SECOND EDITION

Life Skills Progression™

An Outcome and Intervention Planning Instrument for Use With Families at Risk

Linda Wollesen
Brad Richardson

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An Outcome and Intervention Planning Instrument for Use With Families at Risk

Second Edition

by

Linda Wollesen, M.A., RN, LMFT

and

Brad Richardson, Ph.D.

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About the Authors

Linda Wollesen, M.A., RN, LMFT, focused her 35-year career on public health nursing and collaborative community-based services to low-income and ethnically diverse families. She worked as a nursing visitor in housing projects in East Los Angeles, nursing supervisor in Santa Clara, and program manager in Santa Cruz County, all in California. Her clinical expertise included services and care coordination for children and infants who have special needs or who are in foster care. She supervised a research replication site for the David Olds Nurse-Family Partnership in Monterey County.

In addition to earning a bachelor's degree in nursing from California State University at Los Angeles, Ms. Wollesen received her master's degree in marriage, family, and child counseling from the University of Santa Clara and was a licensed therapist.

Ms. Wollesen was the author of the Life Skills Progression™ (LSP) instrument and pioneered the reliability and content work for the tool with the support of a fellowship from ZERO TO THREE: National Center for Infants, Toddlers and Families.

Brad Richardson, Ph.D., is research scientist and adjunct associate professor at The University of Iowa School of Social Work. He serves as co-director of The University of Iowa's Consortium for Substance Abuse Research and Evaluation, Director of The Center for Public Health Evaluation and Research, and Research Director of the National Resource Center for Family Centered Practice, promoting culturally responsive family-centered services through research and evaluation, technical assistance, training, and information dissemination.

One of Dr. Richardson's contributions to science is the development of valid and reliable instruments to assist practitioners in measuring progress—first, to show clients with whom they are working their successes and strengths on which to build, and second, to use aggregate results to measure program outcomes for interested stakeholders (e.g., demonstrating outcomes to funders, managers, and administrators) and to inform program staff of the results being achieved. He has also worked with many agencies on the use of outcome measures to develop quality-improvement strategies to assist in improving program and client outcomes. This work brings together career expertise in research and practice. His work on the reliability and validity of instruments such as the Life Skills Progression, Family Development Matrix, and Automated Assessment of Family Progress has been coupled with practice experience and using results to inform family strengthening, case management, and in-home services. He has also published findings showing how interventions focusing on strengths is one of the most efficient and effective methods to support positive change.

Using a family-centered, strengths-based, and culturally responsive approach, Dr. Richardson has conducted well over 100 evaluations of early childhood, child welfare, juvenile justice, public health, education, justice system, mental health, and substance use projects. He has written extensively on racial and ethnic disparities, as well as social determinants of health, and he works to improve service systems in areas such as child welfare, juvenile justice, chronic disease, cancer, and aging. He served as National DMC Coordinator on the Board of the Coalition for Juvenile Justice, championing a focus on racial disparities, which led to his testimony before the National Acad-

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emies in support of the Developmental Approach to Juvenile Justice and Child Welfare. He also served as Chair of the American Public Health Association's Cancer Forum and is a long-standing member and Vice Chair of the Iowa Integrated Health Planning and Advisory Council for substance use and mental health.

A NOTE ON THIS EDITION

Together, Ms. Wollesen and Mr. Richardson began discussing establishing a national center for the LSP in 2016. Those discussions quickly led to identification of a need for renewing the information in *Life Skills Progression*™ with a second edition. This idea was immediately supported by Brookes Publishing. In 2018, Ms. Wollesen and Mr. Richardson established the Life Skills Progression National Center at the University of Iowa, Des Moines campus. This second edition brings together their knowledge of the use of the LSP since it was conceived, as well as developments in the field since the publication of the original *Life Skills Progression*™ in 2006.

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About the Contributor

Sandra Smith, Ph.D., MPH, is adjunct associate professor at the University of Massachusetts, Amherst. She is a ZERO to THREE Fellow of the National Center for Infants, Toddlers and Families. Dr. Smith has conducted research and published numerous articles and textbook chapters on maternal health literacy and empowerment of women. She has authored maternal and child health education materials and trainings demonstrating effective use of health literacy principles, and methods to empower women to manage personal and family health and health care.

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Preface

One fifth of American children live in poverty. And for the last several decades, those of us working with families who live in poverty have fought for funding—our own type of poverty. When did the first budget cuts and hiring freezes happen? The 1960s, I think. I can't remember a time when I didn't spend as much time finding ways to fund services as I spent on ensuring quality of service.

I am still puzzled by why this should be true. As a nation, we are a caring people. However, we are more afraid of the sudden violence of terrorists than we are of the slow, ugly effects of poverty. The walls of social isolation between upper- and middle-income families and low-income families render invisible the dangers of poverty. We can't understand why they can't just do what they need to do to not be poor. . . . Education is free, jobs are available, just go to work and get off welfare. . . . Just say no and stop having children if you can't afford to feed them! Those of us who work in the barrios and ghettos, whose passion is to see low-income parents and their babies find a better way, who know how hard it is to climb out of poverty, have been too busy doing the work to successfully advocate for prevention and early intervention services. Our programs continue to lie at the bottom of the federal and state funding priorities as more money is spent on wars than on health and preventive services for our own citizens.

In the 1990s, home visitation services were thought to be a promising practice, but studies have continued to show only modest results, with the exception of one program that demonstrated a 79% decrease in child abuse in a longitudinal controlled study. The first time I heard David Olds present his study, I cried with relief that someone had finally proved that what we do in home visitation is important, improves outcomes, and saves money. My relief was short-lived, however, because I knew that what he had demonstrated for one nurse visitation program could not be generalized to any other visitation program. There was no way we could link to the outcomes of his study, even for nursing visitation. When I read the Packard Foundation's *The Future of Children—Home Visiting: Recent Program Evaluations* (Gomby & Culross, 1999) and realized that most of us were not demonstrating significant outcomes—or at least the studies showed we didn't—I frankly didn't believe it. I believed instead that the problem is not our inability to produce outcomes but our inability to demonstrate the outcomes we produce! My experience in the field didn't reflect "modest outcomes."

As the Olds Nurse-Family Partnership (NFP) model expanded past clinical trials to other sites, I worked for 5 years to find the 3 million dollars it would take to fund a site in my area. I wanted to see where the magic was in that model, to see what the rest of us weren't doing or didn't know, and to see what data were collected. The new funding source that I wanted to tap was California First 5, funded by new tobacco taxes, which required child outcomes. I needed to find a way to demonstrate child outcomes, but child outcomes depended on parent skills and outcomes. There were no outcome tools that measured individual parent and infant/toddler outcomes, and so my reflective process began and I wrote the Life Skills Progression™ (LSP) outcome tool. The LSP became the outcome instrument for the Monterey County NFP funding.

I began thinking in terms of outcomes. *What were the outcomes that we wanted to see for our mothers and infants? What did the family look like when we first met them? What life skills did the parents need to parent well, to move out of poverty, and to benefit from health and social services? What are the*

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discrete steps of progress toward these life skills that we had not described but work with unconsciously all the time? The thought process that went into the LSP was lengthy, but the time it took to actually write the first draft was amazingly short. One Saturday morning I felt compelled to try to define the main home visitation outcomes for parents and babies, and to capture the sequential steps from "as bad as it gets" to "as good as it can be." Four intense hours later, the rough format for the LSP was in place. The next day, I showed it to a colleague who had been my best source of reflection, and I felt like a child showing my homework: "Look at what I did!"

Because I had the support of the director of nurses within the health agency, funding was found to test the LSP for reliability. It looked very good! That allowed us to pilot the tool within the agency, build the database (a painful experience), obtain the funding for the NFP replication, expand the pilots to other visitation programs, and gain the experience needed to refine the tool. At that point, magic happened: Joy Browne, Ph.D., from the University of Colorado Medical School–NICU, reviewed the LSP and encouraged me to apply for a ZERO TO THREE fellowship, and I was accepted. Kathryn Barnard, Ph.D., became a mentor for the project, and the fellowship provided me with the professional support needed to carry out the content validity review for final refinement. Vicky Youcha, Ed.D., facilitated the application to Paul H. Brookes Publishing Co. Meanwhile, simply by word of mouth, other agencies around the country began asking for training to use the LSP.

What evolved is a utilization-focused outcome evaluation tool for high-risk families with young children that is as useful clinically to the home visitor as it is for collecting cohort outcome data. The LSP is used by the visitor to sort and organize information gathered from visits, screening tools, and observations into a usable summary of a parent's and child's status. When completed sequentially in 6-month increments, the LSP makes progress visible. When done for a caseload, intermediate outcomes become available for statistical analysis. Data collected on a caseload can be analyzed to reveal progressive intermediate outcomes when compared with the baseline measure.

It is my dearest wish that the LSP, as it is used across the United States, will show the effective outcomes of home visitation so that policy and budget makers come to understand its value and fund our programs. I hope that the outcomes will prove so compelling that universal visitation, at least for families living in poverty, will be funded nationally. My second wish is that visitors and supervisors use the LSP to reflect together in ways that improve and empower interventions. As I train staff in different models (e.g., nursing, social work, parent educator and paraprofessional, national systems, stand-alone community-based organizations), I am aware of the need and potential benefit of learning what works best from the various service models. Finally, I wish that the LSP will become just the starting place for defining what parent–child outcomes are and what progress toward those outcomes looks like. The LSP's greatest potential service is its power to change how we think together for the benefit of families and the health of our country.

Linda Wollesen

REFERENCE

Gomby, D., & Culross, P. (1999). *The future of children—Home visiting: Recent program evaluations.* The David and Lucile Packard Foundation. https://www.futureofchildren.org

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1 An Introduction to the Life Skills Progression™ (LSP)

"Anyone can count the seeds of an apple, but who can count the apples in a seed?"
—Early American proverb

SUPPORTING AND MEASURING FAMILY PROGRESS

This book is about counting both the "seeds" and the "apples" of family change and reaffirming the belief that change for the good does happen and that it can be facilitated. Societal change for the better does not just happen accidentally; it takes work. Determined parents, wanting a better life for themselves and their children, make positive change happen using the relationships, resources, and information provided by home visitors, friends, family, and other resources accessible to them.

The problems and challenges facing families with low income are many; they are complex and interrelated, and they often span generations of family members. Home visits to families during pregnancy and after the birth of a child by nurses, parent educators, and trained community workers have become an important and effective method to build relationships, offer support, and provide information and referrals (e.g., Azzi-Lessing, 2011, 2013). Complex lives make it difficult for everyone, family or home visitor, to notice incremental progress in life skills as parents adjust to new parenthood. As a result, the structured measurement of family progress is an even more challenging task.

The complexity of outcome measurement and competing demands about what the outcomes of home visitation services are, or should be, have been the products of diverse interventions and program evaluations focused primarily on short- and intermediate-term outcomes. Further complexity has been added by the increasing regulatory compliance and performance measures and the rapid and significant change in what Halfon et al. (2000) referred to as *ultimate health outcomes.* These ultimate outcomes include important goals such as the Healthy People 2030 leading health indicators (U.S. Department of Health and Human Services [DHHS], 2022b). They target factors such as reduced infant mortality, child abuse, teen pregnancy, drug use, and maternal depression. The *California Health Report,* a publication by the RAND Corporation and Wellness Foundation, describes a useful conceptual framework for the determinants of health and well-being in which Halfon et al. (2000) modified and expanded the earlier work of Evans and Stoddart (1994). Halfon et al. described the interlinked chain of structures, processes, and outcomes as a "critical pathway" of influences from structural determinants to process determinants to intermediate outcomes and ultimate health outcomes. Recent public health work by the Centers for Disease Control and Prevention (CDC; U.S. DHHS, 2022c) has further defined the concept of social determinants of health (SDOH), including five leading health indicators: health care access and quality, education access and quality, social and community context, economic stability, and neighborhood and built environment. Resources such as safe and affordable housing, access to education, public

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safety, availability of healthy foods, local emergency/health services, and environments free of life-threatening toxins enhance quality of life and can have a significant influence on population health outcomes. Healthy People 2030 highlights the importance of SDOH and health literacy for achieving overall health and well-being.

How this theory of change, SDOH, and health outcomes fit with what home visitors and parents do is important and will be described in more detail in Chapter 2. The critical pathway model helps build a conceptual bridge for how home visitation programs can learn to connect the dots between parental outcomes and the ultimate health outcomes. These connections will not happen unless we focus with clarity on what constitutes positive parental outcomes. This process includes defining the steps of personal growth for parents, recognizing the steps parents take and the outcomes home visitors observe and document on the Life Skills Progression™ (LSP), and linking the interventions that may well be the significant catalyst for growth.

Health scientists, evaluators, and epidemiologists focus on population data, trends, and ultimate outcomes. The home visitor's focus is on individual parents, the caseload, the program goals, and the community. Then, the visitor asks how to get to the ultimate outcomes from individual parent and program outcomes. Outcomes have not generally focused on the skills or progress of individual parents. As a result, many individual parent intermediate outcomes have not been well defined and have not been tracked over time or tallied to describe caseload characteristics and cohort progress. The LSP fills the gap in intermediate outcome measurement by defining and quantifying periodic pictures of parent and child outcomes. With this tool, a profile of parent and cohort progress begins to emerge and can be mapped over time.

The LSP measures a parent's life skills. The definition of a life skill is an ability, behavior, or attitude needed to achieve and maintain a healthy and satisfying life for families. The LSP describes individual parent and infant/toddler progress using 43 categories of life skills that reflect the array of basic skills needed to live and parent well. The LSP tracks important infant developmental and regulatory outcomes. Only when we capture the complex interrelationships of life skills and parental progress in achieving them will we truly understand what influences the long-term outcomes of vulnerable families living in poverty.

The information summarized in the LSP provides clinically useful and succinct outcome information about individual parents and entire caseloads to home visitation and social service programs. Some families can independently identify their needs, utilize new information, and locate needed community resources. Many cannot. Home visitation programs generally serve the most challenged families in order to support the parents' need to master life skills.

Home visitors encounter parents who are struggling with the simultaneous challenges of parenting and the effects of poverty. Issues of immigration, acculturation, language, and race further complicate issues associated with poverty. Health care disparity (limited access to health care services, varying standards of care, and ineffective health education) has an impact on intermediate and ultimate health and birth outcomes. Social isolation, having less than high school education, poor employment skills and job options, and limited child care all add to the burden of life and to poor ultimate outcomes.

Although a variety of scales have been available to assess family risk, until the LSP there has not been a valid and reliable broad-based parent/child outcome tool available to track progress of high-risk, low-income parents and their young children ages 0–3 years that is also useful for case planning. The LSP can measure change that is needed for the results-based accountability and utilization-focused evaluation of outcomes required by funding sources and administrators (see Chapter 2). If supporting a parent's process toward a positive outcome is the art and craft of home visitation, then measurement of incremental progress in parent and child life skills is exactly what is needed in order to measure and document progress toward ultimate goals and outcomes.

POVERTY AND POOR OUTCOMES

Families, and especially children living in poverty, have an impact on the health, education, welfare, justice, and psychosocial systems because of the long-term consequences and related costs associated with poverty. According to the National Center for Children in Poverty (NCCP), one-fifth of children in the United States live in poverty, including 2.1 million children

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younger than age 3 (Koball & Jiang, 2018). These children face a greater likelihood of impaired development associated with impoverished environments. Impaired developmental experiences and relationships affect infants' and toddlers' brain development, ability to form attachment relationships to a primary caretaker, and ability to regulate moods. These neurological and chemical responses can be permanent. Family stress affects the stress level of the baby, and stress inhibits the parent's ability to create a nurturing environment (NCCP, 2002). Children who live and grow in an impoverished family environment have a greater likelihood of experiencing poor nutrition, exposure to environmental toxins, maternal depression, substance use, family violence, and child abuse/neglect and involvement with public child welfare and related systems. Each of these factors can inhibit typical development (Gavin & Lissy, 2000). Diminishing child care resources, poor quality care, and prohibitive costs for good child care services add another environmental risk. These factors all combine to increase the likelihood of unintended consequences and profoundly negative outcomes for the family, child, and society. The NCCP is an excellent resource for information about poverty; the comparison between *deep poverty*, *poverty*, and *non-poor* are presented at http://frs.nccp.org/tools. In particular, see the report by Koball et al. (2021).

Even in light of the compelling data regarding the effects of poverty, home visitation programs constantly face challenges, including the following:

- Maintaining or increasing funding and political support for the model
- Identifying and utilizing the most effective interventions
- Demonstrating positive parent/child outcomes and long-term cost-effectiveness

Unlike most economically advanced countries, the United States does not fund universal home visitation services for new parents. The preventive home visitation services that do exist for identified high-risk families are frequently underfunded in most states and communities. The lack of adequate funding can be attributed in part to the fact that one-to-one home visitation services are perceived to be expensive and the fact that the short- and long-term effects of programs are seldom seen by those who pay for the services. A study of the cost-effectiveness of case management and home visitation done by the U.S. DHHS, Health Resources and Services Administration (HRSA) supports the short- and long-term benefits and cost-effectiveness of positive home visitor relationships with vulnerable mothers and their children (Gavin & Lissy, 2000). It is difficult to imagine that visitation services are not cost-effective given that the long-term costs of not providing them spread across so many service systems and generations.

The service cost estimates for the six largest U.S. visitation programs run between $5,000 and $8,500 per family per year (Yarnoff et al., 2019). One federally funded intensive intervention program, Early Head Start (EHS), estimated costs for one site at $11,500 per family per year; costs may be lower, depending on labor costs for a given area (Gomby, 2005). Categorical funding streams and continuous underfunding have contributed to the inability of programs to demonstrate positive outcomes and cost-effectiveness with solid evidence. This is particularly true when multiple funding sources are necessary to sustain a program. For example, one LSP pilot site was a medium-sized parent education program in a mid-sized California county, and it survived because of, and in spite of, 17 different funding sources. Each funding source had different outcome requirements, different data requirements, and unique quarterly reports.

Despite the value evaluation services provide, they represent a cost for programs that face pressures to maximize direct service delivery to families in need. As a result, many programs do not conduct evaluations unless they are required to do so. Unfortunately, a formal evaluation is frequently perceived as extra paperwork or as a threat, or it is considered an impediment to providing services, instead of being seen as an essential element for fidelity, efficiency, and success. This may be related to the lack of awareness of utilization-focused evaluation concepts or the lack of a common frame of reference between the program and the evaluator. The type and amount of data required from staff, who are already required to manage large amounts of paperwork, have a very real impact on the degree to which program staff welcomes evaluation. It is in this context that the LSP provides valuable and time-efficient outcome data for programs by measuring incremental outcomes and demonstrating program effectiveness in ways that will preserve home visitation services for low-income families. Outcome data have also been shown

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to be useful as indicators of fidelity and quality of the model being implemented (Gross et al., 2022). Although many prefer face-to-face home visitation, increasing acceptability of the effectiveness of virtual home visitation requires adjustments to the way services are provided. For those adapting to virtual home visitation, there is a growing amount of work on effective strategies and research comparing in-person to virtual outcomes (Gross et al., 2021) and a plethora of research and training on effective virtual meetings (e.g., Institute for the Advancement of Family Support Professionals, 2022; Stand for Children, 2022).

CHAPTER OVERVIEWS

This book provides background material and instruction on the use of the LSP for individual assessment, for intervention and program planning, and for data analysis to capture caseload progress. The secondary purpose of this book is to describe the "best practice" factors that are most likely to produce significant positive change in high-risk families so that programs can determine what intervention changes they might want to incorporate in order to improve their effectiveness.

Chapter 2 summarizes the struggle since the mid-1980s to describe the outcomes that are unique to the home visitation field. The executive summary of home visitation outcomes in *The Future of Children* report (Gomby & Culross, 1999) stated that only "modest" results should be anticipated from visitation programs. The report generated the need for programs to find or create tools that measured the outcomes that were actually occurring because of visitation work with families and to improve interventions.

Chapter 3 summarizes current thinking on what constitutes best practices for home visitation programs and what is likely to produce measurable and significant results.

Chapter 4 supplies important background information about the development and field-testing of the LSP, including the reliability and validity testing. It also describes the purpose of the LSP and what it does and does not cover.

Chapter 5 provides instructions for using the LSP and explains how to use and score the LSP within the context of home visitation programs. This chapter is the user's manual for staff. Training of staff in the use and scoring of the LSP is required to ensure reliability. Chapter 5 includes instructions for completion of the LSP heading data and gives criteria to determine scores for each of the 43 scales.

Because the LSP is a summary of visitor information and perceptions about a parent and child, the use of other screening and assessment tools is expected and encouraged, particularly for child development and maternal depression. The concept of a *target score* for each scale is introduced, and examples are given for how to use target scores to show outcome progress. Target scores are the behavioral descriptions listed in the columns that are at the acceptable or desirable outcomes level. Confidentiality and issues related to the Health Insurance Portability and Accountability Act (HIPAA, 1996) are also included.

Chapter 6 suggests how to use the individual parent's LSP in reflective supervision, for intervention planning, and for family-centered case plans. Instructions on how to compare sequential LSP scores are provided along with examples.

Chapter 7 was added to this second edition of the LSP due to mounting evidence for the importance of health literacy. Maternal health literacy is discussed as an empowering personal and community asset developed by health education and skills development through home visitation. Health literacy is an outcome from the usual activities of home visitation and affects other clinical outcomes. Strategies for improving health literacy using reflective questions are discussed.

Chapter 8 is about program evaluation, process evaluation, and outcomes-based evaluation. It is written specifically for use by administrative and clinical program staff who need to understand and plan evaluation and who do not usually have evaluator training. The reasoning and methodology for evaluating any program are outlined, and the use of the LSP data and how to use them to understand outcomes are discussed in detail with illustrations.

Chapter 9 describes some of the implementation steps and planning necessary to begin to use the LSP within a single program location, within a program operating in multiple sites, and in large state or national systems. At the end of the book, the **Appendices** contain checklists and

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forms to be used with the LSP. A sample case, with forms filled in, is provided (Appendix F) to illustrate the LSP. Appendix A, the Life Skills Progression™ Instrument, as well as Appendix B (Abbreviations Used in the Life Skills Progression™), Appendix E (LSP Data Entry Form), and Appendix H (Cumulative LSP Score Sheet), along with Chapter 5, Instructions for Using and Scoring the LSP, are tools for everyday use. Appendix C (Emerging Best Practice for Home Visitation Checklist) contains the key elements for home visitation best practice, and Appendix D ("Better Together": Home Visitation Community Collaboration Planning Worksheet) is a tool for facilitating community collaboration. Appendix G (Selene and Jason's Story [as told with the LSP]) is a case example told with the LSP, and Appendix I (Sample Cumulative LSP Score Sheet: "Selene and Jason") is an example of the use of the cumulative LSP Score Sheet based on the case example of Selene and Jason. Appendix K (LSP Data Report Planning Tool) is helpful for planning how to present LSP data. Appendix L provides a list of a wide variety of resources that home visitors will find helpful.

EARLY CHILDHOOD / WORKING WITH FAMILIES

"I wish every home visiting program would be using the LSP scale! I think it would improve practice, enhance the field, and ensure continued financial support to continue this important work. Mothers and babies, children and families deserve nothing less."
—Joanne Martin, Dr.PH., M.S., FAAN, Founding Director, The MOM Project; Former Director, HFA Indiana Training & Technical Assistance Project

"An essential resource for family engagement and collaborative planning with families. [The authors] share a broad range of practical guidance that is a must-read for professionals committed to supporting and strengthening families."
—Dr. Jeremy Christopher Kohomban, President and CEO of The Children's Village; President of Harlem Dowling

Use the LSP with ASQ®-3 & ASQ®:SE-2!
With items that match the ASQ developmental areas, the LSP makes it easy to summarize the developmental data you gathered with the ASQ system.

AN ESSENTIAL TOOL for home visiting programs, the LSP is the most efficient, reliable way to evaluate a parent's life skills: the abilities, behaviors, and attitudes they need to achieve a healthy and satisfying family life. For use with at-risk, low-income pregnant and parenting individuals with children from birth to 5 years of age, the LSP is a field-tested, validated, and reliable tool that generates a broad, accurate portrait of life skills with measures in 8 domains:

- Relationships With Family and Friends
- Relationships With Children
- Relationships With Supportive Resources
- Education and Employment
- Health and Medical Care
- Mental Health and Substance Use
- Basic Essentials
- Infant/Toddler Development

This all-in-one manual includes everything you need to use the LSP: detailed instructions, information on the tool's development and field testing, best practices in the field, and the tool itself (provided as a fillable PDF). Easy to complete in about 10 minutes, the LSP helps your program establish baseline and ongoing assessment profiles of clients, identify strengths and needs, plan interventions, and demonstrate the effectiveness of your practices through monitoring of outcomes.

NEW IN THIS EDITION:

- New chapter on using the LSP to promote maternal health literacy
- Guidance on completing the LSP during virtual home visits
- LSP Instrument and downloads now provided as fillable PDFs
- Updated research, citations, and information throughout
- Updates and improvements based on customer surveys and feedback from the field
- Scoring descriptions updated for clarity

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