administer the program through state agencies. The federal government's share of a state's Medicaid program expenditures is inversely related to the per capita income of the state and ranges from 50.0 to 79.65 percent. Administrative costs are generally matched at 50 percent except for certain items—such as installation of computer systems—which are matched at a higher rate. States are responsible for setting reimbursement rates.

Relationships With Other Programs

The federal Maternal and Child Health Services Block Grant and the Community Health Center, Migrant Health Center, Family Planning and Child Immunization programs subsidize providers of free or reduced-fee health services. The WIC Program provides free nutritional screening and education and food supplements to certain low-income women and children at nutritional risk. States may set the need standard for this program as high as 185 percent of the federal poverty level.

Recent Funding and Participation Levels

Total fiscal year 1985 program costs were $41 billion, $22.7 billion paid by the federal government. Of 21.8 million recipients that year, 9.7 million were children (and 5.5 million were adults) in AFDC families, another 1.2 million were non-cash-assisted recipients and include some of the groups served under these eligibility extensions. While they represented 5.6 percent of the recipients, non-cash-assisted recipients accounted for only 2.1 percent of Medicaid payments. The majority of payments (73.5

percent) were made on behalf of SSI-related recipients, who represented only 27.9 percent of all recipients.

Illustrations of the Criteria

Tables IV.1-IV.3 provide illustrative indicators of the evaluation criteria for the Medicaid eligibility extensions as well as suggested measures and analyses, where these seemed to be indicated.

Table IV.1: Medicaid Eligibility Extensions Indicators—Need for the Program

Evaluation criterion	Indicators	Measures and analyses
Problem magnitude	Extent of population of pregnant women, infants, and children lacking health insurance	Relationship of family income to the federal poverty level
		Eligibility category
		Family structure and employment status
		State and local area
		Trends over time in proportion of uninsured low-income pregnant women and children
	Extent of insured population of pregnant women, infants, and children lacking coverage for preventive health care	Relationship of family income to federal poverty level
		Eligibility category
		State and local area
	Extent of poor and near-poor pregnant women, infants, and children ineligible for Medicaid through AFDC and SSI programs	Eligibility category
		Family structure and employment status
		State
	Adequacy of the state family income and resource limits for the AFDC program	
Problem seriousness	Relationship of lacking health insurance to receipt of health care, by family income	Timing and frequency of prenatal, well-baby, and well-child care
		Early detection and treatment of childhood diseases
		Receipt of childhood immunizations by age 2 or by school entry
		Having a regular source of health care
		Receipt of dental care
		Utilization of services by children with chronic health problems
	Relationship of receipt of preventive health services to health status	Incidence of poor pregnancy outcomes (low-birthweight infants)
		Incidence of perinatal mortality
		Incidence of chronic and acute childhood illnesses
	Cost of care for preventable conditions	Delivery and postpartum care for complicated pregnancies
		Neonatal intensive care
		Care for chronic childhood diseases

(continued)

Evaluation criterion	Indicators	Measures and analyses
Duplication	Availability by state and local area of free or reduced-fee health care to uninsured low-income pregnant women and children through other federal programs	Maternal and Child Health Services Block Grant
		Community and Migrant Health Centers
		WIC Program
		Head Start program
		Indian Health Service
		Veterans Administration
	Comprehensiveness of services (relative to Medicaid) available through these federal programs	Preventive services for pregnant women and children
		Diagnostically-related outpatient care
		Dental care, hospitalization, and other services such as pharmaceuticals
	Extent to which these federal programs serve targeted populations	Income requirements as compared to state's Medicaid standards
		Enrollment of uninsured low-income pregnant women and children
	Availability of free or reduced-fee health care to uninsured low-income pregnant women and children through state and locally-funded programs	Private charity hospitals and philanthropy
		State and local area
	Comprehensiveness of the services available through these nonfederal programs	Preventive services for pregnant women and children
		Diagnostically-related outpatient care
		Dental care, hospitalization, and other services such as pharmaceuticals
	Number of uninsured low-income pregnant women and children served by these nonfederal programs	
	Comprehensiveness of private insurance coverage of preventive services for pregnant women and children	Relationship of family income to poverty level
	Coverage of handicapped children's health and rehabilitation services through the Education for All Handicapped Children Act	

Table IV.2: Medicaid Eligibility Extensions Indicators—Implementation of the Program

Evaluation criterion	Indicators	Measures and analyses
Interrelationships	Access to follow-up treatment for problems identified in screening	Extent of Medicaid contracts with federally-supported and other clinics and health centers
		Participation of private physicians (obstetricians, family physicians, and pediatricians) in Medicaid
		Availability of special programs for high-risk pregnant women (comprehensive teenage pregnancy programs)
	Accessibility of health care providers to patients	Time spent with patient, patient time spent waiting
		Open weekends and evenings
		Located near target populations
	Extent of state and local coordination with health care providers	Informing hospital discharge planners of eligibility requirements and covered services
		Permitting providers to distribute and help patients make application
		Co-location of Medicaid eligibility workers
		Automatic eligibility determinations for WIC applicants
	Extent of federal and state coordination with other federal health programs by state	CDC[a] state grants for purchase and delivery of vaccines
		Maternal and Child Health Services Block Grant
	Extent of coordination with public assistance agencies	Automatic eligibility determination for AFDC, SSI, and Food Stamp program applicants
	Limitations of continuity of care and access to care through other parts of Medicaid program, by state	Demonstration projects using HMOs[b] or case managers for cost-containment
		Proximity of Medicaid reimbursement rates to local providers' usual fees for service
Program fidelity	Number of states adopting each optional eligibility extension, including presumptive eligibility for pregnant women	
	Effects of state cost-control strategies on range of coverage	Lengthy neonatal hospital stays
		Care for chronically-ill, technology-dependent children
		Number of medically-recommended preventive care visits for pregnant women and children
		Medical conditions not directly related to pregnancy
	Extent to which EPSDT program provides prevention, treatment, and assistance services over and above regular Medicaid coverage, by state and local area	Health care
		Transportation assistance
		Outreach to eligible populations, including homeless

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Evaluation criterion	Indicators	Measures and analyses
Administrative efficiency	Improved access through providing presumptive eligibility to pregnant women applicants	Type of providers approved to employ this provision
		Participation of health care providers
	Complexity of program application process	Patient's willingness or ability to complete application
		Length of application approval process
		Difficulties associated with verification procedures
		Complexity of application form
		Similarity of method for determining income eligibility to methods used by other needs-based programs
	Length of approval process for prior authorization of health services, where required	Applications taken at health centers and clinics
		Quality and method of publicity
	Extent of outreach to potential program participants	
	Degree of integration of EPSDT and Medicaid patient medical records	

[a]Centers for Disease Control.

[b]Health Maintenance Organizations.

Table IV.3: Medicaid Eligibility Extensions Indicators—Effects of the Program

Evaluation criterion	Indicators	Measures and analyses
Targeting success	Enrollment of eligible population, for the options each state adopted	Relationship of family income to poverty level
		Eligibility category
		Family structure and employment status
		Prior insurance coverage
		Homelessness
		State and local area
		Urban or rural residence
	Increased participation rates over time	
Achievement of intended objectives	Improved access to health care among the newly enrolled, by relationship of family income to poverty level	Earlier receipt and extended continuity of care
		Receipt of medically-recommended frequency and timing of prenatal, well-baby, and well-child care, by maternal age and marital status
		Treatment of problems identified in EPSDT screening
	Improved quality of care received	Decreased use of hospital emergency rooms as source of nonemergency care
Cost-effectiveness	Costs of prenatal care versus reductions in expenditures for treating complicated births and for neonatal intensive care	Full federal, state, and local costs of financing such care
	Costs of preventive health care for children versus reductions in expenditures for treating childhood chronic diseases	Full federal, state, and local costs of financing such care
	Costs of incorrectly granting presumptive eligibility versus effects of improving early access to prenatal care	
	Full costs and effects of expanding Medicaid eligibility versus subsidizing more clinics and health centers through federal health care block grants	

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Evaluation criterion	Indicators	Measures and analyses
Other effects	Improvement in health status of low-income pregnant women and children among newly enrolled	Reduced incidence of poor pregnancy outcomes (low birthweight and preterm birth)
		Reduced incidence of perinatal mortality and morbidity
		Reduced length of neonatal hospital stays
		Reduced incidence of chronic illness and disability
	Reduced Medicaid expenditures in the long term for infants and children	More frequent use of less expensive preventive services
		Reduced incidence and duration of neonatal intensive care
		Reduced use of acute services in an inpatient setting
	Reduced expenditures for other programs	Long-term institutional care
		Special education
		Early intervention programs for infants and toddlers
	Redirection of block grant and Community and Migrant Health Centers funds	Decreased expenditures on primary health care
		Increased outreach and support services (e.g., transportation)
		Expanded service to persons ineligible for Medicaid
	Increased federal Medicaid expenditures in the short term	
	Increased work incentives by detaching eligibility from welfare receipt	Increased participation in workfare programs offering Medicaid eligibility
	Societal goals	Increased reliance on the government for health insurance coverage
		Contribution to the nation's progress toward the Surgeon General's goals for reducing infant mortality and low birthweight

Child Welfare Services Program

Program Description

Authorization

The Child Welfare Services program was authorized in 1968 as Title IV-B of the Social Security Act of 1935 by Public Law 90-248 and was restructured by Public Law 96-272 in 1980.

Problems

The neglect, abuse, exploitation, and delinquency of children sometimes require family services and temporary living arrangements outside the home. However, many foster care placements are unnecessary and inappropriate; inadequate services are provided to strengthen and reunify families and prevent the need for foster care; and states have poor information about children in foster care.

Purpose and Goals

The program assists states and localities in providing services to children and their families in order to protect and promote the welfare of children; to prevent or remedy the neglect, abuse, exploitation, or delinquency of children; to prevent unnecessary separation of children from their families; to return children in foster care to their families or place them in suitable adoptive homes; and to ensure adequate care of children in foster placement.

Program Operation

This program provides federal matching funds—without federal income eligibility requirements—to state agencies for the provision of child welfare services for the above purposes. The 1980 child welfare reforms require that in order to receive title IV-B incentive funds over a certain minimum, a state must at least meet five conditions: (1) have a foster care information system from which the status, demographic characteristics, location, and placement goals for every child in foster care during the past 12 months can be determined; (2) have a case plan designed to achieve the least restrictive (most family-like) placement in close proximity to the parents' home; (3) have an independent administrative review of the case every 6 months to determine the continuing appropriateness of services and continuing necessity of placement and to project when the child can be returned home or otherwise permanently placed; (4) have a dispositional hearing—within 18 months of original foster care placement—in a family or juvenile court or other competent court-appointed body; and (5) offer services to help children, where possible, return to their home or to obtain another permanent placement such as

adoption. Once $266 million is appropriated for this program for 2 consecutive years, a state must provide preplacement services aimed at preventing the need for removing the child from the home in order to receive its full allotment of federal matching funds.

Administrative Structure

The HHS Administration for Children, Youth, and Families (ACYF) allocates funds to state agencies on the basis of, among other factors, the state's population under age 21 and per capita income. Grants are to represent no more than 75 percent of the state and local program costs. There are no federal requirements regarding distribution of funds within the state. Allocations above a minimum are available to a state only if ACYF determines that the 1980 reforms (above) have been implemented. In fiscal year 1986, 40 states were found to be in compliance; the rest were either unapproved or awaiting decision. State agencies are responsible for administering the funds.

Relationships With Other Programs

According to HHS estimates, the majority of federal and state funds for child welfare services (through this and other related programs described below) are spent on foster care services and the remainder on counseling and rehabilitation, adoption subsidies and services, and child protective services.

The Title IV-E Foster Care program provides federal matching funds for state expenditures on foster care maintenance payments and related administrative costs (including staff training) for the care of children eligible for the Aid to Families With Dependent Children program. Eligibility for these funds is linked to implementation of certain of the 1980 child welfare reforms noted above and others. The Title IV-E Adoption Assistance program provides matching funds for state programs to lessen the barriers to adoption of children with "special needs."

The Title IV-E Independent Living initiatives assist states and localities in establishing and carrying out programs directed at assisting foster care children age 16 or older in preparing for leaving foster care. Services eligible for federal funds include enabling children to seek a high school diploma (or its equivalent) or enroll in vocational training; training in daily living skills, budgeting, and career planning; services coordination and the establishment of outreach programs; and development of individualized plans for participants.

The Social Services Block Grant (SSBG) supports a variety of activities, including preventing and remedying the abuse, neglect, or exploitation of children and certain adults and preserving, rehabilitating, or reunifying families. It is estimated that about $500 million of the $2.7 billion appropriated for these grants is spent on child welfare, foster care, and adoption activities.

Also under title IV-B, federal grants are available to public or nonprofit institutions of higher learning, and public or nonprofit agencies and organizations engaged in research or child welfare activities for research and demonstration projects in the field of child welfare. Contracts or jointly financed cooperative agreements are also available to state and public and other organizations for similar purposes. Additionally, federal grants are available to public or nonprofit institutions of higher learning for special projects for training personnel in the field of child welfare, including traineeships.

Recent Funding and Participation Levels

Appropriations for fiscal year 1986 were $198 million, $222.5 million for fiscal year 1987, and $239.35 million for fiscal year 1988. There are no requirements to report program participation, but data from the Voluntary Cooperative Information System show that in 1984, 462,000 children received foster care services, 193,000 entered foster care, and 184,000 left foster care.

Illustrations of the Criteria

Tables V.1-V.3 provide illustrative indicators of the evaluation criteria for the Child Welfare Services program as well as suggested measures and analyses, where these seemed to be indicated.

Table V.1: Child Welfare Services Program Indicators—Need for the Program

Evaluation criterion	Indicators	Measures and analyses
Problem magnitude	Incidence (number and rate) of children and families in need of child welfare services, by state and local area	Victim of abuse or neglect
		Absence or incapacity of parent or guardian
		Child's disability
		Family conflict
		Child's status offense or delinquency
		Adoption incomplete
		Adoption disrupted
	Incidence of inappropriate foster care placements	Lengthy stays in temporary facilities
		Status offenders in corrections or detention facilities
		Inadequate supervision for multiproblem or seriously troubled youth
	Incidence of placement difficulties	Age at initial referral and reason
		Ethnicity
		Multiple placements
		Rate of returning to foster care
		Adoption disruptions
		Time spent in foster care before permanent placement found
	Adequacy of state and local resources	Staff caseloads compared to accepted standards
		Time after referral before services provided
		Availability of foster and adoptive families relative to need
		Overcrowded facilities
		Availability of residential care relative to need
	Adequacy of local agency services	Staff qualifications and experience
		Extent of planned services delivered
		Availability of home-based services or other supervision alternatives
		Quality of screening and training of foster and adoptive parents
	Trends over time in above indicators of problem magnitude	

(continued)

Evaluation criterion	Indicators	Measures and analyses
Problem seriousness	Relationship of inadequate child welfare resources and services to foster care problems	Incidence of neglect or abuse in placements
		Incidence of deaths and repeated abuse in open child protection cases
		Dissolution rates for foster care and adoptive placements
		Irregularity of foster children's visits with parents
		Length of time in foster care
		Rates of recidivism to foster care
	Relationship of foster care placement to children's healthy development	Emotional and cognitive development
		Physical health
		Behavioral problems in school
		Academic performance
		Substance abuse
		Delinquency
		Later ability to hold a job
		Homelessness as an adult
		Later abuse or neglect of their own children
	Relationship of child abuse and neglect to children's healthy development	Emotional and cognitive development
		Physical health
		Behavioral problems in school
		Academic performance
		Substance abuse
		Delinquency
		Later ability to hold a job
		Later abuse or neglect of their own children
	Co-incidence of child abuse with spouse abuse and other adult criminal behavior	

(continued)

Evaluation criterion	Indicators	Measures and analyses
Duplication	Extent to which Title IV-E Foster Care and Adoption Assistance programs support services to families of children in foster care	Nature of family services covered by title IV-E
		Proportion of foster care population eligible for title IV-E matching funds
		Extent of support provided for training child welfare workers
	Extent to which Title IV-E Independent Living initiatives provide needed services to older children in foster care	Nature and quality of services provided
		Proportion of foster care population served
	Extent to which federal education programs for handicapped children provide support to families referred for child welfare services	Nature and quality of services provided
		Proportion of child welfare population eligible and served
	Extent to which DOJ programs support improvement of state and local practices	Services for status offenders
		Crisis intervention with families in conflict
		Juvenile and family court procedures and resources
		Investigation and referral of reported child or spouse abuse
		Extent to which DOJ programs serve children in foster care
	Extent to which federal Child Abuse Prevention and Treatment demonstration funds support improvement of family support services	Relevance of demonstration projects to child welfare agency activities
		Size and distribution of grants
	Size, permanency, and geographic distribution of other federal mental health or social service programs (especially Social Services Block Grant) which support improvement in local services	Crisis intervention and continuing services for families in conflict
		Runaway and homeless youth
		Truants and school dropouts
		Rehabilitation and social support for families of individuals with mental, emotional or physical handicaps
		Adoption and foster care
		Substance abuse
		Preventive family development
	Size, permanency, and geographic distribution of private and nonfederal funds supporting mental health and social services	Crisis intervention and continuing services for families in conflict
		Shelter and services for runaway and homeless youth
		Services for truants and school dropouts
		Rehabilitation and social support for families of individuals with mental, emotional, or physical handicaps
		Adoption and foster care
		Substance abuse treatment
		Preventive family development services

Table V.2: Child Welfare Services Program Indicators—Implementation of the Program

Evaluation criterion	Indicators	Measures and analyses
Interrelationships	Extent to which state laws and regulations affect implementation of federal reforms	Definitions of child physical and sexual abuse and emotional neglect
		Procedures and evidence required for substantiating abuse and neglect
		Types of persons required to report suspected nonaccidental injury and neglect of children
		Required response time between receipt of abuse report and conducting a home investigation
		Jurisdictional and procedural requirements for emergency removal of child from home
	Availability of mental health and social services to which to refer children and families	
	Extent of case coordination with local juvenile justice, mental health, education, protective services, foster care, adoption, and other social service agencies	Extent of coordination of services to multiproblem families
		Number of children screened out of the delivery system by child protective services
		Number of children screened in or out of delivery system by juvenile justice system
	Extent of coordination with related federal programs in child welfare	Coordination of funds from title IV-B child welfare training grants and title IV-E funds to provide adequate staff training
		Dissemination to service providers of research and demonstration project results on how to improve child welfare services
	Adequacy of state payment rates for foster care board and foster parent services for recruitment and retention of foster families	

(continued)

Evaluation criterion	Indicators	Measures and analyses
Program fidelity	States's ability to track the characteristics, status, and location of children in foster care within past 12 months, by state	Existence and adequacy of statewide information systems
		Accuracy of data elements
		Completeness of census
		Adequacy of procedures for maintaining accuracy and completeness
		Accessibility of data
	Extent and adequacy of preplacement preventive services, by state and local area	Proportion of cases that receive services before removing child from the home (counseling, day care, homemakers, crisis intervention)
		Concordance of services provided with assessment of family's needs
		Degree to which courts enforce mandate for "reasonable efforts" to prevent child removal
	Adequacy of case plan system, by state and local area	Extent of involvement of child and family in developing plan
		Extent to which placement and services reflect child's needs
		Thoroughness and specificity of plans
		Extent to which services are provided as planned
		Evidence of attempts to return child home or locate suitable permanent placement
	Adequacy of case review system, by state and local area	Independence of administrative review of foster care cases, role of citizen review panels (where used)
		Proportion of cases receiving administrative review every 6 months
		Proportion of cases receiving dispositional court hearing within 18 months of placement
		Thoroughness of reviews of appropriateness of services and placement
		Extent to which reviews result in actual changes for child
	Extent and adequacy of reunification services provided, by state and local area	Evidence of attempts to determine feasibility of returning child home
		Extent of services and support (transportation) to facilitate parental visits
		Extent of services provided to prepare child and family for child returning home
		Proportion of reunified families continuing to receive services and of what type
	Adequacy of recruitment, screening, and monitoring of foster homes for suitability and adequacy of licensing criteria, by state and area	

(continued)

Evaluation criterion	Indicators	Measures and analyses
Administrative efficiency	Degree to which compliance with 1980 reforms is enforced	Timeliness of both federal and state on-site reviews
		Thoroughness of reviews
		Use of legislated sanctions
	States' ability to track current location and status of children in placement and children receiving services in the home	
	Existence and adequacy of financial reporting systems	No more funds than allowed are spent on foster care maintenance payments
	Administrative burden on state and federal agencies of handling title IV-E children separately from other children in foster care	Duplication of AFDC program records or staff

Table V.3: Child Welfare Services Program Indicators—Effects of the Program

Evaluation criterion	Indicators	Measures and analyses
Targeting success	Extent to which current federal grant allocation formula targets resources to states most in need	Incidence of children in need of services
		Ability of state agency to provide required services
	Increased proportion and number of intact families served	Increased absolute number of families receiving preventive services
Achievement of intended objectives	Increased number of states in compliance with 1980 reforms	Foster care placement information system
		Preplacement preventive services
		Case plan and review system
		Family reunification services
	Reduction in state spending on foster care relative to preventive and reunification services	Reduction in proportion of expenditures for Title IV-E Foster Care
		Reallocation of unused title IV-E funds to protective and preventive services
	Reduction in child abuse and neglect in families receiving child welfare services	Reduced number of child abuse or neglect reports received
		Reduced incidence of nonaccidental injury and death to children
		Reduced incidence of chronic neglect
	Improved quality of foster care home and institutional placements	Improved or increased services provided during placement
		Increased number of qualified foster care homes available, especially among minorities and in cities
		Increased frequency of parental visits, where possible and appropriate
		Improved quality of interaction between child and parents
		Reduced incidence of abuse and neglect in these placements
		Increased achievement of the least restrictive placement required
	Reduction in number of inappropriate placements	Multiple placements
		Lengthy stays in temporary facilities
		Inadequate supervision for seriously troubled youth
	Reduction in length of time children spend in foster care awaiting adoption, reunification, other permanent placement	
	Improvement in state local resources	Improvement in quality of staff experience and qualifications
		Conformance of staff caseloads to accepted standards
		Increased range of services to families
		Increased consideration of alternatives to foster care placement

(continued)

Evaluation criterion	Indicators	Measures and analyses
Cost-effectiveness	Full costs and effects of emphasizing preplacement and reunification services over foster care placement	Children's well-being
		Agency staff workload
	Costs of administering the Title IV-E Foster Care program separately from the Title IV-B Child Welfare Services program	Administrative burden
		Cost-effectiveness of funding staff training through title IV-B versus title IV-E
	Costs and effects of using child welfare workers as mental health providers instead of referral to mental health professionals	Costs of comparable staff training
		Potential slippage in coverage through referral for services
	Costs and effects of targeting services to multiproblem or more serious cases	
Other effects	Improved well-being of children and families served	Reduced number of school dropouts
		Reduced number of runaways
		Reduced juvenile delinquency
		Improved family relations
		Extent of families' problems resolved
		Reduced stress of other problems on multiproblem families
	Displacement of local funds	Decreased level of state and local public and private support for child welfare services
	Unintended consequences of child welfare reforms	Increased incidence of children returning to foster care after premature discharge
		Exacerbation of child and family problems due to delayed entry into foster care
		Increased proportion of seriously troubled children entering foster care
		Increased need for institutional foster care placements

Juvenile Justice and Delinquency Prevention Grants

Program Description

Authorization

The Juvenile Justice and Delinquency Prevention grants program was authorized by Public Law 93-415 in 1974 and is currently authorized through fiscal year 1988.

Problems

High rates of juvenile delinquency, especially serious offenders and alcohol and drug abusers, represent a threat to life and property and a waste of human resources. Inappropriate procedures are used for handling juvenile offenders, especially status offenders, and resources are inadequate at the state and local levels to respond effectively to both of these problems.

Purpose and Goals

The purposes of the Juvenile Justice and Delinquency Prevention Program include providing federal resources, leadership, and coordination to (1) develop and implement effective methods of preventing and reducing juvenile delinquency; (2) divert juveniles from the traditional juvenile justice system and provide alternatives to institutionalization; (3) improve the quality of juvenile justice in the United States; (4) increase the capacity of state and local governments and public and private agencies to conduct effective juvenile justice and delinquency prevention and rehabilitation programs; and (5) provide research, evaluation, and training services in the field of juvenile delinquency prevention.

Program Operation

The Office of Juvenile Justice and Delinquency Prevention (OJJDP) of the Department of Justice (DOJ) awards formula grants to states and "special emphasis" discretionary grants to public and private nonprofit agencies to improve juvenile delinquency prevention and juvenile justice practices. State agencies, called Criminal Justice Coordinating Councils, administer the formula grants.

The state formula grants are awarded to state planning agencies from a formula that bases awards, over a minimum of $225,000, on the size of the state population under age 18. Grant awards are contingent on approval of a 3-year state plan (and subsequent annual updates) as well as compliance with federal mandates concerning the handling of juveniles (see below). Not less than 75 percent of the grant must be used

for "advanced techniques" in developing, maintaining, and expanding programs and services that aim to prevent delinquency (through the home and school); provide diversion from, and community-based alternatives to, secure facilities; provide a diversity of alternatives within the justice system; establish standards; provide rehabilitation services; generally improve the system's handling of serious offenders; or coordinate services between the juvenile justice, child welfare, and criminal justice systems.

The special emphasis grants are awarded directly by OJJDP to public or private agencies or individuals. These grants must be used for developing and implementing or maintaining community-based alternatives to institutionalization, the means for diverting juveniles from the juvenile justice and corrections systems, juvenile advocacy programs, prevention and treatment programs for serious offenders (including gang members), a coordinated national program of law education, and programs to strengthen and maintain the family unit to prevent or treat delinquency. Each of these purposes must be covered each fiscal year. In addition, up to 10 percent of these funds can be used to develop and implement new approaches to prevent delinquency through education and employment-related programs, remove juveniles from adult jails, and encourage state adoption of model national standards through amending state laws if necessary.

Administrative Structure

OJJDP monitors the states' progress on the federal mandates to deinstitutionalize status offenders and nonoffenders; separate detained juveniles from adult offenders incarcerated because they have been convicted of a crime or are awaiting trial on criminal charges; and with some exceptions, remove juveniles from adult jails and lockups.

Within OJJDP, the National Institute of Juvenile Justice and Delinquency Prevention (NIJJDP) provides training and technical assistance to states and localities, develops and supports model state legislation and programs for preventing and controlling delinquency, supports research and evaluation, and synthesizes and disseminates information on the magnitude, causes, prevention, and control of juvenile delinquency through the Juvenile Justice Clearinghouse.

OJJDP also participates in the coordination of federal agency involvement in juvenile justice activities through membership on the Coordinating Council on Juvenile Justice and Delinquency Prevention. The Council is

an independent federal agency consisting of representatives of 18 federal agencies, divisions, and bureaus whose programs are concerned with juvenile delinquency.

Relationships With Other Programs

Several federal programs support related demonstrations and ongoing services aimed at, for example, assisting youth with education and employment and providing social services to families. OJJDP can transfer discretionary funds to any executive agency to support programs with related purposes. The Coordinating Council represents an effort to coordinate these federal activities.

Recent Funding and Participation Levels

Annual appropriations for fiscal years 1985-1987 were $70.2 million and for 1988, $66.7 million. The two types of grants receive 81.5 percent of these funds; 11 percent is reserved for NIJJDP activities. The remaining 7.5 percent is for OJJDP technical assistance and other administrative responsibilities.

Illustrations of the Criteria

Tables VI.1-VI.3 provide illustrative indicators of the evaluation criteria for the Juvenile Justice and Delinquency Prevention Grants program as well as suggested measures and analyses, where these seemed to be indicated.

Table VI.1: Juvenile Justice Program Indicators—Need for the Program

Evaluation criterion	Indicators	Measures and analyses
Problem magnitude	Incidence and geographical distribution of juvenile delinquency	Frequency and percent of juvenile offenses (and offenders) that are status versus criminal offenses serious criminal offenses alcohol or drug-abuse related gang related committed by repeat offenders
		Percent of juveniles committing crimes
		Percent of their crimes by major crime types
		Trends over time
	Inappropriate handling of juveniles, by state and local area	Incidence of juveniles held in adult facilities (and percent held there but separated by "sight and sound" from adults)
		Incidence of status offenders held in secure and nonsecure facilities (and percent of states using valid court order amendment to detain status offenders in secure facilities)
	Availability of alternatives within and outside the juvenile justice system, by state and local area	Diversion policies
		Community-based residential facilities
		Nonresidential programs providing supervision and family services
		Programs for nonoffenders who contact the juvenile justice system
	Adequacy of state and local resources, by state	Extent of overcrowding in detention and correctional facilities and in residential alternative settings
		Excessive caseloads for courts and probation staff
		Percent of institutionalized youth who receive required education, health, mental health, employment preparation, and rehabilitation services
		Trends over time

(continued)

Evaluation criterion	Indicators	Measures and analyses
Problem seriousness	Costs to society of delinquency	Incidence of victims by age and type of crime
		State and local expenditures per offender, from enforcement through detention, incarceration, probation, and community alternative programs
		Dollar value of property damage and loss
		Incidence of personal injury and death
	Consequences associated with improper handling of juveniles	Abuse of youths in institutions
		Suicide and violence among those institutionalized
		Deprivation of minors' rights
		Youths released from institutions without employment preparation
		Recidivism with more serious offenses
	Relationship of committing juvenile offenses to later social difficulties	Dropping out of school
		Inability to hold a job
		Substance abuse
		Committing offenses as an adult
Duplication	Geographic distribution, size and permanency of other DOJ programs and activities that support improvement of state and local justice systems	Law enforcement
		Diversion
		Adjudication
		Sentencing
		Detention
		Rehabilitation of juveniles
		Extent to which gangs and serious or drug-related offenders are targeted
	Geographic distribution, size, and permanency of nonfederal funds for identifying and promoting use of effective and appropriate juvenile justice techniques	Privately funded research and demonstrations
		State and local government programs
	Geographic distribution, size, and permanency of programs funded by other agencies (Education, Labor, Health and Human Services) which target delinquent youth or youth at risk of delinquency	Prevention of school violence and dropouts
		Child protective services and foster care
		Family-oriented social services
		Preparation for employment
		Substance abuse

Table VI.2: Juvenile Justice Program Indicators—Implementation of the Program

Evaluation criterion	Indicators	Measures and analyses
Interrelationships	Extent to which state laws and regulations act as barriers to modifying state and local practices to federal models	Classification of status offenses as criminal offenses
		Lowering the age of juvenile status
		Ability of states to waive juveniles to adult courts
		Limitations on or protection of parents' and minors' civil rights
		Size, staffing, or activity requirements for detention and correctional facilities
		Licensing, regulations, and reimbursement policies that limit participation of the private sector in developing alternatives
	Availability of the family, mental health, and other social services needed for diversion of nonserious offenders	Community-based residential facilities
		Nonresidential services
		State and local area
	Extent of coordination between the juvenile justice system and local child welfare and mental health systems	Case referrals
		Coordination of planning and resources to make diversion alternatives available
		State
	Size of the formula grants relative to state and local expenditures on their juvenile justice system	
Program fidelity	Conformance of approved formula grant plans and actual expenditures with legislation and regulations	Proportion of funds spent on priority activities
	Conformance of the special emphasis grants awarded with the legislation and regulations	Proportion of funds spent on priority activities
	Adequacy of federal and state monitoring of state progress on mandates	Frequency and depth of on-site inspections
		Quality of data provided by the states
		Federal enforcement of legislated sanctions against states not found in compliance with mandates
	Responsiveness of OJJDP to local practitioners' needs (within the limits of the legislation)	Information development
		Technical assistance and training
		Development of national standards and model legislation
		Award of special emphasis grants
	Extent of community input into state plans for allocating the formula grant funds, by state	State Advisory Groups

(continued)

Evaluation criterion	Indicators	Measures and analyses
Administrative efficiency	Extent to which program evaluation is built into special emphasis demonstration projects and quality of evaluations	
	Comprehensiveness of OJJDP's identification of promising juvenile justice practices in the field, as well as those sponsored or developed by other executive agencies	Coordination with other federal research sponsors
	Timeliness of OJJDP's dissemination of results of its research and evaluation syntheses and response to information requests	State planning agencies and program managers
		Other OJJDP staff and contractors involved in technical assistance and training, development of national standards and model legislation, and award of special emphasis grants
	OJJDP's ability to track activities funded by both formula and special emphasis grants	Amount of funds and dates of expected products
		Coverage of purposes enunciated in the legislation
		Monitoring and justification of overhead expenditures
	Adequacy of state agencies' monitoring of local compliance with approved plan for formula grant	Financial management
		Participants' receipt of services

Table VI.3: Juvenile Justice Program Indicators—Effects of the Program

Evaluation criterion	Indicators	Measures and analyses
Targeting success	Extent of use of OJJDP's special emphasis grants and training and technical assistance	Help states with mandated activities
		Meet identified needs of states and localities (within legislative purposes)
	Extent to which allocation formula (as currently constructed) reflects state differences in need	Incidence and seriousness of delinquency
		Adequacy of state and local resources
		Progress on federal mandates
		Availability of alternatives to juvenile justice system
	Extent to which states allocate funds to localities most in need	Amounts allocated reflect differences in local resources
		Conformance of funded projects with identified needs
	Extent to which local projects reach intended target populations	

(continued)

Evaluation criterion	Indicators	Measures and analyses
Achievement of intended objectives	Extent to which OJJDP information development activities and special emphasis grants identify effective and ineffective services and handling procedures	Quality of evidence on effectiveness provided by evaluations funded
		Adequacy of study designs
		Quality of research information provided
	Special projects' achievement of objectives	Immediate goals, (strengthened family, reduced youth alienation, increased school completion)
		Long-term goals, (diminished frequency or seriousness of crimes committed)
	Increased use of alternatives to traditional juvenile justice system	Community-based residential facilities
		Day programs and other alternatives to residential facilities
		Diversion to family and mental health services
	Correction of identified problems in juvenile justice system procedures	Improved conditions of confinement
		Decreased suicides and violence in facilities
		Change in states' juvenile codes to reflect national standards and model legislation
	Deinstitutionalization of status offenders	Reduction or elimination of pretrial detention
		Reduction or elimination of commitment to institutions for serious offenders
		Number of states in compliance
		Extent of problem in states not in compliance
	Separation of juveniles from adult offenders	Reduction or elimination of juveniles from adult jails and lockups
		Separation by sight and sound in such facilities
		Number of states in compliance
		Extent of problem in states not in compliance
	Output of Coordinating Council on Juvenile Justice and Delinquency Prevention	Joint projects
		Position statements
		Procedures for joint review of program or project proposals
		Shared or joint dissemination of promising practices
	Use of the results of OJJDP's information collection and syntheses	National standards
		Model legislation
		Advice to states for state plans
		Training and technical assistance activities
		Selection of special project grants
	Number of OJJDP-funded projects continued with state and local funding	

(continued)

Evaluation criterion	Indicators	Measures and analyses
Cost-effectiveness	Full costs and effects of prevention efforts	Services to prevent delinquency among at-risk youth versus those to reduce frequency and seriousness of recidivism among offenders
		Preventive services provided through child welfare, mental health, and other social service delivery systems versus through juvenile justice system
	Full costs and effects of improvements in handling juveniles	Improving handling of juvenile offenders versus identifying new methods to prevent and reduce juvenile delinquency
Other effects	State revisions to their juvenile codes	Recategorizing status offenses as more serious crimes or as mental health concerns
		Using valid court order to detain status offenders in secure facilities
		Lowering the age of juvenile status
		Easing the ability to waive juveniles to adult court and adult facilities
	Increased citizen awareness of and participation in juvenile justice system	State Advisory Group activities
	Equity in OJJDP procurement process	Number and dollar amount of contracts awarded through open competition
		Adequacy of justifications for sole-source procurements
	Unintended effects of recommended handling of juvenile offenders	Increased or more serious offenses committed by juveniles released through diversion or deinstitutionalization who did not receive needed services

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