Evidence of Effectiveness in AmeriCorps-Funded Interventions

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CONTENTS

TABLES

FIGURES

EXECUTIVE SUMMARY

Agencies throughout the federal government and other grant-making institutions are increasingly conducting systematic evidence reviews and synthesizing the results of well-executed research to identify interventions that have evidence of effectiveness. These efforts can help funders make strategic decisions on how they can most effectively and efficiently address individual and community needs. These reviews and syntheses can also enhance funders' decisions about scaling up specific interventions that show the most promise in order to expand the scope of their impact.

AmeriCorps invests significant resources in interventions designed to improve lives and strengthen communities and in evaluating the effectiveness of these interventions.[1] To gain insights about which funded interventions work and which of those might be ready to scale, the agency funded the project known as Scaling Evidence-Based Models in 2016. Conducted by Mathematica, this project is designed to help deepen the agency's understanding of the most effective interventions it has funded and its knowledge base on issues involved in scaling them. This information will also help inform the agency's interest in identifying the intervention components that are critical for an intervention's effectiveness. The project has two parts. The first—the subject of this report—aims to identify AmeriCorps-funded interventions with evidence of effectiveness, which we sometimes call interventions that work. We define evidence of effectiveness as rigorous research that has shown favorable impacts on the majority of the targeted outcomes for people receiving the intervention services. The second part of the process—discussed in the companion report "Planned Scaling Activities of AmeriCorps-Funded Organizations" (Selekman et al. 2020)—is meant to identify how the effective interventions and the organizations implementing them might be ready for scaling.

Research questions

1. What interventions consistently demonstrate evidence of effectiveness for their targeted outcomes?
   - Which AmeriCorps-funded interventions demonstrate evidence of effectiveness on participants' outcomes?
   - Among interventions with evidence of effectiveness, what are their characteristics?
2. What intervention characteristics demonstrate evidence of effectiveness at a scale that suggests readiness for replication more widely?
   - How effective are AmeriCorps interventions with evidence of effectiveness?
   - What characteristics of the interventions might be associated with the estimated impacts?

The current report provides the findings for the interventions funded between 2015 and 2019 by the AmeriCorps State and National program and between 2010 and 2015 by the Social Innovation Fund (SIF), which were the programs and grantee cohorts of interest to AmeriCorps that had evidence documents available for review for this project. See Appendix A for more

[1] As of September 29th, 2020, the Corporation for National and Community Service is operating under the name AmeriCorps.

information on the process and rubric that Mathematica used to review the evidence documents.

Mathematica used two primary research questions to identify interventions with evidence of effectiveness (see sidebar). We answered the first research question by developing and applying standards to assess the rigor of the research submitted by AmeriCorps State and National 2015–2019 and SIF 2010–2015 grantees as evidence of the funded interventions' effectiveness. We refer to these standards as the Mathematica effectiveness standards throughout this report.[2] Mathematica described each intervention in terms of its alignment with AmeriCorps' focus areas and priority objectives, funding year, and factors related to AmeriCorps' mission: reaching different communities (operationalized as urban/rural and region of country) and using AmeriCorps members in providing services directly to participants or supporting the delivery. We answered the second research question using a meta-synthesis analysis to uniformly measure the magnitude of an intervention's impact and to compare the effectiveness of interventions with different participant outcomes.

AmeriCorps focus areas

- **Disaster services** helps communities across the country prepare for, respond to, and recover from natural and other disasters.
- **Economic opportunity** addresses housing, financial literacy, and employment needs of low-income individuals and families.
- **Education** helps communities design and implement results-driven, cost-effective solutions that support students from cradle to career.
- **Environmental stewardship** (environment) trains youth and unemployed and underemployed citizens in conservation and green jobs, reconnects Americans to the outdoors, and supports successful science-based conservation strategies.
- **Healthy futures** uses a three-pronged approach of health-focused assistance, prevention, and intervention to educate and maintain healthy communities.
- **Nonprofit organizational capacity** (org capacity) helps organizations expand the reach, efficiency, or effectiveness of their programs.
- **Veterans and military families** (veterans) serves and engages the talents of veterans and military families.

A. Summary of key findings

1. What interventions consistently demonstrate evidence of effectiveness?

Thirty-nine percent of interventions (32 out of 82 interventions) implemented by grantees given a strong or moderate evidence rating in a systematic evidence review by independent contractors and reviewers for AmeriCorps (other than Mathematica)[3] met the evidence of

[2] Mathematica's effectiveness standards and AmeriCorps evidence ratings for grantees have similarities but also important differences. For example, Mathematica's effectiveness standards include studies providing detailed technical information on the research design's internal validity and requiring a consistency of positive findings across the range of outcomes that were assessed in an evaluation, but these are not AmeriCorps evidence rating requirements.

[3] The third-party AmeriCorps contractors and reviewers (other than Mathematica) assessed the studies submitted by grantees for their interventions as potentially being able to produce causal evidence for their interventions. The contractor then applied an AmeriCorps evidence rating at the grantee or subgrantee level—not the intervention level—based on the quality of evidence that grantees submitted. For this project, Mathematica reviewed the evidence submitted by grantees that received a moderate or strong evidence rating.

effectiveness standards developed for this project (which, as noted above, we refer to as the Mathematica effectiveness standards). Among the assessed criteria, the primary reasons that studies did not meet the Mathematica standards were (1) a lack of internal validity that gives confidence that the intervention, and not other factors, impacted intervention participants (46 percent); (2) results that were not consistently favorable (44 percent); and (3) a lack of a comparison group (40 percent). The 32 interventions that met the Mathematica standards fell primarily in the education focus area (56 percent), with 28 percent aligning with the economic opportunity focus area and 16 percent falling under the healthy futures focus area (see sidebar for AmeriCorps focus areas). These 32 interventions were predominately implemented in urban settings (97 percent), although 16 percent were implemented in rural areas. About half (47 percent) were implemented in more than one region of the country, and more than one-quarter (29 percent) had AmeriCorps members involved in delivering services or supporting the delivery.[4]

2. What intervention characteristics demonstrate evidence of effectiveness at a scale that suggests readiness for replication more widely?

Participants in the AmeriCorps-funded interventions meeting the Mathematica effectiveness standards had better outcomes than 61 percent of participants who did not receive the intervention. This represents an 11 percentage point increase in beneficial outcomes. The size of this impact varied by focus area. Interventions in the education and healthy futures focus areas increased beneficial outcomes for intervention participants by 9 percentage points, compared to those not receiving the intervention. For interventions in the economic opportunity focus area, the impact reached 14 percentage points. The size of the impacts varied by AmeriCorps' priority objective. Interventions aligning with the employability, K–12 success, postsecondary education support, school readiness, and supportive family environments priority objectives had statistically significant positive impacts. Impacts did not vary by geographic region, or the use of AmeriCorps members, which suggests that interventions might be equally effective across communities and that AmeriCorps members are as effective as other types of personnel at delivering or supporting the delivery of services. Impacts also did not vary by intervention funding year, which suggests that AmeriCorps has year-to-year consistency in identifying interventions supported by rigorous evidence of effectiveness.

[4] All interventions currently funded by the AmeriCorps State and National program are required to include AmeriCorps members in the interventions' service delivery model. In this report, we describe whether AmeriCorps members were part of the service delivery model as described in the evidence documents that grantees submitted when applying for funding. Some grantees with AmeriCorps funding before 2015–2019 may have had AmeriCorps members deliver services, and the evidence for the intervention's effectiveness submitted by these grantees reflects their use. Other grantees may not have had prior AmeriCorps funding and therefore submitted evidence for their intervention's effectiveness that did not include AmeriCorps member involvement.

B. Implications of the findings

These findings lead Mathematica to make three recommendations to help AmeriCorps build a larger portfolio of interventions that work. By increasing the proportion of funded interventions with evidence of effectiveness—while also funding potentially innovative programs that have not yet had time to demonstrate their effectiveness— AmeriCorps would likely be better able to improve outcomes of participants, thereby improving lives and strengthening communities.

Our three recommendations include the following:

- **Help grantees conduct studies that rigorously assess whether their intervention has an impact.** Of the 82 interventions from funded grants that had a strong or moderate AmeriCorps evidence rating, 39 percent met the Mathematica effectiveness standards developed for this project. Most of the interventions that did not meet these standards did not provide studies that were rigorously designed or executed in such a way that study outcomes could be attributed to the intervention and not to other factors.
- **When funding interventions, consider prioritizing those that show impacts across multiple outcomes.** AmeriCorps funds interventions in different phases of their development and with a range of evidence supporting them. Some interventions are likely innovative and in the process of building the evidence needed to show that they work. For these interventions, AmeriCorps could work with grantees to develop their intervention model to build evidence of its effectiveness once the model is fully developed. In most cases, however, AmeriCorps funds interventions with a fully developed model. For these interventions, rigorous research providing evidence of their effectiveness is needed; without such evidence, it is unclear whether these interventions funded by AmeriCorps improve participant outcomes.
- **Target funding for scaling at effective interventions.** Findings from this study suggest that the interventions that AmeriCorps funds have the potential to impact communities, especially in the areas of education and economic opportunity. Should AmeriCorps target funding for scaling interventions that work and show a readiness to be scaled, the agency's ability to help build strong communities would likely be enhanced.

I. INTRODUCTION

Agencies throughout the federal government and other grant-making institutions are increasingly conducting systematic evidence reviews and synthesizing the results of well-executed research to identify interventions that have evidence of effectiveness. These efforts can help funders make strategic decisions about how they can most effectively and efficiently address individual and community needs. These evidence reviews can also enhance funders' decisions about scaling up interventions that show the most promise in order to expand the scope of their impact.

AmeriCorps was established as a federal agency in 1993 with a mission to improve lives, strengthen communities, and foster civic engagement through service and volunteering.[5] The AmeriCorps State and National program and the three AmeriCorps Seniors programs (RSVP, Senior Companions, and Foster Grandparent) are the main avenues through which the agency currently achieves this mission; the Social Innovation Fund (SIF) also provided funding to innovative community-based programs from 2010 to 2016.

In 2017, an estimated 73,000 AmeriCorps members at more than 20,000 locations across the country carried out programs in the agency's statutory focus areas (see sidebar).[6] Examples of the services members provided include the following (AmeriCorps 2017):

- Supporting youth through teaching, tutoring, mentoring, and after-school programs
- Assisting Americans affected by hurricanes Harvey, Irma, and Maria
- Working with nonprofits, police departments, and local agencies to prevent and reduce opioid abuse
- Providing veterans and their families with employment services, benefits counseling, and transportation to medical appointments

AmeriCorps focus areas

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- **Nonprofit organizational capacity** (org capacity) helps organizations expand the reach, efficiency, or effectiveness of their programs.
- **Veterans and military families** (veterans) serves and engages the talents of veterans and military families.

[5] As of September 29th, 2020, the Corporation for National and Community Service is operating under the name AmeriCorps.

[6] Because the three AmeriCorps Seniors programs were not part of the analysis undertaken in this report, we do not discuss them. AmeriCorps (2016) provides a more detailed description of AmeriCorps' programs.

- Partnering with mayors, police departments, and local nonprofits to reduce crime, rebuild housing, remove blight, and expand economic opportunity in urban areas

Community-based programs supported by the SIF addressed challenging social problems in the focus areas of economic opportunity, healthy futures, and youth development (AmeriCorps 2015). Programs funded include those with the following objectives:

- Increase access to depression treatment in low-income rural communities
- Turn around low-achieving schools
- Increase tax savings by opening banking accounts for low- to moderate-income families
- Increase employment by providing transitional employment and supports to stabilize lives
- Use sports to improve body mass indices and waist circumferences of children in underserved urban communities

Because AmeriCorps strives to be a good steward of taxpayer dollars and operate programs in a cost-effective manner (AmeriCorps 2017), it uses third-party evaluations, systematic reviews, and meta-synthesis analyses to build knowledge of its funded interventions with evidence of beneficial impacts on participants (Zhang and Sun 2016; JBS International 2015). In addition, it funded the Scaling Evidence-Based Models project in 2016 to gain insights about which of the AmeriCorps State and National and SIF interventions were effective and might be ready to scale. Conducted by Mathematica, this project is designed to generate practical knowledge about how AmeriCorps might foster the successful scaling of effective interventions and help support AmeriCorps' efforts to identify which interventions work and how they can work for more people. This information will also help inform the agency's interest in identifying the intervention components that are critical for an intervention's effectiveness.

Research questions guiding the project

How do organizations define scaling?

- How is scaling defined and operationalized by AmeriCorps-funded organizations?

What interventions work?

- What interventions consistently demonstrate evidence of effectiveness for their targeted outcomes?
- What intervention characteristics demonstrate evidence of effectiveness at a scale that suggests readiness for replication more widely?

How do organizations scale successful interventions?

- What organizational resources are necessary to successfully scale interventions?
- What funders (philanthropic, public, and private) support scaling efforts?
- How are organizations scaling interventions (up or down) with fidelity and integrity?
- How are organizations adapting or modifying interventions when they scale?
- What facilitates and what hinders scaling?
- What role does evaluation play in scaling efforts (process, outcome, or impact data)?

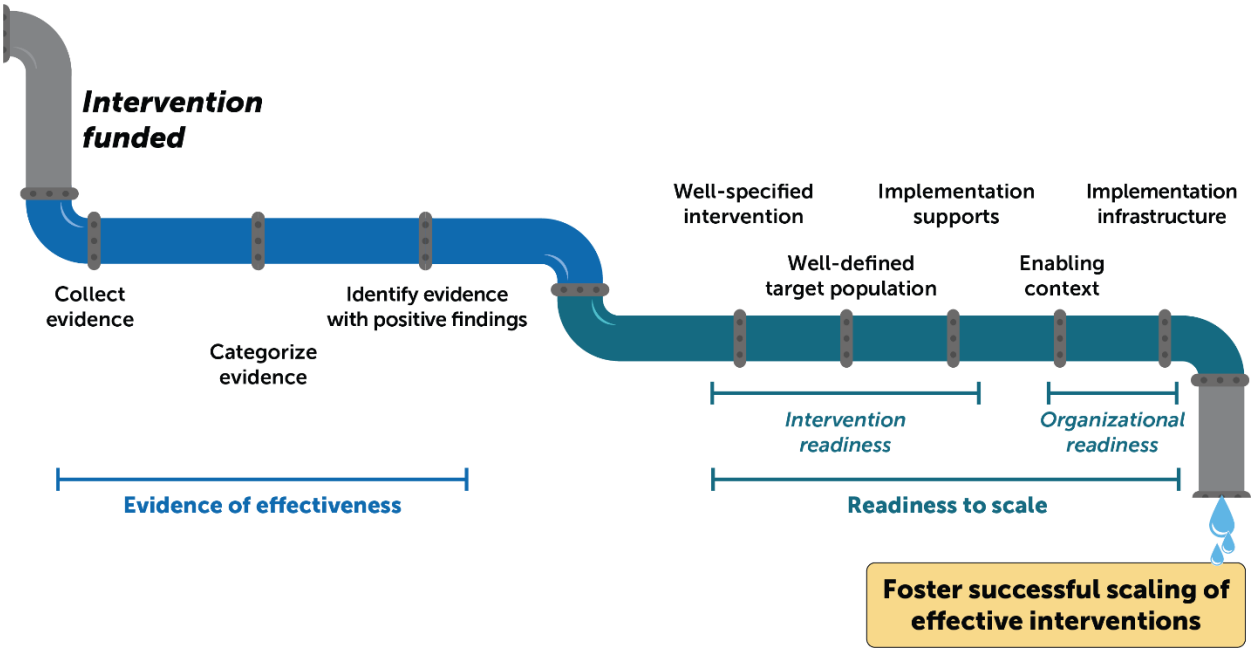
In this chapter, we provide an overview of the project (Section A), explain briefly the evidence review and meta-synthesis component of the project that is the subject of this report (Section B), and outline the structure for the rest of the report (Section C).

A. Overview of the Scaling Evidence-Based Models project

The Scaling Evidence-Based Models project was funded to deepen AmeriCorps' understanding of how to scale effective interventions and to answer three overarching research questions (in bold) and nine subquestions (indicated by bullets) shown in the sidebar on the previous page. A review of the evidence—the subject of this report—addresses the second question and its subquestions. The first and third research questions are addressed in an analysis of AmeriCorps-funded organizations' scaling plans to understand scaling readiness (Selekman et al. 2020) and by a process study that examines three AmeriCorps-funded organizations in depth to learn how they scaled their interventions and what factors facilitate or hinder scaling.

The project developed and applied the Scaling Programs with Research Evidence and Effectiveness (SPREE) process to help AmeriCorps identify which of its funded interventions demonstrate evidence of effectiveness and a readiness to scale (Maxwell and Richman 2019). The SPREE process has two distinct parts, each of which is represented in Figure I.1. The first part—the subject of this report—is designed to identify AmeriCorps-funded interventions with evidence of effectiveness, which we define as those that met the project's effectiveness standards (discussed in Section B) and produced favorable findings on the majority of targeted outcomes among participants receiving the intervention. We often refer to interventions that have provided evidence of effectiveness as interventions that work. The second part—discussed in "Planned Scaling Activities of AmeriCorps-Funded Organizations" (Selekman et al. 2020)—is designed to determine the extent to which the effective interventions and the organizations implementing them demonstrate a readiness for scaling.

Figure I.1. The Scaling Programs with Research Evidence and Effectiveness (SPREE) process



B. Overview of the meta-synthesis study

Because interventions that can improve participant outcomes are needed to build stronger communities, the project only considers interventions with evidence of effectiveness as possibilities for scaling. The research team developed a process for identifying interventions that work (see Appendix A) and then analyzed those interventions in terms of the strength of their effectiveness and characteristics.

1. Identifying the interventions that work with the SPREE process

The SPREE process shown in Figure I.1 is structured so that interventions that do not work (first part of the figure) or are not ready to scale (second part) are systematically eliminated from consideration for scaling. Taken together, the three stages in the first part of the figure ensure that the interventions being considered for scaling work. These three stages are as follows:

- **Collect evidence.** To identify interventions that work, one must first compile an inventory of potential interventions of interest, which includes information on the intervention services and the target population for the intervention, and the supporting documents that present evidence of the intervention's effectiveness (called evidence documents). These evidence documents, which typically take the form of research evaluations of the implemented interventions, provide the necessary information for evaluating whether the interventions and supporting evidence meet the standards that are set in the next stages of the SPREE process.

AmeriCorps requires its AmeriCorps State and National- and SIF-funded grantees to provide evidence documents that present evidence of their interventions' effectiveness. We compiled the evidence documents for the AmeriCorps State and National 2015–2019 grantees and SIF 2010–2015 grantees, which were the programs and grantee cohorts of interest to AmeriCorps that had evidence documents available for review for this project. Although most evidence documents submitted were in the form of research evaluations, some were literature reviews, descriptive survey results, or process or implementation studies.

Table I.1. AmeriCorps evidence ratings

Evidence rating	Criteria
Pre-preliminary (used by AmeriCorps State and National only)	Some data collection and testing
Preliminary	Outcome study, such as pre- and post-test with no comparison group or post-test only for treatment and comparison groups
Moderate	Study designs that support causal conclusions but have limited generalizability beyond the study context
Strong	Study designs that support causal conclusions that assess the intervention nationally, regionally, or at the state level

We used AmeriCorps' tiered-evidence framework (AmeriCorps 2016; see Table I.1) for rating evidence to determine which evidence documents we should compile from specific AmeriCorps State and National 2015–2019 and SIF 2010–2015 grantees.[7] The AmeriCorps evidence ratings are applied at the grantee or subgrantee level—not the intervention level—based on the quality of evidence that grantees submit. Independent contractors and reviewers for AmeriCorps (other than Mathematica) assign moderate or strong ratings to grantees that presented evidence generated from at least one study with a design that, if done well, could provide confidence that the intervention improves participant outcomes. Such studies assess an intervention's impacts on participants' outcomes by studying differences in outcomes between those receiving the intervention (treatment group) and a comparable group of individuals not receiving the intervention (comparison group). Mathematica compiled the evidence documents from grantees with a moderate or strong evidence rating and considered only these documents eligible for review.[8]

[7] Both AmeriCorps State and National and SIF have tiered-evidence frameworks to rate the quality of evidence submitted to AmeriCorps. Although the programs differ in the evidence categories used (for example, only AmeriCorps State and National uses the pre-preliminary evidence rating) and in the language used to describe the criteria for the evidence categories, both reserve the moderate and strong evidence ratings for grantees providing evidence based on studies that used rigorous research designs to support causal conclusions. Evidence ratings are assigned at the grantee level only for AmeriCorps State and National grantees and at either the grantee or subgrantee level for the SIF program, depending on which entity is implementing the intervention. Grantees can submit more than one evidence document for all interventions they are seeking to implement with AmeriCorps funding.

[8] These are the evidence documents that grantees submitted to AmeriCorps. We did not search for or review other evidence documents that exist for these interventions.

- **Categorize evidence**. Because variations exist in the quality of evidence presented, it is important to assess whether the documents meet research standards for evidence of effectiveness. Assessment can include utilizing existing evidence standards, such as those developed by federal research clearinghouses, or developing one's own. Ultimately, the collected evidence documents would be reviewed under these standards to determine the extent to which there is confidence that the intervention, and not other factors, caused the estimated impacts for those receiving the interventions.

  Mathematica developed effectiveness standards to assess the internal validity of evidence documents (Table I.2) using standards created by existing clearinghouses (What Works Clearinghouse, Clearinghouse for Labor Evaluation and Research, and Home Visiting Evidence of Effectiveness). Studies with internal validity provide greater confidence that any differences in outcomes between the treatment and comparison groups can be attributed to the intervention and not to other factors (Shadish et al. 2002 provide a detailed discussion).

Table I.2. Standards for categorizing evidence

Standards	Evidence has …
Internal validity	
Low attrition	Few individuals in the treatment or comparison group who left the study
No reassignment	No individuals randomly assigned to comparison group switched to the treatment group or vice versa
Baseline equivalence	Individuals in the treatment and comparison groups in the final sample used for analysis of outcomes that did not differ on at least some observable characteristics
No confounding factors	A design that precluded factors other than the intervention from potentially being responsible for the estimated impacts
Project objectives	
Study design	A comparison group
Reporting on methods	Adequate information on research design and statistical approach to gauge impacts
Evaluator independence	An evaluator who was external to the grantee
Scaling plan alignment	Alignment with the intervention planned for scaling

- We also categorized the evidence documents against other objectives for the project. We created effectiveness standards to determine which interventions were examined with studies that had designs that used a comparison group, had methods that were adequately described, were conducted by an external evaluator, and were for interventions aligned to a grantee's planned scaling activities (Table 1.2). The first three effectiveness standards (study design, reporting on methods, and evaluator independence) helped ensure rigor and objectivity so the evidence could show that the intervention caused participant outcomes. Finally, alignment with the scaling plan, the fourth criterion, helped ensure that grantees were planning to scale the intervention with evidence that it works. For example, a grantee planning to scale a specific parent education intervention could not present evidence of another parent education intervention as proof of its effectiveness.[9]

- **Identify evidence with positive findings.** Because the ultimate goal is scaling interventions that have evidence that they work, we must also define what constitutes whether an

[9] See Selekman et al. (2020) for the extent to which grantees proposed to modify these interventions when scaling.

intervention has positive findings by producing favorable impacts on participants. This entails establishing (1) how much evidence is needed, whether one or multiple evidence documents show favorable findings on participant outcomes; and (2) the prevalence of positive findings within a given evidence document, such as whether there must be positive findings on the majority of assessed outcomes or whether positive findings for at least one outcome are sufficient.

Because the Scaling Evidence-Based Models project is interested in AmeriCorps grantees' scaling of interventions that work, Mathematica developed effectiveness standards to identify which interventions have consistently positive findings. An intervention was defined as having consistently positive findings if it showed favorable results on the majority of primary outcomes that the intervention sought to improve in at least one evidence document.[10]

Overall, the Mathematica effectiveness standards for interventions—that is, studies having evidence with internal validity, aligning evidence to project objectives, and having positive findings—build on the AmeriCorps evidence ratings assigned to grantees. Mathematica's effectiveness standards and AmeriCorps evidence ratings for grantees have similarities but also important differences. For example, Mathematica's effectiveness standards include studies providing detailed technical information on the research design's internal validity (for example, demonstrating baseline equivalence between the individuals in the treatment and comparison groups in the final analytic sample), which is not part of AmeriCorps State and National's evidence rating determinations. The AmeriCorps State and National and SIF programs' evidence ratings only required positive findings on one outcome of interest to quality for a moderate or strong rating. Mathematica's effectiveness standards required consistency of positive findings across the range of outcomes that were assessed in an evaluation. Such differences mean that a grantee can receive a strong or moderate AmeriCorps evidence rating but its intervention may not meet Mathematica's effectiveness standards. An important similarity between the Mathematica effectiveness standards and the AmeriCorps evidence ratings is that both are intended to be applied to studies of interventions implemented in a diverse set of focus areas (for example, interventions in the areas of education, economic opportunity, and environmental stewardship). Although this approach provides consistency in how these studies are reviewed, we recognize that conducting rigorous research evaluations or accurately measuring intervention impacts might be especially difficult for certain types of outcomes or with specific target populations.

Additionally, since our review was focused on evidence documents from grantees given a moderate or strong evidence rating from the AmeriCorps State and National 2015–2019 and SIF 2010–2015 funding years, we needed to consider whether there were any changes in how either of the AmeriCorps programs described the evidence requirements and guidelines for the interventions eligible for funding over time. For example, the AmeriCorps State and National program modified its Notice of Funding Opportunity (NOFO) requirements and guidelines in 2019 to place a higher value of evaluation points on applicants' evidence base relative to prior

[10] For AmeriCorps' evidence review, a grant could receive a strong or moderate evidence rating if the evidence submitted achieved a favorable result on only one priority outcome.

years. Applicants were also instructed to ensure that the proposed intervention clearly aligned with the evidence base on characteristics of the beneficiary population, characteristics of the population delivering the intervention, dosage and design of the intervention, the context in which the intervention is delivered, and outcomes of the intervention. Another example is that under the 2015 NOFO, applicants could receive a moderate evidence rating using non-experimental studies, whereas the 2016-2019 NOFOs required experimental or quasi-experimental studies to attain a moderate evidence rating. The effectiveness standards developed for this project created an opportunity to apply the same criteria to all grantees, regardless of funding year.

2. Describing interventions that work

Mathematica used the rubric in Appendix A to conduct a systematic review of each evidence document provided by grantees with a strong or moderate AmeriCorps evidence rating to determine which interventions had evidence that they work. Mathematica extracted information from each evidence document to summarize the intervention and provide a high-level assessment of its evidence of effectiveness. If multiple evidence documents were submitted for a single intervention, summaries were compiled across the evidence documents to determine the overall evidence of effectiveness for that intervention. This process was used to answer the research question "What interventions consistently demonstrate evidence of effectiveness for their targeted outcomes?"

The research question "What intervention characteristics demonstrate evidence of effectiveness at a scale that suggests readiness for replication more widely?" is complicated to answer because of the diverse set of interventions that AmeriCorps funds. Although this diversity allows AmeriCorps to offer communities an opportunity to select from an array of interventions to meet their needs, it presents challenges for synthesizing and comparing research findings because funded interventions produce a variety of outcomes for participants (for example, improvements in test scores, reductions in body mass index, and increases in employment rates). To address this issue, we used an effect size index. An effect size index provides a uniform measure of the magnitude of outcome differences between the treatment and the comparison groups across different types of interventions and quantifies how effective an intervention is. This approach affords an opportunity to compare the effectiveness of different interventions with various participant outcomes. Appendix C describes the specifics of what effect sizes are, how they are calculated, and how they were used in the report's meta-analysis.

C. Road map for the report

This report details our findings from analyses of AmeriCorps-funded interventions with evidence that they work in improving participant outcomes. In Chapter II, we describe results of the process to identify those interventions that work and their characteristics, and in Chapter III, we present our findings from the meta-analysis on the magnitude of the impacts of the interventions that work. We provide a summary of the main findings and highlight implications from them in Chapter IV. We include three appendices to support the discussion in the chapters. In Appendix A, we provide a copy of the rubric used to extract information from the evidence documents; in

Appendix B, we provide the characteristics of the 32 interventions with evidence that they work; and in Appendix C, we provide the technical details (such as how effect sizes were calculated) and data tables for the meta-synthesis analysis.

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II. AMERICORPS-FUNDED INTERVENTIONS WITH EVIDENCE THEY WORK

AmeriCorps funds a multitude of interventions that seek to address the needs of local communities through volunteerism and national service. Because AmeriCorps is interested in fostering the successful scaling of effective interventions to increase the number of individuals and communities positively affected by these services, the agency must identify which funded interventions work. In this chapter, we present the results from the process used to identify and describe the AmeriCorps-funded interventions that met Mathematica's effectiveness standards. We answer the research question "What interventions consistently demonstrate evidence of effectiveness for their targeted outcomes?" by answering these two subquestions:

- Which AmeriCorps-funded interventions demonstrate evidence of effectiveness on participants' outcomes?
- Among interventions with evidence of effectiveness, what are their characteristics?

We answered the research questions with our systematic review of evidence documents. We applied the evidence review process discussed in Chapter I to a set of interventions funded through 154 grants with continued funding and a strong or moderate AmeriCorps evidence rating as determined by third-party evaluators. These 154 grantees planned to implement 82 interventions. In Section A of this chapter, we describe the process and corresponding analysis used to determine which interventions work and why interventions without evidence of effectiveness did not meet evidence standards. For the interventions that do work, we describe their characteristics in Section B.

Key findings

- Thirty-two interventions (39 percent) out of the 82 interventions from grants with a strong or moderate AmeriCorps evidence rating met Mathematica's effectiveness standards that indicate they improved participant outcomes.
- Interventions did not meet Mathematica's effectiveness standards primarily for these reasons (which were relatively similar across funding years):
  - They did not have studies with internal validity (46 percent): 87 percent of these did not show baseline equivalence between the treatment and comparison groups.
  - They did not have consistently favorable findings for the intervention (44 percent).
  - They did not have studies with a comparison group (40 percent).
- The 32 interventions that were assessed as working had these characteristics:
  - They fell primarily in the education focus area (56 percent), with 28 percent and 16 percent falling into the economic opportunity and the healthy futures focus areas, respectively. The predominance of education interventions reflects, at least in part, the preponderance of AmeriCorps interventions in the education focus area: Of the AmeriCorps State and National 2015–2019 and SIF 2010–2015 interventions included in the full sample, 54 percent were in the education focus area.
  - They were predominately implemented in urban settings (97 percent), with 16 percent implemented in rural areas (most of these were also implemented in urban settings).
  - They were distributed across the geographic regions in the United States, with about half implemented in multiple geographic regions (47 percent).
  - Some (29 percent) had AmeriCorps members involved in the service delivery model.

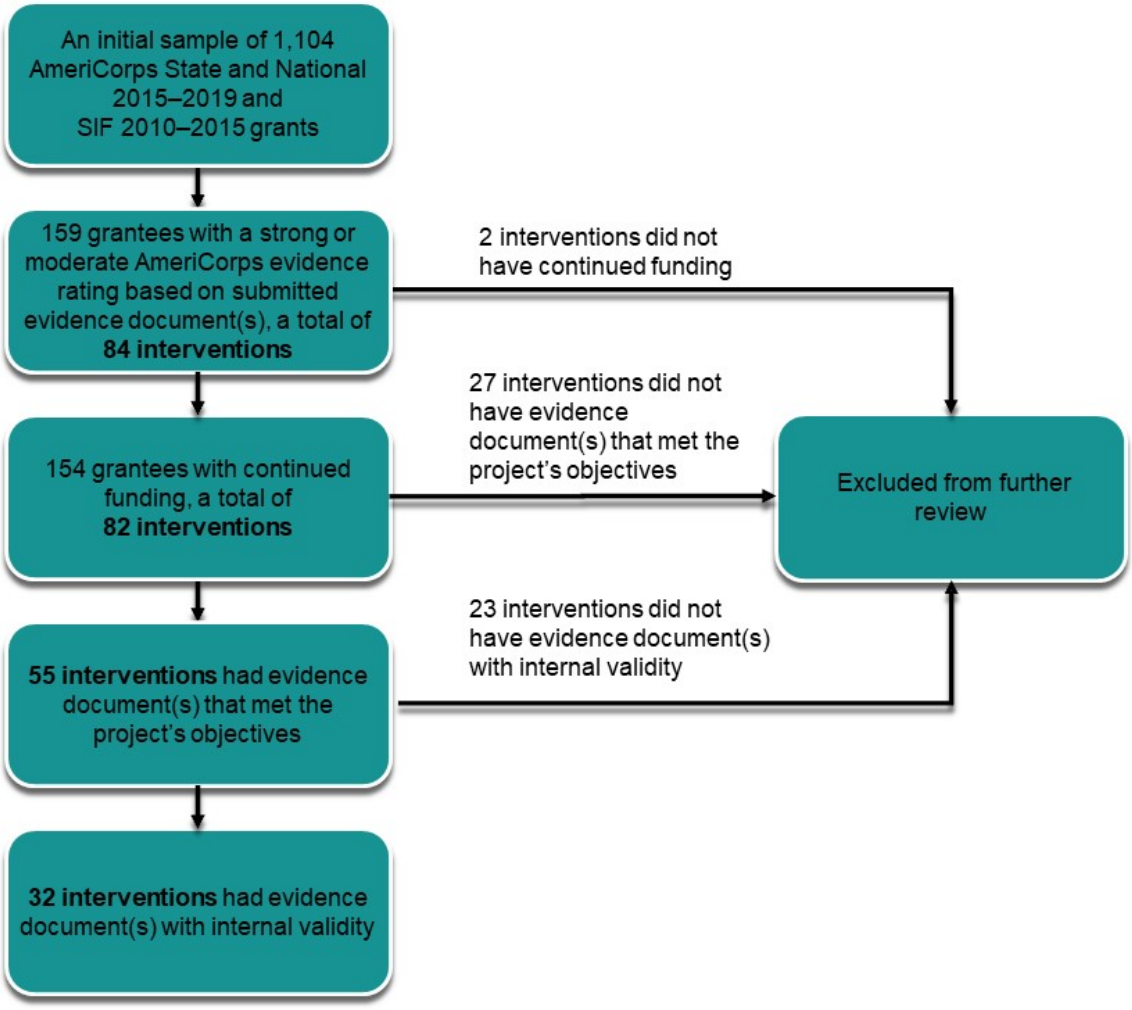
A. Identifying AmeriCorps-funded interventions with evidence of effectiveness

Figure II.1 illustrates the process that produced the assessment that 32 AmeriCorps-funded interventions provided evidence that the interventions work:

- Of the 1,104 AmeriCorps State and National 2015–2019 and SIF 2010–2015 grantees, 154 (14 percent) had a strong or moderate AmeriCorps evidence rating and continued funding. Independent contractors and reviewers for AmeriCorps (other than Mathematica) assessed the studies submitted by grantees for their interventions as potentially able to produce causal evidence that their interventions work. These 154 grantees planned to implement 82 interventions.

- Thirty-two (39 percent) of the 82 interventions implemented by grantees with a strong or moderate AmeriCorps evidence rating met Mathematica's effectiveness standards. The other 50 interventions (61 percent) had studies that did not consistently show favorable findings for the intervention; did not have a comparison group; did not have sufficient detail to allow an assessment of the study; or did not have internal validity, mainly because of a lack of equivalence at baseline between the treatment and comparison groups.

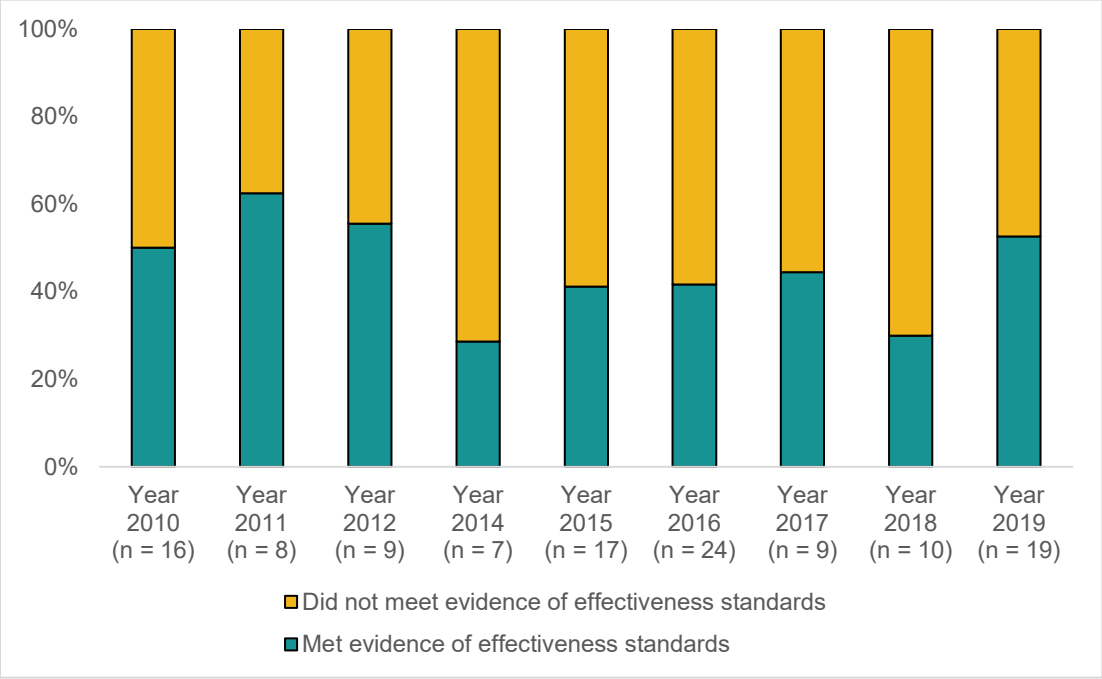
Figure II.1. Identifying interventions with evidence of effectiveness



SIF = Social Innovation Fund.

Figure II.2 displays the percentage of interventions implemented by grantees with strong or moderate AmeriCorps evidence ratings that met Mathematica's effectiveness standards by the grantee funding year. Though the percentage of interventions that met effectiveness standards ranged from 29 percent (in 2014) to 63 percent (in 2011), we caution readers to interpret these numbers with care given the small number of these grants in a given funding year.

Figure II.2. Percentage of interventions with studies that had evidence of effectiveness



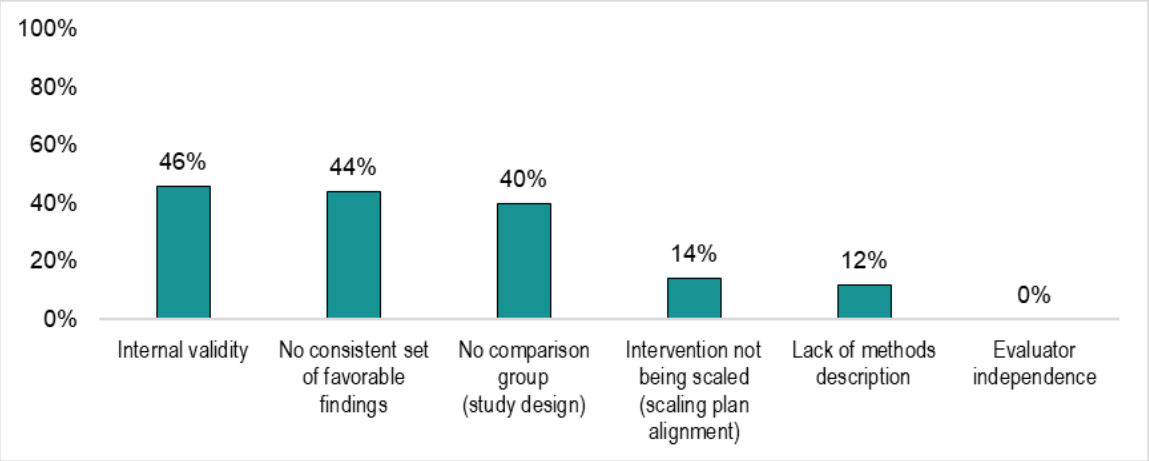
Source: Eighty-two interventions from AmeriCorps State and National 2015–2019 and SIF 2010–2015 grantees with a strong or moderate AmeriCorps evidence rating that were reviewed with Mathematica's effectiveness standards.

Note: The number of interventions that met or did not meet the effectiveness standards in a funding year are displayed within the chart bars. The total number of interventions do not add to 82 because an intervention could have been funded across multiple years.

Figure II.3 illustrates the reasons that 61 percent of interventions implemented by grantees with strong or moderate AmeriCorps evidence ratings did not meet Mathematica's effectiveness standards. As we discussed in Chapter I, we used a two-stage process to assess evidence documents, with internal validity assessed at the end of the process, so we caution readers to interpret these numbers with care.[11]

[11] Because grantees could submit multiple evidence documents, an intervention could have had one study that met the effectiveness standards and another that failed to do so. Interventions continued through the two-stage review process (where we first reviewed documents against the project objective and positive findings criteria before applying the internal validity criteria) as long as they had at least one evidence document that met effectiveness standards. However, this means that the internal validity criteria were not applied to the evidence documents screened out at the first stage of the review process, so it is possible that the percentage of interventions with studies not having internal validity could be greater than what is reported in Figure II.2.

Figure II.3. Reasons interventions were without evidence of effectiveness: Percentage with studies that did not meet each standard



Source: Fifty interventions from AmeriCorps State and National 20152019 and SIF 2010–2015 grantees with a strong or moderate AmeriCorps evidence rating that did not provide evidence documents that met Mathematica's effectiveness standards.

Note: Percentages do not add to 100 percent because interventions could be represented in more than one category; multiple evidence documents submitted for an intervention could have failed to meet different effectiveness standards, or a single evidence document could have failed to meet more than one effectiveness standard. Some of the interventions that did have evidence that they work also had other studies that did not meet these effectiveness standards. These interventions are not included in the percentages presented in the figure.

As this figure shows, there were several reasons for not meeting the effectiveness standards:

- **Nearly half (46 percent) of the interventions did not have studies with internal validity.** Of the 23 interventions that did not have studies with internal validity, 87 percent provided evidence documents that did not demonstrate baseline equivalence between the treatment and comparison groups. Sometimes, studies used statistical techniques (for example, propensity score matching) to create similar treatment and comparison groups but did not conduct analyses that showed the groups for whom outcomes were compared were similar before the intervention. Another 13 percent had the presence of other factors (confounds) that might explain outcome differences between the treatment and comparison groups.

- **Almost half of the interventions (44 percent) did not have studies that showed consistently favorable impacts.** Although the studies submitted for these interventions sometimes showed some statistically significant favorable findings, the majority of findings related to the studies' primary research questions were not statistically significant.[12]

- **About 40 percent of the interventions did not have studies with a comparison group.** These studies include those that presented descriptive survey results of program participants, process studies, literature reviews, and outcome studies with program participants only.

[12] Statistical significance was defined at the $p < 0.05$ level.

- **About 14 percent of interventions had evidence documents that were not aligned with the grantees' proposed scaling.** Some grantees proposed scaling a combination of interventions but did not submit evidence documents for each of the interventions. For example, one grantee intended to use several employment training interventions for its young adult target population but only submitted evidence for one of those interventions.

- **About 12 percent of interventions did not have evidence documents with sufficient information about their research methods.** Such studies often did not discuss in detail how the data were collected and analyzed.

The reasons interventions were without evidence of effectiveness did not seem to vary by a function of funding year.

B. Characteristics of interventions that work

Mathematica examined the characteristics of the 32 interventions with evidence of effectiveness with respect to how they align to the AmeriCorps focus areas and priority objectives and to the agency's mission to use national service to help all types of communities across the country. In this section of the report, we describe the general characteristics of these 32 interventions.[13] Appendix B provides a detailed description of each intervention with respect to its focus area, priority objective, core elements, implementation setting, and inclusion of AmeriCorps members in the service delivery model.

1. Interventions in the education, economic opportunity, and healthy futures focus areas had evidence that they work.

Among the interventions with evidence that they work, most were in the focus area of education (56 percent), 28 percent were in economic opportunity, and 16 percent were in healthy futures (see Table II.1).[14] None of the interventions that focused on environmental stewardship, nonprofit organizational capacity, veterans and military families, and criminal justice had research evidence suggesting that they work. Some of these differences arise from the distribution of funded interventions in the sample of grants that had a

Table II.1. Interventions by focus area

	Percentage of interventions	
	That work	Funded
Education	56%	54%
Economic opportunity	28%	22%
Healthy futures	16%	15%
Environment	0%	5%
Org capacity	0%	2%
Veterans	0%	1%
Other (Criminal justice)	0%	1%
Disaster services	0%	0%
Number	32	82

[13] In this report, we do not identify the 32 individual interventions by their proper names. Instead, we refer to them by the AmeriCorps focus area to which they align (for example, Economic Opportunity 1 through 4, Education 1 through 13, Healthy Futures 1 through 4). We use this type of terminology so that the focus of the report is on the broader portfolio of effective interventions that AmeriCorps funds and the evidence grantees submit to support their effectiveness, not on the effectiveness of specific interventions per se.

[14] One intervention (Education 12) was classified under two AmeriCorps focus areas: education and healthy futures. We discuss this intervention under the education focus area because the study submitted evidence for this intervention that mostly assessed whether the intervention improved academic outcomes.

strong or moderate AmeriCorps evidence rating. Interventions in economic opportunity represented a relatively larger percentage of interventions that work (28 percent) than their share of the funded sample (22 percent). Interventions in the focus areas of environmental stewardship represented a relatively smaller proportion of those showing evidence of working (0 percent) than their share of the funded sample (5 percent). The proportion of education and healthy futures interventions that work was similar to the proportion of those in the funded sample. There were no interventions with research evidence suggesting that they work in the focus areas of nonprofit organizational capacity and veterans and military families, though these represented a small share of the funded sample. There were no interventions that focused on disaster services in the funded sample. Overall, though AmeriCorps' funded interventions with a strong or moderate evidence rating were distributed across six of its focus areas (and included an intervention focused on criminal justice, which is not a designated AmeriCorps focus area), the interventions with research evidence suggesting that they work were concentrated within three focus areas, with the majority of them in the education area.

2. The education and economic opportunity focus areas, but not the healthy futures focus area, had interventions that were assessed as working in each of their priority objectives.

To achieve its goals for improving individual and community outcomes across all focus areas, the AmeriCorps strategic plan identified priority objectives in each focus area. AmeriCorps sets priority objectives to help the agency focus its resources and ensure that the agency and its grantees are working toward common goals. Our analysis of the 32 interventions that work showed that all education and economic opportunity priority objectives were addressed by these interventions, but this was not the case for all healthy futures priority objectives.[15]

a. Education

The 18 interventions in the education focus area that provided evidence of working spanned across the three priority objectives:

Education priority objectives

Improve

- K–12 success
- Postsecondary education support
- School readiness

- Eleven interventions (61 percent) focused on K–12 success. These interventions provided a wide range of services for different age groups, from literacy development programs in elementary schools to one-on-one tutoring for high school students.
- Five interventions (28 percent) focused on postsecondary preparation support in high schools, such as providing students with information on the financial aid process and support during and after the transition from secondary to postsecondary school.

[15] An intervention can be aligned with more than one priority objective. We discuss one intervention (Education 5) under the K–12 success priority objective because the majority of outcome measures aligned with this priority objective. Although we did not directly examine this issue, it is possible that, as noted in Chapter I, conducting rigorous research evaluations or accurately measuring intervention impacts has been especially challenging in some priority objective areas.

- Two interventions (11 percent) focused on school readiness. These interventions included literacy development support in preschools and home visiting for parents of young children to develop children's literacy skills.

b. Economic opportunity

The nine interventions in the economic opportunity focus area that provided evidence of working spanned across the three priority objectives:

Economic opportunity priority objectives

Improve

- Employability
- Financial literacy
- Housing

- Six interventions (67 percent) addressed employability through employment or education assistance, internships, job training, or other employment supports.
- Three interventions (33 percent) targeted financial literacy and used three distinct strategies. One intervention (which also targeted employment) provided financial counseling and income support counseling. Another intervention provided financial assistance in the form of matched savings accounts, in which participants could deposit some of their tax refunds and earn an incentive. The third intervention provided financial and benefits counseling and tax preparation services.
- One intervention (11 percent) targeted housing by building, rehabilitating, or repairing homes.

c. Healthy futures

Only one intervention in the healthy futures focus area provided evidence of effectiveness that aligned to a priority objective. This sports-based intervention targeted childhood obesity by promoting physical exercise and healthy nutrition among participating children. None of the interventions targeted the priority objectives of increasing access to health care or facilitating aging in place. Four other interventions that were in the healthy futures focus area and had evidence of effectiveness did not align with a designated healthy futures priority objective. They were designed to foster supportive family environments and reduce child maltreatment and abuse by providing behavioral skills training with and home visits to parents and families.

Healthy futures priority objectives

Address

- Childhood obesity
- Access to health care
- Aging in place

Although the actual services that each intervention offered varied by focus and topic area—for example, education interventions may have offered academic tutoring, whereas economic opportunity interventions may have offered job search and placement services—we identified two common service delivery modes across all focus areas:[16]

- **Formal education and training.** Nearly all interventions—28 of the 32 interventions (88 percent)—included a formal education or training component, meaning that program participants received a standardized curriculum, delivered either individually or in a group

[16] Service delivery modes can also be referred to as intervention strategies or components.

setting. This component included delivery of academic and test preparation curricula to students in the education area, job skills and readiness training for adults in the economic opportunity area, and recreational and sports instruction for youth in the healthy futures area.

- **One-on-one support.** A total of 23 of the 32 interventions (72 percent) included a one-on-one service component, meaning that staff met individually with program participants to deliver services. This component included mentoring for students in education interventions, financial counseling for adults in economic opportunity interventions, and individual home visits to deliver parenting support in the healthy futures area.

3. Interventions that work were implemented in urban and rural settings with fairly even distribution across geographic regions.

AmeriCorps is dedicated to helping address the needs of communities across the United States and working to ensure that all types of communities, including underserved rural areas, are included. Our analysis suggests that the interventions that work were implemented in both urban and rural areas and in communities across the nation:

- **Almost all interventions (97 percent) were implemented in urban areas, with 16 percent implemented in rural areas.** Four interventions (13 percent) that work implemented in urban areas—three in the education focus area and one in the healthy futures focus area—were also implemented in rural areas. One healthy futures intervention was implemented exclusively in rural areas.

- **Interventions were implemented across the country.** About half of the interventions with evidence that they work (47 percent) were implemented across multiple geographic regions. Regional breakdowns indicate that 50 percent were implemented in the Northeast, 41 percent in the West, 34 percent in the South, and 28 percent each in the Midwest. The regional distribution of interventions did not seem to vary greatly across the focus areas.

4. More than one-quarter (29 percent) of interventions that work had AmeriCorps members involved in providing services directly to participants or supporting service delivery.

AmeriCorps' mission uses national service participants to strengthen communities and improve outcomes for individuals.[17] Identifying and strengthening effective interventions that use national service helps the agency achieve this goal. Although these national service participants can provide a wide range of services for grantees, our analysis suggests that nine interventions (29 percent) that work used AmeriCorps members to deliver services directly to beneficiaries or

[17] This report uses the phrase *national service participants* to refer to all of those who dedicate time and skills to address local community needs through AmeriCorps' national programs. AmeriCorps refers to individuals serving through the AmeriCorps State and National program as *members* and the three AmeriCorps Seniors programs (RSVP, Senior Companions, and Foster Grandparent) as *volunteers*.

support the delivery of essential functions in implementing the intervention.[18] This percentage varied little across the focus areas. The direct services provided included tutoring, site coordination, and college planning supports in the education focus area; employment or financial counseling in the employment opportunity area; and home visitations that delivered parent education and made referrals to support services. The remaining 71 percent of interventions that met Mathematica effectiveness standards were supported by evidence documents in which AmeriCorps members were not a part of delivering intervention services.[19]

[18] All interventions currently funded by the AmeriCorps State and National program are required to include AmeriCorps members in the interventions' service delivery model. In this report, we describe whether AmeriCorps members were part of the service delivery model as described in the evidence documents that grantees submitted when applying for funding. Some grantees with AmeriCorps funding before 2015–2019 may have had AmeriCorps members deliver services, and the evidence for the intervention's effectiveness submitted by these grantees reflects their use. Other grantees may not have had prior AmeriCorps funding and therefore submitted evidence for their intervention's effectiveness that did not include AmeriCorps members' involvement.

[19] Our review determined AmeriCorps members' involvement in delivering intervention services based on evidence documents' explicitly referencing AmeriCorps members in the description of the intervention. It is possible that some evidence documents did not provide sufficient information on the personnel involved in the intervention delivery, including the presence of AmeriCorps members. As a result, our finding that 29 percent of interventions that work had AmeriCorps members involved in providing services can be viewed as a conservative estimate of AmeriCorps member involvement in these interventions.

III. IMPACTS OF INTERVENTIONS WITH EVIDENCE THEY WORK

In this chapter, we report results of a meta-analysis that estimated the size of the effects for the interventions identified in Chapter II as having evidence of effectiveness. We address the project's research question "What intervention characteristics demonstrate evidence of effectiveness at a scale that suggests readiness for replication more widely?" by answering two subquestions:

- How effective are AmeriCorps interventions with evidence of effectiveness?
- What characteristics of the interventions might be associated with the estimated impacts?

We answered the first question using effect sizes to measure the magnitude of an intervention's impact and to compare the effectiveness of interventions with different participant outcomes uniformly. We were able to calculate at least one effect size for 30 of the 32 interventions, which include effect sizes for 1,408 outcomes, 419 of which were outcomes that corresponded to an evaluation's stated main focus (often referred to as primary outcomes).[20] An effect size is a standard measure of the extent to which individuals in the treatment and comparison groups are different from each other on various types of study outcomes (for example, reading achievement, income levels, and positive parenting behaviors). Without a standard measure, it is difficult to compare the relative impacts of interventions across different focus areas (for example, comparing education interventions to healthy futures interventions). For all analyses, we calculated weighted average effect sizes (the overall impact estimates across all assessed outcomes) to capture the intervention's impact and used a 95 percent confidence interval (CI) to show the range in which the actual impact falls with a 95 percent probability. We answered the second question by comparing effect sizes across the interventions' characteristics: focus areas, priority objectives, geographic locations, and role of AmeriCorps members.

What is an effect size?
An effect size is a standard measure of the extent to which individuals in the treatment and comparison groups are different from each other on various types of study outcomes.

In Section A of this chapter, we present results that answer the first research question, and in Section B, we provide results that answer the second question. See Appendix C for details on how we calculated effect sizes and conducted the analysis.

[20] The information on two interventions (Economic Opportunity 9 and Healthy Futures 5; see Appendix B) was insufficient to calculate effect sizes for this analysis. The study reported effect sizes based on gain scores, which are not comparable to those based on means. We also did not have enough information to calculate Hedges' *g* or the Cox index for 161 outcomes across all of the interventions.

Key findings

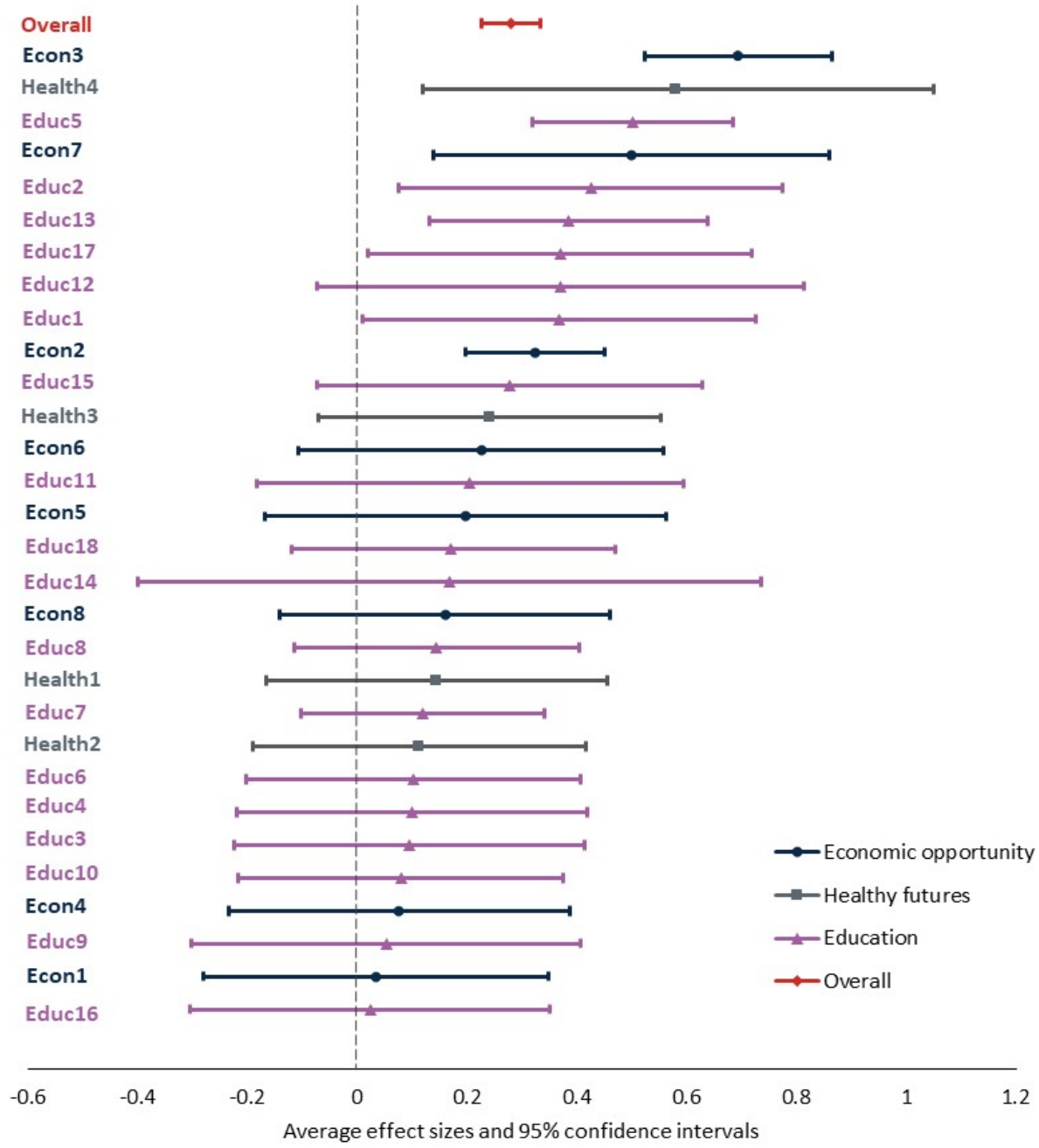
Participants in AmeriCorps-funded interventions with evidence that they work had better outcomes than those who did not participate. The average intervention participant outperformed those not receiving the intervention by 11 percentage points in beneficial outcomes.

- **Different focus areas had different impacts.** The average participant in interventions in the economic opportunity focus area had better outcomes than 64 percent of those who did not participate. The average participant in interventions in the education and healthy futures focus areas had better outcomes than 59 percent of their comparison group counterparts.
- **Most priority objectives had impacts.** The interventions in the employability, K–12 success, postsecondary education support, and school readiness priority objectives were likely to have positive impacts. Although not an AmeriCorps priority objective, interventions classified as focusing on supportive family environments were also likely to have a positive impact.
- **Impacts did not vary by use of AmeriCorps members.** These results suggest that AmeriCorps members are as effective as other types of intervention personnel at delivering services.
- **Impacts did not vary by geographic region or by funding year.** These results suggest that interventions might be equally effective across the United States. The results also suggest that AmeriCorps has year-to-year consistency in identifying interventions supported by rigorous evidence of effectiveness.

A. Magnitude of effects of interventions with evidence they work

Figure III.1 illustrates the average effect sizes for the interventions with evidence that they work. This figure displays the average effect size across all the identified interventions (displayed as "overall") and for each individual intervention in three AmeriCorps focus areas. This figure, like all figures in this chapter, displays effect sizes in different colors and shapes. The confidence interval—which shows the range in which the actual effect size is likely to fall with a 95 percent probability—is shown by the horizontal line running through each colored shape. When this line crosses the 0 point, which is shown by a vertical line from the x-axis, we are not certain if the intervention has an impact. When the horizontal line does not cross the 0 point, we are at least 95 percent certain that the intervention has a beneficial impact.

Figure III.1. Overall and intervention average effects for primary outcomes



Note: Each line, except the overall line, represents a single intervention with the focus area of the intervention designated by different colors, shapes, and labeling. Appendix Table C.1 provides detailed information on the average effect size for the individual interventions.

Econ = economic opportunity; Educ = education; Health = healthy futures.

The AmeriCorps interventions with evidence that they work had a statistically significant average effect size of 0.28. The What Works Clearinghouse (WWC) improvement index (What Works Clearinghouse 2020, pp. 17–18) suggests that this effect size means that the average person receiving an AmeriCorps-funded intervention (treatment group) would perform better

than 61 percent of individuals who did not receive the intervention (comparison group). Because the average treatment group member without the intervention would outscore 50 percent of the comparison group, the 0.28 effect size indicates an 11 percentage point increase in beneficial outcomes. The average effect size for the individual interventions varied, with most interventions (21 of 30) having overall impacts that were not statistically significant, as indicated by the fact that the 95 percent confidence interval lines cross zero. Of the nine interventions with significant impacts, (1) three were economic opportunity interventions focused on employability; (2) five were education interventions, with three focused on K–12 success, one on postsecondary education support, and the other one on school readiness; and (3) one was a healthy futures intervention focused on supportive family environments.[21]

This pattern of findings appears comparable to previous analyses of the overall effectiveness of AmeriCorps-funded interventions, with Zhang and Sun (2016) finding that interventions implemented by SIF grantees had an overall average effect size of 0.28. However, it is important to note how the previous analysis and the one performed for this study differ on the interventions examined. The sample of interventions analyzed by Zhang and Sun (2016) were SIF-funded programs with AmeriCorps evidence ratings ranging from preliminary through strong. The Mathematica findings reported here include interventions funded through AmeriCorps State and National and SIF with grantees having a strong or moderate AmeriCorps evidence rating, and interventions had rigorous research designs, showed consistently favorable findings, and aligned with plans for scaling. Because of these differences, especially those related to the level of evidence required to support the interventions' effectiveness, readers should use caution when comparing magnitudes of effects discussed in this study to other meta-analyses performed with AmeriCorps-funded interventions.

B. Magnitude of effects by intervention characteristics

To assess whether the effect sizes significantly varied by any intervention characteristics, we compared the average effect sizes for interventions across focus areas, priority objectives, geographic region (single versus multiple regions), the involvement of AmeriCorps members in delivering services or supporting the delivery, and funding year. Rural/urban comparisons could not be made because only one intervention operated exclusively in rural areas.

Key finding

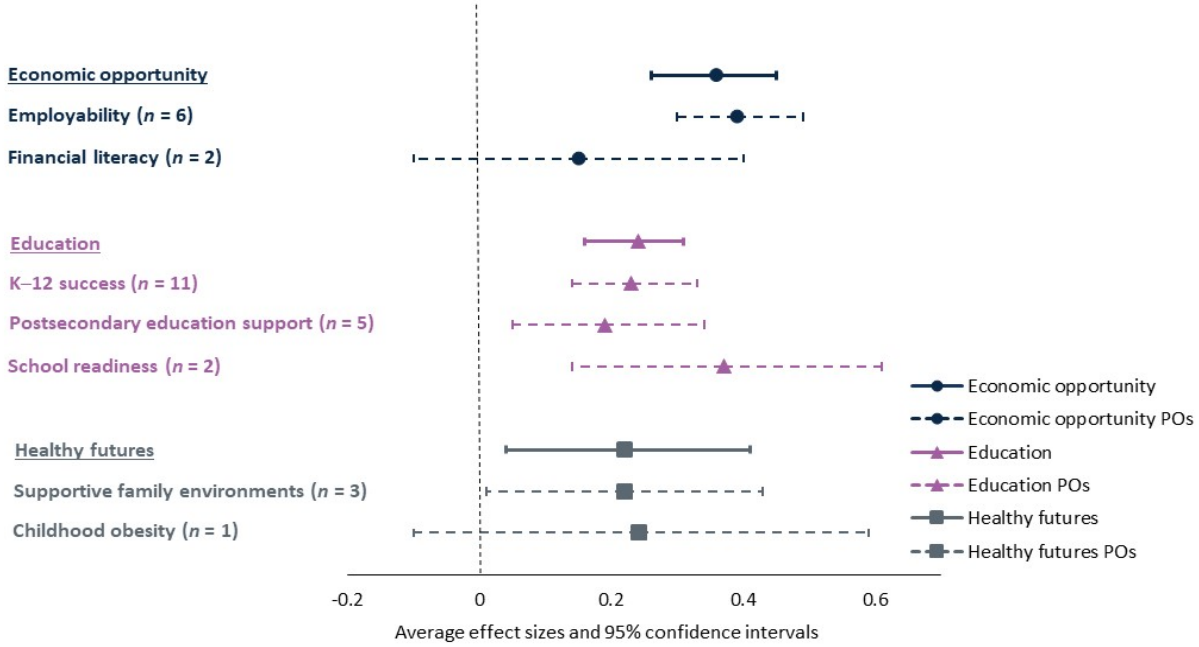
Interventions in the economic opportunity focus area had the largest average effect size.

Figure III.2 displays the average effect sizes for the interventions by the focus area and priority objectives under which they were classified. The solid lines represent the average effect sizes for the AmeriCorps focus areas, and the dashed lines correspond to average effect sizes of the priority objectives in the focus area. Some focus areas and priority objectives did not have interventions with evidence of effectiveness; they are not displayed in the figure. As the figure shows, interventions in the economic opportunity area had the largest average effect size (0.36), which translated into a 14 percentage

[21] The average effect size information presented in Figure III.1 and Appendix Table C.1 is based on the analysis of the studies' priority outcome measures. See Appendix Table C.4 for the average effect size information based on all outcome measures, which is not represented in Figure III.1.

point increase in favorable outcomes for participants. This finding is largely driven by the sizable impacts found for interventions Econ2, Econ3, and Econ7 (shown in Figure III.1). Effect sizes for interventions in the education focus area were also large (0.24); they correspond to a 9 percentage point increase in favorable outcomes for participants. The healthy futures focus area had an effect size of similar magnitude (0.22) that was also statistically significant.

Figure III.2. Intervention average effect sizes by focus area and priority objective



Note: Solid lines indicate focus area, and dashed lines indicate priority objectives (POs). The parentheses show the number of interventions in each characteristic. Focus areas and POs without interventions with evidence that they work are not shown. Education 5 was categorized under the K–12 success priority objective, and Economic Opportunity 1 was categorized under employability based on the majority of outcome measures assessed for these interventions. Although the supportive family environments area is not a designated AmeriCorps priority objective, we display the average effect size for the interventions categorized under this area.

The size of the effects also varied for interventions aligned with different priority objectives. In the economic opportunity focus area, interventions that focus on employability (0.39) appeared to outperform those that focus on financial literacy (0.15). In the education focus area, interventions that focus on school readiness produced the largest effect sizes (0.37), followed by K–12 success interventions (0.23), and then by the postsecondary education support intervention (0.19). For healthy futures interventions, the childhood obesity intervention (0.24) had a similar effect size to supportive family environments interventions (0.22).[22] Five objectives—employability, K–12 success, postsecondary education support, school readiness, and supportive family environment—achieved statistically significant average effect sizes. The average effect sizes in the remaining priority objectives—financial literacy and childhood obesity—were not

[22] The supportive family environments area is not a designated AmeriCorps priority objective, but we discuss this category to provide more information on the interventions in the healthy futures focus area.

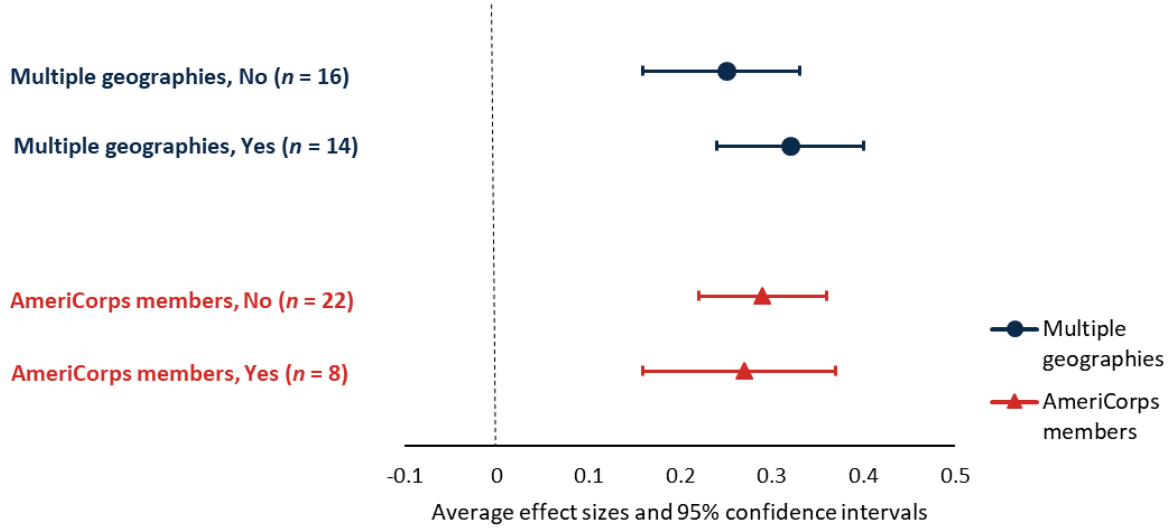
statistically significant, perhaps partly because of the small number of respective qualified studies. In addition, the difference in the average effect sizes between priority objectives within a focus area (results not shown) were not statistically significant from each other.

Key finding

Interventions in which AmeriCorps members provided direct services to participants or supported the delivery had a similar effect size to interventions that did not include AmeriCorps members.

Figure III.3 shows how average effect sizes varied by geography and whether AmeriCorps members provided direct services to participants or supported the delivery. Interventions implemented nationally or in multiple regions had an effect size of 0.32, compared to the effect size of 0.25 for interventions implemented in a single region. The difference of 0.07 was not statistically significant ($p = 0.23$). Interventions in which AmeriCorps members provided direct services to participants or supported the delivery had an effect size of 0.27, which was similar to the 0.29 effect size for interventions delivered or supported by personnel that did not include AmeriCorps members (the difference of 0.02 was not statistically significant, $p = 0.70$). This suggests that AmeriCorps members can be as effective in delivering services or supporting the delivery as other types of professionals.

Figure III.3. Average effects by intervention characteristics

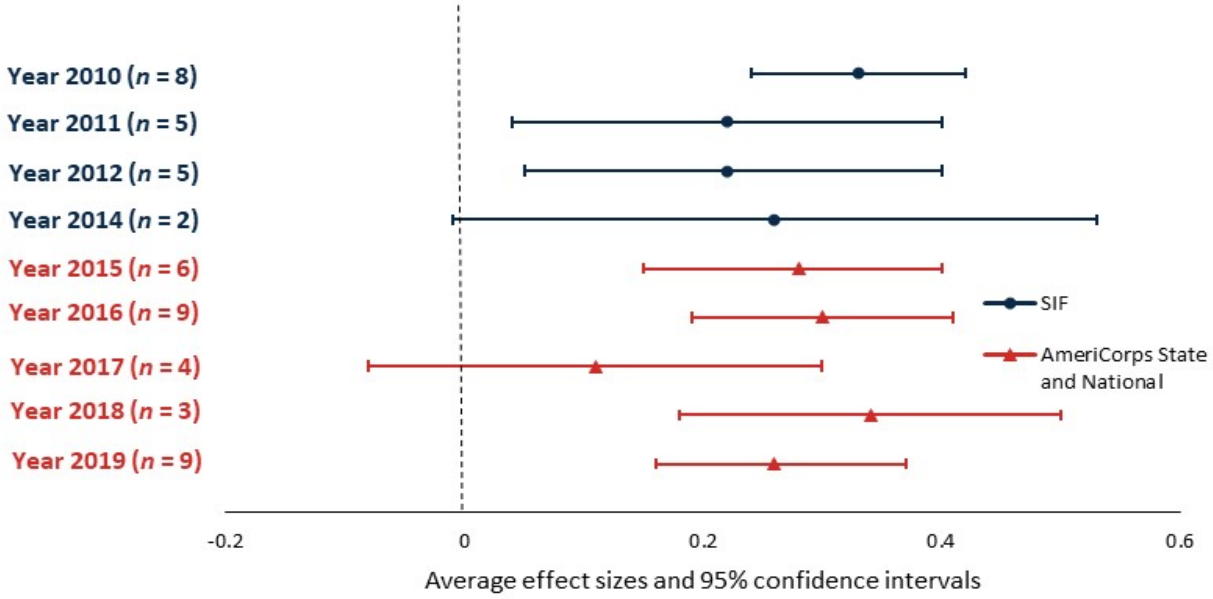


Note: The parentheses show the number of interventions in each characteristic. Appendix Table C.2 provides detailed information on the average effect size for the intervention characteristics categories.

Figure III.4 shows how average effect sizes varied by funding year for SIF grantees and AmeriCorps State and National grantees (2015–2019). The average effect sizes by funding year for interventions funded from 2010 to 2014 (SIF grantees) ranged from 0.22 to 0.33, whereas the average effect sizes by funding year for interventions funded from 2015 to 2019 (AmeriCorps State and National grantees) ranged from 0.11 to 0.34. Overall, the size of the effects did not vary substantially for interventions aligned with the different funding source. The only notable exception, the effect size of 0.11 for the 2017 funding year, was not statistically significant. This

suggests that AmeriCorps has year-to-year consistency in identifying interventions supported by rigorous evidence of effectiveness, with little variation across the agency's funding programs.

Figure III.4. Average effects by funding year and source



Note: There were no interventions funded by SIF in 2013. The 2015 SIF-funded interventions reviewed by the project did not meet the project's evidence of effectiveness standards. The parentheses show the number of interventions in each funding year. Interventions were included in the funding year average effect size estimate for each year that it was funded (in other words, interventions could appear in multiple funding years). Because a specific intervention could have been funded across multiple years, we did not compare whether interventions in one funding year had a greater impact on participant outcomes than interventions funded in a different funding year. Appendix Table C.3 provides detailed information on the average effect size for the funding year categories.

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IV. SUMMARY, RECOMMENDATIONS, AND NEXT STEPS

The focus of this report, shown in the first part of the SPREE process in Figure I.1 in Chapter I, was to identify the AmeriCorps-funded interventions that have been found through rigorous research to improve outcomes for people receiving the intervention services. For these effective interventions, we identified their characteristics—their alignment with AmeriCorps focus areas and priority objectives, as well as AmeriCorps' mission in terms of geography and use of AmeriCorps members—and estimated how effective they were in improving participants' outcomes. In this chapter, we describe the key findings that resulted from the research (Section A) and discuss the implications of these findings for AmeriCorps (Section B).

A. Summary of findings

Out of 82 interventions from 154 grants with continued funding that had a strong or moderate AmeriCorps evidence rating, we identified 32 interventions that met Mathematica's effectiveness standards. The other interventions were eliminated from the review process because their evidence documents (1) raised concerns about internal validity, which makes it difficult to conclude that the intervention was the cause of improved participant outcomes; (2) lacked consistently favorable findings for the intervention; or (3) had study design issues, such as not having a comparison group.

The interventions that met this study's effectiveness standards aligned with some of the AmeriCorps focus areas and priority objectives and somewhat with AmeriCorps' mission to use national service participants to strengthen communities across the country. The interventions were confined to the education, economic opportunity, and healthy futures focus areas (representing three of the seven AmeriCorps focus areas), with the majority having an education focus. The three AmeriCorps priority objectives in the education focus area (school readiness, K–12 success, and postsecondary education support) and the three priority objectives in the economic opportunity focus area (employability, financial literacy, and housing) each had interventions with evidence that they work. One effective healthy futures intervention was aligned with the childhood obesity priority objective (other healthy futures interventions focused on supportive family environments, although this is not an AmeriCorps priority objective). Most of the AmeriCorps-funded interventions were implemented in urban areas (97 percent), with 16 percent also implemented in rural areas. Four interventions (13 percent) were implemented in both urban and rural areas. About half (47 percent) were spread across the different regions of the United States, and the remainder (53 percent) were in one region only. AmeriCorps members were incorporated into one-quarter (25 percent) of the interventions, with AmeriCorps members delivering direct services to participants or supporting the intervention delivery.

The interventions that work had sizable impacts. Interventions in the education, healthy futures, and economic opportunity focus areas increased the probability of improving participants' outcomes by 9, 9, and 14 percentage points, respectively, compared to individuals not receiving the intervention. The interventions aligned to the different AmeriCorps priority objectives varied in the size of their impacts, with interventions focused on participants' employability and school

readiness having the largest effects (translated into 15 and 14 percentage points, respectively). The interventions also had significant impacts on participant outcomes regardless of whether they were implemented within a single geographic region or across multiple regions. Interventions that used AmeriCorps members had impacts that were similar to interventions in which AmeriCorps members were not involved.

B. Recommendations

These findings have several implications for how AmeriCorps can strengthen its efforts to identify, develop, and scale effective interventions to meet the needs of local communities. Specifically, there are several ways AmeriCorps can support and generate evidence for effective interventions and prioritize interventions for scaling.

- **Help grantees conduct studies that rigorously assess whether their intervention has an impact.** One of AmeriCorps' core principles in working with grantees is to help advance the rigor of the agency's research evaluations over a grant's life, with the goal of developing a strong evidence base for funded interventions. This principle is best reflected in a progression of evidence tiers that range from pre-preliminary through strong evidence for grantees. That 39 percent of interventions funded by grants with a strong or moderate AmeriCorps evidence rating met Mathematica's effectiveness standards indicates that AmeriCorps might consider developing additional resources to help its grantees build stronger evidence of effectiveness for their interventions. In particular, our project found that interventions did not meet the Mathematica effectiveness standards because of study design and internal validity issues (Figure II.2). Grantees delivering these interventions could benefit from additional technical assistance in the areas in which their evidence did not meet the project's standards for evidence of effectiveness. Ultimately, these supports have the potential to help increase grantees' awareness of how to produce evidence based upon well-designed and well-implemented studies with high internal validity.
- **When funding interventions, consider prioritizing those that show impacts across multiple outcomes.** For this project, interventions were eliminated from the review process if their supporting evidence showed that the interventions did not have consistently favorable impacts on their participants' outcomes (see Figure II.2). This suggests that AmeriCorps should consider an intervention's effectiveness when making funding decisions. One way to consider effectiveness might be to award more points to interventions that have a consistent, positive impact on participants' outcomes. For example, suppose there were two literacy development interventions, both of which had supportive evidence with strong study designs that had high internal validity, but one intervention significantly impacted all targeted literacy outcomes for its participants, whereas the other had positive impacts on just one targeted outcome out of several that were examined. AmeriCorps could prioritize the consistently effective intervention for funding by assigning it a higher score.

  AmeriCorps makes a concerted effort to fund interventions across all levels of its rating continuum. AmeriCorps funds some new, innovative interventions that are in the process of developing their intervention model and evidence of its effectiveness. It also funds more established interventions to sustain or scale their implementation. For these fully developed

interventions, AmeriCorps could emphasize obtaining evidence that the interventions work when making strategic decisions about continuing their funding.

- **Target funding for scaling effective interventions.** The findings from this study support AmeriCorps' vision for scaling effective interventions to help more individuals across the United States through the use of national service participants. Our findings suggest that some interventions funded by AmeriCorps are effective in improving participant outcomes in urban and rural communities across the various regions in the country. Our findings also indicate that AmeriCorps-funded interventions delivered by AmeriCorps members were similar in their effectiveness to interventions that did not involve members. AmeriCorps could consider focusing more on supporting grantees seeking to scale these effective interventions to help more individuals or new communities throughout the country and enhance the presence of AmeriCorps members in the service delivery model.

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APPENDIX A:

REVIEW PROCESS AND INTERVENTION REVIEW RUBRIC

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In this appendix, we describe the review rubric and process that Mathematica used for extracting information on the characteristics of the 32 interventions identified as having evidence that they work. These interventions were among those proposed by AmeriCorps State and National 2015–2019 and the Social Innovation Fund 2010–2015 grantees that were judged by an independent, third-party evaluator contracted by AmeriCorps as providing strong or moderate evidence for their intervention (see Table I.1 in Chapter I).

Table A.1 describes the criteria we applied to each evidence document to determine eligibility for further review. We developed these criteria to align with the overarching goal of the project: to identify interventions with evidence of effectiveness that grantees intended to scale to produce a wider impact.

Table A.1. Standards for categorizing evidence of effectiveness

Criterion	Question	Yes or No
Project objectives		
Study design	Did the study use a comparison group in its research design to allow for causal inferences to be drawn about the impact of the intervention?	
Reporting on methods	Did the study sufficiently describe its research design and statistical approach? For example, did the study provide adequate information on the formation of its study groups and the statistical procedures used to gauge the impacts of the intervention?	
Evaluator independence	Was the study conducted by an evaluator external to the grantee?	
Impact findings	Did the study show consistently favorable findings on the intervention's outcomes of interest? Having consistently favorable findings is defined as having intervention impacts that are statistically significant across the majority of confirmatory research questions examined in the study.	
Scaling plan alignment	Is the intervention assessed in the study aligned to the intervention the grantee plans to scale up?	
Internal validity		
Attrition	If the study was a randomized controlled trial (RCT), did the study experience high attrition?[23] Attrition from the study sample (overall and differential attrition between the study groups) can compromise the initial equivalence of the groups and lead to biased estimates of an intervention's effects. To determine the potential for attrition bias, we used the What Works Clearinghouse (2020) model,[24] which combines the overall and differential attrition rates a study may encounter, and generates acceptable and unacceptable levels of bias.	

[23] Attrition is examined only for RCTs and is not applicable to studies using quasi-experimental designs because for this study design type, only the *analytic* sample with post-test outcomes (not the initial sample present at the onset of the study) is considered when determining evidence quality.

[24] We used the What Works Clearinghouse's "optimistic" assumptions for assessing unacceptable levels of expected bias. See https://ies.ed.gov/ncee/wwc/Docs/referenceresources/wwc_standards_handbook_v4.pdf.

Criterion	Question	Yes or No
Reassignment	If the study was an RCT, did the study use reassignment? Reassignment, or switching study participants from the comparison group to the intervention group (or vice versa) after random assignment, is another major internal validity concern for RCTs. Using reassignment would undermine the important assumption that the intervention and comparison groups are similar at baseline due to random assignment.	
Baseline equivalence	For an RCT study that had high attrition or used reassignment or a study that used a quasi-experimental design, did the study demonstrate baseline equivalence? That is, did it show that the intervention and comparison groups in the final analytic sample are similar on a pre-test outcome measure at baseline? When intervention and comparison groups are not formed through a randomization process (or when RCTs experience high attrition or use reassignment), it is possible that groups could differ in unobservable ways at baseline even if they appear similar on their measured characteristics. Unmeasured baseline differences can bias estimates of the intervention's impact. As a result, studies must demonstrate baseline equivalence, showing that the intervention and comparison groups have similar observable characteristics at baseline. For this review, equivalence had to be established on at least one primary outcome measure, meaning there were no statistically significant differences on primary outcome measures for the analytic sample at baseline. If a statistical difference occurred, the study would have to statistically control for these baseline differences when analyzing post-test outcomes.	
Confounding factors	Does the study have the presence of a confounding factor that makes it difficult to distinguish between the effect of that factor and the intervention, thus making it impossible to attribute any potential impacts solely to the intervention? One common confounding factor is when some aspect of the research design lines up with either the intervention or comparison group, also referred to as an "n = 1 confound." For example, if the intervention or comparison group comprises a single unit (school, classroom, teacher), the study would not be able to isolate the effect of the intervention from other observable or unobservable characteristics of that unit. Interventions bundled with other services not being studied can also make it impossible to isolate the unique impact of the intervention.	

A structured review template was also used to extract intervention impact information from all evidence documents that met our evidence quality standards to assess the evidence of effectiveness and determine the magnitude of effects. For each evidence document, we recorded all outcomes measured at the end of the intervention for each independent study sample. Two researchers independently coded relevant information for the meta-analysis from each report using the same set of coding guidelines. The coders resolved any discrepancies through consensus and consulted a senior coder when consensus could not be reached.

The intervention review rubric was applied only to the evidence documents that met our study's effectiveness standards. When applying this rubric, we did not consult other external sources (for example, we did not query authors to collect more information not available in the documents or web searches to find additional information on the interventions). Several interventions supported their effectiveness by providing more than one evidence document that met the project's effectiveness standards. A separate assessment was created for each evidence document, and the information was then combined to provide an intervention-level summary of characteristics that informed the evidence supporting each intervention.

Reviewing these documents required systematic procedures to ensure that we reliably extracted standardized information from each document. Trained reviewers documented the interventions' characteristics using the rubric; in addition, a third-party consultant, external to Mathematica, reviewed all evidence documents authored by Mathematica to reduce any potential conflicts of interest. Reviewers classified each intervention and documented the characteristics of each intervention being reviewed, focusing on describing the intervention as implemented and evaluated. Study team leaders also reviewed the evidence documents and completed assessments to ensure that they contained complete and accurate information. The reviewer and study team leader discussed and resolved any discrepancies, and an additional study team leader was consulted if a consensus could not be reached. All finalized assessments were also reviewed by a Mathematica researcher external to the project as a final quality assurance procedure.

I. INTERVENTION REVIEW SECTION

The intervention review section of the rubric is structured to extract information from documents submitted by AmeriCorps grantees that report evaluation findings for AmeriCorps-funded interventions. The information extracted through the use of this rubric section describes the characteristics of the intervention when it was evaluated. It contains six subsections. The first subsection collects information about the context in which an intervention was implemented, and each of the next five subsections collects information on one of the five conditions needed for scaling.

A. Context for the intervention

Table A.I.1 provides the first subsection of the rubric, which includes three types of questions about the context in which the intervention unfolds:

1. **Description of the intervention**, according to AmeriCorps nomenclature. The nomenclature includes the intervention's (1) focus area, (2) topic area, (3) intended outcome domain(s), and (4) intended outcome(s). The appendix provides a list of predetermined response options for classifying the intervention per the nomenclature, with the "other" response indicating that the predetermined areas do not adequately describe the intervention.
2. **Local area context**, including contextual features that could affect implementation of the intervention, including any regional, state, and local contextual features; demand for the intervention at the local level; and partners.
3. **Measures of implementation**, including the percentage of participants who complete the intervention and cost per participant. The measures require a definition of components (participant, completer, and costs).

Table A.I.1. Questions about context for the intervention

Question	Response options	Additional guidance
I. Description of the intervention		
1. What is the intervention's focus area?	Only one focus area.	Focus areas include disaster services, economic opportunity, education, environmental stewardship, healthy futures, nonprofit organizational capacity, and veterans and military families.
2. What is (are) the intervention's topic area(s)?	Up to two topic areas listed in Table 1 in the appendix.	The topic area provides greater specificity about the intervention's broad goals than about the focus area. For example, an intervention may fall into the "economic opportunity" focus area. If it helps low-income people obtain employment, however, it would fall into the "employability" topic area.
3. What is (are) the intervention's outcome domain(s)?	Up to two outcome domains listed in Table 1 in appendix that fall within the topic area selected.	The outcome domain provides greater specificity than the topic area. The intervention aimed at helping low-income people obtain employment may do so by providing industry skill training, which is the intervention's outcome domain. The veterans and military families, disaster services, and nonprofit organizational capacity focus areas and some of the education topic areas do not have outcome domains.
4. What is (are) the intervention's outcome(s)?	Up to four outcomes listed in Table 1 in appendix.	Outcomes are the targets that the intervention seeks to affect. In the example of the industry skill training intervention, an outcome might be certifications/skills obtained by participants. Outcomes may span several outcome domains within a given topic area.
II. Local area context		
1. Might the regional, state, and local context facilitate or challenge implementation of the intervention?	Yes, contextual considerations might affect implementation. No, contextual considerations are not mentioned.	Regional, state, and local contextual factors can challenge or facilitate implementation of an intervention. Such factors may include community stakeholders, the political environment, or the local economy. For example, an affordable housing intervention that was implemented during a local economic downturn could see increased demand for its services. Question 2 is skipped with a "no" response.
2. What are the major features of the regional, state, and local context that could have affected implementation of the intervention?	[open-ended]	Describe any features of the regional, state, or local context that may have been salient in implementing the intervention.
3. Does evidence exist for local demand for the intervention?	Yes (full), local demand exists for the intervention. Yes (limited), local demand exists, but details are not available. No, local demand for the intervention is not mentioned.	Local demand may be identified by conducting a needs assessment, landscape analysis, or informal data collection through attendance at community meetings or conversations with key stakeholders.

Question	Response options	Additional guidance
4. Do key partners play a role in implementing the intervention?	Yes, implementation partners are identified. No, partners are not identified.	The organization may use partners to deliver services or assist with implementation of the intervention. Question 5 is skipped with a "no" response.
5. What role do the key partners play in implementing the intervention?	[open-ended]	Describes the partners or contractors that assisted with implementation of the intervention, including the role played by each.
III. Measures of implementation		
1. What is the **intended** overall completion rate for participants in the intervention?	[open-ended]	Intended intervention completion rate during a specific time period. Interventions often set forth completion goals for participants.
2. What is the **actual** overall completion rate for the intervention?	[open-ended]	Actual rate of participants' completion of the intervention during a specific time period.
3. Is cost-per-participant information discussed?	Yes, cost per participant is discussed. No, cost per participant is not mentioned.	Cost-per-participant information may be presented as part of a cost-benefit analysis. Question 4 is skipped with a "no" response.
4. What is the cost per participant for the intervention?	[open-ended]	The average cost of delivering the intervention per participant, including the year the costs were captured and information about the resources reflected in the calculation (the cost of personnel time, materials, space rental, partner services, among other items).

B. Well-specified intervention

This subsection addresses the first condition of the scaling readiness framework—a well-specified intervention. It includes questions in six areas (Table A.I.2). The first area describes the intervention, and the next four describe a different dimension of each core element. The last area describes what it takes a participant to complete the intervention.

1. **Core elements**, including identification of the intervention by its name. Core elements are activities that were part of the intervention and were intended to achieve the intervention's ultimate outcome domain and outcomes.
2. **Mode of service delivery**, including how each element was designed to be delivered to participants.
3. **Intensity,** including how often and for how long each element was offered to participants and how much of each element each participant received.
4. **Personnel needs,** including the intervention's personnel structure. A personnel structure includes the job titles of personnel who delivered the intervention, the number of individuals involved in delivery of the intervention, reliance on AmeriCorps national service participants, and qualifications of personnel.

5. **Setting**, including location (geography) and venue (the place where activities occurred, such as a community center, home, nonprofit organization, park, school).
6. **Definition of completion**, including criteria for being considered a participant in the intervention and what a participant needed to do to be considered a "graduate" or completer of the intervention.

In some cases, the rubric refers to a standardized, name-brand intervention (for example, Teach For America). A standardized intervention adheres to a specific model or curriculum in terms of the scope and sequence of the intervention's content. It spells out the same type and amount of services that each participant should receive. In a nonstandardized intervention, each participant's need determines the type and amount of services delivered; as a result, each participant experiences the intervention differently.

Table A.I.2. Questions about specifying the intervention

Question	Response options	Additional guidance
I. Core elements		
1. What is the name of the intervention?	[open-ended]	Use of a standardized, name-brand intervention rather than the local intervention name.
2. What are the designed core elements of the intervention?	[open-ended]	Core elements are the set of activities or curricula that result in participants' receipt of services, such as a description of services, the content area of the intervention, the existence of a standardized intervention model, the services or curriculum comprising the intervention, and the content area of the intervention to be delivered. A standardized intervention is considered to have a clearly specified intervention. Examples of core elements are tutoring, facilitator-led classes or workshops, one-on-one coaching, case management, electronic or telephone communication with participants, and building the capacity of an organization or partner organization. The description must align with the selected categorical responses in Table A.1 in the appendix.
3. Were all of the intervention's core elements implemented?	Yes, all core elements were implemented. No, some core elements were not implemented.	Question 4 is skipped with a "yes" response.
4. Which core elements of the intervention were implemented?	[open-ended]	Identify all core elements implemented.

Question	Response options	Additional guidance
5. Were any **purposeful** changes made to the intervention core elements implemented as compared to an earlier version of the model (including adaptations and modifications)?	Yes, intervention core elements were purposefully changed. No, intervention core elements were not purposefully changed.	Organizations may make changes to the intervention core elements prior to implementation, referred to as purposeful changes. Purposeful changes could extend to the intervention content, service delivery mode, intensity, and personnel needs (for example, a model designed for classroom training of service providers may have changed to one-on-one training). Implementing a "2.0" version is also a purposeful change. Differences between intended and actual implementation are not considered purposeful changes if, for example, the actual duration was shorter than intended, but the intended duration did not differ from the intervention model. Question 6 is skipped with a "no" response.
6. What purposeful adaptations or modifications did the organization make?	[open-ended]	Describes all purposeful changes made to the intervention core elements.
7. Were any **planned** changes made to the intervention during the implementation period?	Yes, planned changes were made to the intervention during implementation. No, planned changes were not made to the intervention during implementation.	During implementation, an organization may decide to make changes to an intervention, referred to as planned changes. Planned changes may include modifications to activities or services, mode of delivery, source of delivery, setting, or intensity. For example, an organization may have decided to offer an intervention in a new setting, extend the period of service delivery, or change the originally planned activities in order to test whether such changes would increase participant outcomes. Question 8 is skipped with a "no" response.
8. What were the planned changes to the intervention and the reasons for them?	[open-ended]	Describes all planned changes to intervention core elements.
II. Mode of service delivery		
1. What is the mode of delivery for each element?	[open-ended]	The service delivery model specifies how services are delivered, who delivers services, and the mode through which services are delivered. Organizations should provide a description of the way in which each core element is delivered. For example, peer educators or teams of facilitators may deliver services in groups or one-on-one meetings and through the use of electronic communication or in-person meetings.
III. Intensity		
1. What is the **intended** frequency of delivery of each element?	[open-ended]	For each element implemented, describes how often the element is intended to be offered during a specific time period.
2. What is the frequency with which each element was **actually** implemented (on average)?	[open-ended]	For each element implemented, describes how often the element was actually offered during a specific time period.

Question	Response options	Additional guidance
3. What is the **intended** duration of attendance for each element?	[open-ended]	For each element implemented, includes the intended length of time participants were supposed to receive an element during a specific time period.
4. What is the **actual** duration of attendance for each element (on average)?	[open-ended]	For each element implemented, describes the actual length of time participants received an element during a specific time period.
5. What is the **intended** number of hours of service receipt for each session of each element?	[open-ended]	For each element implemented, describes how many hours participants were supposed to receive an element during a specific time period.
6. What is the **actual** number of hours of service receipt for each session of each element (on average)?	[open-ended]	For each element implemented, describes the number of hours that participants actually received an element during a specific time period.
7. What is the **intended** total number of hours of programming for each element?	[open-ended]	For each element implemented, describes the total number of hours of services that participants were scheduled to receive.
8. What is the **actual** total number of hours of programming for each element (on average)?	[open-ended]	For each element implemented, describes the total number of hours of services that participants actually received, on average, during a specific time period.
IV. Personnel needs		
1. How many individuals deliver the intervention (overall and by intervention element)?	[open-ended]	Describes the number of individuals, by job title, who directly delivered the services across all locations, both overall and by element. For example, if an after-school reading intervention used 3 national service participants to lead classroom sessions and 9 classroom teachers to provide one-on-one tutoring across three locations, the response would state, “12 personnel overall: 3 participants (classroom sessions) and 9 teachers (one-on-one tutoring).”
2. Who delivers the services per intervention element?	[open-ended]	For each core element, lists job titles of individuals who directly delivered services, including several job titles as necessary. For example, if an after-school reading intervention used national service participants to lead classroom sessions and classroom teachers to provide one-on-one tutoring, the titles of both the participants and teachers are listed, along with the service element delivered by each group.
3. Does the intervention’s personnel structure include AmeriCorps service participants?	Yes, AmeriCorps participants are included in the personnel. No, these groups are not mentioned.	Question 4 is skipped with a “no” response.

Question	Response options	Additional guidance
4. What role do AmeriCorps participants play?	[open-ended]	Describes the role played by AmeriCorps participants. For example, “participants provided tutoring services for an after-school intervention.”
5. What qualifications are the required or preferred as a prerequisite for the personnel involved in delivering the intervention?	[open-ended]	Describes qualifications for each job title involved in delivering the intervention. Qualifications could include experience or expertise in delivering the needed services or education/training. For example, a nutrition education intervention requires educators to hold a degree in nutrition and demonstrate at least two years of teaching experience.
6. Does the organization intend or plan for a different personnel structure or personnel qualifications or training from what was originally intended or planned?	Yes, personnel plans differ from the personnel as implemented. No, personnel plans do not differ from the personnel as implemented.	Describes how the intended personnel plan, including the job titles of those who delivered the intervention, the number of individuals involved in service delivery, whether the personnel included AmeriCorps national service participants, personnel qualifications, and training plans for personnel, differed from the plan that was implemented. Question 7 is skipped with a “no” response.
7. How does the personnel structure differ from what was originally intended or planned?	[open-ended]	Describes the differences between the planned personnel structure and the implemented personnel structure. Includes the job titles of those who delivered the intervention, the number of individuals involved in service delivery, and whether the personnel included AmeriCorps service participants.
VII. Setting		
1. What are the geographic location(s) of the intervention, and what sites are included in implementation?	[open-ended]	For all locations, describes the geographic region, location, and whether the intervention was implemented in a rural or urban setting (or both). For example, an intervention implemented in two regions of the United States, three cities or areas, and several school districts and schools within each district would state, "Northeast and Southern regions, including New York, NY (Brooklyn): three school districts, 10 schools; Washington, DC: one school district, 8 schools; eight rural counties in southwestern Virginia (two school districts, 4 schools).”
2. In what venue(s) are the intervention core elements implemented?	[open-ended]	The implementation setting is where an intervention physically takes place, such as community center, home, nonprofit organization, park, school, and residential facilities. Organizations may implement core elements in different settings. For example, an intervention may have included job training at an American Job Center and job coaching on site with employers; both the American Job Center and employer settings, along with the job training and job coaching activities, are listed.

Question	Response options	Additional guidance
3. Did the **evaluation** enroll participants from a subset of intervention locations?	Yes, the locations for the evaluation were a subset of places where the intervention was implemented. No, the locations for the evaluation and implementation were the same.	The evaluation of the intervention may be conducted with participants from a subset of the locations in which the intervention was implemented. For example, an intervention may have been implemented in two cities, but the evaluation included participants in only one city. Question 4 is skipped with a "no" response.
4. What locations were included in the evaluation?	[open-ended]	Describes geographic locations indicating where the evaluation occurred and the number of locations.
VI. Definition of completion		
1. Is intervention participant defined?	Yes, participant is defined. No, participant is not defined.	Definition of a participant describes the minimum amount of services needed to be received in order to be considered a "participant" in the intervention. For example, individuals may enroll in an intervention and be considered a participant even if they never receive any services. Alternatively, participants may be defined as only those individuals who enroll and receive at least one service through the intervention. Question 2 is skipped with a "no" response.
2. What is the definition of an intervention participant?	[open-ended]	Describes the amount of services an individual must receive in order to be considered a "participant."
3. Is completion of the intervention defined?	Yes, completion is defined. No, completion is not defined.	Definition of completion indicates what participants must do to be considered "completers" or "graduates." For example, participants may have to complete a course and obtain a certificate in order to complete an intervention. Question 4 is skipped with a "no" response.
4. What is the definition of intervention completion?	[open-ended]	Describes what participants must do to be considered "completers" or "graduates."

C. Well-defined target population

This subsection addresses the second condition of the scaling readiness framework—a well-defined target population. It includes questions about the target population along three major dimensions (Table A.I.3):

1. **Intervention as it was designed**, including the characteristics of the target population as the intervention was originally designed.
2. **Intervention as it was implemented**, including the characteristics of the population that was eligible to participate in the intervention as it was implemented.
3. **Evaluation sample for the intervention,** including the participants in the evaluation sample.

Table A.I.3. Questions about defining the target population

Question	Response options	Additional guidance
I. Intervention as it was designed		
1. What is the target population for the intervention as it was designed?	[open-ended]	Describes the characteristics of the population that the intervention was originally designed to serve. Includes risk factors, age or grade ranges, participants' locations, gender, and so forth. In the case of several target populations, describes each population.
II. Intervention as it was implemented		
1. Who is eligible to participate in the intervention as it was implemented by the organization?	[open-ended]	Describes who is eligible to participate in the intervention as implemented. Includes risk factors, age or grade ranges, participants' locations, gender, and so forth, along with inclusion and exclusion criteria and information for several target populations.
2. Does the intervention as it is implemented enroll participants primarily from a specific racial or ethnic group?	Yes, participants are primarily from one of the prespecified racial or ethnic categories. No, participants are not primarily from a racial or ethnic category.	Racial/ethnic groups include African American, Hispanic, and other. An even distribution of African American, European American, and Hispanic participants is considered a "no" response.
3. Does the intervention as it is implemented enroll participants primarily from a certain age group?	Yes, participants are primarily from one of the prespecified age group(s). No, participants are not primarily from a certain age group(s).	Age categories include 0-5, 6-9, 10-7, 18-24, 25 55, and 56+. The intervention may be designed to serve participants in a specific age category, but, during implementation, participants from a different age category might enroll. Age group categories include all ages in that range. For example, if an intervention enrolled 4- to 6-year-old children, the response would be "0-5 and 6-9."
4. Does the intervention as it is implemented enroll participants primarily from any of the key populations?	Yes, participants are primarily from one of the prespecified key populations. No, participants are not primarily from a key population.	Key populations include low-income households/individuals, developmentally disabled individuals, homeless individuals, parents/caregivers of young children, parolees, and veterans/military families.
III. Evaluation sample for the intervention		
1. Does the evaluation sample differ from the target population of the intervention as it is implemented?	Yes, the evaluation sample and target population differ for the intervention as implemented. No, the evaluation sample and target population do not differ for the intervention as implemented.	Differences may arise if the evaluation sample was a subset of the population served by the intervention. For example, an intervention may have targeted 1,000 students in grades 9 through 12 in Chicago and Detroit, but the evaluation may have considered the outcomes of only 250 of those students in all grades and in both cities. Although the evaluation sample might be representative of the population it served, it does not include all of those served. Questions 2 through 5 are skipped with a "no" response.

Question	Response options	Additional guidance
2. How does the evaluation sample differ from the target population for the intervention as it is implemented?	[open-ended]	Describes how the evaluation sample differs from the population intended to receive the intervention.
3. Does the evaluation measure outcomes of participants **primarily** from a particular racial or ethnic group?	Yes, the evaluation measured outcomes of participants primarily from a prespecified racial or ethnic group(s). No, the evaluation did not measure outcomes of participants primarily from a racial or ethnic group(s).	Racial/ethnic groups include African American, Hispanic, and other. An even distribution of African American, European American, and Hispanic participants is considered a "no" response.
4. Does the evaluation measure outcomes of participants primarily from a certain age group?	Yes, the evaluation measured outcomes of participants from a certain age group(s). No, the evaluation did not measure outcomes along the age dimension.	Age categories include 0-5, 6-9, 10-17, 18-24, 25-55, and 56+.
5. Does the evaluation measure outcomes of participants from any of the key populations?	Yes, the evaluation measured outcomes of participants from a prespecified key populations. No, the evaluation did not measure outcomes of participants from the key populations.	Key populations include low-income households/individuals, developmentally disabled individuals, homeless individuals, parents/caregivers of young children, parolees, and veterans/military families.

D. Implementation supports

This section of the rubric addresses the third condition of the scaling readiness framework—implementation supports. It includes questions in six major areas, each of which describes the supports that help ensure quality in implementation (Table A.I.4).

1. **Implementation monitoring team**, including how the organization ensures fidelity to the intervention model (whether an organization delivered an intervention as intended). It also includes whether implementation issues arose, and whether the organization made any purposeful changes to the implementation supports.
2. **Performance procedures**, including performance goals and benchmarks for how personnel deliver the intervention.
3. **CQI**, including the ongoing, systematic process of identifying, describing, and analyzing strengths and challenges during implementation, along with the collection and use of data to improve the intervention's processes.
4. **Preservice and inservice training for the personnel**, including initial and ongoing training for those who deliver the intervention as well as the identification of those responsible for the delivery of training.

5. **Communication systems**, including the elements that facilitate high quality communication among intervention leaders, personnel, and partners.
6. **Data systems**, including efforts to track, measure, and store information about implementation and to use the information to help make decisions for monitoring and CQI.

Table A.I.4. Questions about implementation supports

Question	Response options	Additional guidance
I. Implementation monitoring team		
1. Is an implementation monitoring team described?	Yes (full), an implementation monitoring team is described, with details provided. Yes (limited), an implementation monitoring team is described, but with no details provided. No, an implementation monitoring team is not mentioned.	A monitoring team ensures that implementation takes place as planned. Team members may play other roles in the organization, such as supervisors, project managers, and project directors, or they may be other personnel dedicated exclusively to ensuring implementation of the intervention takes place with fidelity to the model. Question 2 is skipped with a "no" response.
2. Which personnel make up the implementation monitoring team?	[open-ended]	Describes the team members, including their titles and responsibilities, who are monitoring implementation of the intervention with fidelity to the model.
3. Does a process exist for monitoring service delivery to assess fidelity to the intervention as planned?	Yes, steps exist for monitoring fidelity. No, steps to monitor fidelity are not mentioned.	A process for monitoring fidelity to the intervention model ensures that services are being delivered as intended. The process for monitoring implementation fidelity could include collection of service delivery data through observations during site visits or regular reviews of service data entered into a data system. References to processes for assessing whether the "intervention is delivered as intended" are considered in assessing fidelity. Discussions of monitoring quality or other facets of implementation are not considered. Question 4 is skipped with a "no" response.
4. How is implementation fidelity monitored?	[open-ended]	Describes the steps taken to monitor implementation with fidelity, including identification of the individual (by job title) responsible for assessing fidelity, frequency of implementation monitoring, processes for managing/supervising personnel involved in service delivery, and frequency of personnel management or supervisory meetings.

Question	Response options	Additional guidance
5. Are issues or challenges noted regarding implementation fidelity?	Yes, issues were noted. No, issues regarding fidelity were not mentioned.	Fidelity issues include variation among instructors in the manner in which they deliver the curriculum across classes or cohorts and unplanned modifications to the intervention during the evaluation, such as changing an implementation site or adjusting the curriculum to meet the target population's unexpected needs. Question 6 is skipped with a "no" response.
6. What issues or challenges are noted regarding implementation fidelity?	[open-ended]	Describes any issues or challenges reported with implementation of the intervention with fidelity.
7. Who was responsible for supervising personnel involved in service delivery?	[open-ended]	Describes, by job title, who supervised the personnel involved in service delivery. If more than one personnel member responsible for supervising the individuals involved in service delivery, identifies each title and who was supervised.
8. How were personnel involved in service delivery supervised?	[open-ended]	Describes the frequency and format of supervision for each job title. For example, supervision may take place on a weekly, monthly, or as needed basis and may be in the form of one-on-one meetings or small team meetings. Supervision extends to check-in meetings, case note reviews, administrative data analysis, communication, and supports for supervisors.
9. Did any implementation supports **purposefully** change from an earlier version of the intervention model before the start of implementation?	Yes, the implementation supports changed from an earlier version of the model before the start of implementation. No, the implementation supports did not change from an earlier version of the model before the start of implementation.	Organizations may make changes to implementation supports before the start of implementation. Purposeful changes to implementation supports may include changes related to the following: the personnel structure, personnel training, supervision and performance management, implementation monitoring, communication processes, and data systems. Question 10 is skipped with a "no" response.
10. What **purposeful** changes were made to the intervention's implementation supports?	[open-ended]	Describes implementation supports that purposefully differ from an earlier design of the intervention. Changes may include any support related to the following: steps to ensure fidelity, the personnel structure, personnel training, supervision and performance management, monitoring, communication, and data systems.

Question	Response options	Additional guidance
II. Performance procedures		
1. Are performance benchmarks established for personnel involved in service delivery described?	Yes (full), performance benchmarks established for personnel involved in service delivery are described, with details provided. Yes (limited), performance benchmarks established for personnel involved in service delivery are described, but with no details provided. No, performance benchmarks established for personnel involved in service delivery were not mentioned.	Performance benchmarks are specific goals that personnel involved in service delivery must meet as related to delivery of the intervention, such as the number of participants contacted per personnel member or the number of participants served per personnel member. Question 2 is skipped with a "no" response.
2. What were the performance benchmarks established for personnel involved in service delivery?	[open-ended]	Describes the performance benchmarks established for personnel involved in service delivery, such as the number of participants contacted per personnel member or the number of participants served per personnel member. If different performance goals are set for specific job titles, goals are listed by job title; for example, "case managers are required to contact 12 participants per day."
3. Are procedures for monitoring achievement of performance benchmarks described?	Yes, procedures for monitoring achievement of performance benchmarks are described, with details provided. Yes (limited), procedures for monitoring achievement of performance benchmarks are described, but with no details provided. No, procedures for monitoring achievement of performance benchmarks were not mentioned.	Procedures for monitoring achievement of performance benchmarks include how benchmarks are measured and collected, who reviews progress toward benchmarks, and the frequency of performance monitoring. Question 4 is skipped with a "no" response.
4. What were the performance benchmarks monitoring procedures?	[open-ended]	Describes the procedures for monitoring achievement of performance benchmarks including how benchmarks are measured and collected, who reviews progress toward goals, and how frequently benchmarks for goals are captured and reviewed. If different performance monitoring procedures are set for specific job titles or roles, monitoring procedures are listed by job title.

Question	Response options	Additional guidance
III. Continuous quality improvement (CQI)		
1. Are CQI processes for the intervention described?	Yes (full), CQI processes are described, with details provided. Yes (limited), CQI processes are described, but with no details provided. No, CQI processes are not mentioned.	Continuous quality improvement processes refer to procedures for continuously assessing the quality of the intervention as implemented to improve implementation practice. CQI includes regularly testing the intervention and making adjustments as needed, with continual retesting of the modifications to ensure that the intervention is succeeding as planned. Question 2 is skipped with a “no” response.
2. What were the CQI processes for the intervention?	[open-ended]	Describes the process for testing the intervention, including how frequently CQI data is collected.
3. Were data analyzed to support CQI for the intervention?	Yes (full), data were analyzed and used for CQI, with details provided. Yes (limited), data were analyzed and used for CQI, but with no details provided. No, the analysis and use of data for CQI was not mentioned.	CQI requires the collection of data on performance benchmarks and use of the data to provide ongoing personnel development training and the delivery of technical assistance to partners. Data analysis to support CQI includes examining personnel achievement of performance benchmarks. Question 4 is skipped with a “no” response.
4. How were data analyzed to support CQI for the intervention?	[open-ended]	Describes how performance data were used to continuously improve intervention implementation.
IV. Preservice and inservice training for personnel		
1. Is the initial training to deliver the intervention received by personnel described?	Yes (full), initial personnel training to deliver the intervention is described, with details provided. Yes (limited), initial personnel training to deliver the intervention is described, but with no details provided. No, initial personnel training to deliver the intervention is not mentioned.	Training for service delivery given to personnel before implementation begins includes training on intervention content (such as a training on a curriculum used in the intervention), methods for service delivery (such as motivational interviewing), and client processing procedures (such as intake procedures). Question 2 and 3 are skipped with a “no” response.
2. What initial training did personnel receive to deliver the intervention?	[open-ended]	Describes, for each job title, initial personnel training for delivery of the intervention. Specifies when training occurred and training content and format (such as classroom, online). For example, a "summer training institute" for teachers occurs in person (through classroom sessions and practice teaching) in the summer before teachers begin teaching.

Question	Response options	Additional guidance
3. Who delivered the initial training?	[open-ended]	Describes, by job title, who delivered the initial training (for example, supervisors, personnel involved in service delivery, and partners). Separately identifies people with different job titles who delivered different types of training. For example, Teach For America personnel might deliver a "summer training institute" for teachers.
4. Is the ongoing training to deliver the intervention received by personnel described?	Yes (full), ongoing personnel training to deliver the intervention is described, with details provided. Yes (limited), ongoing personnel training to deliver the intervention is described, but with no details provided. No, ongoing personnel training to deliver the intervention is not mentioned.	Training for personnel involved in service delivery during implementation and throughout the service delivery period includes refresher trainings on intervention content, methods for service, and client processing procedures (such as intake procedures). Question 5 and 6 are skipped with a “no” response.
5. What is the ongoing training needed to deliver the intervention?	[open-ended]	Describes, by job title, the ongoing training that helps service providers deliver the intervention. Details include when and how often training occurred, content (for example, curriculum content, use of data systems), and format (for example, classroom, online).
6. Who delivered the ongoing training?	[open-ended]	Describes, by job title, who delivered the ongoing training (for example, supervisors, service providers, and partners).
V. Communication systems		
1. Is a communication system to support coordination among personnel and partners the described?	Yes (full), a communication system is described, with details provided. Yes (limited), a communication system is described, but with no details provided. No, a communication system is not mentioned.	Communication systems support coordination among personnel and partners and specify the frequency and the expected duration of communication, the parties responsible for communication, and the expected duration of communication. Systems may vary in the extent to which they specify and standardize communication. For example, a detailed plan may state that, for the first six months of the intervention, service providers must meet as a group with their supervisor for one hour each week to discuss topics related to recruitment and engagement of participants; for the next six months, meetings must take place monthly in the form of hour-long sessions to discuss service provision. Question 2 is skipped with a “no” response.
2. What was the communication system for supporting coordination personnel and partners?	[open-ended]	Describes the communication system, including the frequency and duration of the communication between personnel and with any partners, and which individuals are included in the communication system.

Question	Response options	Additional guidance
3. Is a process for ensuring the communication system functioned as intended described?	Yes (full), a process for ensuring the communication system functioned is described, with details provided. Yes (limited), a process for ensuring the communication system functioned is described, but with no details provided. No, a process for ensuring the communication system functioned is not mentioned	Processes to ensure a communication system functions as intended include obtaining feedback from personnel regarding the communication system and tracking the communication that takes place. Details include how feedback was obtained regarding the functioning of the communication system. For example, a communication system may have included logs of how often personnel met together\ or used regular check-ins with personnel eliciting feedback on how easily they feel they are able to get in contact with each other or key intervention partners. Question 4 is skipped with a "no" response.
4. What was the process for ensuring the communication system functioned as intended?	[open-ended]	Describes the process for ensuring the communication system functioned as intended.
VI. Data systems		
1. Is a data system to support data collection, analysis, and decision making described?	Yes (full), a data system is in place, with details provided. Yes (limited), a data system is mentioned, but with no details provided. No, a data system is not mentioned.	Data systems (for example, a management information system or a standardized Excel spreadsheet) capture enrollment and participation data and generate reports on participation trends. Such systems support data collection, analysis, and decision making. A detailed description specifies the information captured by the system, the organization's capacity to analyze recorded data, and how the organization uses the data to support its decision-making processes. Question 2 is skipped with a "no" response.
2. What was the data system developed to support data collection, analysis, and decision making?	[open-ended]	Describes the data system developed to support data collection, analysis, and decision making.
3. Is a process for ensuring data quality described?	Yes (full), a process for ensuring data quality is described, with details provided. Yes (limited), a process for ensuring data quality is described, but with no details provided. No, a process for ensuring data quality is not mentioned.	Processes for ensuring that the data collected are of high quality, such as checking for the completeness, accuracy, consistency, and timeliness of the data. For example, there is a plan to check participation data entered into a data system with paper records of attendance or case note file reviews. Question 4 is skipped with a "no" response.
4. What was the process for ensuring the quality of the data collected through the data system?	[open-ended]	Describes the process for ensuring that the data collected through the data system was of high quality.

Question	Response options	Additional guidance
5. Is a data system to support data collection, analysis, and decision making described?	Yes (full), a data system is in place, with details provided. Yes (limited), a data system is mentioned, but with no details provided. No, a data system is not mentioned.	Data systems (for example, a management information system or a standardized Excel spreadsheet) capture enrollment and participation data and generate reports on participation trends. Such systems support data collection, analysis, and decision making. A detailed description specifies the information captured by the system, the organization's capacity to analyze recorded data, and how the organization uses the data to support its decision-making processes. Question 2 is skipped with a "no" response.

E. Enabling context

This subsection addresses the fourth condition of the scaling readiness framework—the enabling context. It includes three aspects of the context in which organizations provide services (Table A.I.5):

1. **Support for the intervention,** including support from organizational leadership and partner agencies for implementing and evaluating the intervention.
2. **Innovation and learning,** including earlier activities that the organization might have undertaken in an effort to introduce new practices or improve the intervention and the organization's ability to understand the reason for any successes.
3. **Improvement in response to challenges,** including the identification of any challenges that organizations have encountered during implementation of the intervention and the solutions to those challenges.

Table A.I.5. Questions about the enabling context

Question	Response options	Additional guidance
I. Leaders, key stakeholders, and partners support for the intervention		
1. Is support from organizational leaders for the intervention described?	Yes (full), support from organizational leaders for the intervention is described, with details provided. Yes (limited), support from organizational leaders for the intervention is described, but with no details provided. No, support from organizational leaders for the intervention is not mentioned.	Describes organizational leaders and their commitment to the intervention. For example, organization leaders are described as engaging in planning activities or making implementation of the intervention a priority for the organization. Question 2 is skipped with a "no" response.
2. How was support from organizational leaders for the intervention demonstrated?	[open-ended]	Describes how support was demonstrated by organizational leaders.

Question	Response options	Additional guidance
3. Is support from stakeholders and/or partners for the intervention described?	Yes (full), support from stakeholders and/or partners for the intervention is described, with details provided. Yes (limited), support from stakeholders and/or partners for the intervention is described, but with no details provided. No, support from stakeholders and/or partners for the intervention was not mentioned.	Describes stakeholders' and/or partners' commitment to the intervention. Stakeholders and partners include service delivery partners or leadership at implementation sites. Support may be demonstrated by securing space for service delivery at local implementation sites or removing responsibility for non-intervention related workload for personnel involved in service delivery. Question 4 is skipped with a "no" response.
4. How was support from organization stakeholders and/or partners for the intervention demonstrated?	[open-ended]	Describes how support was demonstrated by stakeholders and/or partners.
II. Innovation and learning		
1. Is there any description of the organization's earlier efforts to be innovative?	Yes (full), efforts to be innovative are described, with details provided. Yes (limited), efforts to be innovative are described, but with no details provided. No, efforts to be innovative were not mentioned.	Describes organizational efforts to identify, develop, and implement new ways of meeting community needs. For example, organizational innovation could include offering new products or services or identifying novel ways of delivering regularly available services. Question 2 is skipped with a "no" response.
2. What were the innovative efforts described?	[open-ended]	Describes organization's efforts to be innovative.
3. Is there a description of the organization's efforts to improve its interventions?	Yes (full), efforts to improve its interventions are described, with details provided. Yes (limited), efforts to improve its interventions are described, but with no details provided. No, efforts to improve its interventions are not mentioned.	Describes the way in which organizations have improved interventions. Improvement may be demonstrated by a description of how the organization advanced its practices and enhanced the current service array. For instance, the evaluated intervention may have improved upon a previous version of the intervention by making changes to its recruitment strategies. Question 4 is skipped with a "no" response.
4. What were the improvement efforts described?	[open-ended]	Describes organization's efforts to improve interventions.
5. Is there any discussion of successes regarding implementation of the intervention?	Yes (full), implementation successes are discussed, with details provided. Yes (limited), implementation successes are discussed, but with no details provided. No, implementation successes were not mentioned.	Describes successes related to implementing intervention core elements, recruiting or serving the target population(s), supporting implementation, and creating an enabling context. Question 6 is skipped with a "no" response.

Question	Response options	Additional guidance
6. What were the implementation successes of the intervention and the reasons for those successes?	[open-ended]	Describes the implementation successes and the reasons for those successes.
III. Improvement in response to challenges		
1. Is there any discussion of challenges regarding implementation of the intervention?	Yes, challenges were discussed. No, challenges were not discussed.	Challenges could be related to intervention components, target population(s), implementation supports, and the enabling context. Question 2 is skipped with a "no" response.
2. What were the challenges regarding implementation of the intervention and solutions to those challenges?	[open-ended]	Includes the implementation challenges and the solutions to those challenges, if any.

F. Implementation infrastructure

This section of the rubric addresses the fifth condition of the scaling readiness framework—implementation infrastructure. It includes questions in four major areas, each of which describes the organization's infrastructure in support of implementation of the intervention (Table A.I.6).

1. **Financial resources**, including how the organization demonstrates that it or its partners successfully supported implementation of the intervention with dedicated financial resources.
2. **Sufficient personnel**, including whether the organization dedicated the personnel needed either to implement or scale the intervention.
3. **Materials,** including the standardization of materials and tailoring of materials to meet participants' needs.
4. **Physical space**, including the availability of space necessary for service delivery.
5. **Human resource system**, including a human resource system that is critical in typically overseeing three highly important, recognized implementation drivers—hiring, training, and ongoing supervision.

Table A.I.6. Questions about implementation infrastructure

Question	Response options	Additional guidance
I. Financial resources		
1. Does the organization provide funding for implementation of the intervention?	Yes (full), adequate funding is in place, with details provided. Yes (limited), adequate funding is in place, but with no details provided. No, funding is not mentioned.	Describes the amount and source of funds and, if applicable, partners' funding for implementation of the intervention. Question 2 is skipped with a "no" response.
2. What funding was provided by the organization for implementation of the intervention?	[open-ended]	Describes the funding provided by the organization for implementation of the intervention.
II. Sufficient personnel		
1. Does the organization provide personnel to implement the intervention (including dedicated supervisors and service providers)?	Yes (full), the organization provides dedicated personnel, with details provided. Yes (limited), the organization provides dedicated personnel, but with no details provided. No, dedicated personnel are not mentioned.	Describes the number of personnel needed for implementation, whether personnel worked exclusively on intervention implementation or also had nonintervention responsibilities, and, if applicable, partners' role in providing personnel for the intervention. Question 2 is skipped with a "no" response.
2. How many personnel were provided by the organization to implement the intervention?	[open-ended]	Describe the number of personnel needed for implementation.
III. Materials		
1. Is there a description of materials needed for the intervention?	Yes (full), intervention materials are described, with details provided. Yes (limited), intervention materials are mentioned, but with no details provided. No, needed intervention materials are not mentioned.	Describes the materials needed to implement the intervention, such as workbooks, culturally sensitive documents, or other handouts. Question 2 is skipped with a "no" response.
2. What were the materials needed for the intervention?	[open-ended]	Describes the intervention materials needed for implementation.
IV. Physical space		
1. Is there a description of the physical space needed for the intervention?	Yes (full), the physical space is described, with details provided. Yes (limited), the physical space is described, but with no details provided. No, the physical space is not mentioned.	Describes the physical space needed for implementation, such as the size or number of classrooms needed to fit the target number of participants or the availability of private meeting spaces for one-on-one service delivery. Question 2 is skipped with a "no" response.
2. What physical space was needed for implementation of the intervention?	[open-ended]	Describes the physical space needed for implementation.

Question	Response options	Additional guidance
V. Human resource system		
1. Is a human resource system in place to hire, supervise, and develop the personnel?	Yes (full), a human resource system is in place, with details provided. Yes (limited), a human resource system is in place, but with no details provided. No, a human resource system is not mentioned.	A human resource system supports implementation through processes and procedures for hiring personnel who meet qualifications for implementation with fidelity; for defining a supervisory structure (including the identification of who reports to whom, the frequency of supervisory meetings, mechanisms for reporting on personnel progress); and for providing personnel development (including planned training for personnel and opportunities for performance monitoring and improvement). A clearly defined human resource system specifies how these supports are routinized and whether procedural guidelines are developed to standardize the supports. Question 2 is skipped with a "no" response.
2. What was the human resource system put in place for the intervention?	[open-ended]	Describes the human resource system put in place for the intervention.

II. SCALING READINESS SECTION

The scaling readiness section of the rubric is used to assess an intervention's readiness to be scaled and the organization's ability to support that scaling as described in the organization's narrative application for funding or in the organization's scaling plan. This section is used primarily to assess the degree to which the organization specifies details critical for assessing that the intervention and the organization will be able to successfully implement the intervention and to what degree the intervention proposed for scaling differs from the intervention that was evaluated (and described using the previous section of the rubric that was applied to the intervention's evaluation report). The section includes six subsections. One subsection collects background information about the approach to scaling and the context in which implementation will occur, and the next five subsections collect information on each of the five conditions needed for scaling.

A. Scaling approach and its context

Table A.II.1 provides the first subsection of the rubric, which includes two types of questions about the organization's approach to scaling and the context in which it occurs:

1. **Scaling approach** planned for the intervention. Research from implementation science includes three forms of scaling. (1) **Expansion** extends the intervention to more people in the same target population in the same location. Successful expansion requires the intervention and the organization to serve a larger number of participants with the same service quality and in a manner demonstrating fidelity to the model's design. (2) **Replication** extends the intervention to the same target population, but in a new location. Successful replication requires the intervention and the organization to maintain service quality and fidelity to the

intervention in the new location. (3) **Adaptation** extends the intervention to a new target population. Successful adaption requires the organization to change the intervention in a way that maintains service quality. AmeriCorps also funded some AmeriCorps State and National grantees to sustain or deepen the intervention services instead of scaling the intervention. Some grantees received funds to **sustain** services, which means that the intervention will continue serving the same target population in the current location without any purposeful changes to it. Some grantees received funds to **deepen** services, which means that the intervention will serve the same target population in the current location, but with enhanced services (for example, more hours of job coaching).

2. **Local context and demand** associated with the geographic area where the intervention is proposed for scaling. Local contextual factors include any regional, state, and local features that may affect implementation of the intervention, and local demand factors include evidence of demand for the intervention in the local area.

Table A.II.1. Questions about scaling approach and local context

Question	Response options	Additional guidance
I. Scaling approach		
1. What is the organization's proposed intervention?	[open-ended]	Describes the proposed intervention, including its core components and activities and plans for implementation.
2. How does the organization self-categorize its scaling approach?	Expansion Replication Adaption Sustaining services Deepening services Not described	Describes the **self-categorization** of the scaling approach.
3. Based on the description of the proposed intervention, what is the scaling approach?	Expansion Replication Adaption Sustaining services Deepening services	Describes the scaling approach as defined by implementation science.
4. Will the intervention proposed for scaling be implemented by the organization that developed it?	Yes, the intervention proposed for scaling will be implemented by the organization developing it. No, the intervention proposed for scaling was developed by a different organization.	Describes whether the scaled intervention was developed by the implementing organization or by another entity.
II. Local context and demand		
1. Does the organization provide evidence of demand in the local area for the intervention that is being scaled?	Yes (full), evidence exists for local demand for the intervention being scaled, with details provided. Yes (limited), demand exists for the intervention being scaled, but with no details provided. No, local demand is not mentioned or does not exist.	Means of illustrating local demand include the results of a needs assessment, a landscape analysis specifying the scope of the intervention, or informal data collection via attendance at community meetings or conversations with key stakeholders. The results of such efforts must motivate the proposed scaling approach.

Question	Response options	Additional guidance
2. Does the organization provide evidence that the local, regional, or state context will be conducive to scaling the intervention?	Yes (full), the context will be conducive to scaling, with details provided. Yes (limited), the context will be conducive to scaling, but with no details provided. No, the context is not mentioned or not conducive to scaling.	Evidence exists that key community partners will value the intervention and that stakeholders at the local, regional, or state level will not impede implementation. Such evidence might include memorandum of understanding, grants, contracts or more formal arrangements, as well as tacit relationships, such as board memberships.

B. Well-specified intervention

This subsection addresses the first condition of the scaling readiness framework—the well-specified intervention—as described in the grantee's plan for scaling. It includes overall questions on the core elements of the intervention proposed for scaling and their dimensions for service delivery, as well as the definition of participants completing the intervention (subsection A.I.2 describes these dimensions). The subsection asks questions about five dimensions of intervention specification (Table A.II.2): (1) core elements (services, the intervention's content area, and whether a standardized intervention model is used), (2) mode of service delivery, (3) intensity, (4) personnel needs, (5) setting, and (6) definition of completion. For each, questions (1) categorize the specificity of the proposed intervention elements, (2) identify differences between the proposed intervention element and the evaluated intervention element (as described in the intervention evaluation reports and captured in subsection A.I.2 of the rubric), and, if applicable, (3) report the rationale for differences between the proposed intervention element and evaluated intervention element. If the organization proposes to expand to a new population or replicate the intervention, it may not make any changes to the intervention itself.

Table A.II.2. Questions about specifying the intervention proposed for scaling

Question	Response options	Additional guidance
I. Core elements		
1. Are the core elements of the intervention well specified?	Yes (full), core elements are well specified, with details provided. Yes (limited), core elements are specified, but with no details provided. No, core elements are not mentioned.	Core elements are the set of activities or curricula that result in participants' receipt of services, such as a description of services, the content area of the intervention, the existence of a standardized intervention model, the services or curriculum comprising the intervention, and the content area of the intervention to be delivered. A standardized intervention is considered to have a clearly specified intervention.

Question	Response options	Additional guidance
2. Do the proposed core elements differ from those in the evaluation?	Yes (full), proposed core elements differ from those evaluated, with details of the differences provided. Yes (limited), proposed core elements differ from those evaluated, but with no details provided. Do not know; proposed core elements are not defined. No, proposed core elements for the evaluation and intervention are the same.	The proposed core elements of the intervention for scaling may differ from the core elements of the intervention that were evaluated. Changes to the intervention could include the addition of services, the modification of existing services, the discontinuation of some services, the addition of content, or the use of a new curriculum, all described in sufficient detail to allow an external audience to replicate them. Question 3 is skipped with a "don't know" or "no" response.
3. Does a rationale or support exist for the proposed change(s) to the core elements?	Yes, a rationale or support for the change(s) is provided. No, a rationale or support is not provided.	Organizations may provide a reason for differences between the proposed intervention core elements and the evaluated core elements. Support might refer, for example, to research showing that a proposed change has positive impacts on outcomes.
II. Mode of service delivery		
1. Is the service delivery model well-specified?	Yes (full), the service delivery model is well-specified, with details provided. Yes (limited), the service delivery model is specified, but with no details provided. No, the service delivery model is not mentioned.	The service delivery model specifies how services are delivered, who delivers services, and the mode through which services are delivered. For example, services may be delivered in groups or one-on-one meetings, by peer educators or teams of facilitators, and the through the use of electronic communication or in-person meetings. A standardized intervention clearly specifies the service delivery model.
2. Does the proposed service delivery model differ from the service delivery model implemented during the evaluation?	Yes (full), the proposed service delivery model differs from the intervention evaluated, with details provided. Yes (limited), the proposed service delivery model differs from the intervention evaluated, but with no details provided. Do not know; the service delivery model is not defined. No, the proposed and evaluation service delivery models are the same.	The proposed service delivery model for the intervention for scaling may differ from the service delivery model of the intervention that was evaluated. Changes to the service delivery model could include the type of delivery (such as face-to-face meetings or electronic communications) and the nature of delivery (such as in a group or one-on-one meetings). Question 3 is skipped with a "don't know" or "no" response.
3. Does a rationale or support exist for the proposed change(s) to the service delivery model?	Yes, a rationale or support for the change(s) is provided. No, a rationale or support for the proposed change(s) is not provided.	Organizations may provide a reason for differences between the proposed interventions' service delivery mode and the evaluated service delivery mode. Support could include research showing that a proposed change has positive impacts on outcomes.

Question	Response options	Additional guidance
III. Intensity		
1. Is the intensity of the intervention well-specified?	Yes (full), the intensity is well-specified, with details provided. Yes (limited), the intensity is specified, but with no details provided. No, the intensity is not mentioned.	Describes the total number of hours of intervention programming participants will receive. This is based on how long an intervention will last (duration) and the amount of services participants will receive (dosage), including the frequency of intervention interaction and hours of service.
2. Does the proposed intensity of the scaled intervention differ from the intensity of the intervention evaluated?	Yes (full), the proposed intensity differs from the intervention evaluated, with details of the differences provided. Yes (limited), the proposed intensity differs from the intervention evaluated, but with no details provided. Do not know; the intensity is not defined. No, the proposed and evaluated intensity is the same.	The proposed intensity of the intervention for scaling may differ from the intensity of the intervention that were evaluated. Differences may include changes to how long an intervention lasts, how many times a participant and a service provider meet, and how many hours of service content a participant receives. Question 3 is skipped with a “don’t know” or “no” response.
3. Does a rationale or support exist for the proposed change(s) to the intensity of the intervention?	Yes, a rationale for the change(s) is included, with details provided. No, a rationale for the change(s) to dosage or duration is not mentioned.	Organizations may provide a reason for differences between the proposed interventions’ intensity and the evaluated intensity. Support might include research showing that a proposed change has positive impacts on outcomes.
IV. Personnel needs		
1. Are the qualifications clearly specified for the personnel involved in delivering the intervention?	Yes (full), personnel qualifications are clearly specified, with details provided. Yes (limited), personnel qualifications are specified, but with no details provided. No, personnel qualifications are not mentioned.	Clearly specified qualifications for each job title involved in delivering services for the scaled intervention. Qualifications could include required training or education and experience levels of the personnel delivering the intervention services.
2. Do the proposed personnel qualifications after scaling differ from the qualifications of personnel delivering services as part of the evaluation?	Yes (full), the proposed personnel qualifications differ from the intervention evaluated, with details of the differences provided. Yes (limited), the proposed personnel qualifications differ, but with no details of the differences provided. Do not know; the personnel qualifications are not defined. No, the proposed and evaluation personnel are the same.	The proposed personnel of the intervention for scaling may differ from the personnel of the intervention that were evaluated. Differences in personnel qualifications may include education, experience, or various levels of training. Question 3 is skipped with a “don’t know” or “no” response.
3. Does a rationale or support exist for the proposed change(s) to the personnel qualifications?	Yes, a rationale or support exists for the personnel qualifications change(s). No, a rationale for the proposed change(s) is not mentioned.	Organizations may provide a reason for differences between the proposed interventions’ personnel and the personnel of the evaluated intervention. A rationale could include research showing that a proposed change has positive impacts on outcomes.

Question	Response options	Additional guidance
V. Setting		
1. Is the implementation setting clearly specified?	Yes (full), the implementation setting is clearly specified, with details provided. Yes (limited), the implementation setting is specified, but with no details provided. No, the implementation setting is not mentioned.	Implementation setting includes the geographic location of implementation and where an intervention takes place. The description of the implementation setting may include the city and state; whether the intervention is being implemented in a school, community-based organization, or workforce center; and the number of implementation settings. The number of implementation sites is not considered a change unless the new sites are located in a new city, state, or type of setting (such as a different implementing agency).
2. Does the proposed implementation setting differ from the evaluation's implementation setting?	Yes (full), the proposed setting differs from the evaluation setting, with details provided. Yes (limited), the proposed setting differs from the evaluation setting, but with no details provided. Do not know; the setting is not described. No, the proposed and evaluation setting are the same.	The proposed implementation setting of the intervention for scaling may differ from the implementation setting of the intervention that was evaluated. Differences in the implementation setting might include delivering services in a new city, state, region, or urban/rural area as well as switching from a community-based to a school-based intervention. Question 3 is skipped with a "don't know" or "no" response.
3. Does a rationale or support exist for the proposed change(s) to the implementation setting?	Yes, a rationale exists for the change(s). No, a rationale is not provided for the proposed change(s).	Organizations may provide a reason for differences between the implementation setting of the proposed intervention and the setting of the evaluated intervention. A rationale could include research showing that a proposed change has positive impacts on outcomes.
VI. Definition of completion		
1. Are the criteria for completion well-specified?	Yes (full), the criteria for completion are well-specified, with details provided. Yes (limited), the criteria for completion are specified, but with no details provided. No, the criteria for completion are not mentioned.	Criteria for completion indicates what participants must do to be considered "completers" or "graduates" for the intervention for scaling. To sufficiently specify the completion criteria, there must also be a definition of a "participant," including the minimum amount of services needed to be received in order to be considered a "participant." For example, to be considered a participant, a youth must attend at least 1 case manager meeting; to be considered a completer or graduate, participants must attend 10 case manager meetings.

Question	Response options	Additional guidance
2. Do the criteria for completion differ from the criteria described in the evaluated intervention?	Yes (full), the proposed completion criteria differ from the criteria for the intervention evaluated, with details provided. Yes (limited), the proposed completion criteria differ from the criteria for the intervention evaluated, but no details are provided. Do not know; the completion criteria are not described. No, the proposed and evaluated criteria for completion are the same.	The completion criteria of the intervention for scaling may differ from the completion criteria of the evaluated intervention. Changes to the criteria for completion might include requiring a new minimum amount of services to be attended to be considered a participant or a change in the number of services received to be considered a graduate of the intervention. Question 3 is skipped with a "don't know" or "no" response.
3. Does a rationale or support exist for the proposed change(s) to the participant completion definition?	Yes, a rationale or support for the change(s) is provided. No, a rationale or support for the proposed change(s) is not provided.	Organizations may provide a reason for differences between the completion criteria of the proposed intervention and the completion criteria of the evaluated intervention. A rationale could include research showing that a proposed change has positive impacts on outcomes.

C. Well-defined target population

This subsection of the rubric addresses the second condition of the scaling readiness framework—well-defined target population. It includes questions discussed in subsection A.I.3 about the target population proposed for scaling (Table A.II.3) and describes differences between the proposed target population after scaling and the population studied in the evaluation. If the organization proposes to expand the population size or replicate the intervention, it may not make any changes to the target population.

Table A.II.3. Questions about the target population proposed for scaling

Question	Response options	Additional guidance
1. Is the target population well-specified?	Yes (full), the target population is clearly specified, with details provided. Yes (limited), the target population is specified, but with no details provided. No, the target population is not mentioned.	Describes who is eligible to participate in the intervention, including inclusion and exclusion criteria. For example, a proposed intervention to serve unemployed adults should include examples of eligible age ranges (for example, 18-64), length of unemployment, and any other inclusion or exclusion criteria such as no felony conviction.
2. Does the proposed target population differ from the evaluation sample?	Yes (full), the proposed and evaluation populations differ, with details of the differences provided. Yes (limited), the proposed and evaluation populations differ, but with no details of the differences provided. Do not know; the populations are not defined. No, the proposed and evaluation populations are the same.	Changes to the target population include age requirements (for example, expanding the eligible age range from 11- to 13-year-old children to 10- to 14-year-old children), personal characteristics (for example, risk factors or education levels), or eligibility (for example, veterans or youth). Question 3 is skipped with a “don’t know” or “no” response.
3. Does a rationale or support exist for the proposed change(s) to the target population?	Yes, a rationale exists for the change(s), with details provided. No, no rationale for the change(s) is mentioned.	A rationale could include research showing that a proposed change has had positive impacts on outcomes in other studies or that modifications could be based on the recommendations.

D. Implementation supports

This section of the rubric addresses the third condition of the scaling readiness framework—implementation supports. It includes questions about the implementation supports discussed in subsection A.I.4 that are available for the scaled intervention (Table A.II.4): (1) implementation monitoring team, (2) performance procedures, (3) CQI, (4) preservice and inservice training for the personnel, (5) communication system, and (6) data system.

Table A.II.4. Questions about implementation supports for the intervention proposed for scaling

Question	Response options	Additional guidance
I. Implementation monitoring team		
1. Is a team proposed to monitor implementation of the scaled intervention?	Yes (full), a team is proposed, with details provided. Yes (limited), a team is described, but with no details provided, No, a team is not mentioned,	A monitoring team ensures that implementation takes place as planned. Team members may play other roles in the organization (such as supervisors, project managers, and project directors) or they may be other personnel members dedicated exclusively to ensuring that the intervention is implemented with fidelity to the model. Details include specific information about members of the implementation team.
2. Does a process for monitoring fidelity to the intervention model exist for the scaled intervention?	Yes (full), a process for monitoring fidelity to the intervention model is described, with details provided. Yes (limited), a process for monitoring fidelity to the intervention is described, but with no details provided. No, a process for monitoring fidelity is not mentioned	A process for monitoring fidelity to the intervention model ensures that services are being delivered as intended. The process for monitoring implementation fidelity could include collecting service delivery data through observations during site visits or regular reviews of service data entered into a data system. Details include identification of the individual (by job title) responsible for assessing fidelity, frequency of implementation monitoring, processes for managing/supervising personnel members, and frequency of personnel management or supervisory meetings.
II. Performance procedures		
1. Do performance benchmarks exist for personnel involved in service delivery of the scaled intervention?	Yes (full), performance benchmarks are described, with details provided. Yes (limited), performance benchmarks are described, but with no details provided. No, performance benchmarks are not mentioned.	Performance benchmarks are specific goals that personnel must meet as related to delivery of the scaled intervention, such as such as the number of participants contacted per personnel member or the number of participants served per personnel member.
2. Do procedures for monitoring achievement of performance benchmarks exist for the scaled intervention?	Yes (full), procedures for monitoring achievement of performance benchmarks are described, with details provided. Yes (limited), procedures for monitoring achievement of performance benchmarks are described, but with no details provided. No, procedures for monitoring achievement of performance benchmarks are not mentioned.	Procedures for monitoring achievement of performance benchmarks include how benchmarks are measured and collected, who reviews progress toward benchmarks, and the frequency of performance monitoring.

Question	Response options	Additional guidance
III. Continuous quality improvement (CQI)		
1. Are CQI processes proposed for the scaled intervention?	Yes (full), CQI processes are proposed, with details provided Yes (limited), CQI processes are proposed, but with no details provided. No, CQI processes are not mentioned.	CQI processes refer to procedures for continuously assessing the quality of the intervention as implemented to improve implementation practice. CQI includes regularly testing the intervention and making adjustments as needed, with continual retesting of the modifications to ensure that the intervention is succeeding as planned. Details include a description of the data collected throughout this process.
2. Does a plan exist to analyze data to support CQI for the scaled intervention?	Yes (full), data analysis to support CQI are described, with details provided. Yes (limited), data analysis to support CQI are described, but with no details provided. No, data analysis to support CQI is not mentioned.	CQI requires the collection of data on performance benchmarks and use of the data to provide ongoing personnel development training and the delivery of technical assistance to partners. Describes plans for using data to support CQI includes examining personnel achievement of performance benchmarks.
IV. Preservice and inservice training for personnel		
1. Do plans exist to provide initial training to personnel to deliver the scaled intervention?	Yes (full), initial training plans are described, with details provided. Yes (limited), initial training plans are described, but with no details provided. No, initial training plans are not mentioned.	Training for service delivery given to personnel before implementation begins includes training on intervention content (such as a training on a curriculum used in the intervention), methods for service delivery (such as motivational interviewing), and client processing procedures (such as intake procedures).
2. Do plans exist to provide ongoing training to personnel to implement the scaled intervention?	Yes (full), ongoing training plans are described, with details provided. Yes (limited), ongoing training plans are described, but with no details provided. No, ongoing training plans are not mentioned.	Training for service delivery given to personnel during implementation and throughout the service delivery period, includes refresher trainings on intervention content, methods for service, and client processing procedures (such as intake procedures).

Question	Response options	Additional guidance
V. Communication system		
1. Does a communication system exist to support coordination among personnel and partners for the scaled intervention?	Yes (full), a communication system exists, with details provided. Yes (limited), a communication system is mentioned, but with no details provided. No, a communication system is not mentioned.	Communication systems support coordination among personnel and partners and specify the frequency and expected duration of communication and the parties responsible for communication. Systems may vary in the extent to which they specify and standardize communication. For example, a detailed plan may state that, for the first six months of the intervention, service providers must meet as a group with their supervisor for one hour each week to discuss topics related to recruitment and engagement of participants; for the next six months, meetings must take place monthly in the form of hour-long sessions to discuss service provision.
2. Do processes exist for ensuring the communication system is functioning as intended for the scaled intervention?	Yes (full), processes for ensuring the communication system is functioning as intended are described, with details provided. Yes (limited), processes for ensuring the communication system is functioning as intended are described, but with no details provided. No, processes for ensuring the communication system is functioning as intended are not mentioned	Processes to ensure a communication system functions as intended include obtaining feedback from personnel regarding the communication system and tracking the communication that takes place. Details include how feedback was obtained regarding the functioning of the communication system. For example, a communication system may have included logs of how often personnel met together or used regular check-ins with personnel eliciting feedback on how easily they feel they are able to get in contact with each other or key intervention partners.
VI. Data system		
1. Does a data system exist to support data collection, analysis, and decision making for the scaled intervention?	Yes (full), a data system is described, with details provided. Yes (limited), a data system is described, but with no details provided. No, a data system is not mentioned.	Data systems capture enrollment and participation data and generate reports on participation trends. Such systems support data collection, analysis, and decision making. Details include the information captured by the system, the organization's capacity to analyze recorded data, and how the organization uses the data to support its decision-making processes.
2. Does a process exist for ensuring the data quality for the scaled intervention?	Yes (full), a process for ensuring the data quality is described, with details provided. Yes (limited), a process for ensuring the data quality is described, but with no details provided. No, a process for ensuring the data quality is not mentioned.	Processes for ensuring that the data collected are of high quality, such as checking for the completeness, accuracy, consistency, and timelines of the data. For example, there is a plan to check participation data entered into a data system with paper records of attendance or case note file reviews.

E. Enabling context

This subsection addresses the fourth condition of the scaling readiness framework—the enabling context. It includes questions about the organizational supports discussed in subsection A.I.5 that are available for the scaled intervention (Table A.II.5). Support for scaling pertains to the organization's leaders and key stakeholders, as well as to the organization's culture and its focus on innovation, learning, and improvement. The enabling context involves questions in three major areas about the system in which organizations provide services: (1) organizational leadership and partner support, (2) innovation and learning and (3) improvements in response to challenges.

Table A.II.5. Questions about the enabling context for the organization proposing the scaling

Question	Response options	Additional guidance
I. Leaders, key stakeholders, and partners support for the intervention		
1. Is support from organizational leaders for scaling the intervention described?	Yes (full), support from organizational leaders for scaling the intervention is described, with details provided. Yes (limited), support from organizational leaders for scaling the intervention is described, but with no details provided. No, support from organizational leaders for scaling is not mentioned.	Describes organizational leaders and their commitment to scaling the intervention. For example, organization leaders are part of the team that is overseeing the AmeriCorps State and National grant and the scaling plan for the intervention. Question 2 is skipped with a "no" response.
2. Is support from stakeholders and/or partners for scaling the intervention described?	Yes (full), support from stakeholders and/or partners for scaling the intervention is described, with details provided. Yes (limited), support from stakeholders and/or partners for scaling the intervention is described, but with no details provided. No, support from stakeholders and/or partners for scaling the intervention is not mentioned.	Describes stakeholders and/or partners' commitment to scaling the intervention. Stakeholders and partners include service delivery partners or leadership at implementation sites. Support may be demonstrated by securing space for service delivery or removing responsibility for non-intervention related workload for service providers so they can focus on scaling the intervention.
II. Innovation and learning		
1. Has the organization previously participated in efforts to be innovative?	Yes (full), efforts to be innovative are described, with details provided. Yes (limited), efforts to be innovative are described, but with no details provided. No, efforts to be innovative were not mentioned,	Describes organizational efforts to identify, develop, and implement new ways of meeting community needs. For example, organizational innovation could include offering new products or services or identifying novel ways of delivering regularly available services.

Question	Response options	Additional guidance
2. Has the organization previously participated in activities to improve its interventions?	Yes (full), efforts to improve its interventions were described, with details provided. Yes (limited), efforts to improve its interventions were described, but with no details provided. No, efforts to improve its interventions were not mentioned.	Describes the way in which organizations have improved interventions. Improvement may be demonstrated by a description of how the organization advanced its practices and enhanced the current service array. For instance, the evaluated intervention may have improved upon a previous version of the intervention by making changes to its recruitment strategies.
II. Improvements in response to challenges		
1. Did the organization previously face challenges in supporting intervention implementation?	Yes (full), the organization faced challenge(s), with details provided. Yes (limited), the organization faced challenges, but with no details provided. No, no challenges are described.	Describes earlier challenges experienced by the organization in providing organizational support for implementation of the intervention. For example, organizational leaders might have changed or a previous leader might not have endorsed the intervention and thus refused to dedicate personnel to its implementation. Question 2 is skipped with a “no” response.
2. Did the organization make improvements to address earlier challenges in providing organizational support for the scaled intervention?	Yes (full), the organization made improvements to address challenge(s), with details provided. Yes (limited), the organization made improvements to address challenges, but with no details provided. No, improvements to address challenges were not mentioned.	Describes improvements made to address challenges that may include a change in organizational structure or the identification of new funding sources.

F. Implementation infrastructure

This subsection addresses the fifth condition of the scaling readiness framework—implementation infrastructure. It includes questions about the implementation infrastructure discussed in subsection A.I.6 that are available for the scaled intervention (Table A.II.6): (1) financial resources, (2) sufficient personnel to implement the intervention, (3) materials, (4) physical space, and (5) a human resource system.

Table A.II.6. Questions about implementation infrastructure for the organization proposing the scaling

Question	Response options	Additional guidance
I. Financial resources		
1. Will the organization provide funding for the scaled intervention?	Yes (full), funding for scaling exists, with details provided. Yes (limited), funding after scaling exists, but with no details provided. No, funding for scaling is not mentioned.	Describes how the organization and, if applicable, its partners will provide funding to implement the intervention after scaling. Details include the amount and source of funds and the plan to continue providing funds in the future.
II. Sufficient personnel		
1. Will the organization provide dedicated personnel to implement the scaled intervention?	Yes (full), personnel plans are described, with details provided. Yes (limited), personnel plans exist, but with no details provided. No, personnel plans are not mentioned.	Describes the number of personnel who will work on implementation (as compared to the number required by the intervention model), whether personnel will work exclusively on intervention implementation, and, if applicable, partners' role in providing personnel to implement the intervention.
III. Materials		
1. Will the organization have the materials needed for the scaled intervention?	Yes (full), materials are described, with details provided. Yes (limited), materials are mentioned, but with no details provided. No, materials are not mentioned.	Describes how the organization will obtain materials needed for implementation after scaling, such as workbooks, culturally sensitive documents, or other handouts.
IV. Physical space		
1. Will the organization have the physical space needed for the scaled intervention?	Yes (full), the physical space is described, with details provided. Yes (limited), the physical space is mentioned, but with no details provided. No, the physical space is not mentioned.	Describes how the organization has or will obtain the physical space needed for implementation after scaling, such as classrooms to fit the target number of participants or private meeting spaces for one-on-one service delivery.
IV. Human resource system		
1. Is a human resource system in place to hire, supervise, and develop the personnel for the scaled intervention?	Yes (full), a human resource system is in place, with details provided. Yes (limited), a human resource system is mentioned, but with no details provided. No, a human resource system is not mentioned.	Describes a human resource system to support implementation after scaling. Details specify how the human resource system supports processes and procedures for hiring appropriate personnel, describe a supervisory structure, and provide for personnel development, including a description of how supports are routinized and standardized.

APPENDIX B:

CHARACTERISTICS OF INTERVENTIONS WITH EVIDENCE OF EFFECTIVENESS

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In Table B.1, we provide details about the characteristics of each of the 32 interventions with demonstrated evidence that they work. Characteristics include the intervention's focus area, priority objective, core elements, implementation setting, and use of AmeriCorps members in service delivery. Our review determined AmeriCorps members' involvement in delivering intervention services based on evidence documents' explicitly referencing AmeriCorps members in the description of the intervention. It is possible that some evidence documents did not provide sufficient information on the personnel involved in the intervention delivery, including the presence of AmeriCorps members. Information for the interventions was extracted from the evidence documents submitted to AmeriCorps using the review rubric described in Appendix A.

Table B.1. Characteristics of interventions with evidence of effectiveness

Interventions by focus area (Intervention name)	Priority objective	Core elements	Implementation setting	AmeriCorps members referenced in evidence document?
Economic opportunity 1 (Financial Opportunity Centers)	Employability and financial literacy	• Financial counseling • Employment search/placement assistance • Income support counseling	• Community-based organizations • Urban • Geographic area described as nationally or across multiple regions	Yes
Economic opportunity 2 (National Fund for Workforce Solutions)	Employability	• Assistance obtaining employability and training credentials • Assistance enrolling in college and specialized apprenticeships • Job readiness training • Pre-apprenticeship training • Industry-focused training • Job search assistance • Career advancement services	• Community-based organization and employers • Urban • Midwest	No
Economic opportunity 3 (Work Advance)	Employability	• Intensive screening • Pre-employment and career readiness services • Occupational skills training • Job development and placement services • Career retention and advancement services	• Community-based organizations and employers • Urban • Northeast, Midwest, and South	No
Economic opportunity 4 (SaveUSA)	Financial literacy	• Matched savings accounts for low- and moderate-income tax filers	• Community-based organizations • Urban • Northeast and South	No
Economic opportunity 5 (Professional Training Corps)	Employability	• Applicant recruitment and screening • Academic and professional skills instruction • College coursework • Internships • Career support and mentoring • Stipends • Connecting participants to employment and education opportunities	• College campuses and internship sites • Urban • Northeast	No

Interventions by focus area (Intervention name)	Priority objective	Core elements	Implementation setting	AmeriCorps members referenced in evidence document?
Economic opportunity 6 (Single Stop)	Financial literacy	• Financial counseling • Tax preparation • Benefits screening and counseling • Legal counseling • Immigration consultations	• College campuses • Urban • Northeast	No
Economic opportunity 7 (Genesys Works)	Employability	• Summer training program for workplace technical and communication skills • Paid internships • Ongoing college and career coaching and support • Alumni program	• Training centers and internship sites • Urban • West	No
Economic opportunity 8 (Year Up)	Employability	• Learning communities • Advising and mentoring • Social worker support • Stipends • Training for workplace technical and communication skills • Paid internships	• Program offices and internship sites • Urban • Northeast, Midwest, South, and West	No
Economic opportunity 9 (Habitat for Humanity)	Housing	• Build or repair safe and affordable homes	• Housing build sites • Urban • South and West	Yes
Education 1 (Blue Engine)	K–12 success	• Tutoring or supplemental instruction	• High schools • Urban • Northeast	No
Education 2 (Citizen Schools)	K–12 success	• Apprenticeships • High school application support • College preparation information • Leadership skills instruction • Alumni program	• After-school in middle and high schools • Urban • Northeast	No
Education 3 (Experience Corps)	K–12 success	• Literacy tutoring	• Elementary schools • Urban and rural • Northeast and South	No
Education 4 (Jeffco Summer of Early Literacy Program)	K–12 success	• Literacy instruction • Professional support for teachers • Parenting events	• Summer camp in elementary schools • Urban • West	No
Education 5 (Minnesota Reading Corps)	K–12 success and school readiness	• Whole-class literacy enrichment activities • One-on-one or small-group literacy tutoring	• Elementary schools, early childhood centers, and community-based institutions • Urban and rural • Northeast and Midwest	Yes

Interventions by focus area (Intervention name)	Priority objective	Core elements	Implementation setting	AmeriCorps members referenced in evidence document?
Education 6 (Playworks)	K–12 success	• Organized recess activities • Class game time • Youth leadership program • After-school activities	• Elementary schools • Urban • Geographic area described as nationally or across multiple regions	No
Education 7 (Reading Partners)	K–12 success	• One-on-one tutoring • Dedicated school space and use of materials • Structured and individualized curriculum • Student assessments for data-driven instruction • Rigorous and ongoing training for teachers • Instructional supervision	• Elementary schools • Urban and rural • Northeast, South, and West	Yes
Education 8 (SEED School of Washington, DC)	K–12 success	• Academic program with individual interventions as needed • Student life program • College counseling • Student support services	• Boarding school for middle and high school • Urban • Northeast	No
Education 9 (SPARK Literacy Program)	K–12 success	• Individual literacy tutoring • Family engagement/ communication	• Elementary schools and parents' homes • Urban • Midwest	No
Education 10 (Teach for America)	K–12 success	• Preservice training for teachers • Training and professional development while teaching	• Residential program on university campuses and schools • Urban • Geographic area described as nationally or across multiple regions	No
Education 11 (College Possible)	Postsecondary education support	• Scholastic Assessment Test (SAT) and American College Testing (ACT) preparation • College admissions consulting/support • Financial aid consulting/support	• High schools • Urban • Midwest	Yes
Education 12 (Home Instruction for Parents of Preschool Youngsters)	School readiness	• Instructional home visits • Parent/child literacy activities • Parent monthly group meetings and instruction	• Parents' homes • Urban • West	No
Education 13 (Jumpstart)	School readiness	• Whole-class and small-group language and literacy activities • Individual language and literacy activities • Family involvement/ communication • Volunteer engagement in projects	• Preschools and early childhood centers • Urban • Northeast and West	Yes

Interventions by focus area (Intervention name)	Priority objective	Core elements	Implementation setting	AmeriCorps members referenced in evidence document?
Education 14 (Bridge Project)	K–12 success	• Evidence-based reading intervention program • Small-group instruction • One-on-one tutoring • Provision of reading materials to students	• Elementary schools • Urban • South and West	No
Education 15 (Youth Build)	Postsecondary education support	• Structured curriculum • College counseling, planning activities, and transition supports • Financial aid planning and assistance • Partnerships with local postsecondary institutions	• College campuses and local community locations • Urban • Northeast, Midwest, South, and West	No
Education 16 (Afford Program)	Postsecondary education support	• Financial aid planning sessions and workshops • Free Application for Federal Student Aid (FAFSA)/Dream Act certification • College award letter review sessions • Summer outreach to students	• High schools • Urban • West	Yes
Education 17 (Opportunity Works Program)	Postsecondary education support	• Accelerated instruction to help achieve high school diploma/equivalency • Personalized guidance and mentoring to promote high school completion • Dual enrollment in credit-bearing courses • College and career-ready skills development • Guidance on transitioning to college	• Community-based organizations, community colleges, dropout reengagement centers, and high schools • Urban • Northeast, South, and West	No
Education 18 (Success Boston Coaching)	Postsecondary education support	• Coaching on life skills, study skills, help-seeking skills, and academic skills • Job and career mentoring	• College campuses and virtual settings • Urban • Northeast	Yes
Healthy futures 1 (Birth and Beyond Home Visitation Program)	Supportive family environments	• Parenting instruction	• Parents' homes • Urban • West	Yes
Healthy futures 2 (SafeCare Home-based Services)	Supportive family environments	• Behavioral skills training in caregiving, household management, and parenting skills	• Parents' homes • Urban and rural • Geographic region not described	No

Interventions by focus area (Intervention name)	Priority objective	Core elements	Implementation setting	AmeriCorps members referenced in evidence document?
Healthy futures 3 (Soccer for Success)	Childhood obesity	• Physical activity (soccer skills learning and practice) • Nutrition instruction • Youth development activities	• Schools, public parks, and community centers • Urban • Northeast, Midwest, South, and West	No
Healthy futures 4 (Access to School)	Supportive family environments	• Parenting education • Parent and child interactive learning activities • Comprehensive care management for families • Adult English as a Second Language instruction	• Preschools • Urban • Midwest	No
Healthy futures 5 (Triple-P Parenting Program)	Supportive family environments	• Media and information about positive parenting • Individual consultation and seminars • Brief consultations with information and active skills training • Individual active skills training program • Augmented individual active skills training program	• Community centers in direct contact with parents and families (schools, health centers, social services) • Rural • South	No

Source: Evidence documents submitted by grantees to AmeriCorps.

Note: The table shows the 32 interventions funded by the AmeriCorps State and National 2015–2019 and SIF 2010–2015 programs with evidence of effectiveness, as determined by the standards discussed in Chapter I. One grantee proposed to implement Healthy Futures 2 and Healthy Futures 4 together, with separate evidence documents submitted for each.

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APPENDIX C:

METHODS AND TABLES FOR THE META-ANALYSIS

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In this appendix, we provide details of the approach for conducting the study's meta-analysis. We describe the meta-analytic approach for constructing the effect size metrics used for the analysis in Chapter III of the report (Section A), assessing the magnitude of effects for individual interventions and by the characteristics of interest (Section B), and conducting analyses on the sensitivity of our results to the details of the research design (Section C).

A. Calculating the effect size indices

The interventions in our analysis had three different focus areas—education, economic opportunity, and healthy futures—and the studies that assessed their effectiveness used a variety of outcome measures (for example, income levels, achievement test scores, and child maltreatment rates). The challenge in evaluating such diverse interventions lies in determining a method to synthesize a study's results in a way that allows us to assess its overall effectiveness and compare its effectiveness with that of other interventions. The effect size metric helps resolve this challenge by serving as a standard measure of the extent to which individuals in the treatment and comparison group differ from each other on study outcomes. This standardization allows us to compare the relative impacts of interventions that target increased math achievement scores for middle school students to those that focus on improving employment outcomes for adults (for example).

The first step needed to prepare for such an analysis is to collect information from each study on the effect size or to use results presented in the study to calculate it. Effect sizes can be calculated in two ways, depending on how the outcomes are measured.

1. **Hedges' *g*.** When outcomes are captured as continuous scales, effect sizes are calculated using Hedges' *g* (Hedges 1982), which takes the Cohen's *d* effect size and adjusts it to incorporate small sample sizes. Accordingly, the effect size (*d*) is calculated, first, as the difference between the treatment group outcome mean and the comparison group outcome mean divided by the pooled standard deviation (the amount of variation on the outcome that exists across both groups in the study). The formula for conducting this calculation is

$$d = \frac{x_T - x_C}{\sqrt{\frac{(n_T - 1){s_T}^2 + (n_C - 1){s_C}^2}{n_T + n_C - 2}}}$$

   where *x* is the mean, *n* the sample size, and *s* the post-intervention standard deviation for the treatment (*T*) and comparison (*C*) samples. If standard deviations were not reported, we estimated the effect sizes using other information, such as *t*-statistics and *p*-values. Next, the Hedges' *g* correction (Hedges 1982) is applied by multiplying the effect size index (*d*) by a factor of ω, which is calculated as $(1 - 3/[4N - 9])$, where *N* is a combined sample size of treatment and comparison groups. Whenever possible, the effect size was calculated using study outcomes that had been adjusted for other data that had been collected (for example, pre-test scores or background characteristics of the study participants). For example, we used achievement post-test scores that adjusted for participants' achievement pre-test scores when calculating the effect size.

2. **The Cox index.** When outcomes are captured as a dichotomous measure, the difference in group averages is calculated as the difference in the probability of the occurrence of an event. The effect size measure we used for dichotomous outcomes is the Cox's index, which yields effect size values similar to the values of Hedges' *g*:

$$d_{cox} = \omega \left[ln \left(p_t / [1 - p_t] \right) - ln \left(p_c / [1 - p_c] \right) \right] / \ 1.65$$

where ω is the correction for small sample sizes; p_t and p_c are the probability of an outcome for sample members in the treatment and comparison groups, respectively; and the effect size is given by d_{cox} When program impacts were reported in an odds ratio, percentages, or proportions, we converted them to the Cox's index using well-documented formulas (What Works Clearinghouse 2020, p. 23).

Overall, we included or calculated at least one effect size for 30 of the 32 interventions that were assessed to work, with calculations including 1,408 effect sizes.[25] A total of 419 of these outcomes were classified as "primary outcomes" because they corresponded to an evaluation's stated research questions (that is, the main focus of the study). Outcomes that aligned to other evaluation research questions (such as exploratory research questions) were considered to be secondary outcomes.

B. Assessing magnitude of effects for individual interventions and their characteristics

We used SPSS macros generated by Lipsey and Wilson (2001) to estimate the average effect sizes and their associated standard errors and confidence intervals (that is, how precise the average effect size estimate is). We carried out these analyses using the following methods:

- We created a weighted average effect size for each intervention. Because studies analyzed multiple outcome differences for each intervention, we wanted the outcome differences with the most precision to count more toward the intervention's average effect size than outcome differences with greater variation. This is known as weighting each effect size by the inverse of the variance. The precision (variance) is primarily a function of the size of the sample on which the effect size is based.

- We included a random effect size component in the weighted average effect size calculation. The random effects model allows the effect sizes to vary, a feature that is consistent with the diverse set of interventions analyzed (Borenstein et al. 2009).[26]

[25] The information on healthy futures and economic opportunity interventions, Health5 and Econ9, were insufficient to calculate effect sizes for this analysis. The study reported effect sizes based on gain scores, which are not comparable to those based on means. We also did not have enough information to calculate Hedges' *g* or the Cox index for 161 outcomes across all of the interventions.

[26] Fixed effects models assume one true effect size across the interventions, which seems unlikely given the diversity in interventions. In addition, the homogeneity of the effect size statistic (Q) was rejected across all comparisons, which indicated a significant amount of heterogeneity in effect sizes and precluded use of the fixed

(continued)

- Many studies reported multiple effect sizes on the same participant samples (for example, two measures of reading achievement), and it was not feasible to assume independence of the effect size estimates. To control for dependencies, we used the synthetic effect size approach (Lipsey and Wilson 2001). That is, we first aggregated a dependent set of effect sizes into a single independent average effect size. We then combined that estimate with other independent effect sizes reported for the intervention to create the overall average effect size for the intervention.

We used the effect sizes for two types of analyses:

- **Estimating an intervention's overall effect size.** Because AmeriCorps is interested in identifying interventions that work across the various participant outcomes they target, effect sizes for all outcomes were combined to generate a single weighted average effect size for the intervention. We synthesized effect sizes within each study to create an overall assessment of the effectiveness of each intervention and tested each for statistical significance (see Figure III.1 and Appendix Table C.1). This analysis told us the percent chance that the intervention had an overall impact on participants' outcomes, with average effect sizes supported by a *p*-value of less than 0.05 demonstrating evidence that the interventions work.
- **Comparing effect sizes across interventions.** Because AmeriCorps is also interested in how the interventions they fund are successfully addressing the goals set in the agency's strategic plan, we combined and compared an intervention's effectiveness to interventions with different characteristics (focus area, priority objectives, community characteristics, involvement of AmeriCorps members, and funding year). For example, we combined the average of the effect sizes for all interventions in the education focus area and compared the result to the average effect size for all interventions in the economic opportunity focus area (see Figures III.2, III.3, and III.4 in Chapter III and Appendix Tables C.1, C.2, and C.3). This analysis told us two things: (1) whether specific groups of interventions had an overall, statistically significant impact on participants' outcomes and (2) whether the overall impacts from one group had a greater impact on participant outcomes than those of another group.

Appendix Tables C.1, C.2, and C.3 provide detailed information on the results presented in Figures III.1 to III.4 in Chapter III. The terms and acronyms included in these tables (and Appendix Table C.4) are as follows:

- **Average effect size** is the measure of the average magnitude of the difference between the treatment group and the comparison group on the study outcomes. The effect size shows the magnitude of the impact (or the difference between the treatment and comparison group) relative to the standard deviation of the measure. A positive average effect size value indicates that the outcomes for the treatment group exceeded those for the comparison group.

effects model. In general, random effects models are more conservative than the fixed effects model because they result in wider confidence intervals (Borenstein et al. 2009).

- **Standard error** measures how precisely or accurately our sample of average effect size estimates represents the population. The smaller the standard error, the more precisely estimated the average effect size.
- ***p*-values** represent the probability that the observed finding was obtained by chance when there is actually no true impact of the intervention on participants' outcomes. A *p*-value less than 0.05 indicates that the average effect size (that is, the average magnitude of the difference on the study outcomes between the treatment group and the comparison group) is statistically significant.
- **-95% confidence interval (CI) and +95% CI** show the lower (-95% CI) and upper (+95% CI) bound of the range within which we can be 95 percent certain that the true average effect size lies.
- **The *p*-value of difference (Qb)** represents whether the differences between the average effect sizes of intervention characteristic categories (for example, yes or no for AmeriCorps members delivering intervention services or supporting the delivery) were statistically significant from each other.

C. Sensitivity analyses

Effect sizes can vary with characteristics of the study, particularly the size of the sample and the design of the research (Lipsey 1992; Slavin and Smith 2009). We therefore assessed whether differences in the estimated effect sizes varied along these lines.

- **Study sample size.** Research has consistently demonstrated that studies with smaller sample sizes tend to have much larger positive effects than those with larger sample sizes (Slavin and Smith 2009). In our study, the median sample size used in the intervention group was 293 subjects. Therefore, we categorized intervention evaluations that had sample sizes of 293 or less as small and those with sample sizes greater than 293 as large. Our analysis showed that evaluations with smaller sample sizes had an average effect size of 0.41, whereas evaluations with larger sample sizes had an average effect size of 0.20—a statistically significant difference. Therefore, our finding indicates that effect sizes produced by interventions evaluated with smaller samples were greater than those generated by interventions evaluated with larger samples.
- **Study research design.** Interventions were categorized into two types based on how the studies created the treatment and comparison groups for the evaluation: nonrandom (quasi-experimental designs were used in 13 evaluations) and random (experimental designs were used in 17 evaluations). The average effect size was 0.27 for evaluations using random assignment and 0.30 for evaluations using nonrandom assignment. The difference between the average effect sizes was not significant. This finding suggests that research designs used to evaluate the interventions we identified did not vary in their ability to detect impacts on participant outcomes.

The average effect size for each intervention can also vary based on the type and number of outcomes used to calculate it. Our main analyses presented in Chapter III used average effect sizes based upon primary outcome measures for each intervention. As shown in Table C.4, we

replicated our analysis of each intervention by calculating average effect sizes that included all outcomes (primary and secondary). In general, the inclusion of secondary outcome measures when constructing the average effect sizes did not change the pattern of the results. The average effect sizes and their statistical significance were relatively similar at the overall, focus area, priority objective, and individual intervention levels to those presented in the main analysis that include only primary outcomes. There was an exception with one intervention (Education 2); its average effect size was statistically significant when only primary outcomes were included but was nonsignificant when based on primary and secondary outcomes.

Table C.1. Intervention effects: Overall, by focus area, priority objective, and intervention; primary outcomes

	Average effect size	Standard error	*p*-value	-95% CI	+95% CI
Overall (all interventions)	**0.28**	**0.03**	**0.00**	**0.23**	**0.33**
Economic opportunity interventions	**0.36**	**0.05**	**0.00**	**0.26**	**0.45**
Employability	**0.39**	**0.05**	**0.00**	**0.30**	**0.49**
Economic opportunity 1	0.03	0.16	0.83	-0.27	0.34
Economic opportunity 2	0.32	0.06	0.00	0.20	0.45
Economic opportunity 3	0.70	0.09	0.00	0.53	0.86
Economic opportunity 5	0.20	0.18	0.28	-0.16	0.56
Economic opportunity 7	0.50	0.18	0.006	0.14	0.86
Economic opportunity 8	0.16	0.15	0.28	-0.14	0.46
Financial literacy	**0.15**	**0.13**	**0.25**	**-0.10**	**0.40**
Economic opportunity 4	0.08	0.16	0.62	-0.23	0.38
Economic opportunity 6	0.23	0.17	0.18	-0.10	0.55
Education interventions	**0.24**	**0.04**	**0.00**	**0.16**	**0.31**
K–12 success	**0.23**	**0.05**	**0.00**	**0.14**	**0.33**
Education 1	0.37	0.18	0.04	0.01	0.72
Education 2	0.43	0.18	0.02	0.08	0.77
Education 3	0.10	0.16	0.55	-0.22	0.41
Education 4	0.10	0.16	0.53	-0.21	0.41
Education 5	0.50	0.10	0.00	0.32	0.68
Education 6	0.10	0.15	0.68	-0.20	0.40
Education 7	0.12	0.11	0.27	-0.10	0.34
Education 8	0.15	0.13	0.27	-0.11	0.40
Education 9	0.05	0.18	0.77	-0.30	0.40
Education 10	0.08	0.15	0.59	-0.21	0.37
Education 14	0.17	0.29	0.56	-0.40	0.73
Postsecondary education support	**0.19**	**0.08**	**0.01**	**0.05**	**0.34**
Education 11	0.21	0.20	0.30	-0.18	0.59
Education 15	0.21	0.11	0.07	-0.02	0.43
Education 16	0.02	0.17	0.89	-0.30	0.35
Education 17	0.37	0.18	0.04	0.02	0.72
Education 18	0.17	0.15	0.25	-0.12	0.47
School readiness	**0.37**	**0.12**	**0.002**	**0.14**	**0.61**
Education 12	0.37	0.23	0.10	-0.07	0.81
Education 13	0.39	0.13	0.002	0.14	0.64
Healthy futures interventions	**0.22**	**0.10**	**0.02**	**0.04**	**0.41**
Supportive family environments	**0.22**	**0.11**	**0.049**	**0.00**	**0.43**
Healthy futures 1	0.14	0.16	0.35	-0.16	0.45
Healthy futures 2	0.11	0.15	0.46	-0.18	0.41

	Average effect size	Standard error	*p*-value	-95% CI	+95% CI
Healthy futures 4	0.58	0.24	0.01	0.12	1.05
Childhood obesity	**0.24**	**0.18**	**0.17**	**-0.10**	**0.59**
Healthy futures 3	0.24	0.16	0.12	-0.06	0.55

Note: There were 419 primary outcomes across 30 interventions: 46 unique samples contributed effect sizes to intervention effects. Each row represents an intervention categorized under a specific focus area and priority objective.

Table C.2. Intervention effects: Overall, by intervention and evaluation characteristics; primary outcomes

	Average effect size	Standard error	*p*-value	–95% CI	+95% CI	*p*-value of difference (Qb)
Multiple geographies						
No (*n* = 16)	0.25	0.04	0.00	0.16	0.33	0.23
Yes (*n* = 14)	0.32	0.04	0.00	0.24	0.40	
AmeriCorps members delivering intervention services or supporting the delivery						
No (*n* = 22)	0.29	0.04	0.00	0.22	0.36	0.70
Yes (*n* = 8)	0.27	0.05	0.00	0.16	0.37	

Note: In parentheses, we note the number of interventions that correspond to each intervention characteristic. The *p*-value of difference (Qb) indicates whether the difference across categories is statistically significant.

Table C.3. Intervention effects: Overall, by funding year and source; primary outcomes

	Average effect size	Standard error	*p*-value	-95% CI	+95% CI
Overall (all interventions)	**0.28**	**0.03**	**0.00**	**0.23**	**0.33**
SIF					
Year 2010 (*n* = 8)	0.33	0.05	0.00	0.24	0.42
Year 2011 (*n* = 5)	0.22	0.09	0.02	0.04	0.40
Year 2012 (*n* = 5)	0.22	0.09	0.01	0.05	0.40
Year 2014 (*n* = 2)	0.26	0.14	0.06	-0.01	0.53
AmeriCorps State and National					
Year 2015 (*n* = 6)	0.28	0.06	0.00	0.15	0.40
Year 2016 (*n* = 9)	0.30	0.06	0.00	0.19	0.41
Year 2017 (*n* = 4)	0.11	0.10	0.26	-0.08	0.30
Year 2018 (*n* = 3)	0.34	0.08	0.00	0.18	0.50
Year 2019 (*n* = 9)	0.26	0.05	0.00	0.16	0.37

Note: In parentheses, we note the number of interventions that correspond to each year. SIF = Social Innovation Fund. For Year 2013, *n* = 0. Because a specific intervention could have been funded across multiple years, we did not conduct statistical tests that compare whether interventions in one funding year had a greater impact on participant outcomes than interventions funded in a different funding year.

Table C.4. Intervention effects: Overall, by focus area, priority objective, and intervention; primary and secondary outcomes

	Average effect size	Standard error	*p*-value	–95% CI	+95% CI
Overall (all interventions)	**0.24**	**0.03**	**0.00**	**0.19**	**0.29**
Economic opportunity interventions	**0.28**	**0.04**	**0.00**	**0.20**	**0.36**
Employability	**0.30**	**0.04**	**0.00**	**0.22**	**0.39**
Economic opportunity 1	0.00	0.16	1.00	-0.31	0.31
Economic opportunity 2	0.34	0.06	0.00	0.21	0.46
Economic opportunity 3	0.37	0.09	0.00	0.20	0.53
Economic opportunity 5	0.21	0.22	0.34	-0.22	0.65
Economic opportunity 7	0.50	0.18	0.006	0.14	0.86
Economic opportunity 8	0.11	0.15	0.47	-0.19	0.41
Financial literacy	**0.11**	**0.11**	**0.29**	**-0.10**	**0.33**
Economic opportunity 4	0.03	0.16	0.85	-0.27	0.33
Economic opportunity 6	0.20	0.16	0.20	-0.11	0.51
Education interventions	**0.22**	**0.04**	**0.00**	**0.15**	**0.29**
K–12 success	**0.21**	**0.04**	**0.00**	**0.13**	**0.30**
Education 1	0.37	0.18	0.04	0.02	0.72
Education 2	0.27	0.18	0.14	-0.08	0.62
Education 3	0.10	0.16	0.55	-0.22	0.41
Education 4	0.10	0.16	0.53	-0.21	0.41
Education 5	0.50	0.09	0.00	0.32	0.68
Education 6	0.10	0.15	0.49	-0.19	0.40
Education 7	0.09	0.11	0.39	-0.12	0.31
Education 8	0.12	0.13	0.35	-0.14	0.39
Education 9	0.05	0.18	0.77	-0.29	0.40
Education 10	0.08	0.15	0.59	-0.21	0.37
Education 14	0.17	0.29	0.56	-0.40	0.73
Postsecondary education support	**0.17**	**0.07**	**0.01**	**0.04**	**0.30**
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Education 15	0.15	0.11	0.17	-0.07	0.38
Education 16	0.06	0.16	0.73	-0.27	0.38
Education 17	0.29	0.18	0.10	-0.06	0.64
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School readiness	**0.39**	**0.11**	**0.00**	**0.17**	**0.60**
Education 12	0.37	0.23	0.10	-0.07	0.81
Education 13	0.39	0.13	0.00	0.14	0.64
Healthy futures interventions	**0.22**	**0.09**	**0.01**	**0.05**	**0.39**
Supportive family environments	**0.21**	**0.10**	**0.03**	**0.02**	**0.39**
Healthy futures 1	0.14	0.15	0.35	-0.16	0.45

	Average effect size	Standard error	*p*-value	–95% CI	+95% CI
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Healthy futures 4	0.58	0.24	0.01	0.12	1.05
Childhood obesity	**0.24**	**0.15**	**0.11**	**-0.06**	**0.54**
Healthy futures 3	0.24	0.16	0.12	-0.06	0.55

Note: There were 1,408 primary and secondary outcomes across 30 interventions: 46 unique samples contributed effect sizes to intervention effects. Each row represents an intervention categorized under a specific focus area and priority objectives.

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