

**ACF PERFORMANCE PROGRESS REPORT  
COVER PAGE  
ACF-OGM-SF-PPR**

		Page 1	of Pages	
<b>1. Federal Agency and Organization Element to Which Report is Submitted</b>  Dept of Health & Human Services ACF Children's Bureau		<b>2. Federal Grant or Other Identifying Number Assigned by Federal Agency</b>  90CA1756	<b>3a. DUNS</b> 094616936  <b>3b. EIN</b> 91-1019392	<b>4. Reporting Period End Date (MM/DD/YYYY)</b>  3/31/2013
<b>4. Recipient Organization (Name and complete address including zip code)</b>  Yakima Valley Farm Workers Clinic 518 West First Avenue Toppenish, WA 98948			<b>5. Recipient Identifying Number or Account Number</b>  n/a	
<b>6. Project/Grant Period</b> Start Date: (Month, Day, Year) 9/30/2007		<b>7. Reporting Period End Date</b> (Month, Day, Year) 3/31/2013	<b>8. Final Report?</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  <b>9. Report Frequency</b> <input type="checkbox"/> annual <input checked="" type="checkbox"/> semi-annual <input type="checkbox"/> quarterly <input type="checkbox"/> other (If other, describe: _____)	
<b>10. Performance Narrative</b>  See report attached.				
<b>11. Other Attachments</b> <i>(attach other documents as needed or as instructed by the awarding Federal Agency)</i>				
<b>12. Certification: I certify to the best of my knowledge and belief that this report is correct and complete for performance of activities for the purposes set forth in the award documents.</b>				
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<b>13. Agency use only</b>				

**ACF PERFORMANCE PROGRESS REPORT  
Appendix B - Program Indicators  
ACF-OGM-SF-PPR**

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Program Indicators			
(1) Item	(2) Activity Description	(3) Indicator	(4) Explanation
B-01	<b>Major activities and accomplishments during this period</b>		See report attached.
B-02	<b>Problems</b>		See report attached.
B-03	<b>Significant findings and events</b>		See report attached.
B-04	<b>Dissemination activities</b>		See report attached.
B-05	<b>Other Activities</b>		See report attached.
B-06	<b>Activities planned for next reporting period</b>		See report attached.

Children's Bureau Discretionary Grants Program  
Nurse Home Visitation Cluster

Yakima Valley Farm Workers Clinic  
Enhanced Yakima County Nurse-Family Partnership (EYCNFP)  
Program at Children's Village  
Grant No. 90CA1756

FINAL REPORT  
Covering 9/30/2007 through 3/31/2013

I. Executive Summary

With this Children's Bureau funding, Yakima Valley Farm Workers Clinic (YVFWC) implemented the Enhanced Yakima County Nurse-Family Partnership (EYCNFP) demonstration project at Children's Village in Yakima, Washington in partnership with Yakima Valley Memorial Hospital (YVMH). The primary program model used was the evidenced-based Nurse-Family Partnership program, providing nurse home visits from early in pregnancy through the children's second birthday. The target population for this project was first-time low-income mothers in Yakima County, Washington. With the EYCNFP the local Yakima County NFP project added two components to the base intervention— Healthy Marriage/Responsible Father services for clients and Mental Health Consultant services for program staff. With funding under the Children's Bureau Discretionary Grants Program, Nurse Home Visitation Cluster, YVFWC served 155 first-time mothers and their children over the 5½ years of the demonstration project

Results detailed in this report indicate that the program was implemented with success including meeting the projected number of parents and children served and implementing the base intervention with fidelity. All planned activities related to the core nurse home visitation intervention were implemented as planned with no problems – these included recruiting and training staff, enrolling the target 150 clients into the intervention, providing the base nurse home visitation intervention, collecting data, establishing and maintaining an Evaluation Advisory Committee, and assuring the quality of the overall program. Most activities related to the healthy marriage/responsible fatherhood program component were also implemented, although there were substantial problems with implementation of the main healthy marriage/responsible fatherhood intervention. These are discussed in detail in this report.

In terms of outcomes – available measures indicate that almost all outcomes were met. These include improved access to supportive community services, decreased family conflict/family management problems, improved parent-child interaction, healthy family development, reduced child maltreatment and increased father/partner involvement over time. We have insufficient evidence to determine whether or not the intended outcomes of improved family communication, increased healthy relationships between parents and enhanced fatherhood were met. This is largely related to the challenges in implementing the HM/RF component of the planned intervention.

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## II. Introduction and Overview

### A. Overview of the community, population and problem

#### Community

Yakima County is a rural and semi-rural county located in Central Washington State, with high rates of poverty and high rates of out-of-home child welfare placements. Yakima County experiences among the highest rates in the state of child abuse referrals accepted by the state Division of Children and Family Services – 41.05 per 1,000 compared with 35.25 per 1,000 for the state as a whole. A much higher proportion of Yakima County residents are Hispanic, Native American, Spanish-speaking, and <19 years of age than the state. In addition, a much higher proportion of Yakima County residents live in poverty, have very low education levels and are migrant/seasonal farmworkers than the state as a whole.

#### Organization

The primary partners included in the ACF-funded demonstration project were Yakima Valley Farm Workers Clinic (YVFWC) and Yakima Valley Memorial Hospital (YVMH). YVFWC is a large community/migrant health center and Federally Qualified Health Center with primary care sites in Washington and Oregon. YVMH is a large tertiary care hospital in Yakima, Washington serving all of central Washington State. Both agencies have long histories of operating maternal-child home visiting programs in Yakima County to serve the wide variety of needs in the childbearing population. YVFWC and YVMH have operated the base intervention, the Yakima County NFP collaboratively since 2003. Both agencies employ nursing staff in the program, and both employ various supportive and management staff who provide support to the program.

As lead agency and fiscal agent, YVFWC has extensive experience in administration, development, implementation, management, and evaluation of family support services including existing (non-NFP) maternal-child home visiting services, behavioral treatment programs for children, therapeutic foster care, and parenting education. YVFWC has a strong history of working collaboratively with child/family agencies serving the target population when implementing family support and child abuse prevention programming.

YVFWC and YVMH both accredited by the Joint Commission for Accreditation of Healthcare Organizations (JCAHO), and their respective nurse home visitation programs are compliant with JCAHO standards for home visitation programs.

#### Children/Families

The target population for the Enhanced Yakima County NFP demonstration project has been low-income, first-time mothers, their partners and their children in Yakima County. The project successfully served 155 pregnant/parenting women and their families over the course of its 5½-year duration. As detailed in Table 1 below, 52.9% of these clients were teenagers (<=19), 76.1% were Hispanic, 34% were Spanish-speaking, 56.1% had less than a high school graduation at enrollment, and 78.4% were single at enrollment. Although not detailed in Table 1, all clients met criteria for low income in order to be eligible for the program using the criteria of WIC eligibility (185% FPL).

Table 1: EYCNFP Client Characteristics N=155		
	#	%
<15 years	3	2.0%
15-17 years	48	31.2%
18-19 years	31	20.1%
Hispanic	118	76.1%
White	19	12.3%
Native American	6	3.9%
Race Other/Unknown	12	7.7%
Spanish-speaking	52	34.0%
<HS graduation at enrollment	87	56.1%
Single, never married	116	78.4%

*Characteristics collected at Intake*

### The Problem

The problem that the proposed demonstration project was intended to address is the urgent need for child maltreatment prevention and family support services in Yakima County. As detailed in Table 2 below, at the inception of the demonstration project, children and families in Yakima County faced much higher rates of multiple risk factors known to contribute to risk for child maltreatment than in Washington State as a whole. Children and families in Yakima County faced higher rates of extreme economic and social deprivation, family management problems, family history of substance abuse, low school achievement, low commitment to school, early initiation of problem behavior, non-violent and violent crimes, substance abuse, and family health problems.

**Table 2: Risk Factors in Yakima County  
 DSHS Child/Family Risk & Protection Profile Yakima County, 2006**

Risk Factor	Key Indicators	Level of Risk	
		Yakima County	Washington State
Extreme Economic & Social Deprivation	Temporary Assistance to Needy Families (TANF) Age 0-17	229.93 per 1,000	107.64 per 1,000
	Food Stamp Recipients (All Ages)	236.47 per 1,000	118.46 per 1,000
	Percentage of the Workforce that is Unemployed (Age 16+)	7.55 per 100	5.54 per 100
Family Management Problems	Victims Accepted in Child Abuse Referrals	41.05 per 1,000	35.25 per 1,000
Family History of Substance Abuse	Adults in Alcohol and Drug Treatment (State funded)	24.30 per 1,000	13.38 per 1,000
	Alcohol and Drug Related Deaths (all ages)	10.63 per 100 deaths	11.01 per 100 deaths
Low School Achievement	Poor Academic Performance 2006 Grade 4 WASL	66.16 per 100	52.83 per 100
	Poor Academic Performance 2006 Grade 7 WASL	76.19 per 100	60.11 per 100
Low Commitment to School	Freshman who leave school before their senior year	24.96 per 100	17.43 per 100
Early Initiation of Problem Behavior	Alcohol and Drug Related Arrests, Age 10-14	6.08 per 1,000	2.6 per 1,000
	Property Crime Arrests, Age 10-14	20.83 per 1,000	9.39 per 1,000
	Vandalism Arrests, Age 10-14	6.20 per 1,000	2.19 per 1,000
	Total Arrests of Young Children, Age 10-14	45.05 per 1,000	23.12 per 1,000
Non-Violent Crime	Adult Property Crime Arrests	14.65 per 1,000	6.85 per 1,000
	Property Crime Arrests, Age 10-17	35.45 per 1,000	16.77 per 1,000
Violent Crime	Adult Violent Crime Arrests	2.77 per 1,000	1.6 per 1,000
	Violent Crime Arrests, Age 10-17	4.83 per 1,000	2.17 per 1,000
	Domestic Violence Offences – All Ages	9.82 per 1,000	6.57 per 1,000
Substance Abuse	Alcohol and Drug Treatment, Age 10-17 (State Funded)	21.83 per 1,000	10.63 per 1,000
	Adult Alcohol Related Arrests	12.04 per 1,000	10.83 per 1,000
	Alcohol Related Traffic Fatalities	66.67 per 100 traffic fatalities	41.42 per 100 traffic fatalities
	Alcohol Violation Arrests, Age 10-17	8.40 per 1,000	6.50 per 1,000
	Drug Law Violation Arrests, Age 10-17	7.65 per 1,000	4.33 per 1,000
Child/Family Health	Sexually Transmitted Diseases, Age 0-19	5.39 per 1,000	4.01 per 1,000
	Suicides and Suicide Attempts Age 10-17	100.09 per 100,000	52.21 per 100,000
	Births to Mothers Aged 10-17	15.48 per 1,000	5.93 per 1,000

Available at: <http://www1.dshs.wa.gov/rda/research/4/47/updated/default.shtm> accessed May 2007

## **B. Overview of Program Model**

### Project Goals, Activities/Interventions, Outcomes

The goal of the Enhanced Yakima County Nurse-Family Partnership Program has been to prevent child abuse and neglect and promote healthy family development among low-income first time mothers, their partners and their children in Yakima County by decreasing family management problems and family conflict, by improving the relationship among parents, and between parents and children, and by increasing family support for high-risk families raising young children.

#### *Program Activities (from logic model)*

##### Nurse Home Visitation Activities:

- 1) Recruit 3 nursing staff for expanded NFP team at Children's Village
- 2) Train new NFP staff in collaboration with NFP National Center
- 3) Enroll 150 first-time, low-income mothers in the Enhanced YCNFP
- 4) Provide instruction, practice and assessment in parent-child interaction, community referrals, relationship skills, family functioning, and fatherhood skills
- 5) Collect data on above skills development
- 6) Establish and maintain Evaluation Advisory Committee
- 7) Assure the quality of the Program

##### Healthy Marriage/Responsible Fatherhood (HM/RF) Activities:

- 8) Advisory Committee participation by NFP and HM/RF programs
- 9) Training on HM/RF intervention
- 10) Randomize 50% of new enrollees to receive HM/RF information & referral
- 11) Program staff engage in retention

#### *Program Outcomes (from logic model)*

##### Immediate Outcomes:

- 1) Improved family communication
- 2) Improved access to supportive community services for high-risk families
- 3) Decreased family conflict/family management problems

##### Intermediate Outcomes:

- 4) Enhanced fatherhood skills among partners of first-time, low-income mothers
- 5) Improved Parent-Child Interaction

##### Long-Term Outcomes:

- 6) Healthy Relationships among Parents
- 7) Healthy family development
- 8) Reduced child maltreatment

The program was built on the successful implementation of the evidence-based Nurse-Family Partnership program. Developed by Dr. David Olds, the NFP is an evidence-based nurse home

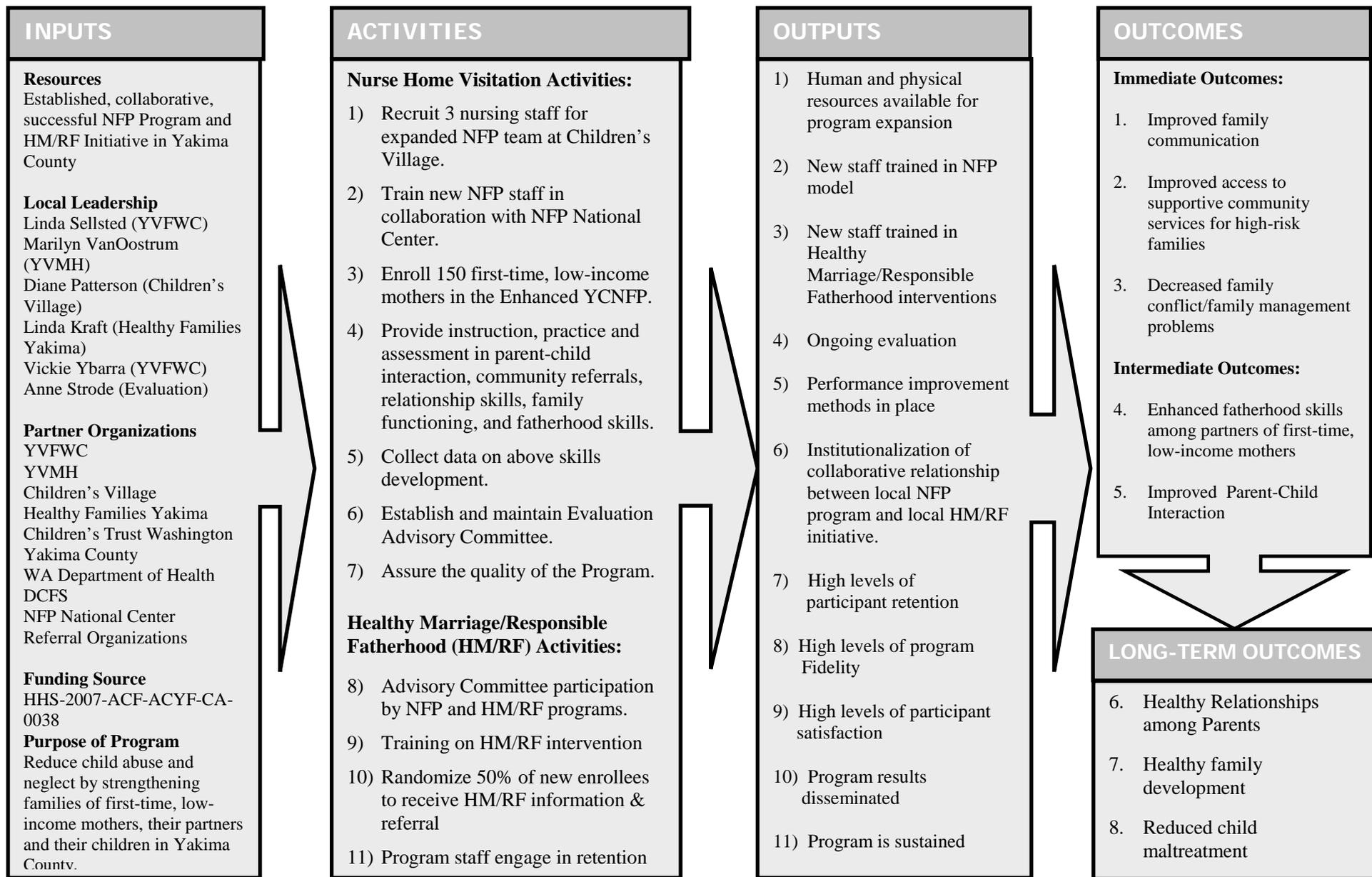
visitation model that has been demonstrated to improve the health, well-being and self-sufficiency of low-income, first-time parents and their children. NFP was first tested over twenty years ago and has been examined through three randomized trials to reduce child abuse and neglect, improve maternal and child well-being, enhance maternal life course development, and improve child school readiness. The Nurse-Family Partnership program provides nurse home visits from early in pregnancy through the children's second birthday for first-time low-income mothers.

For the ACF-funded program, the local program "enhanced" the core NFP intervention to add the HM/RF randomization and intervention component as well as the Mental Health Consultant component. Thus the ACF-funded demonstration project is labeled the Enhanced Yakima County NFP program, and was situated within the larger Yakima County NFP program.

### Logic Model

The logic model detailing inputs, activities, outputs and outcomes is included below. Note that while this logic model is largely the same as was included in the original grant application for this demonstration project, there have been some minor modifications. First, items in the "Activities" column have been re-ordered and modified from the original to reflect Final Report format of reporting separately on Nurse Home Visitation Activities and HM/RF Activities. Second, items in the "Outcomes" column have been re-ordered from the original to reflect the Final Report format of classifying all outcomes as Immediate, Intermediate or Long-Term Outcomes.

# LOGIC MODEL – ENHANCED YAKIMA COUNTY NURSE-FAMILY PARTNERSHIP PROGRAM AT CHILDREN’S VILLAGE



Notes: 1) Activities re-ordered and modified from original to reflect Final Report format of Nurse Home Visitation Activities and HM/RF Activities.  
2) Outcomes re-ordered from original to reflect Final Report format of Immediate, Intermediate and Long-Term Outcomes.  
All else is the same as in original grant.

## Collaboration

The Enhanced Yakima County Nurse-Family Partnership program incorporated strong collaboration among primary collaborating partner agencies that agreed to carry out the work of the demonstration project, and among other community and state-level partners that referred clients to the project and others that participated in the project Evaluation Advisory Team. The primary collaborating partners agreed to carry out the proposed work of the demonstration project as follows:

- 1) Yakima Valley Farm Workers Clinic (YVFWC) – Served as grant recipient, fiscal agent, employed 2 of the EYCNFP nursing staff, referred clients and served as evaluation lead.
- 2) Yakima Valley Memorial Hospital (YVMH) – Employed the NFP nursing supervisor, employed one of the EYCNFP nursing staff, and participated in evaluation advisory team.
- 3) Children’s Village (CV): Housed EYCNFP portion of the project, and participated in evaluation advisory team.
- 4) Healthy Families Yakima (HFY): The Community Health Marriage Initiative entity for Yakima County, agreed to provide Healthy Marriage/Responsible Fatherhood classes, provide training for YCNFP staff, and participate in the evaluation advisory team. Healthy Families Yakima was one of 14 sites in the nation to receive an ACF grant under the 1115 waivers for the Community Health Marriage Initiative (Beard et al. 2012). They proposed to serve Yakima County NFP clients using their own ACF grant funds.

Memoranda of Understanding from YVMH, CV and HFY with YVFWC were included in the initial 2007 grant application as a demonstration of agreement to participate as noted above.

## C. Overview of the Evaluation

### Evaluation Design, Data Collection, Analysis

Evaluation staff for the Enhanced Yakima County NFP program proposed to collect a variety of quantitative and qualitative data in order to track the activities and outputs detailed in the logic model and to evaluate whether or not the outcomes/impact described in the logic model had been achieved.

Measurement of program effectiveness, implementation and program services was accomplished by reviewing data collected on the base intervention by the NFP developer, the National Service Office (NSO). The NSO provides the local Yakima County NFP with quarterly summary reports on program activities and program quality/fidelity measures.

Measurement of outcomes included use of a number of specific tools to assess specific competencies gained by participants. These included the NCAST Teaching Scale to reliably assess parent-child interaction, the HOME evaluation of the home environment to evaluate healthy family development, and Section F from the Community Healthy Marriage Initiative evaluation tool to evaluate relationship quality. Additional planned quantitative data collection included a pre/post evaluation tool for the HM/RF classes to evaluate impact of the classes, as well as service delivery data to evaluate volume and locations of community referrals and presence/absence of domestic violence.

The local project planned to accomplish measurement of the primary program impact, reduction of child maltreatment, by the contracted Evaluation Consultant Anne Strode with the Washington State University (WSU) Institute for Mental Illness Research and Training. Ms. Strode had worked

as an Evaluation Consultant with YVFWC on two prior projects, she had access and experience with the necessary statewide child abuse/neglect datasets, and she was familiar with the target community in Yakima County. The local regional office of the state Division of Children and Family Services (DCFS), which maintains the state database for child abuse/neglect referrals and accepted referrals, had agreed to cooperate with the proposed EYCNFP Program and assist with IRB application as well as participate in the ongoing project Evaluation Advisory Team. The DCFS letter indicating cooperation for impact evaluation purposes was included in the grant application.

The local program evaluation staff facilitated local data analysis of individual-level client data by building a local database to complement the individual-level client data collected by the program developer. Merging the data collected locally that was entered into the developer's web-based system with our additional locally collected data was intended to provide the most complete individual-level data set possible from which to evaluate outcomes. Further, the lead local evaluator for the project utilized STATA statistical software to conduct necessary statistical analyses.

### Problems Encounters in Evaluation

The local EYCNFP project encountered three primary challenges in completing the Evaluation as planned. These challenges generally revolved around the need to collect additional data for the ACF-funded demonstration project that were not a part of regular data collection for the base nurse home visitation intervention. The challenges included 1) building a local data collection system to complement existing centralized data systems; 2) completeness of data collection for additional data; and 3) challenges obtaining state Child Protective Services (CPS) data on intervention clients.

#### *Building data collection system*

The National Service Office (NSO) of the Nurse-Family Partnership (NFP) program maintains a web-based data collection system that licensed sites are required to use to input data on all clients served, services provided, and staffing. The Yakima County NFP program has made use of this system since its inception. Securing funding under the ACF Nurse Home Visitation program required that the local program collect additional data on clients and outcomes in addition to what was being collected for the core NFP intervention. To address the issue of additional data collection and reporting, the local evaluation staff contracted with an Access consultant to create a freestanding data collection system for the additional data. Additionally, evaluation staff worked with the NSO and arranged to receive regular downloads of local Yakima County NFP data from the NSO in electronic (FTP) form. The Access consultant designed merges so that the NSO data could be merged with the locally collected Access data. Ultimately it was the merged data that the local evaluation staff primarily used for analysis and reporting to ACF on processes and outcomes.

While the process described above did meet the needs of the local program for additional data collection and reporting for the ACF Nurse Home Visitation grant, the system was not sustainable. It became more complex over time to merge and ensure data quality. In 2009 the NSO migrated to a new web-based data collection system, which caused an interruption in the FTP downloads as well as a problem with the content of those downloads. For example, some fields were missing data completely that was not migrated to the new system.

Building an additional local data collection system was costly, both in terms of money and staff time. Although it met the needs for ACF reporting, it was unsustainable and caused ongoing operational challenges.

### *Completeness of Data Collection*

The base nurse home visitation intervention for the local Yakima County demonstration project, EYCNFP, requires substantial data collection by nursing staff and data input by local support staff. Data collected and input into the online web-based NFP system include information on clients, services delivered and nursing staff. Thus the existing burden of data collection on nursing staff delivering the direct intervention is quite large for just the base intervention. Additional data collection is considered only when absolutely necessary, as it was for the evaluation for the ACF-funded Nurse Home Visitation program.

As can be seen in the outcomes reported for this project, some of the additional measures demonstrate collection rates that are lower than we would have hoped for. While the data collected are adequate to analyze and report here, local evaluation staff would have preferred more complete data collection for the additional measures (ex: NCAST, HOME, CHMI).

On a related note, the new federal funding stream for nurse home visitation activities (MIECHV) has represented a large enough investment in NFP home visitation that the NSO has modified the measures in its web-based data collection system. Inclusion in the base intervention in this manner ensures that data collection on the additional MIECHV measures will be supported by NSO training and reinforcement – data collection of these additional measures will be built into the NSO-driven system and this support will likely result in higher rates of data collection than we experienced with additional measures locally.

### *Obtaining State CPS Data*

Our measure of choice to determine the extent to which our long-term program outcome of reduced child maltreatment was met was individual-level confidential data on substantiated referrals for clients (both parents and children). Local program evaluation staff first submitted an application to the Washington State IRB seeking access to individual-level client CPS data on substantiated child maltreatment referrals for children and parents served by the ACF-funded EYCNFP program. This application was submitted at the suggestion of Region 2 Children's Services (CPS) administrators as the appropriate manner in which to gain access. As reported in the semi-annual reports, that initial 2010 IRB application was denied due to lack of an adequately developed research plan – reviewers asked for a more detailed analysis plan to justify the need for individual-level data.

In 2011 the evaluation consultant who worked on the initial 2010 IRB submission left the program. The local program evaluation staff picked up this effort again in 2012, and worked on obtaining individual-level client data on CPS, based on our initial understanding with the DCFS Region 2 Administrator who provided a letter of commitment for our 2007 ACF grant application. After much back and forth between the Washington State IRB and the DCFS Contracts office (who handles data sharing agreements for these data) during Fall 2012, Washington State in December 2012 determined that we could not have access to individual-level client CPS data in the absence of signed client consents.

The decisions of the Washington State IRB and the DCFS Contracts office seem reasonable in light of current IRB and confidentiality laws and rules, both state and national. While we were disappointed that the individual-level data on child maltreatment will not be available to us, it is clear that our evaluation team pursued access to these data as directed by the Region 2 DCFS administrator per his 2007 letter of commitment, and the direction we received from other DCFS regional staff and the Washington State IRB between 2007-2010. Our local program retained an

evaluation consultant with experience successfully accessing sensitive state databases for evaluation purposes (Juvenile Rehab). She worked directly with DCFS regional staff from the beginning of our ACF contract to plan for how we would access data, and as a result of that contact and planning she produced our 2010 Washington State IRB application that was rejected.

While it may appear clear in retrospect that our least cumbersome route to these data would have been simply to implement client consent at the beginning of the demonstration project, we felt we had been provided a more direct route to more complete data by multiple DCFS staff in 2007-2010. Voluntary client consent for CPS data generally produces less-than-complete coverage (for example, we have been informed that the Spokane NFP program obtained approximately 55% coverage using voluntary client release of information for this same contract). Incomplete coverage leads to estimates of the outcome measure that simply are not accurate, and may be seriously biased downward (as the least risky clients may be the most likely to authorize access to child maltreatment data). There are also issues about time-frame, as authorization for release of information may be valid for only 90-days, while the most appropriate data for outcome evaluation purposes is collected a year or more after the client has exited the program. For all of these reasons, we felt at the time that our approach to gaining access to the data directly from DCFS was the best, and had every reason until very recently to believe this was a feasible route to take.

As a result of this challenge, we make use of programmatic data to estimate rates of child maltreatment experienced by clients served in this project rather than state CPS reports.

### III. Project Implementation/ Process Evaluation

#### A. Program Implementation

##### Project Meetings

The ACF-funded EYCNFP project built on an existing NFP program in Yakima County, so did not require substantial planning prior to implementation. There were initial meetings for the first two years between YCNFP staff and managers and the Healthy Families Yakima (HFY) coordinator to plan for the intervention and to participate in one another's' advisory groups as agreed to prior to implementation. Management and staff of the two programs (YCNFP and HFY) met as many as 8 times during this two year period to plan for services and referrals, create data sharing agreements, and represent their respective program to the others' advisory group.

Additionally, local supervisory and evaluation staff did meet a number of times early in the project with ACF staff and JBA staff to plan for additional data requirements for the ACF-funded demonstration project.

##### Project Staffing, Training, and Supervision

###### *Staffing & Training*

The NFP National Service Office (NSO) requires initial training for all new staff: Unit 1: onsite "distance learning", Unit 2: face-to-face session in Denver, CO (approx. 4 days), Unit 3: onsite "distance learning", and for the supervisor, an additional trip to Denver for a fourth unit. PIPE, a full parenting curriculum, is imbedded in the initial education sessions. Additional training required by NFP includes Ages & Stages Questionnaire and NCAST training. Annually supervisors are required to attend an education session in Denver. Team meeting guidance is also supplied to supervisors for them to provide ongoing topics of continuing education during their monthly team meetings and on-line learning modules are available on demand.

The main staffing for the ACF-funded demonstration project was three NFP nurses and a portion of an NFP supervisor. Since the ACF-funded demonstration project built on an existing NFP program in Yakima County, full staffing occurred relatively early in the project. Two nurses were re-assigned to the ACF-funded demonstration project who had already received training from the National NFP center, and so could begin delivering services on day one of the ACF-funded YCNFP. The same was true with the NFP supervisor. The third NFP nurse hired in March 2008 received three days of face-to-face NFP training in Denver in May 2008 (Unit 2), part of the more than 60 hours of instruction she received from the Nurse-Family Partnership Professional Development Team through June 2009. In addition to instruction that is specific to the NFP home visiting intervention, in August she attended training in NCAST and PIPE locally.

Throughout implementation, YVFWC and YVMH were committed to implement the enhanced evidence-based model in a culturally- and linguistically-competent manner to meet the needs of Spanish-speaking clients and families. This was done through a commitment that at least half of direct-service provider nurses needed to be fluently bilingual and with training in cultural competency. So in addition to the other training noted here, all direct-service nurse home visitation staff also received initial and ongoing training in cultural competency.

The Mental Health Consultant for the project was identified and brought in under contract during the first 6 months of the program. She also attended the national NFP training in November 2008.

Finally, Healthy Families Yakima provided training about Healthy Marriages/ Responsible Fatherhood classes to EYCNFP nurse team during the first semi-annual reporting period, covering the curriculum that is used in the classes, the specifics of each site, and the referral process.

### *Supervision*

NFP Nursing Supervisors nationwide are trained to provide Nurse Home Visitors clinical supervision with reflection, demonstrate integration of the theories, and facilitate professional development essential to the Nurse Home Visitor role through specific supervisory activities including 1:1 clinical supervision, case conferences, team meetings and field supervision. Supervision is required weekly with each home visitor. Case conferences and team meetings are held on a weekly basis. Joint home visits in the field must be conducted at least quarterly with each nurse.

The ACF-funded EYCNFP met the NFP NSO expectation for nurse supervisor-to-staff ratio of no more than 8 nurse home visitors per full-time supervisor. The EYCNFP supervisor provided the required activities for nurse supervision throughout the ACF-funded demonstration project, including weekly hour-long one-to-one reflective supervision, program development, referral management and other administrative tasks. In addition, the EYCNFP supervisor led monthly case conference and team meetings throughout the ACF-funded demonstration project, as well as completed field supervision (joint home visits) quarterly with each nurse, using the NFP Visit Implementation Scale.

### **Model Fidelity**

Client and home visiting data were collected by nurses and entered into the NFP NSO online data entry system by data entry staff. Throughout the ACF-funded demonstration project, quarterly fidelity reports from the NSO were utilized to guide improvements in program implementation. Through continuous monitoring, the supervisor was able to identify variance in performance outcomes and implement improvement processes.

Additionally, the EYCNFP reported numerous fidelity indicators on regular semi-annual project reports to ACF. The local EYCNFP typically outperformed the NFP National quality and fidelity indicators in a majority of the indicators measures where such comparisons were appropriate. The final report on quality and fidelity indicators, through 3/31/2013, is included at the end of this report as Appendix A. Note that this table was also included in our ACF semi-annual report for the period ending 3-31-2013.

Finally, the local EYCNFP incorporated principles and processes of implementation science into our local program, as an investment in future program quality and sustainability. In March 2011 our local program conducted its first self-assessment of the seven drivers of successful implementation described by the National Implementation Research Network, and subsequently created and completed a performance improvement plan based on the results of that assessment.

### **Project Enrollment and Randomization**

The program goal of 150 clients enrolled was reached as of 9/30/2012. A total of 155 clients were enrolled into the ACF-funded demonstration project. Fifty-four percent (75/150) of families enrolled in the Enhanced YCNFP were randomly assigned to referral to the Healthy Families Yakima PREP program.

## Dissemination

Throughout the ACF-funded demonstration project, the EYCNFP was proactive in disseminating information about the project at the local, state and national level. Most of that activity took place at the state level and helped to support sustainability.

At the local level, the largest local Yakima newspaper the Yakima Herald-Republic, ran an in-depth front-page feature on the local EYCNFP ON March 13, 2008. Excerpts from this article are included in Appendix B of this report, including an insert on involving the father in home visits. Also at the local level, the Nurse Supervisor and Local Evaluator presented the program by invitation to the local Yakima Downtown Rotary Club in February 2009.

At the state level, throughout the ACF-funded demonstration project the EYCNFP Nurse Supervisor was an active participant in local and statewide meetings of maternal-child health program representatives from throughout Washington State during which she was able to disseminate information on activities and achievements of the local program. This type of dissemination and state leadership on the part of the EYCNFP Nurse Supervisor helped ensure the local program was considered when sustainability funds became available.

The Nurse Supervisor participated in 2 state advisory committees around evidence-based home visitation. The Washington Home Visiting Coalition Program Committee, which met monthly, to provide advisory input and written recommendations regarding evidence-based home visitation in Washington State. The Committee provides input to the state Department of Early Learning, Department of Health, State legislators, and other groups requesting information on evidence-based home visiting. The Nurse Supervisor also served on the Washington State Home Visiting Advisory Committee, which met quarterly. The Advisory Committee provided support and input in the development of the state home visiting plan. Specifically advising the Partnership Group and the Cross-Agency Governance Structure, this includes the director of DEL, DOH Secretary, DSHS Secretary, and the Executive Director of the Council for Children and Families.

In addition, the EYCNFP Nursing Supervisor participated in two national platforms to disseminate information about the local ACF-funded project. First, she co-presented at a workshop at the DHHS HRSA Tribal Maternal, Infant, and Early Childhood Home Visiting Program Grantee Kickoff Meeting & Tribal Early Learning Communities Consortium during January 2011 in Washington, D.C. Second, she presented a National Webinar at the request of the funder, "Matching Evidence Based Home Visiting Model(s) to Community Needs, Resources and Benchmarks".

Finally, the local evaluator for EYCNFP did submit an abstract to the journal PEDIATRICS under their special call for abstract released in August 2012. Although we ultimately were not invited to submit a paper for the PEDIATRICS special issue on maternal, infant, and early childhood home visiting, preparing the abstract and thinking through the potential paper provided a basis from which we may choose to work on future papers.

## Sustainability

The EYCNFP started a local Sustainability Workgroup in May 2010 to begin planning for sustainability funding to continue the local program after the end of ACF funding. The Sustainability Workgroup included Diane Patterson (Children's Village Director, YVMH), Marilyn VanOostrum (EYCNFP Nurse Supervisor, YVMH), Linda Sellsted (EYCNFP Project Coordinator, YVFWC), Katherine Smalley (YVFWC Evaluation Specialist) and Vickie Ybarra (EYCNFP Lead

Local Evaluator, YVFWC). From May 2010 through November 2012, the Sustainability Workgroup met on average every-other-month. During this time Workgroup members crafted a Sustainability Strategy including short, medium, and long-term strategies, conducted prospect research, and actively explored alternative potential public funding sources.

In November 2012 when it became clear that sustainability of local services would be achieved through funding from the Washington State Home Visiting Services Account and the federal MIECHV (Maternal, Infant, and Early Childhood Home Visitation) funding coming to Washington State, Workgroup members switched from sustainability planning to implementing transition.

**B. Interventions/Activities #1-#7 – Nurse Home Visitation Component**

Activity #1 – NHV Component: Recruit 3 nursing staff for expanded NFP team at Children’s Village			
Outputs	Contextual Events/ Community Change	Facilitators	Challenges/Barriers
This activity was accomplished during the first six months of the start of the ACF-funded demonstration project. Two then-current NFP nurses were recruited/ reassigned to the ACF-funded demonstration project and one additional bilingual/ bicultural nurse was hired 3/6/2008.	None relevant to this activity.	The program leadership were and are committed to meeting needs of the client base and maintaining cultural and linguistic competence in the program by ensuring at least half of program nurses are bilingual/bicultural.	None relevant to this activity.

**Lessons Learned about how to deal with challenges regarding Activity #1-NHV Component:**

Although the local program experienced no unanticipated challenge in recruiting the third nurse needed to implement the YCENFP program, we do recognized that bilingual nursing staff can be more difficult to recruit than non-bilingual staff, at least two institutional factors worked in our favor in this endeavor. First, the Yakima County NFP program is viewed by public health nurses in the community (across the four agencies in the community that employ public health nurses) as a favorable program in which to work. This has to do with the quality of the evidence-based program, the mission, its placement at Children’s Village and the quality of the program supervisor. Second, operating the Yakima County Enhanced NFP program as a partnership between two agencies – YVMH and YVFWC – allows the program to attract from two separate but highly qualified pools of nurses who are already employed. YVFWC in particular is known for attracting bilingual nursing staff because of its large patient base of Spanish-speaking patients. Thus in addition to recruiting directly from the pool of qualified nurses in the general community, the program is able to draw specifically from among nurses already employed at both agencies who are known by the agencies from their previous work.

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<b>Activity #2 – NHV Component: Train new NFP staff in collaboration with NFP National Center</b>			
<b>Outputs</b>	<b>Contextual Events/ Community Change</b>	<b>Facilitators</b>	<b>Challenges/Barriers</b>
The two nurses who were re-assigned had already had training from the National NFP center, and so could begin delivering services on day one of the YCENFP. The NFP nurse hired in March 2008 received three days of face-to-face NFP training in Denver in May 2008 (Unit 2), part of the more than 60 hours of instruction she received from the Nurse-Family Partnership Professional Development Team through June 2009. In addition to instruction that is specific to the NFP home visiting intervention, in August she attended training in NCAST and PIPE locally. The new Mental Health Consultant attended the national NFP training in Nov. 2008.	None relevant to this activity.	The program developer at the National NFP Center maintains a regular annual schedule for staff training on-site in Denver, as well as web-based supplemental training.	None relevant to this activity.

**Lessons Learned about how to deal with challenges regarding Activity #2-NHV Component:**

The local program experienced no unexpected challenges regarding Activity #2-NHV Component.

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<b>Activity #3 – NHV Component: Enroll 150 first-time, low-income mothers in the Enhanced YCNFP</b>			
<b>Outputs</b>	<b>Contextual Events/ Community Change</b>	<b>Facilitators</b>	<b>Challenges/Barriers</b>
The program goal of 150 clients enrolled was reached as of 9/30/2012. A total of 155 clients were enrolled into the ACF-funded demonstration project.	None relevant to this activity.	The local YCENFP program maintains a solid base of community partners who continued to refer to the program throughout the ACF-funding period.	Enrollment did occur somewhat slower than expected.

**Lessons Learned about how to deal with challenges regarding Activity #3-NHV Component:**

The main barrier to enrollment was simply a matter of receipt of referrals and clients agreeing to be enrolled in the program. As it became clear that the last ACF-funded clients would enroll later than expected, serving these clients beyond the end of ACF-funding became an issue in our local sustainability planning efforts. We did not wish to drop these clients in the middle of their services simply because ACF funding ended. At the end of ACF funding (3/31/2013) the local program was still serving 42 ACF-funded clients. For sustainability, the local program is contracting with Washington State to provide NFP home visiting services in Yakima County with MIECHV funding (federal Maternal-Infant Early Childhood Home Visitation). The local program has negotiated with the state of Washington to allow 10 previously-ACF-funded NFP clients to continue receiving services under MIECHV funding (those who were enrolled after 4/1/2012). The two YCNFP implementing agencies (YVFWC and YVMH) have committed to serve the remaining 32 clients served with ACF funding who are not eligible for transition to MIECHV funding (enrolled before April 1, 2012) on agency subsidy.

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<b>Activity #4 – NHV Component: Provide instruction, practice and assessment in parent-child interaction, community referrals, relationship skills, family functioning, and fatherhood skills</b>			
<b>Outputs</b>	<b>Contextual Events/ Community Change</b>	<b>Facilitators</b>	<b>Challenges/Barriers</b>
Nurses provided these services to 155 ACF-funded clients in 4,077 completed home visits.	None relevant to this activity.	The base nurse home visitation intervention, Nurse-Family Partnership, is a protocolized intervention with a centralized web-based data collection system that allows us to analyze visits to clients funded under this program.	There were no challenges/barriers to provision of the base nurse home visitation intervention.

**Lessons Learned about how to deal with challenges regarding Activity #4-NHV Component:**

The local program experienced no unexpected challenges regarding Activity #4-NHV Component.

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<b>Activity #5 – NHV Component: Collect data on above skills development.</b>			
<b>Outputs</b>	<b>Contextual Events/ Community Change</b>	<b>Facilitators</b>	<b>Challenges/Barriers</b>
Nurses collected and data entry staff entered data on 155 ACF-funded clients in 4,077 completed home visits.	None relevant to this activity.	The base nurse home visitation intervention, Nurse-Family Partnership, is a protocolized intervention with a centralized web-based data collection system that allows us to analyze visits	There were no challenges/barriers to data collection or data entry of the base nurse home visitation intervention.

		to clients funded under this program.	
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**Lessons Learned about how to deal with challenges regarding Activity #5-NHV Component:**

The local program experienced no unexpected challenges regarding Activity #5-NHV Component.  
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<b>Activity #6 – NHV Component: Establish and maintain Evaluation Advisory Committee</b>			
<b>Outputs</b>	<b>Contextual Events/ Community Change</b>	<b>Facilitators</b>	<b>Challenges/Barriers</b>
The EYCNFP Evaluation Advisory Committee was established during the first semi-annual reporting period). It met 8 times over the course of the ACF-funded demonstration project (12/2007; 3/2008; 6/2008; 12/2008; 6/2009; 12/2009; 6/2010; and 2/2011).	None relevant to this activity.	High levels of community and state/local agency support for the EYCNFP project from the beginning.	As the project matured it became a challenge to keep the committee meetings relevant and compelling enough to permit participants to prioritize this activity – so attendance dropped off toward the latter years of the project. An additional challenge, as noted in the 4/1/2011-9/30/2011 reporting period was the loss of Betsy Nagle-McNaughton from YVFWC and the evaluation team in 2011.

**Lessons Learned about how to deal with challenges regarding Activity #6-NHV Component:**

The EYCNFP Evaluation Advisory Team included representatives from: Washington State Department of Health, DCFS Region 2 Administration DSHS/ Division of Children and Family Services, Children’s Trust / WCPCAN, Healthy Families Yakima, Yakima Valley Farm Workers Clinic, Yakima County Community Services, and Yakima Valley Memorial Hospital / Children’s Village as well as the contracted Evaluator and an Evaluation Specialist from Yakima Valley Farm Workers Clinic.

As a result of both challenges noted above, the decision was made to drop the meeting frequency back to once/year beginning in 2011, which seemed most appropriate for a mature project. During the last 12-18 months of the project more project leadership attention turned to sustainability, as did the attention of many of the Evaluation Advisory Team members; it seemed to make sense to forego additional team meetings during the last year in favor of increased efforts on sustainability.  
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<b>Activity #7 – NHV Component: Assure the quality of the Program</b>			
<b>Outputs</b>	<b>Contextual Events/ Community Change</b>	<b>Facilitators</b>	<b>Challenges/Barriers</b>
Local program leadership monitored and responded to quarterly quality and fidelity reports produced by the National NFP office. The Yakima County NFP program consistently met or exceeded NFP National program performance on the vast majority of the quality and fidelity indicators tracked. Details of these indicators were reported in semi-annual reports throughout the ACF-funded demonstration project.	None relevant to this activity.	The program developer, the National NFP Program Office, maintains a centralized web-based data collection system and produces regular quarterly quality and fidelity reports for each local program.	There were no challenges/barriers to assuring quality of the local program.

**Lessons Learned about how to deal with challenges regarding Activity #7-NHV Component::**

There were no challenges/barriers to assuring quality of the local program. The final report of program quality and fidelity indicators for the EYCNFP is included as Appendix A of this report.  
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**C. Interventions/Activities #8-#11 – Healthy Marriage/Responsible Fatherhood (HM/RF) Component**

<b>Activity #8 – HM/RF Component: Advisory Committee participation by NFP and HM/RF programs</b>			
<b>Outputs</b>	<b>Contextual Events/ Community Change</b>	<b>Facilitators</b>	<b>Challenges/Barriers</b>
Participation in Advisory Committees did occur during the first two years of the program (10/1/2007-9/30/2009).	None relevant to this activity.	Program leadership from both the EYCNFP and separate local HM/RF project were committed in the beginning to this activity.	It became clear in early 2009 that the local, separate ACF-funded HM/RF project was not able to respond to EYCNFP referrals nor to meet the needs of EYCNFP clients.

**Lessons Learned about how to deal with challenges regarding Activity #8-HM/RF Component:**

The intent with this activity was that representatives from both the local NFP project and the local and separate ACF-funded Healthy Marriage/Responsibility Fatherhood (HM/RF) project participate in one another’s Advisory Committees. Local leadership of the EYCNFP program believed this would help support the working relationship between the two programs over the course of the ACF-funded home visitation project.

It became clear in early 2009 that the local HM/RF project was not organized sufficiently to respond to YCENFP referrals or to meet the needs of EYCNFP clients. Most of the HM/RF classes that were available in the early part of this project were provided by protestant churches and targeted more mature couples who had ties to the church, and they simply did not have the capacity to deal appropriately with young, single, multi-problem mothers and their partners. This finding is consistent with the findings of Wood et al. (2010) in their report to ACF, “Strengthening Unmarried Parents’ Relationships: The Early Impacts of Building Strong Families”.

The biggest breakthrough in working with this challenge occurred in June 2010, when the EYCNFP team met with one Healthy Families Yakima contracted class provider to explore more direct avenues for providing these specific HM/RF services to NFP clients. That one provider was open to meeting the needs of the EYCNFP clients, but we found that enthusiasm and interest waned after just a few months.

Healthy Families Yakima was the local organization that YVFWC and EYCNFP partnered with to deliver the HM/RF services to clients enrolled in the base nurse-home visitation intervention. As described in the ACF OPRE Report #2012-10 “Piloting a Community Healthy Marriage Initiative in Four Sites” (Beard et al. 2012), Healthy Families Yakima was funded to implement healthy marriage/responsible fatherhood classes in Yakima County under an 1115 waiver awarded in 2005 and ended in 2011. Although the ACF OPRE Report notes that Healthy Families Yakima served 400 clients during the course of its funding, it was able to serve only 4 of the EYCNFP clients that we referred.

While we believed that having a local, separate ACF-funded HM/RF project in the community at the start of our proposed EYCNFP project would be a facilitator to delivering this service, we found just the opposite to be true. While having a separate ACF-funded demonstration project partner could have been a facilitator to meeting the goals of the funded project if the local program was strong and effective, the program’s focus on a different client base, and general weakness and ineffectiveness in serving our local NFP clients impacted our ability to deliver on our proposed objectives.

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Activity #9 – HM/RF Component: Training on HM/RF intervention			
Outputs	Contextual Events/ Community Change	Facilitators	Challenges/Barriers
Healthy Families Yakima provided training about Healthy Marriages/ Responsible Fatherhood classes to EYCNFP nurse team during the first semi-annual reporting period, covering the curriculum that is used in the classes, the specifics of each site, and the referral process.	None relevant to this activity.	Program leadership from both the EYCNFP and separate local HM/RF project were committed in the beginning to this activity.	There were no challenges or barriers to completing this initial training.

**Lessons Learned about how to deal with challenges regarding Activity #9-HM/RF Component::**

The local program experienced no unexpected challenges regarding Activity #9-HM/RF Component.

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<b>Activity #10 – HM/RF Component: Randomize 50% of new enrollees to receive HM/RF information &amp; referral</b>			
<b>Outputs</b>	<b>Contextual Events/ Community Change</b>	<b>Facilitators</b>	<b>Challenges/Barriers</b>
Fifty-four percent (75/150) of families enrolled in the Enhanced YCNFP were randomly assigned to referral to the Healthy Families Yakima PREP program.	None relevant to this activity.	Program leadership from both the EYCNFP and separate local HM/RF project were committed in the beginning to this activity.	There were no challenges or barriers to randomization of clients and provision of information. Barriers occurred later in the project when it became clear that referred clients were unable to access HM/RF services.

**Lessons Learned about how to deal with challenges regarding Activity #10-HM/RF Component:**

See notes on Lessons Learned under Activity #8 above.

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<b>Activity #11 – HM/RF Component: Program staff engage in retention activities and report client attendance</b>			
<b>Outputs</b>	<b>Contextual Events/ Community Change</b>	<b>Facilitators</b>	<b>Challenges/Barriers</b>
Four referred clients completed the HM/RF course by 9/30/2010. None of the remaining 71 EYCNFP clients referred to HM/RF accessed HM/RF services.	None relevant to this activity.	Program leadership from both the EYCNFP and separate local HM/RF project were successful in negotiating systems and agreements by which to share information on client attendance across programs.	It became clear in early 2009 that the local, separate ACF-funded HM/RF project was not able to respond to EYCNFP referrals nor to meet the needs of EYCNFP clients.

**Lessons Learned about how to deal with challenges regarding Activity #11-HM/RF Component::**

See noted on Lessons Learned under Activity #8 above.

## IV. Project Outcome Evaluation

### A. Immediate Outcomes

Expected Outcome #1: Improved Family Communication			
Data Collection Method	Source of information	Timeframe	Analysis Method
Observation by home visiting nurse	NFP Home Visit Encounter Form Nurse Ratings of: Partner Present for HV Partner Engagement Partner Understanding of Material Partner Conflict with Material	Cumulative 10/1/2007 – 3/31/2013	1. Compare clients randomized to receive HM/RF referrals against those randomized to not receive HM/RF referrals.  ttest of group means  2. Compare partner involvement indicators over time.

**Findings and Interpretation for Expected Outcome #1:** Overall, the 155 ACF-funded demonstration clients received 4,077 completed home visits over the course of the project; and overall the partner/father was present in 17.0% of the visits. Clients randomized to not receive HM/RF referral experienced somewhat higher rates of visits with partners present (19.3%) compared with a slightly lower 15.8% of visits with partners present among clients randomized to receive HM/RF referral.

Randomized to receive HM/RF referral:

No: 19.3% of 1,424 completed visits partner present

Yes: 15.8% of 2,653 completed visits partner present

When they are present, analyses of home visiting nurse ratings of partners' engagement, understanding and conflict with material during the visit reveal no statistical difference in partner level of engagement or understanding between clients randomized to receive referrals to the HM/RF intervention and those randomized to not receive referrals. The differences in the level of conflict with the material reported during the visit approaches statistical significance ( $p=.0570$ ) with partners of clients randomized to receive HM/RF referrals having greater conflict with the visit material covered (mean=1.11) than partners of clients randomized not to receive referrals (mean=1.05). Caution should be taken in interpreting this difference, conflict with material scores for both groups are very low overall. The data below detail these findings.

Partner Engagement in Home Visit when present:

Randomized to receive HM/RF	Mean Engagement Score (1=low 5=high)
No n=275 visits with partner present	3.25
Yes n=419 visits with partner present	3.18
	t=.8708 p=.3842

Partner Understanding of Material when present:

Randomized to receive HM/RF	Mean Understanding Score (1=low 5=high)
No n=274 visits with partner present	3.58
Yes n=419 visits with partner present	3.62
	t=-.6852 p=.4935

Partner Conflict with Material when present:

Randomized to receive HM/RF	Mean Conflict Score (1=low 5=high)
No n=274 visits with partner present	1.05

Yes n=419 visits with partner present 1.11 t=-1.91 p=.0570

In an effort to determine if partners were more involved over time, we conducted another analysis examining partner involvement in the different years of the intervention, regardless of randomization status.

As detailed in Table 3 below, we do observe trends in the expected direction in terms of partner presence at home visits, and engagement, understanding and conflict with material when he is present. In 2007, partners were present for only 15% of demonstration client home visits, and that increased to 23.9% in 2011 and 2012. Average partner engagement scores when present ranged from a low of 2.8 in 2007 to a high of 3.4 in 2013. Average partner understanding scores increased from a low of 2.7 in 2007 to a high of 3.8 in 2009 and a steady 3.6 in 2011, 2012 and 2013. Average partner conflict (with material) scores ranged from a high of 1.3 in 2007 and 2008 to a low of 1.0 in 2009, 2010, 2011 and 2013.

Table 3: Partner Involvement in Visits over Time EYCNFP ACF-Funded Demonstration Clients N=4,077 total visits				
	% Visits Partner Present	Ave Partner Engagement Score	Ave Partner Understanding Score	Ave Partner Conflict Score
<b>2007</b> (N=140)	15.0%	2.8	2.7	1.3
<b>2008</b> (N=615)	17.7%	3.3	3.5	1.3
<b>2009</b> (N=1,061)	11.9%	3.2	3.8	1.0
<b>2010</b> (N=989)	15.7%	3.1	3.7	1.0
<b>2011</b> (N=629)	23.9%	3.5	3.6	1.0
<b>2012</b> (N=482)	23.9%	3.3	3.6	1.1
<b>2013</b> (N=161)	11.2%	3.4	3.6	1.0

These results appear to indicate that the nursing staff were implementing methods to engage partners more in their regular home visits with clients, resulting in a greater proportion of visits with partners present, and better average scores on partner engagement, understanding and conflict (with material) as the years in the project went on. So even though we observed no significant differences in these measures of partner engagement in home visits based on randomized or not, we do see evidence of increased partner/father involvement over time.

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Expected Outcome #2: Improved Access to Supportive Community Services			
Data Collection Method	Source of information	Timeframe	Analysis Method
Report by home visiting nurses	NFP Home Visit Encounter Form	Cumulative 10/1/2007 – 3/31/2013	Report number of referrals to community services, and services to which most referrals are made.

**Findings and Interpretation for Expected Outcome #2:** Home visiting nurses have made an average of 35.9 community service referrals for each ACF client served since the start of funding for the program. Of the many categories of referrals tracked, the highest numbers are for primary care provider (2,373 referrals ) childbirth education (146 referrals), WIC (137 referrals), mental health (107 referrals) and other (1,871 referrals).

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Expected Outcome #3: Decreased Family Conflict/Family Management Problems			
Data Collection Method	Source of information	Timeframe	Analysis Method
Report of domestic violence by client	NFP Relationship Assessment Form	Cumulative 10/1/2007 – 3/31/2013	Report number of clients reporting domestic violence at intake and later in case. If sufficient numbers, compare clients randomized to receive HM/RF referrals against those randomized to not receive HM/RF referrals.

**Findings and Interpretation for Expected Outcome #3:** The number of clients reporting physical abuse within the last 12 months does decrease the longer the client is involved with the program. While these numbers are small and should be interpreted with caution, the trend is encouraging. In addition, the number of clients reporting at the same reporting times that they are currently afraid is low. This seems to indicate that although women may be experiencing abuse, they are dealing with the issue in ways that lead them to feel safer.

Note that data are not disaggregated by HM/RF referrals due to low numbers that prevent subgroup comparisons.

ACF Clients Reporting Emotional or Physical Abuse within last 12 months:

Intake	30
Pregnancy (36 weeks)	8
Infancy (12 months)	11

ACF Clients Reporting being currently “afraid of any current or previous male partner or someone else important to you”.

Intake	2
Pregnancy (36 weeks)	0
Infancy (12 months)	1

## B. Intermediate Outcomes

Expected Outcome #4: Enhanced Fatherhood Skills among Partners			
Data Collection Method	Source of information	Timeframe	Analysis Method
Data sharing arrangement with Healthy Families Yakima to share evaluations from HM/RF sessions.	Pre/Post HM/RF measures.	Cumulative 10/1/2007- 3/31/2013	Compare pre measures against post measures to determine improvement. Anticipated data only on those who completed HM/RF intervention.

**Findings and Interpretation for Expected Outcome #4:** We are unable to assess this outcome. We successfully worked out a data sharing arrangement with Healthy Families Yakima to share pre/post measure information from clients attending and completing the Healthy Marriage/Responsible Fatherhood courses. Four clients referred for the HM/RF intervention did attend the classes early in the program. As described elsewhere in this report, the ACF-funded Healthy Families Yakima program became unresponsive to referrals of clients from our EYCNFP program, thus no additional randomized clients received the intervention and no data were collected.

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Expected Outcome #5: Improved Parent-Child Interaction			
Data Collection Method	Source of information	Timeframe	Analysis Method
Observation of client-child interaction by home visiting nurses.	NCAST Parent-Child Teaching Assessment Tool	Cumulative 10/1/2007- 3/31/2013	Compare 5 month NCAST results against 18-24 month NCAST results to determine improvement. Compare results for clients randomized to receive HM/RF referrals against those randomized to not receive HM/RF referrals.

**Findings and Interpretation for Expected Outcome #5:** Analysis of 19 matched pre/post administrations available to date of the NCAST Teaching tool identified statistically significant improvements in total scores and parent scores from approximately 5 months to 18-24 months. Child subscale scores showed an improvement, but it was not significant at the  $p=.05$  level (\*) as shown below.

**All ACF Clients together (n=19 matched pairs):**

Average total NCAST Teaching Score Pre (~5 mos)	61.79
Average total NCAST Teaching Score Post (18-24 mos)	61.79
	t=2.98 (paired t-test)
	p=.0079*
Average NCAST Teaching Parent Scores Pre (~5 mos)	42.89
Average NCAST Teaching Parent Score Post (18-24 mos)	45.74
	t=2.166 (paired t-test)
	p=.0439*

Average NCAST Teaching Child Scores Pre (~5 mos)	18.89
Average NCAST Teaching Child Scores Post (18-24 mos)	20.11
	t=1.65 (paired t-test)
	p=.1173

When examining the results disaggregated by HM/RF referral status, we see that the group of clients who were randomized to receive referral to HM/RF are driving these results. Both the parent and total scores for the group randomized to receive referrals demonstrate statistically significant improvements from the 5 month NCATS to the 18-24 month administration. Clients randomized to NOT receive HM/RF referrals show no significant difference from before to after. These results must be interpreted with caution given the very small number in the no referral group.

***Clients Randomized to Receive referral to HM/RF (n=14 matched pairs):***

Average total NCAST Teaching Score Pre (~5 mos)	61.07
Average total NCAST Teaching Score Post (18-24 mos)	66.07
	t=3.91 (paired t-test)
	p=.0018*
Average NCAST Teaching Parent Scores Pre (~5 mos)	42.57
Average NCAST Teaching Parent Score Post (18-24 mos)	46.14
	t=3.24 (paired t-test)
	p=.0065*
Average NCAST Teaching Child Scores Pre (~5 mos)	18.5
Average NCAST Teaching Child Scores Post (18-24 mos)	20.0
	t=1.689 (paired t-test)
	p=.1150

***Clients Randomized to NOT Receive referral to HM/RF (n=5 matched pairs):***

Average total NCAST Teaching Score Pre (~5 mos)	63.8
Average total NCAST Teaching Score Post (18-24 mos)	65.0
	t=0.3286 (paired t-test)
	p=.7950
Average NCAST Teaching Parent Scores Pre (~5 mos)	43.8
Average NCAST Teaching Parent Score Post (18-24 mos)	44.6
	t=0.1944 (paired t-test)
	p=.8554
Average NCAST Teaching Child Scores Pre (~5 mos)	20.0
Average NCAST Teaching Child Scores Post (18-24 mos)	20.4
	t=0.2933 (paired t-test)
	p=.7839



<b>Table 4: Results CMHI Questionnaire</b>				
	Average Pre-Scores (N=50-64)	Average Post-Scores (N=9-11)	Average Difference Paired Pre-Posts (N=5-8)	p-value Paired Pre-Posts (N=5-8)
Quality of Marriage Index (1-5)	4.32	4.34	+0.52	0.5900 (n.s.)
Dyadic Adjustment Scale (DAS-8) (1-6)	4.62	4.57	-0.11	0.5070 (n.s.)
CTS2-Negotiation Subscale (1-4)	3.5	3.35	-0.063	0.6910 (n.s.)
Good Side of Relationship Rating (1-5)	4.30	4.30	+0.50	<b>0.0331*</b>
Bad Side of Relationship Rating (1-5)	3.75	3.30	+0.25	0.6682 (n.s.)

higher scores=more positive scores

n.s.=non significant

\*\*\*\*\*

<b>Expected Outcome #7: Healthy Family Development</b>			
Data Collection Method	Source of information	Timeframe	Analysis Method
Observation & client report of nurturing home environment.	HOME scale	Cumulative 10/1/2007-3/31/2013	Compare 12 month HOME results against HOME results at exit to determine improvement. Compare results for clients randomized to receive HM/RF referrals against those randomized to not receive HM/RF referrals.

**Findings and Interpretation for Expected Outcome #7:** Analysis of 14 matched pre/post administrations of the HOME Inventory tool identified statistically significant improvements in total scores from child age of 12 months to 24 months. Note that scores are not disaggregated by HM/RF referrals due to low numbers that prevent subgroup comparisons. Based on these results, we are fairly confident concluding that this long-term outcome was met.

Average total HOME Pre (12 months)	39.21
Average total HOME Post (24 months)	43.14
	t=3.54 (paired t-test)
	p<.01

\*\*\*\*\*

<b>Expected Outcome #8: Reduced Child Abuse and Neglect</b>			
Data Collection Method	Source of information	Timeframe	Analysis Method
Client self-reports and Nurse reports	NFP centralized data system	Cumulative 10/1/2007-3/31/2013	Examine and report on potential child maltreatment events from the NFP centralized data system.

YCNFP home visiting nurses complete an Infant/Toddler Healthcare Form 4 times during the first two years of the child's life – at 6 months, 12 months, 18 months and at closure at 24 months. At each of those four visits, the nurse is assessing:

- Has the child gone to the emergency room for an injury or ingestion?
- Has the child been hospitalized overnight for an injury or ingestion?
- Is the nurse aware of any CPS referrals for abuse or neglect of the child?
- Has the nurse made any CPS referrals herself for abuse or neglect of this child?

Reporting on any/all of these outcomes is very rare, only 7 of our total 155 clients, or 4.5% of clients served with ACF funding have experienced any of these four outcomes while enrolled in services. This is not unlike the outcome we would have expected if we were able to access individual-level Child Protective Services (CPS) data. Child maltreatment is a rare and significant outcome.

Because these measures do not necessarily indicate substantiated child maltreatment, we label these events “potential” child maltreatment events. These 7 clients experienced a total of 9 events. Of these 7 clients who have experienced any of these potential child maltreatment events, 3 clients experienced one incident of ER for ingestion each, one of these resulted in a hospitalization. The remaining 4 clients experienced a CPS referral. Three of these CPS referrals were made by the home visiting nurse, and one is a nurse-known referral made by someone else. Interestingly, none of the ER/ingestion events were recorded as reported to CPS as suspected child abuse/neglect.

Of the 7 clients, 4 were randomized to receive HM/RF referral and 3 were randomized to the NO referral group. Thus we find there is no difference in the rate of potential child maltreatment events during service delivery between the group of clients randomized to receive referral to the HM/RF intervention and those randomized to not receive such referrals.

***Findings and Interpretation for Expected Outcome #8:*** Clients served by the local ACF-funded EYCNFP program experienced rates of “potential” child maltreatment events at 4.5% (7/155). This rate is somewhat higher than Yakima County overall rate of accepted child maltreatment referrals during the course of the ACF-funded demonstration project (average 39.6 per 1,000 children birth-17 or 3.96%<sup>1</sup>). The rate of actual known CPS referrals in the EYCNFP of 2.58% (4/155) is substantially lower than the county rate of accepted referrals of 3.96%. Especially given the high risk nature of the population served by the EYCNFP project (low-income first time mothers, many adolescents and multi-problem families), the rate of known CPS referrals being lower than the county rate may be viewed as a success in meeting the objective of reduced child maltreatment.

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<sup>1</sup> April 2013 “Risk and Protection Profile for Substance Abuse Prevention in Yakima County.” Washington State Department of Social and Health Services, Research & Data Analysis Division. Rates 2008-2011 averaged, 2011 last available. <http://www.dshs.wa.gov/rda/research/4/47/updated/default.shtm>

## V. Cost Evaluation

### Cost Evaluation Activities & Findings

During the course of this project, the local EYCNFP leadership group took part in a number of efforts to learn more about cost-benefit analysis and apply those learnings to this “cost evaluation” activity for our local program. In early 2010 the program estimated the cost to serve each family in the local program to be \$5,453 per year.

### Interpretation of Findings

Because of the mushrooming of interest nationwide focused on evidence-based home visitation and early childhood programs, four recent publications have documented independent approaches to cost-benefit analysis of the evidence-based Nurse-Family Partnership program (Isaacs 2007; Jones et al. 2008; Karoly et al. 2005; Lee et al. 2008). Two of these (Jones et al. 2008 and Lee et al. 2008) have been published after the start of the Children’s Bureau Nurse Home Visitation funding for the local Yakima County program. These publications estimate a range of net benefits per family served from \$17,180 to \$37,367. In these studies, the cost savings accrue primarily from long-term proven benefits in reduced crime, reduced reliance on public assistance, reduced substance abuse, child abuse, improved test scores and high school graduation rates, and improved employment among mothers.

The estimated local Yakima County program costs at \$5,453/year/family are consistent with the estimated costs per family served cited in these publications (generally between \$7,000-\$9,000 total costs per family served over the course of the approximately 2.5 years of the intervention in early 2000s dollars). With the local enhancement of the Mental Health Consultant position, we would expect our local program to cost a bit more per family than other NFP programs across the country operating without enhancements.

Author/Year	Organization	Benefit
Isaacs (2007)	The Brookings Institution	Total Benefit: High Risk Sample: \$41,419 (minus \$7,271 costs)=\$34,148 Net benefit Full Sample: \$26,298 (minus \$9,118 costs)=\$17,180 Net benefit
Jones et al. (2008)	Prevention Research Center – Penn State	Net Benefit \$37,367 per family served
Karoly et al. (2005)	RAND Corporation	Net Benefit Higher Risk Sample: \$34,148 per family served Full Sample: \$17,180
Lee et al. (2008)	Washington State Institute for Public Policy	Net Benefits: \$18,054  Total Benefits \$26,986 (\$8,936 to program participants; \$8,112 to Taxpayers, \$9,938 to others) Total Costs \$8,931

## Lessons Learned from Cost Analysis Process

While the local program has access to detailed line-item cost data to report on the program sufficient to accomplish the “cost evaluation” objective for our local program, we clearly lacked the specialized skills necessary to complete a more rigorous formalized cost-benefit analysis of our local program. Additionally, given that so many large and specialized organizations have undertaken recent cost-benefit studies of early childhood and evidence-based programs, including the Nurse-Family Partnership, it seems redundant and ineffective for us to try to repeat such studies at the local level. Thus our primary lesson learned with this activity was that cost-benefit analysis is a specialized area of evaluation and is probably best undertaken only with the help of specialists.

## VI. Use of Program Implementation Data to Understand Outcomes

### Program components fostering attainment of expected outcomes

Two program components in particular appear to have been especially effective in fostering attainment of expected outcomes. First, the use of a base nurse-home visitation intervention that is a research-based practice that the funded agency and primary partner had already implemented and successfully established. Second, the Mental Health Consultant enhancement implemented with the ACF-funding.

#### *Evidence-Based Practice*

The ACF-funded Enhanced Yakima County Nurse-Family Partnership program was built on a successful, already-established evidence-based practice in Yakima County. The Nurse-Family Partnership developers have an established system for staff training and support, data collection, performance improvement, and evaluation. These all contributed to the overall success of the ACF-funded demonstration project in providing infrastructure and success on which to build the enhanced program.

#### *Mental Health Consultant*

Although not a central activity or intervention reflected in the logic model, local program leadership believe that the Mental Health Consultant enhancement of the ACF-funded demonstration project enabled the program to retain nurse and nurse supervisor staff throughout the duration of ACF-funding and to improve services that nurses provide to clients experiencing mental health needs. Research on implementation of evidence-based practices finds that in relationship-focused interventions, retention of direct service staff is key to successful implementation and sustainability of interventions (Aarons et al 2009; Glisson et al. 2008). These types of relationship-focused interventions with multi-problem families can leave direct service staff emotionally exhausted, burnt-out and vulnerable to turnover. Organizational supports for direct-service staff can help in creating a work culture and climate that increase staff capacity to continue delivering services for challenging clients and families. Thus we view the Mental Health Consultant position as an essential organizational support for staff retention, staff effectiveness with clients, and ultimately to the success and sustainability of the overall program locally.

### Program policies, practices or procedures related to implementation fostering attainment of expected outcomes

Two program policies/practices/procedures related to implementation appear especially effective in fostering attainment of expected outcomes. First, procedures and focus around fidelity monitoring; and second, attention to implementation drivers.

#### *Fidelity Monitoring*

As reported elsewhere in this report, fidelity monitoring is a strong component of the base Nurse-Family Partnership intervention and the NFP National Service Office provides substantial support to allow the local program to accomplish active and successful performance improvement related to fidelity. The EYCNFP supervisor received regular quarterly fidelity and quality reports on a wide range of indicators from the NSO. She regularly shared this information with nursing staff, and together with nursing staff would prioritize indicators in need of improvement, and implement performance improvement plans to ensure improvement. Both the support of the developer in the

form of data and reports from the NSO, as well as the commitment of the local supervisor and staff to use data to drive continuous performance improvement led to consistently high quality program implementation.

*Attention to Implementation Drivers*

In 2010 the YVFWC Planning and Development Department (the Evaluation Team for this project) undertook an initiative to align its practice in implementation and evaluation more closely with the best practices identified by the National Implementation Research Network (NIRN)<sup>2</sup>. NIRN researchers have identified seven implementation drivers that, when done well, support high-quality program implementation. These include staff selection, training, coaching, performance assessment, decision support data systems, facilitative administration and systems interventions. Additionally, based on the transtheoretical stages of change in organizations, NIRN has cross referenced the seven implementation drivers with five stages of implementation to help programs identify where they may be on the continuum of implementation. These stages of implementation include pre-exploration stage, exploration stage, installation stage, initial implementation stage, and full implementation stage.

In 2011, the Yakima County NFP program completed their first-ever self-assessment of where they believe they are in the Stages of Implementation along the seven Implementation Drivers. Based on that self-assessment, the program worked collaboratively with the YVFWC Planning & Development Department to develop priority activities for program improvement which will be implemented over the coming year. This self-evaluation is intended to lead to program-level performance improvement activities that continue to institutionalize organizational support for the local program within the two partner organizations.

**Staff characteristics/project components fostering attainment of expected outcomes**

Three staff characteristics/project components in particular appear effective in fostering attainment of expected outcomes. First, the attention to direct-service staff qualification; second, strength of supervisory and support staff; and third, organizational culture created by the unique partnership and organization that make up the program.

*Direct-Service Staff Qualifications*

All three of the NFP nurses who were hired and assigned to the ACF-funded EYCNFP are exceptionally well-qualified. As detailed in Table 6 below, together they have 44 years of maternal-child home visitation experience, and two of the three are fluently bilingual (English/Spanish).

Table 6: Experience of EYCNFP Direct-Service Nurses		
Nurse	Years HV Experience	Bilingual
Trishelle Tate	19	Yes
Teresa White	19	No
Sandra Soto-Escalera	6	Yes

Since its inception, the Yakima County NFP program has maintained a commitment to serve clients in their language of choice. Given the large Spanish-speaking population among

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<sup>2</sup> <http://nirn.fpg.unc.edu/>

childbearing women who qualify for NFP in Yakima County, that has meant maintaining 50% of the direct-service staff as fluently bilingual (English/Spanish). The Yakima County NFP nurse supervisor and other management staff who support the program recognize that an intensive relationship-based intervention such as this is most likely to be effective if it is delivered in the language in which the client is most comfortable.

YVFWC maintains a system of language fluency assessment using telephone spoken-language testing for all employees who are considered for positions requiring bilingual ability. This system ensures that all staff in bilingual-required positions have sufficient fluency to meet the needs of clients.

#### *Strength of Supervisory and Support Staff*

In addition to highly qualified direct-service staff, staff who have provided supervision and support to the EYCNFP program have been exceptionally well-qualified as well, with a strong commitment to providing support for direct-service staff to do their jobs well. The Yakima County NFP Supervisor has been with the base NFP program in Yakima County since its inception in 2003, first as a direct-service nurse and then starting in 2004 as the program supervisor. She was raised in the Yakima Valley and knows the community intimately, she is fluently bilingual (English/Spanish), she has 28 years' experience in nurse home-visitation and she has a deep commitment to the NFP intervention and the direct-service staff with whom she works.

Likewise the other management and support staff surrounding the intervention have a deep commitment to supporting success of direct-service staff and the program overall. Over the course of the ACF-funded demonstration project these staff have included administrative support/data entry staff, an accountant, a business manager, and evaluation staff. While there was some staff turnover in the administrative support/data entry position, all the other support positions described here were held by the same people throughout the entire ACF-funded demonstration project. Although not providing direct services themselves, these supportive roles have been critical to the success of the overall intervention and these staff have taken great care and pride in helping support the delivery of this intervention that they recognize is so needed in their communities.

#### *Organizational Culture*

Finally, the unique partnership and organizational culture within which this intervention has been placed has undoubtedly contributed to the success of the ACF-funded EYCNFP program. The Yakima County NFP program is operated jointly by Yakima Valley Farm Workers Clinic and Yakima Valley Memorial Hospital, and has been since its inception. Both agencies employ direct-service staff who work in the program, YVMH has traditionally employed the nursing supervisor, and YVFWC has traditionally employed grant-writing and evaluation staff. The program thus draws on strengths from each agency. In addition, physically placing the program at Children's Village, a collaborative multi-agency service center for children with special needs, has been an important consideration. Children's Village maintains a collaborative, mission-driven, family-centered culture and a climate that is at once supportive of the special children and families it serves and the staff who provide a variety of services. These organizational relationships and arrangements have certainly contributed to the overall success of the program.

## VII. Conclusions

### Overall Project Impact on Children/Families

The at-risk children and families served have been strengthened through implementation of the ACF-funded Enhanced Yakima County Nurse Family Partnership program. Evaluation results indicate that families have experienced improved access to supportive community services, decreased family conflict, improved parent-child interaction, improvements in family development, reduced child maltreatment and increased father/partner involvement over time. We have insufficient evidence to determine whether or not the intended outcomes of improved family communication, increased healthy relationships between parents and enhanced fatherhood were met.

### Overall Project Impact on Agencies/Organizations

This ACF-funded demonstration project has built capacity in the local Yakima County Nurse-Family Partnership as a whole to better assess and respond to client needs around healthy relationships and responsible fatherhood. All Yakima County NFP direct-service nurse home visitation staff (not just the three assigned to the ACF-funded demonstration project) took part in the training made available through this project on Healthy Marriage/Responsible Fatherhood principles and curriculum. All staff have also taken part in supervisor-led discussions and case staffings related to the project. The results of infusing the benefits of the focus on healthy marriage/responsible fatherhood throughout local program are evident in annual staff surveys in which staff report how prepared they are to help their clients “recognize and engage in healthy relationships” and “recognize and support responsible fatherhood”. As detailed in Table 7 below, we see a steady progression of Yakima County NFP nursing staff as a whole moving more toward the “very prepared” end of the response spectrum over the 5½ years of the ACF-funded demonstration project.

Year	Q2A “How prepared are you to help your clients recognize and engage in healthy relationships?”		Q2D “How prepared are you to help your clients recognize and support responsible fatherhood?”		
	Very Prepared	Prepared	Very Prepared	Prepared	Unprepared
2012	50% (3/6)	50% (3/6)	33% (2/6)	50% (3/6)	16.7% (1/6)
2011	0% (0/6)	100% (6/6)	0%	100% (6/6)	0%
2010	16.7% (1/6)	83.3% (5/6)	0%	100% (6/6)	0%
2009	25% (1/4)	75% (3/4)	0%	100% (4/4)	0%
2008	25% (1/4)	75% (3/4)	0%	75% (3/4)	25% (1/4)

Additionally, the ACF-funded demonstration project has enabled the two primary implementing agencies (YVFWC and YVMH) to continue the base Nurse-Family Partnership intervention in this high-need community until more sustainable funding was achieved through the Maternal, Infant, Early Childhood Home Visitation (MIECHV) funds.

## Overall Project Impact on Community

Finally, the ACF-funded Enhanced Yakima County NFP program has strengthened the overall community by strengthening 155 emerging families. Given what is known about the long-term benefits of the Nurse-Family Partnership base intervention, we are confident that the results of the services delivered through the ACF-funded demonstration project will benefit the families and community as a whole for many years to come.

## VIII. Implications of Results and Recommendations

### Recommendations to Administrators

When implementing an evidence-based practice that already requires substantial data collection for the developer, take caution in deciding on additional data collection. While the tools may well have the potential to contribute to understanding the impact of the intervention, additional data collection creates a burden for staff and in the end may not be helpful if data are not collected consistently enough.

When implementing an evidence-based practice, consider measuring staff quality, staff support, and staff retention as additional measures of quality implementation. Fidelity monitoring is necessary but not sufficient. High quality staff who are supported and who stay provide important consistency to ensure quality results. In our case the Mental Health Consultant has been a key additional support for the staff that we believe has contributed to zero staff turnover during the 5½-year demonstration project.

### Recommendations to Funders

We appreciate the opportunity provided by ACF funding to implement an evidence-based program for this very specific at-risk population of emerging families in Yakima County. In addition to meeting the goals outlined in our initial grant application, the success of this project demonstrates that evidence-based programs can be implemented with diverse populations, under the right conditions. In the case of the EYCNFP, the local project demonstrated a high degree of commitment to serving Spanish-speaking clients, Hispanic clients, and Native American clients. The project maintained substantial direct-service nursing staff capacity to deliver services in Spanish, ensured cultural competence training and support for all nursing staff, and attended to the differences in service delivery and outcomes for all racial/ethnic/language subgroups of clients served. This success is an important finding of the demonstration project, and we recommend funders attend to and support appropriate EBP modifications at the local level to ensure the program can be implemented with success in diverse populations.

We also recommend that funders encourage expansion of the use of implementation science to improve implementation of prevention programs, both evidence-based and promising practices. Based on what our local program leaders have learned from monitoring fidelity, attending NIRN (National Implementation Research Network) trainings, and conducting our own NIRN self-assessment on this ACF-funded demonstration project, we have been able to transfer to other non-ACF funded programs to help improve implementation of those programs.

### Recommendations to the General Field

To the general field of Healthy Marriage/Responsible Fatherhood interventions, we would recommend that target populations for these interventions be carefully aligned with what is known about effectiveness of the interventions. Just as with evidence-based child maltreatment prevention programs, where we attempt to match the target population with interventions that have been found to be effective, this seems an important consideration in implementing HM/RF interventions as well. The findings to date suggest that standard HM/RF interventions may not be appropriate for young, multi-problem, unmarried couples. And in fact we found that the HM/RF interventions offered in the early stages of our demonstration project that were geared more toward married, more mature couples who were parishioners of local protestant churches were simply not able to engage and meet the needs of our young, largely unmarried and multi-problem clients.

To the general field of evidence-based practices in family support programs, we would encourage that developers attend more to the growing field of implementation science. In addition to providing for data collection and fidelity monitoring (as important as these are), developers could also be involved in providing training and support around other important aspects of successful implementation.

Finally, we recommend that developers undertake studies with local sites who are implementing evidence-based practices with diverse populations to determine what modifications under what conditions may be necessary/desirable to implement successfully with diverse populations.

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## APPENDIX A: QUALITY AND FIDELITY INDICATORS

Enhanced Yakima County NFP Program Quality and Fidelity Indicators				
No.	Indicator	NFP Program Expectations	NFP National	Yakima NFP Clients
1	Enrolled by 16 weeks gestation	60%	44.8%	<b>54.8%</b>
2	Enrolled by 28 weeks gestation	100%	94.0%	<b>98.8%</b>
3	Nurse caseload	No more than 25 client/FTE nurse		Active caseload </=25
4	Pregnancy Phase Visit Completion	80%	78%	74.0%
5	Infancy Phase Visit Completion	65%	63%	63.0%
6	Toddler Phase Visit Completion	60%	64%	<b>73.0%</b>
7	Pregnancy Phase Visit Content	PH 35-40% EH 5-7% LCD 10-15% MR 23-25% F&F 10-15%	PH 40.8% EH 10.4% LCD 12.5% MR 22.7% F&F 13.4%	PH 37.8% EH 7.3% LCD 13.9% MR 25.1% F&F 15.9%
8	Infancy Phase Visit Content	PH 14-20% EH 7-10% LCD 10-15% MR 45-50% F&F 10-15%	PH 22.0% EH 10.4% LCD 12.3% MR 42.8% F&F 12.6%	PH 20.9% EH 8.8% LCD 12.5% MR 44.5% F&F 13.2%
9	Toddlerhood Visit Content	PH 10-15% EH 7-10% LCD 18-20% MR 40-50% F&F 10-15%	PH 17.0% EH 12.0% LCD 15.2% MR 42.2% F&F 13.6%	PH 15.9% EH 9.8% LCD 16.0% MR 44.2% F&F 14.1%
10	Pregnancy Phase Attrition	</= 10%	15.5%	<b>6.4%</b>
11	Infancy Phase Attrition	</= 20%	33.4%	<b>18.8%</b>
12	Toddlerhood Phase Attrition	</= 10%	18.4%	29.4%
13	Premature Births	</= 7.6%	9.5%	<b>7.2%</b>
14	Low Birthweight	</= 5.0%	9.7%	<b>5.8%</b>
15	Breastfeeding Initiation	>/= 75%	79.5%	<b>93.3%</b>
16	Breastfeeding @ 6 months	>/= 50%	28.7%	<b>36.4%</b>

*Based on 2013 Quarter 1, data through March 31, 2013, cumulative*

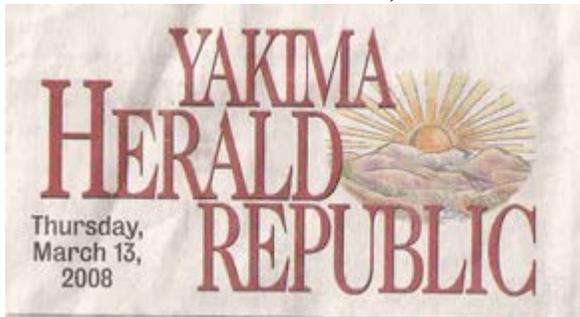
**Bold** = Yakima program outperforming NFP National and/or Program Expectations

Completion rates use only those clients who completed phase in denominator (pregnancy completers, etc)

Visit content codes: PH=Personal Health; EH=Environmental Health; LCD=Life Course Development;

MR=Maternal Role; F&F=Family & Friends.

**APPENDIX B: MARCH 13, 2008 YAKIMA HERALD REPUBLIC**



**THE NURSE-FAMILY PARTNERSHIP**

# Building better parents



Photos by SARA GETTYS/Yakima Herald-Republic  
Trishelle Tate, center, a nurse in Yakima's Nurse-Family Partnership program, talks to Amy Knight, left, while Amy's son, Nathan Tellez-Knight, reads a book on March 16, 2007. The two began meeting in November 2004, when Knight was in the middle of her pregnancy.

*'Startlingly successful' program is boosting parenting skills among our society's most vulnerable women by providing one-on-one mentoring by surrogate mothers, grandmothers, teachers and friends — in other words, nurses. Dr. Spock would be proud.*

# Building better parents

*'Startlingly successful' program is boosting parenting skills among our society's most vulnerable women by providing one-on-one mentoring by surrogate mothers, grandmothers, teachers and friends — in other words, nurses. Dr. Spock would be proud.*

By JANE GARGAS  
YAKIMA HERALD-REPUBLIC

**G**ently cradling her newborn, the 17-year-old looked up at the visitor and asked, "Is this what it looks like to be a good mom?"

"Yes," said her visitor, and she meant it.

That's just one of the poignant moments several local nurses encounter daily in their jobs as surrogate mother, grandma, teacher and friend, blended into one.

They're part of the Nurse-Family Partnership, a national program that endeavors to boost parenting skills among the most vulnerable of women in this country.

And, quite simply, it works.

That's why *The New Yorker* magazine has profiled the program, and why ABC's "Nightline" called it "startlingly successful."

One on one, woman to woman, the NFP is quietly building better parents, by focusing on first-time, low-income mothers.

"It's all about making a better life," explains Trishelle Tate, a nurse in Yakima's program, one of 10 in the state (Spokane is the only other in Eastern Washington).

Here's the premise: if parents are given guidance early on in raising stable families, their babies

## A typical visit

■ NFP nurses offer advice gently, along with encouragement and reassurance for the young mothers they check on. **Page 9A**

will grow up healthier — physically, mentally, emotionally.

Nurses take the program to the prospective mother, starting to visit her home when she's pregnant and continuing until the child turns 2. During two-hour sessions, weekly during the baby's early months, then bi-weekly and monthly, they help quell the universal anxiety of new motherhood.

It's a little like living next door to Dr. Benjamin Spock, the famous pediatrician.

"I feel like I've learned a lot of knowledge and strength to help me continue to be a better mom and person in general," says Amy Knight, who joined the program when she was five months pregnant.

## A sympathetic ear

"We tell them we're going to help them be the best parent they can, support their goals, help connect them with resources," ex-



Trishelle Tate, left, talks with new mother Perla Martinez, discussing the young woman's goals of going back to school and finding work, as well as changes in the behavior of her 2-month-old son.

## MORE ON THE WEB

Go to [www.yakimaherald.com](http://www.yakimaherald.com) for an audio slide show on this story.

plains Marilyn VanOostrum, NFP supervisor. "We ask a lot of questions and do a lot of listening.

"Who doesn't want to be listened to and understood?"

Housed at Children's Village, the countywide program began in August 2003 with four nurses

(a fifth will be added later this month). The service is offered free; funding for the nonprofit agency comes from federal and state grants along with Yakima Valley Memorial Hospital and the Yakima

SEE **YOUNG MOTHERS** PAGE 9A



SARA GETTYS/Yakima Herald-Republic

**Jose Mendoza feeds his 2-month-old son while Trishelle Tate talks with the baby's mother, Perla Martinez, on January 9, 2007.**

One visit to one young family demonstrates how the Nurse-Family Partnership works:

On a recent afternoon, Trishelle Tate, a public health nurse, sat down with Perla Martinez, 15, and José Mendoza, 17, and their 2-month-old son, José Emanuel Mendoza, in the home where they live with José's brother, sister and mother in North Yakima.

Tate asks Perla the strategies she uses to connect with her baby.

"I pick him up when he cries,"

Perla answers tentatively.

"Oh, that's good," reinforces Tate.

"That's better than just popping a bottle in his mouth first thing."

Just as she has for each of the 20 visits she's already had with Perla, Tate offers handouts (on infant crying), leaves homework (a work-sheet for the couple to start a budget), talks about self care (don't scrimp on sleep) and safety (because José Emanuel will soon be rolling over, he can't be left alone on a bed).

Alternately offering gentle advice and reassuring Perla, Tate talks about keeping baby and parents in balance by creating a bedtime routine.

"Babies need to count on you; he needs to know he's going to be fed when he's hungry and put to bed when he's sleepy," she says.

"And if you make a song part of your routine, he'll cherish that. It's a precious gift," the nurse adds.

Parenting can feel overwhelming, she reminds them.

"You've only been parents for two months, and already you've grown as parents and people," she says.

Turning to José, she asks, "What do you most want for your son?"

"To graduate from high school," he answers, saying he regrets dropping out of Davis High School after his first week there. Now he's concentrating on landing a job.

Perla has kept up with her high school work by completing study packets in five subjects.

Tate pours on encouragement. "I really admire you for staying with it," she tells Perla.

— Jane Gargas