
Texas Nurse-Family Partnership Statewide Grant Program Evaluation Report

**As Required by
S.B. 156, 80th Legislature, Regular Session, 2007
(now codified as Sections 531.651 – 531.660, Government Code)**

**Health and Human Services Commission
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Table of Contents

<i>Executive Summary</i>	1
<i>Introduction</i>	3
Background.....	3
NFP Standards	4
TNFP Grant Awards	5
TNFP Program Funding	6
TNFP Program Staff Descriptions	8
Program Eligibility	8
Visitation Process/Schedule.....	3
<i>Process Evaluation</i>	9
Methodology	9
Limitations	10
TNFP Client Demographics.....	10
Adherence to the NFP Model Standards.....	14
Establishment of Paternity	23
<i>Program Outcomes</i>	23
<i>Summary</i>	24
<i>Conclusion</i>	25
<i>APPENDIX A: Program Outcome Results</i>	A-1
Limitations	A-1
Improve Pregnancy Outcomes.....	A-1
Improve Child Health and Development	A-2
Improve Family Economic Self-Sufficiency and Stability	A-4

Executive Summary

S.B. 156, 80th Legislature, Regular Session, 2007, (now codified as Sections 531.651 – 531.660, Government Code), established the Texas Nurse-Family Partnership (TNFP) competitive grant program, through which the Health and Human Services Commission (HHSC) awards grants to public and private entities to implement or expand TNFP programs and operate those programs for at least two years. Section 531.659 requires HHSC, with the assistance of the Nurse-Family Partnership National Service Office (NFPNSO), to prepare and submit an annual report regarding the performance of each grant recipient with respect to providing TNFP program services. Pursuant to Section 531.659, HHSC is submitting the *Texas Nurse-Family Partnership Statewide Grant Program Evaluation Report* for fiscal year 2011, which provides the findings of the process evaluation of the TNFP program for the period of September 1, 2008 through June 30, 2011.

The TNFP program is a voluntary, evidence-based home visitation program shown to improve the health and well-being of low-income first-time mothers and their children. Specially trained registered nurses regularly visit the homes of participating mothers to provide services designed to:

- Improve pregnancy outcomes.
- Improve child health and development.
- Improve family economic self-sufficiency and stability.
- Reduce the incidence of child abuse and neglect.

Nurse-Family Partnership (NFP) programs are located in 33 states. Organizations implementing NFP programs receive professional guidance from the NFPNSO, the nonprofit organization which has oversight of the implementation of the NFP model developed by David Olds. NFP programs are required to provide the NFPNSO with extensive data, which is used to monitor fidelity to the NFP model, improve service delivery and outcomes, and expand the research on the model.

As a result of the initial Request for Proposals (RFP), grants were awarded for the expansion of one existing TNFP site and the development of ten new sites. A subsequent RFP resulted in grant awards for the development of one additional TNFP site and the funding of a TNFP site formerly funded by the Department of Family and Protective Services (DFPS). The 12 TNFP sites are located in the cities of Austin, Dallas, El Paso, Fort Worth, Houston, Lubbock, Port Arthur, and San Antonio. These sites serve 22 counties: Bexar, Chambers, Crosby, Dallas, El Paso, Floyd, Fort Bend, Galveston, Garza, Hale, Hardin, Harris, Hockley, Jefferson, Lamb, Lubbock, Lynn, Orange, Tarrant, Terry, Travis, and Williamson. As of June 30, 2011, these 12 TNFP sites together were maintaining a total caseload of approximately 1,500 clients.

The initial grant period was September 2008 through August 2009 and grant contracts could be extended for an additional six years, contingent upon the availability of funds. The grants supply 90 percent of the total cost of the program. HHSC requires local communities to secure funding for approximately 10 percent of the program cost and to provide administrative staff time, physical space, and utilities. All grantees have direct contracts with HHSC.

The primary goal of the process evaluation was to address whether the TNFP sites implemented the program in accordance with the NFPNSO program objectives, and whether each TNFP site adhered to 18 performance indicators, or NFPNSO model standards, that addressed seven areas of implementation. Evaluation findings are based primarily on standardized NFPNSO reports and supplemental data provided by TNFP program staff.

Key findings of the process evaluation are as follows.

- As a funding condition, TNFP grantees were required to adhere to the TNFP program model standards developed by the NFPNSO. All TNFP sites successfully adhered to the 18 model standards with the exception of Standard 14, which is related to one-to-one supervision, weekly case conferences and team meetings, and field supervision. Eleven of the 12 TNFP sites met all the requirements of Standard 14. The remaining site partially met the requirements of Standard 14.
- TNFP enrolled 3,193 low-income first-time mothers in the first 34 months of providing services, from September 1, 2008, to June 30, 2011. Ninety-eight percent of the clients began receiving program services before the end of their 28th week of pregnancy.
- The average age of TNFP clients was 18 years. Eleven percent of TNFP clients were married, 35 percent were working either full- or part-time, and TNFP clients had a median annual household income of \$16,000.
- Upon enrollment in the TNFP program, 65 percent of TNFP clients were enrolled in Medicaid, 66 percent were receiving Women Infants and Children (WIC) benefits, 26 percent were receiving Supplemental Nutrition Assistance Program (SNAP) subsidies, and 5 percent were receiving Temporary Assistance for Needy Families (TANF) assistance.
- Information about the establishment of paternity was provided to 100 percent of clients, resulting in paternity being established for 313 clients. Evaluators were not able to determine definitively the number of mothers who established paternity as a result of TNFP services. Only those clients who established paternity prior to the birth of their babies are included.

Introduction

S.B. 156, 80th Legislature, Regular Session, 2007, (now codified as Sections 531.651 – 531.660, Government Code), established the Texas Nurse-Family Partnership (TNFP) competitive grant program, through which the Health and Human Services Commission (HHSC) awards grants to public and private entities to implement or expand TNFP programs and operate those programs for at least two years. Section 531.659 requires HHSC, with the assistance of the Nurse-Family Partnership National Service Office (NFPNSO), to prepare and submit an annual report regarding the performance of each grant recipient with respect to providing TNFP program services. Pursuant to Section 531.659, HHSC is submitting the *Texas Nurse-Family Partnership Statewide Grant Program Evaluation Report* for fiscal year 2011, which provides the findings of the process evaluation of the TNFP program for the period of September 1, 2008 through June 30, 2011.

Background

The Nurse-Family Partnership (NFP) program is a voluntary, evidence-based home visitation program shown to improve the health and well-being of low-income first-time mothers and their children.^{1,2} Specially trained registered nurses regularly visit the homes of participating mothers to provide NFP services. TNFP follows the three-goal national NFP model, and includes a fourth service delivery goal. As such, TNFP works with participants to achieve the following four program goals:

- Improve pregnancy outcomes.
- Improve child health and development.
- Improve family economic self-sufficiency and stability.
- Reduce the incidence of child abuse and neglect.

The first NFP pilot program was implemented 15 years ago. Since then, NFP programs have expanded to 33 states and have served more than 130,000 women nationally. Organizations implementing NFP programs receive professional guidance from the Nurse-Family Partnership National Service Office (NFPNSO), the nonprofit organization which has oversight of the implementation of the NFP model developed by David Olds. NFP programs are required to provide extensive data to NFPNSO, which is used to monitor fidelity to the NFP model, improve service delivery and outcomes, and expand the research on the model.

Longitudinal studies on NFP programs around the country have shown long-term benefits of the program that include decreased rates of premature birth, increased relationship stability, improved academic adjustment to elementary school, and reduction of childhood mortality from preventable causes. A minimum amount of participation needed to benefit from the program has not been established; however research indicates that the beneficial impact increases as the amount of participation increases.³

National NFP research findings over the course of the program demonstrate a:

¹ Olds, D.L., Henderson, C.R. Jr, Tatelbaum, R., & Chamberlin, R. (1986). Improving the delivery of prenatal care and outcomes of pregnancy: A randomized trial of nurse home visitation. *Pediatrics*, 77(1), 16-28.

² The TNFP program originated in Colorado, and the first TNFP site was in Elmira, New York in 1978. TNFP mothers from Elmira and their children have been followed since 1978.

³ Nurse-Family Partnership National Service Office. (2008). *Nurse-Family Partnership Model Elements*.

- 79 percent reduction in preterm delivery.⁴
- 23 percent reduction in subsequent pregnancies.⁵
- 20 percent reduction in the use of public programs.⁶
- 48 percent reduction in cases of child abuse and neglect.^{2,3,5}
- 39 percent reduction in injuries among children of low-income mothers.⁷
- 56 percent reduction in emergency room visits for accidents and poisonings.⁸

In addition, a RAND Corporation independent analysis found that the return for each dollar invested in a NFP program was more than 5 dollars for higher-risk populations served and almost 3 dollars for all individuals served.⁹ Four types of governmental savings were identified, including:

- Increased tax revenues.
- Decreased need for public assistance.
- Decreased state expenditures for education, health, and other services.
- Decreased involvement in the criminal justice system.

NFP Standards

Before becoming an NFP implementing agency, the candidate agency must affirm its intention to adhere to the validated NFP model when delivering the program to clients. Such fidelity requires the observance of all NFP model standards (also known as model “elements”). These standards are based on research, expert opinion, field lessons, and/or theoretical rationales. The NFPNSO research suggests that if a program is implemented in accordance with these model standards, the implementing agencies can have reasonably high levels of confidence that results will be comparable to those found in the clinical trials. Conversely, it suggests that if implementation does not meet model standards, results could differ from research results.

NFPNSO requires every NFP program to follow 18 model standards. These standards cover seven areas of implementation. A detailed description of each of the standards is included in the process evaluation (see page 15).

⁴ Olds, D.L., Henderson, C.R. Jr, Tatelbaum, R., & Chamberlin, R. (1986). Improving the delivery of prenatal care and outcomes of pregnancy: A randomized trial of nurse home visitation. *Pediatrics*, 77(1), 16-28.

⁵ Kitzman, H., Olds, D.L., Henderson, C.R. Jr, Hanks, C., Cole, R., Tatelbaum, R., McConnochie, K.M., Sidora, K., Luckey, D.W., Shaver, D., Engelhardt, K., James, D., & Barnard, K. (1997). Effect of prenatal and infancy home visitation by nurses on pregnancy outcomes, childhood injuries, and repeated childbearing: A randomized controlled trial. *Journal of the American Medical Association*, 278(8), 644-652.

⁶ Olds, D., Kitzman, H., Cole, R., Robinson, J., Sidora, K., Luckey, D., Henderson, C., Hanks, C., Bondy, J., & Holmberg, J. (2004). Effects of nurse home visiting on maternal life-course and child development: Age-six follow-up of a randomized trial. *Pediatrics* 114, 1550-1559.

⁷ Reanalysis of Kitzman et al. (1997). *Journal of the American Medical Association*, 278(8), 644-652. This particular outcome reflects a reanalysis of data from the Elmira trial using an updated analytic method conducted in 2006.

⁸ Olds, D.L., Henderson, C.R. Jr, Chamberlin, R., & Tatelbaum, R. (1986). Preventing child abuse and neglect: A randomized trial of nurse home visitation. *Pediatrics*, 78(1), 65-78.

⁹ Karoly, L.A., Kilburn, M.R., & Cannon, J.S. (2005). *Early Childhood Interventions: Proven Results, Future Promise*. The Rand Corporation: Santa Monica, CA.

TNFP Grant Awards

The TNFP program began in Texas in 2006 when the YWCA of Metropolitan Dallas utilized Texas Department of Family and Protective Services (DFPS) Prevention and Early Intervention funds to implement the first NFP program. A year later, the 80th Legislature passed S.B. 156, which directed HHSC to use a competitive grant process to expand the NFP program to sites throughout Texas.

HHSC issued a Request for Proposals (RFP) in February 2008 and received 12 proposals. In September 2008, HHSC issued grants to nine organizations. YWCA of Metropolitan Dallas was awarded a grant to expand its existing NFP program to include an additional 200 clients, and eight other grants were awarded for the development of the ten new TNFP sites.¹⁰

HHSC had to consider several factors in determining which applicants to fund, including:

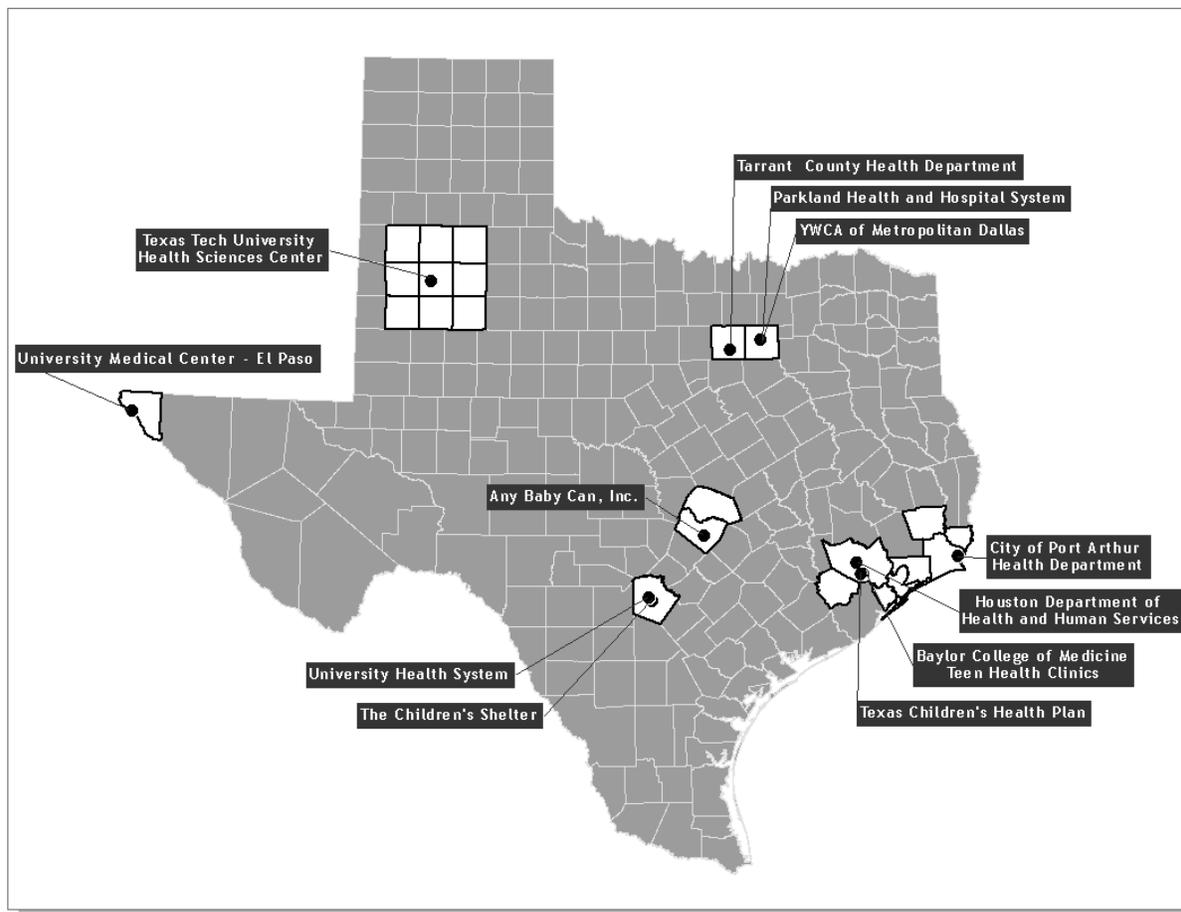
- The need for the program in the community in which the proposed program would operate.
- The applicant's ability to comply with requirements to adhere to the NFP model (including meeting data collection standards).

Program implementation for the new TNFP sites began on September 1, 2008 by hiring staff and ensuring that staff completed NFPNSO mandatory training. The first home visit occurred on September 29, 2008, and all sites were serving clients by the end of January 2009. The first years of implementation focused on building caseloads and ensuring adherence to the model.

In December 2009, HHSC issued a RFP to expand the TNFP program to include an additional 200 clients, increasing the total potential number of clients served to 2,000. HHSC received four proposals and awards were made to YWCA of Metropolitan Dallas and University Medical Center (UMC) of El Paso. With the additional TNFP funding provided to YWCA of Metropolitan Dallas, TNFP began funding an additional 100 YWCA of Metropolitan Dallas clients, including all of the clients previously funded by DFPS. UMC of El Paso was awarded funds to provide NFP services to 100 clients in the El Paso area. The addition of the two new sites brought the total number of TNFP sites to twelve with a maximum ongoing caseload of 2,025 clients (see Figure 1).

¹⁰ The grant to the Houston TNFP Consortium, administered by the Healthy Families Initiatives as the lead agency, included three sites: Baylor, Houston DHHS, and the Texas Children's Health Plan.

Figure 1. TNFP Program Sites



TNFP Program Funding

S.B. 156 required the TNFP program to serve approximately 2,000 clients. The 80th Legislature appropriated \$7.9 million to the TNFP program for fiscal year 2009, enabling TNFP to serve 1,800 clients. The 81st Texas Legislature appropriated \$17.8 million to the TNFP program for the 2010-11 biennium, enabling TNFP to serve an additional 200 clients, for a total of 2,000 clients. In fiscal year 2011, \$8,707,840 in grant funds were awarded to 12 TNFP program sites including the newest service area of El Paso (see Table 1).

The fiscal year 2011 grant amounts shown in Table 1 account for 90 percent of the total cost of the program. In order to operate within the appropriations received and ensure substantial local commitment, HHSC required local communities to fund 10 percent of the program cost. In fiscal year 2010, HHSC began allowing a portion of overhead or administration costs to be included in the grant request as part of the 10 percent funded by the local community. In addition, grantees are required to provide administrative staff time, physical space, and utilities, most of which is still provided as in-kind.

The initial grant period was September 1, 2008, through August 31, 2009 with the understanding that the grant contracts could be extended for an additional six years contingent upon the availability of funds. With the exception of the contract with the Healthy Families Initiative in

Houston, all of the 2008 contracts were extended through August 31, 2010.¹¹ Based on a two-year contract cycle and contingent on the availability of funding, all contracts were further extended through August 31, 2012.

Table 1. Locations of TNFP Programs

Location	Organization	Program Capacity*	Counties Served	FY 2011 Grant Amount
Austin	Any Baby Can, Inc.	200	Travis Williamson	\$750,558
Dallas	Parkland Health and Hospital System	200	Dallas Tarrant	\$773,432
Dallas	YWCA of Metropolitan Dallas	300	Dallas Tarrant	\$1,236,906
El Paso	University Medical Center of El Paso	100	El Paso	\$525,002
Fort Worth	Tarrant County Health Department	200	Dallas Tarrant	\$822,553
Houston	Baylor College of Medicine Teen Health Clinics	100	Ft. Bend Harris	\$546,330
Houston	City of Houston Department of Health and Human Services	100	Ft. Bend Harris	\$584,140
Houston	Texas Children's Health Plan	100	Galveston Ft. Bend Harris	\$608,848
Lubbock	Texas Tech University Health Sciences Center School of Nursing	200	Lubbock Crosby Floyd Garza Hale Hockley Lamb Lynn Terry	\$743,776
Port Arthur	City of Port Arthur Health Department	125	Chambers Hardin Jefferson Orange	\$541,516
San Antonio	The Children's Shelter	200	Bexar	\$777,623
San Antonio	University Health System	200	Bexar	\$797,156
TOTAL		2,025		\$8,707,840

*Number of clients.

¹¹ In 2010, HHSC entered into contracts with the three separate agencies implementing NFP in the Houston TNFP consortium (Baylor, Houston DHHS, and Texas Children's Health Plan) and terminated the contract with Healthy Family Initiatives as the lead agency for the Houston TNFP consortium.

TNFP Program Staff Descriptions

HHSC administers the TNFP competitive grants. The HHSC TNFP team consists of:

- A state nurse consultant who provides statewide clinical support, consultation, program policy development, and technical assistance to the TNFP program sites.
- A project manager who provides statewide management and oversight of day-to-day operations, monitoring, program policy development/consultation, and technical assistance to the TNFP program sites.
- A contract manager who oversees contracts, invoices, vouchers, deliverable receipts, and payments.

Each TNFP program site has three types of staff - nursing supervisors, nurse home visitors, and data entry specialists. The nursing supervisor manages program operations, including the supervision and evaluation of data entry specialists and up to eight nurse home visitors.

The nurse home visitor provides comprehensive nursing services to TNFP clients and their families while striving to maintain the highest standards in clinical nursing practice and adherence to the NFP model. Each nurse home visitor maintains a maximum caseload of 25 clients. A shortage of nurse home visitors (e.g., due to medical, maternity leave or severed employment) may require a re-distribution of clients that may cause a temporary caseload over 25 clients per nurse home visitor in order to continue to provide services to actively enrolled clients.

The data entry specialist provides administrative support to the nursing supervisor and nurse home visitors. Other responsibilities include data entry, office organization, client reminder calls, submitting purchase request for NFP supplies, general clerical duties, and the organization of recruitment and outreach materials.

Program Eligibility

Women eligible to enroll in the TNFP program must meet all of the following requirements:

- Have no previous live births.
- Have an income at or below 185 percent of the federal poverty level.
- Be a Texas resident.
- Be enrolled before the end of the 28th week of pregnancy.

Visitation Process/Schedule

TNFP clients are typically enrolled early in their pregnancy with home visits beginning between the 16th and 28th week of pregnancy. Ideally, visits begin early in the second trimester, between the 14th and 16th week of gestation. Nurse home visitors meet with clients regularly from pregnancy through the child's second birthday, providing a maximum of 65 visits throughout this period. Nurse home visitors visit:

- Weekly for the first four weeks of program participation.
- Biweekly starting in week five until delivery.
- Weekly from delivery until six weeks postpartum.
- Biweekly starting in week 7 until the baby is 21 months old.
- Monthly for the last three months of program participation.

Nurse home visitors provide ongoing assessments, a therapeutic relationship, extensive education, health literacy support, and assistance in accessing resources and health-care coverage, such as Medicaid, during pregnancy and early childhood.

Prior to conducting home visits, NFPNSO requires nurse home visitors to complete extensive training on program administration, implementation issues, and the utilization of standardized data collection materials and client visit protocols. This standardization facilitates fidelity to the NFP program model.

Process Evaluation

The TNFP evaluation detailed in this report spans most of the first three years of grant funding from September 1, 2008, through June 30, 2011. The TNFP program began implementation on September 1, 2008, with the first home visit on September 29, 2008. All of the initial program sites were serving clients by the end of January 2009. The two additional program sites began serving clients in September 2010.

Methodology

Evaluators used three types of information for this report:

- NFPNSO information about NFP programs across the nation.
- Information HHSC TNFP staff obtained from standard monthly Narrative Reports and Staff Requirements Data Reports.
- Information reported by the TNFP sites to NFPNSO.

NFPNSO and HHSC provide several resources to help local programs implement the NFP model with fidelity. Evaluators obtained information about expectations for program implementation from NFPNSO websites, newsletters, and other program documents. Evaluators also used NFP research reports from other states to obtain an additional perspective on program implementation and expectations.

Evaluators obtained data from the NFPNSO Efforts to Outcomes Quarterly Report, which includes information on enrollment and attrition, demographics, and home visit frequency and content.

Limitations

HHSC's program evaluation met the TNFP reporting requirements in Section 531.659, Government Code, with one exception - the evaluators were not able to determine with certainty the number of mothers who established the paternity of an alleged father as a result of TNFP services. Although this report provides data about the establishment of paternity, only those clients who established paternity prior to the birth of their babies with their nurse home visitor are included. It is unknown how many clients completed Acknowledgment of Paternity (AOP) documentation during their hospitalization following the birth of their babies or at a later time point. While establishment of paternity was not part of the standard NFPNSO data collection, the number of AOPs completed in the preceding month and in the current program year was submitted to HHSC for each program site.

The following issues limited the scope of the evaluation, but did not affect the degree to which the evaluation addressed the requirements in Section 531.659, Government Code:

- Because of the extensive NFPNSO reporting requirements, the evaluation utilized data that each TNFP site provided to the NFPNSO.
- On November 1, 2010, NFPNSO transitioned from the web-based Clinical Information System (CIS) data reporting system to the web-based Efforts to Outcomes (ETO) data reporting system. The program monitoring reports including Quality Control Reports previously used by sites to identify data entry errors, missing data, and missing data forms were not available for this reporting period. As a result, it is possible that there may be deviations from the reported totals but these are generally small.
- Concurrent with the new data reporting system, new data collection forms were introduced which made comparison to previous Texas and national NFP data difficult. An example of new data collection is the data on race and ethnicity. The classification scheme was changed to conform to the federal guidelines allowing compatible data across programs receiving federal funding.
- After a review of the quarterly summary table data, program site staff reported some minor discrepancies in the data. Although the discrepancies appear to be very small, due to the small sample size and low occurrence of reported measures any discrepancy may impact the interpretation of the results. Therefore, these results should be viewed with some caution. A brief discussion of program outcomes is included in Appendix A.
- To allow time for data entry and the reconciliation of data issues, evaluators excluded data for July 2011 and August 2011 from the report.

TNFP Client Demographics

Ultimately, the active caseload size for the 12 grantees is expected to reach a total of 2,025 first-time mothers and their children. As of June 30, 2011 the current active caseload was 1,493 clients.¹² From September 1, 2008 through June 30, 2011, the TNFP program enrolled 3,193 low-income first-time mothers.

Age

The median age of TNFP clients at enrollment was 18 years, which is slightly lower than the NFP national median age of 19 years. Thirty-nine percent of TNFP clients were under age 18. This percentage is higher than the national average of 30 percent. The percentage of very young teens (less than 15 years) enrolled in TNFP is 4.1 percent, which is higher than the national total of 2.9 percent.

Gestational Age

Average gestational age at enrollment for TNFP was 19 weeks, which is slightly higher than the NFP national average of 18 weeks.

¹² Due to future funding concerns during the 82nd Legislative Session, 2011, HHSC TNFP staff instituted a hiring freeze on April 13, 2011 at all program sites except University Medical Center of El Paso. This hiring freeze resulted in sixteen unfilled nurse home visitor positions and hindered each site's ability to maintain a maximum active caseload for four months until the hiring freeze was lifted in August 2011.

Ethnicity and Race

On November 1, 2010, ETO data collection forms were modified to conform to the federal classification standards for maintaining, collecting, and presenting data on race and ethnicity.¹³ The federal classification standards include:

- Five categories for data on race: American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, and White.
- Two categories for data on ethnicity: "Hispanic or Latino," and "Not Hispanic or Latino."

Of the 2,947 TNFP clients whose ethnicity was known, 45 percent were not Hispanic or Latina and 54 percent were Hispanic or Latina (see Table 2). The percentage of TNFP clients who were Hispanic or Latina was much higher than the percentage of Hispanic or Latina NFP clients nationally. Due to the changes in data collection practices, the ethnicity was unknown for clients who previously identified as American Indian or Alaska Native, African-American, or Asian/Pacific Islander.

Table 2. Ethnicity of TNFP Clients who's Ethnicity is Known*

Ethnicity	TNFP (n=2,947)	National NFP (n=114,590)
Not Hispanic or Latina	45.3%	73.5%
Hispanic or Latina	54.4%	26.0%
Declined to Self-Identify	0.4%	0.5%

Time period: September 1, 2008- June 30, 2011

* Ethnicity was unknown for 246 or 7.7 percent of TNFP clients.

Of the 2,071 TNFP clients whose race was known, 43 percent were White and 43 percent were Black or African American (see Table 3). Due to the changes in data collection practices, the race was unknown for 1,122 clients. The race of clients who had been classified as belonging to the old "Hispanic or Latina" racial category is unknown and accounts for a large percentage of the missing data. Therefore, because many of these clients would identify as White, the data presented on race may under report the percentage of White TNFP clients.¹⁴

¹³ <http://www.census.gov/population/www/socdemo/race/Ombdir15.html>

¹⁴ According to the 2010 United States Census for Population and Housing, 67 percent of Hispanic Texans classify their race as "White Alone." (<http://factfinder2.census.gov>: Table DP-1: Profile of General Population and Housing Characteristics: 2010 Demographic Profile Data)

Table 3. Race of TNFP Clients who's Race is Known*

	TNFP (n=2,071)	National NFP (n=98,496)
American Indian or Alaska Native	1.2%	5.5%
Asian	0.2%	0.3%
Black or African American	42.8%	28.4%
Native Hawaiian or Pacific Islander	0.0%	0.0%
White	43.2%	56.2%
Multiracial	2.9%	6.2%
Decline to Self-Identify	9.6%	3.5%

Time period: September 1, 2008- June 30, 2011

* Ethnicity was unknown for 1,122 or 35.1 percent of TNFP clients.

Primary Language Spoken

English was the primary language for 86 percent of TNFP clients, and Spanish was the primary language for 13 percent. These numbers were comparable to the primary language percentages of NFP clients across the nation. In addition to bilingual nurses at each site, an interpreter/translator or a nurse home visitor capable of speaking the client's native language was available to clients whose first language was not English or Spanish.¹⁵

Marital Status

The proportion of married TNFP clients was less than the number of married NFP clients nationally, with 11 percent and 15 percent respectively.

Education

The percentage of TNFP clients who reported having completed high school was less than the percentage of NFP clients nationally, 39 percent and 44 percent respectively.

Income

For TNFP clients who reported their income, the median household income was \$16,000 and ranged between \$3,000 and \$45,000. This income level was the same as the median household income for NFP clients nationally.

¹⁵ NFPNSO client materials are only available in English and Spanish.

Employment

At enrollment, 35 percent of TNFP clients reported they were working either part- or full-time (see Table 4). The percentage of TNFP clients who reported working decreased to 32 percent at 6-months postpartum, but increased to 50 percent by 18-months postpartum. While the percentage of TNFP clients working at enrollment was less than NFP clients nationally, the percentage of TNFP clients working at 18-months postpartum was greater than NFP clients nationally.

Table 4. Client Employment Status at Intake at 6-Months, 12-Months, and 18-Months Postpartum*

	Enrollment		6 Months Postpartum		12 Months Postpartum		18 Months Postpartum	
	Number Enrolled	Percent Working	Number Enrolled	Percent Working	Number Enrolled	Percent Working	Number Enrolled	Percent Working
TNFP	3,014	34.6%	1,297	31.8%	837	39.5%	470	50.2%
National NFP	120,986	41.5%	53,434	36.7%	39,955	43.5%	27,845	47.3%

*Includes all participants who completed demographic forms for time period, and answered the question about working status.

Public Assistance Use

Upon enrollment in the TNFP program:

- The percent of TNFP clients accessing the SNAP services was greater than the percent of NFP clients across the nation accessing the same services.
- The overall percentage of TNFP clients receiving Medicaid benefits was similar to the NFP national percentage.
- Fewer TNFP clients were accessing Temporary Assistance for Needy Families (TANF) benefits compared to the percentage of NFP nationally.
- The percentage of TNFP clients accessing Women Infants and Children (WIC) services was similar to the national percentage of NFP clients accessing WIC (see Table 5).

Table 5. Use of Public Assistance at Enrollment

	Number Enrolled	Public Assistance			
		SNAP	Medicaid	TANF	WIC
TNFP	3,193	25.6%	64.5%	4.8%	66.2%
National NFP	129,331	17.8%	62.9%	5.9%	67.8%

Time period: September 1, 2008 - June 30, 2011

Attrition

Fourteen percent of TNFP clients left the program before the end of their pregnancy (see Table 6) which is similar to NFP clients nationally. However, the percentage of those who left the program during pregnancy is higher than the NFP objective of 10 percent.¹⁶ Thirty-seven percent of TNFP clients left the program prior to the end of infancy. This level of attrition was higher than NFP clients nationally and much higher than the NFP objective of 20 percent during infancy.

Primary reasons for attrition include:

- The inability to locate the client.
- The client moved from the service area.
- There was a miscarriage or fetal death.
- The client indicated she received what she needed from the program.
- The client missed an excessive number of visits.

Table 6. Program Attrition During Pregnancy

	Pregnancy		Infancy	
	Number Completed Stage	Percent Attrition	Number Completed Stage	Percent Attrition
TNFP	2,838	14.0%	1,911	37.4%
National NFP*	82,226	13.2%	69,056	33.4%

Time period: September 1, 2008 - June 30, 2011

*NFP Objective is 10% or less during pregnancy and 20% or less during infancy.

Adherence to the NFP Model Standards

HHSC adopted the NFPNSO performance indicators designed to measure each grantee’s performance in terms of the NFP model standards. These performance indicators were implemented as 18 NFP model “standards” that cover seven areas of implementation. By following the model standards, results of the intervention are expected to be similar to the results

¹⁶ The National NFP Program Objectives are drawn from the programs research trials, early dissemination experiences and currently national health statistics (e.g., National Center for Health Statistics, Centers for Disease Control and Prevention; Healthy People 2020). The objectives are long term targets for implementing agencies to achieve over time.

of the randomized control trials conducted by the NFPNSO. This report assesses adherence to NFP program model standards from September 1, 2008 through June 30, 2011.¹⁷

Clients

Standard 1. *Client participation must be voluntary.* NFP services are designed to build self-efficacy. Voluntary enrollment empowers the client and promotes a trusting relationship between the client and the nurse home visitor.

The TNFP program has implemented several protocols to ensure adherence to Standard 1.

- All clients were required to sign a consent form before participation. The TNFP program does not consider a client enrolled until she has a signed consent form.
- The consent form included in the enrollment packet includes explicit language indicating that participation is voluntary.
- If a potential client was a minor, the nurse was required to spend time explaining the program to both the potential client and her guardian. The minor must express interest in the program and her desire to participate, but the guardian must sign the consent form.
- When recruiting potential partner agencies, TNFP staff is required to ensure that the partner agency understands that client involvement must be voluntary. For example, if a TNFP site would like to partner with a local probation office it is required to explain to probation staff that participation in the TNFP program cannot be a condition of parole.

If the TNFP sites had enrollment issues or concerns, NFPNSO and HHSC staff was available to provide guidance and possible solutions.

Standard 2. *Client is a first-time mother.* The intention of the NFP program is to help women when they are vulnerable and more open to receiving additional support. NFPNSO research suggests that first-time mothers may benefit from the NFP program more than those with additional children, possibly because inexperience increases receptiveness to offers of help. The NFPNSO data indicate that limiting enrollment to first-time mothers maximizes the opportunity to improve outcomes for families.

In order to ensure adherence to Standard 2, each TNFP program site asked all potential clients to provide a pregnancy history and report that they had no prior live births. Only those who met this criterion were enrolled in the program. HHSC TNFP staff indicated that since the implementation of the 12 program sites, less than one percent of mothers have been enrolled who were not first time mothers. Inaccurate information provided by the clients about their pregnancy history, and enrollment of one client with a history of early first infant death accounted for enrolling clients who were not first-time mothers.

Standard 3. *Client meets low-income criteria at intake.* At the time of enrollment, each NFP client is required to have an income at or below 185 percent of the federal poverty level. The NFPNSO randomized control trials found that, while all clients benefited from the assistance provided by the NFP program, clients with higher incomes had additional resources available to them outside of the program and did not benefit from the program to the same degree as low-income clients.

¹⁷ Data included in this report ended on June 30, 2011, due to a lag in the availability of program data.

Each TNFP program site verified the income of all potential clients. Each site also obtained eligibility information by determining whether the potential client was receiving Medicaid, WIC funds, or SNAP benefits. A potential client was considered eligible for enrollment if she was receiving public benefits that have an income requirement at or below 185 percent of the federal poverty level, including Medicaid, WIC, and SNAP.¹⁸

Standard 4. *Client is enrolled in the program early in her pregnancy and receives her first home visit by no later than the end of the 28th week of pregnancy.* Early enrollment allows time for the client and nurse home visitor to establish a relationship before the birth of the child. NFPNSO research indicates that early enrollment provides the nurse home visitor the opportunity to address prenatal health behaviors that affect birth outcomes and the child's neurodevelopment.

Ninety-eight percent of TNFP clients were enrolled before the end of the 28th week of gestation.¹⁹ This percentage is greater than the NFP program national average of 94 percent.

Intervention Context

Standard 5. *Client is visited one-to-one, one nurse home visitor to one first-time mother.* The therapeutic relationship between the nurse home visitor and the client must be focused on the individual client's circumstances. By engaging in a one-to-one setting, the nurse home visitor can better strengthen the client's abilities and behavior change to achieve the goals of the program.

The TNFP program closely followed the NFPNSO guidelines pertaining to home visits. Specifically, each nurse home visitor scheduled individual visits with each client. In addition, each TNFP program site is required to ensure an adequate nurse-home-visitor-to-client ratio. On average, each TNFP nurse home visitor had a 24-client caseload.

Standard 6. *The program is delivered in the client's home, which is defined as the place where she is currently residing.* Home visitation is an essential part of the program. When a client is visited in her home, the nurse home visitor has an opportunity to observe, assess, understand, and monitor the client's status. Specifically, the nurse can assess the client's safety, social dynamics, ability to provide basic needs, and the mother-child interaction. NFPNSO defines a "home setting" as a location where the client lives for the majority of time (i.e., she sleeps there at least four nights a week). This may include a shelter, a friend's home, a detention center, or another location. When the client's living situation or her work/school schedule makes it difficult to see the client at home, the visit is conducted in another setting.

According to HHSC TNFP staff, all TNFP program sites met the requirements of this standard. The location of TNFP client home visits was similar to the national data on the location of NFP home visits.

¹⁸ When determining eligibility for the NFP program, NFPNSO indicated that most implementing agencies across the nation use the income eligibility thresholds for WIC, Medicaid, or other public program for low-income families.

¹⁹ At enrollment, each client estimated how long she had been pregnant. After enrollment, sonograms indicated some clients exceeded the 28-week requirement. These clients typically remained enrolled in the program. Also early in program implementation, some sites mistakenly believed that a gestation period of less than 29 weeks met the 28-week requirement. Through further discussion with NFPNSO, HHSC clarified that the gestational period must be no greater than 28 weeks and six days.

Standard 7. *Client is visited throughout her pregnancy and the first two years of her child's life in accordance with the current NFPNSO Guidelines.* The frequency of home visits may influence the effectiveness of NFP programs. Even if clients do not use the nurse home visitor to the maximum level recommended, the visits made can be a powerful tool for change. Research indicates that the earlier a client enters the program, the greater the program's effectiveness. The high frequency of home visits early in the pregnancy and throughout the first two years of the child's life may have the greatest impact on maternal behavior and thereby the highest probability of improving outcomes. For example, substance abuse, smoking, and nutrition greatly influence fetal development. By addressing these issues early with the client, the risks for adverse outcomes for mother and baby can be reduced.

TNFP sites completed 74 percent of the expected home visits during pregnancy based on the NFPNSO Guidelines. This completion rate is equal to the NFP national average. The NFPNSO objective is an 80 percent completion rate during the pregnancy phase. TNFP sites completed 65 percent of expected home visits during infancy and toddlerhood. This completion rate was equal to the NFPNSO objective of at least 65 percent completion rate during infancy and more than the 60 percent completion rate objective in toddlerhood.

Expectations of Nurses and Supervisors

Standard 8. *Nurse home visitors and nursing supervisors are registered professional nurses with a minimum of a baccalaureate degree in nursing.* The NFPNSO research indicates that the public perceives registered nurses as having high standards of ethical practice and honesty. This may give NFP nurses credibility with families, helping make them acceptable providers of the NFPNSO curriculum and welcomed into clients' homes. The nurse home visitors are also required to have a valid nursing license.

As of June 30, 2011, 76 of the nurse home visitors seeing clients had a Bachelors of Nursing (BSN) degree. With HHSC's support, one site submitted a *Variance to Model Standard 8 Request* to NFPNSO for one nurse who did not have a BSN. However, she was only employed for two months. NFPNSO approved this variance. All 13 nursing supervisors had a BSN. In addition, four of the nursing supervisors had master's degrees in nursing, public health, or business administration.

Standard 9. *Nurse home visitors and nursing supervisors complete core educational sessions required by NFPNSO and deliver the intervention with fidelity to the NFP Model.* The NFP program is a highly specialized program that requires extensive training on the NFP model, theories, and structure to deliver the program. The NFPNSO policy is that all nursing staff must complete all NFP education sessions. While NFPNSO does not have a specific timeframe for the completion of all the training sessions, nurse home visitors are required to complete the first two of four NFPNSO training sessions prior to visiting clients.

According to HHSC TNFP staff, as of June 30, 2011, all TNFP nurse home visitors had completed the first two NFPNSO training sessions. In addition, the nurse home visitors are expected to complete other training sessions relevant to the NFP program including the following:

- Instruction on motivational interviewing.
- Partners in Parenting Education (PIPE).
- Ages and Stages (ASQ) and Ages and Stages, Social-Emotional Screening (ASQ-SE).
- Assessment of child health and development.
- Positive parenting and care giving.
- Infant cues and behaviors (Keys to Care giving).
- Texas Health Steps modules.
- The OAG Paternity Opportunity Program.
- Identification of complications during pregnancy.

HHSC TNFP staff also reported that almost all TNFP nurse home visitors had completed all required additional training sessions. The remaining nurses were in the appropriate phases of their training based on hire dates. In addition, HHSC and local TNFP sites provided other training opportunities to staff to complement and enhance training received from NFPNSO. Training needs are identified through ongoing needs assessments conducted by the TNFP State Nurse Consultant and Nurse Supervisors.

Application of the Intervention

Standard 10. *Nurse home visitors, using professional knowledge, judgment and skill, apply NFPNSO Visitation Guidelines focusing the topic of each visit to the strengths and challenges of each family and apportioning time across defined program domains.* NFPNSO visitation guidelines are tools that guide nurse home visitors in the delivery of program content. These guidelines suggest that each visit include information about each of the following six life domains.

- **Personal Health** - Health maintenance practices, nutrition and exercise, substance use, and mental health.
- **Environmental Health** - Home, work, school, and neighborhood.
- **Life Course Development** - Family planning, education, and livelihood.
- **Maternal Role** - Mothering role, physical, behavioral, and emotional care of a child.
- **Friends and Family** - Personal network relationships and assistance with childcare.
- **Health and Human Services** - Linking families with needed referrals and services.

The NFPNSO provides objectives for the overall proportion of time at each home visit devoted to the first five of the six life domains. In accordance with NFPNSO policies, the TNFP nurse home visitors individualize visit content to meet the client's needs rather than adhering to a predetermined schedule. During the client's pregnancy, the TNFP nurse home visitors met or exceeded the NFPNSO objectives for the proportion of home visit time devoted to four of the five domains. The exception was the Maternal Role domain. During the six weeks after the client's baby was delivered, the TNFP nurse home visitors spent the most time during their home visit time on the Personal Health and the Maternal Role domains. As with the pregnancy phase, during the infancy phase the TNFP nurse home visitors met or exceeded the NFPNSO objectives for the proportion of home visits devoted to four of the five domains TNFP nurse home visitors spent less time on the Maternal Role when compared to the national NFPNSO guidelines. This same trend repeated during the toddlerhood phase of the program.

It is important to keep in mind that these are proportions across all home visits for all nurse home visitors. In addition, the proportions need to add up to 100 percent. For example, if a nurse home visitor spent a higher proportion of the allocated visit time on Personal Health, the proportion of home visit time spent on the other domains would decrease even if the nurse home visitor did an excellent job of presenting all of the information for all of the other domains.

Standard 11. *Nurse home visitors apply the theoretical framework that underpins the program, emphasizing self-efficacy, human ecology and attachment theories, through current clinical methods.* These theories serve as the foundation for NFP programs and are reflected in the visit guidelines and training sessions. Nurse home visitors are expected to utilize these guidelines and methods in each home visit.

TNFP nursing supervisors, nurse home visitors, NFPNSO, and HHSC work together to ensure that each TNFP program site closely follows the NFP model. Questions or concerns about model fidelity are addressed through an open dialogue between the TNFP sites, HHSC, and NFPNSO. In addition, each TNFP nursing supervisor evaluates the nurse home visitors to ensure fidelity to the NFP model.

Standard 12. *A full time nurse home visitor carries a caseload of no more than 25 active clients.* A caseload greater than 25 clients would negatively impact the nurse home visitor's ability to develop and establish an adequate therapeutic relationship with each client.

On average, each TNFP nurse home visitor has a 24-client caseload.²⁰ Nurse home visitors temporarily exceeded the maximum caseload to provide services to clients whose nurse home visitor was temporarily absent or permanently left the program. Reasons for exceeding the maximum caseload size included:

- Temporary nursing staff vacancies,
- Newly hired nurses that had not assumed a full caseload, and
- Adding new clients as the number of visits required per month decreases for graduating clients (to ensure as many clients as staffing would allow could be seen).

Reflection and Clinical Supervision

Standard 13. *A full-time nursing supervisor provides supervision to no more than eight individual nurse home visitors.* Because of the expectation of one-to-one supervision, a full-time nursing supervisor should manage no more than eight nurse home visitors. Nursing supervisors are also responsible for referral management, program development, and administrative tasks that include the management of administrative, clerical, and interpreter staff.

According to HHSC TNFP staff, sites have complied with this standard.

Standard 14. *Nursing supervisors 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 one-to-one clinical supervision, case conferences, team meetings and field supervision.* To ensure that

²⁰ Calculations of average nurse caseload were based on nurse home visitors who had been employed with NFP for greater than 11 months to allow them time to build a full caseload. NFPNSO recommends 9-12 months as the average period of time required for nurse home visitors to build full caseloads.

nurse home visitors are clinically competent and supported to implement the NFP program, nursing supervisors provide clinical reflection through specific supervisory activities. These activities include one-to-one supervision, case conferences and team meetings, and field supervision.

- **One-to-one supervision.** Nursing supervisors are required to have a weekly one-to-one meeting with each nurse home visitor to reflect on the nurse's work, including the management of her caseload and quality assurance. According to HHSC TNFP staff, all sites satisfactorily complied with this component of the standard.
- **Case conferences and team meetings.** Nursing supervisors are required to schedule weekly case conferences or team meetings dedicated to joint case review for the purpose of problem solving and professional growth. Team meetings also include discussions of program implementation issues and team building exercises. According to HHSC TNFP staff, all sites met or exceeded the 85 percent minimum threshold for conducting case conferences and team meetings recommended by NFPNSO.
- **Field supervision.** Nursing supervisors are required to conduct a joint home visit with each nurse every four months. According to HHSC TNFP staff, all sites complied with this component of the standard except for one site who partially met this standard.

Program Monitoring and Use of Data

Standard 15. *Nurse home visitor and nursing supervisors collect data as specified by the NFPNSO and use NFP Reports to guide their practice, assess and guide program implementation, inform clinical supervision, enhance program quality, and demonstrate program fidelity.*

Each TNFP program site collected data and used the NFP reports to monitor and improve its operations. The NFPNSO sent each site Quarterly Summary Reports providing statistical information on each sites performance in relation to the NFP national totals. TNFP nursing supervisors reviewed these reports to identify any problems with the data collected and transmitted to NFPNSO and the source of the errors (e.g., data entry, data collection, or other error). The TNFP program sites made appropriate corrections in the database or adjustments in protocol (in consultation with NFPNSO or HHSC, if needed). TNFP nursing supervisors also used the data reports to establish a basis for the development of Quality Improvement Processes.

Agency

Standard 16. *An NFP implementing agency is located in and operated by an organization known in the community for being a successful provider of prevention services to low-income families. The implementing agency should provide visible leadership and support the NFP program with all tools necessary to ensure program fidelity.*

The TNFP program sites are described below. Each site met the Standard 16 criteria.

- **Any Baby Can, Inc.** has a 30-year history of providing preventive home-based programs for expectant, first-time parents with multiple risk factors including poverty, lack of health insurance or access to health care, limited education or job skills, parental disability, mental health concerns, history of family violence, and a history of substance abuse. The primary goals of Any Baby Can include improved birth outcomes, improved parenting behaviors, the reduction of childhood injuries, and increased immunization rates.

- **Parkland Health and Hospital System (HHS)** is an established local government organization with a reputation for being a successful provider of services to low-income families in Dallas County. Parkland HHS has several programs designed to help low-income families obtain health care, including Dallas Healthy Start, the March of Dimes, and Youth Angle Family Access Network.
- **YWCA of Metropolitan Dallas** has been active in the Dallas community since 1908 and has a history of developing and sustaining programs to meet the needs of low-income families. The YWCA offers a continuum of services that help improve women's lives and remove barriers to self-sufficiency. Annually, the YWCA serves more than 6,000 low-to-moderate income families through subsidized childcare centers, financial education development, and parental education and support.
- **Tarrant County Health Department** has a strong foundation in the community and provides a broad array of public health services to prevent disease and injury and to promote health. Through collaborations with community, church and governmental agencies, Tarrant County has worked to address many local health issues affecting low-income families.
- **Baylor College of Medicine Teen Health Clinics** has been providing medical, counseling, and education services for 35 years in some of Houston's poorest neighborhoods. Through seven comprehensive teen health clinics, the Baylor College of Medicine provides community oriented primary and reproductive care to low-income women under 21 years of age. The primary goals of the teen health clinics are to reduce infant mortality, prevent subsequent teen pregnancies, and reduce the incidence of sexually transmitted diseases.
- **City of Houston Department of Health and Human Services (DHHS)** has a long history of assisting at-risk families in the Houston Metropolitan Area. Houston DHHS has historically administered two programs focused on assisting low-income pregnant women: the Targeted Case Management for Children and Pregnant Women program and the Health Families Healthy Futures home visitation program.
- **Texas Children's Health Plan** is the largest combined STAR/Children's Health Insurance Program (CHIP) managed care organization in Harris County. The Texas Children's Health Plan has a maternity management-newborn program, Star Babies, for pregnant Medicaid clients in the Texas Children's Health Plan population. This program provides education and resource assistance to a monthly average of 2,500 pregnant women and their babies. The program includes a home visitation program for high-risk mothers, community outreach, car seat installation services, and other social services.
- **Texas Tech University Health Science Center** was established in 1998 in a medically underserved area of Lubbock to provide primary care services to at-risk families. Texas Tech has several programs designed to provide services to low-income families, including Texas Health Steps, primary care clinics, counseling services, and women's health services.
- **City of Port Arthur Health Department** has more than 100 years of experience providing health, parent, and family support services to low-income families in their community. Port Arthur has past experience in providing home-based services through a maternal and child health grant.
- **The Children's Shelter** has been providing for the health and safety of children in crisis in the San Antonio community since 1901. The Children's Shelter offers medical and dental services; foster care and adoption services; mental health services; outreach programs; and services for pregnant and parenting teens. Through the Mothers and Schools program, The Children's Shelter has collaborated with the San Antonio Independent School District to reduce pregnancy, poverty, high school dropout, and child abuse rates.

- **University Health System** is a publicly supported, academic medical center and safety net provider serving San Antonio and the South Texas region. Historically, University Health System has been the major service provider for low-income families in providing maternal and child health care in Bexar County. University Health System has worked for more than 50 years to improve the outcomes for low-income women and children.
- **University Medical Center of El Paso** has almost 100 years of experience providing health care services to the residents of El Paso and surrounding areas. The University Medical Center of El Paso is the city's only not-for-profit community hospital and provides a variety of inpatient and outpatient services. Each year the hospital provides over 180 million dollars in indigent care services to the uninsured and working poor population in the El Paso community.

Standard 17. *An NFP implementing agency convenes a long-term Community Advisory Board that meets at least quarterly to promote a community support system to the program and to promote program quality and sustainability.* It is important for an implementing agency to have a community advisory board where implementation issues can be vetted and problems addressed. A community advisory board:

- Provides a support network for NFP staff and clients.
- Facilitates awareness of NFP in the community.
- Provides assistance in developing relationships with referral sources and service providers.
- Helps assess and respond to challenges in program implementation.
- Identifies gaps in client resources and services.
- Consults with the NFP staff regarding quality improvement.
- Works with other local, state, and federal entities to generate the support needed to sustain the NFP program.

Each program site has a community advisory board that met quarterly. The two TNFP sites in Dallas share an advisory board, as do the two TNFP sites in San Antonio.

Standard 18. *Adequate support and structure shall be in place to support nurse home visitors and nursing supervisors to implement the program and to ensure that data are accurately entered into the data base in a timely manner.* Support includes the necessary infrastructure to support and implement the program. This includes the necessary physical space, desks, computers, cell phones, filing cabinets, and other equipment to carry out the program. It also includes employing a person primarily responsible for key administrative support tasks for NFP staff, such as entering data and maintaining report accuracy. Each implementing agency must have the equivalent of a half-time general administrative staff member for every 100 clients to support the nurse home visitors and nursing supervisors.

All 12 TNFP sites have established an adequate support structure to ensure effective implementation and accurate data entry. Each TNFP program site has dedicated support staff. Nine sites have one full-time person providing data entry and other administrative assistance, one site with 12 nurse home visitors has a full-time person and a half-time person, and two sites have one half-time person filling that role.

In addition, each implementing agency has dedicated space, desks, computers, and other equipment to its TNFP program. The majority of each site's overhead is paid by the implementing agency.

Establishment of Paternity

Section 531.653, Government Code, requires TNFP program sites to assist clients in establishing paternity of their babies. Information on paternity establishment was provided to 100 percent of TNFP clients between July 1, 2009 and June 30, 2011. During this time period, 313 of the 3,193 TNFP clients completed Acknowledgment of Paternity (AOP) documentation with their nurse home visitor prior to delivery (see Table 7). It is unknown how many clients completed AOP documentation during their hospital stay following the birth of their baby or at a later time point.

Table 7. Establishment of Paternity

Provider	Number of Clients who Completed Acknowledgment of Paternity Documentation*
Any Baby Can	44
Parkland HHS	25
Dallas YWCA	27
UMC at El Paso	4
Tarrant County	37
Baylor	8
Houston DHHS	17
Texas Children's Health Plan	8
Texas Tech	64
Port Arthur	27
The Children's Shelter	12
University Health System	40
TNFP	313

Time period: July 1, 2009 - June 30, 2011

* Only clients who submit AOP documentation before the birth of their babies are included.

Program Outcomes

The aim of the TNFP program is to improve the health and self-sufficiency of low-income, first-time parents and their children by improving pregnancy outcomes, improving child health and development, improving family economic self-sufficiency and stability, and reducing child abuse and neglect. TNFP sites gather program outcome data associated with these program goals:

- **Improve pregnancy outcomes.** TNFP sites collect data on preterm delivery and low birth rates, NICU use, and incidence of pregnancy complications.

- **Improve child health and development.** TNFP sites collect data on the frequency of ER visits, hospitalizations, and well-child check-ups.
- **Improve family economic self-sufficiency and stability.** TNFP sites collect data on the intervals between the first and second child, work force participation, and the use of public assistance.
- **Reduce child abuse and neglect.** TNFP sites collect data on the frequency of hospitalizations (including visits to the emergency room) for injury and ingestion.²¹

After a review of the quarterly summary table data, program site staff reported some minor discrepancies in the data. Although the discrepancies appear to be very small, due to the small sample size and low occurrence of reported measures any discrepancy may impact the interpretation of the results. Therefore, these results should be viewed with some caution. A brief discussion of program outcomes is included in Appendix A.

Summary

The NFP program successfully implemented 12 TNFP sites across Texas, enrolling 3,193 low-income first-time mothers and has a current TNFP caseload of 1,493 low-income first time mothers. The average age of TNFP clients was 18 years. Eleven percent of TNFP clients were married, 35 percent were working either full- or part-time, and TNFP clients had a median annual household income of \$16,000.

As a condition of their funding, TNFP grantees were required to adhere to the TNFP program model standards developed by the NFPNSO. All TNFP sites successfully adhered to the 18 model standards covering seven areas of implementation except for one site which met 17 of the 18 model standards and partially met the other model standard.

- **Clients (Standards 1-4)** - Each client participated in the program voluntarily, was a first-time mother, and met the low-income criteria. Ninety-eight percent began receiving program services before the beginning of their 29th week of pregnancy.
- **Intervention Context (Standards 5-7)** - Each nurse home visitor visited clients in accordance with NFPNSO guidelines.
- **Expectations of the Nurses and Supervisors (Standards 8-9)** - Each grantee followed the NFPNSO guidelines regarding staff training and experience.
- **Application of the Intervention (Standards 10-12)** - Each nurse home visitor followed the NFPNSO visitation guidelines during client visits, used current clinical methods to apply the NFP theoretical framework, and with the exception of six nurse home visitors, did not have a caseload greater than 25 clients.
- **Reflection and Clinical Supervision (Standards 13-14)** - Each nursing supervisor provided supervision to no more than eight nurses and provided clinical supervision and feedback in accordance with NFPNSO guidelines. Overall, each nursing supervisor provided sufficient one-to-one supervision.
- **Program Monitoring and Use of Data (Standard 15)** - Each grantee collected data in accordance with NFPNSO guidelines.
- **Agency (Standards 16-18)** - Each grantee was located in an organization known for providing prevention services and had the organizational structure to support the

²¹ Ingestion is used as a surrogate measure for child abuse and neglect.

implementation and operation of an NFP program. The entire program met regularly with a community advisory board to discuss implementation issues.

Conclusion

The focus of the TNFP evaluation is the examination of the fidelity of TNFP grantees to the NFPNSO model. The TNFP grantees adhered to all of the NFP model standards except for one site. The small deviations observed in field supervision and one-to-one supervision is not expected to affect the outcomes of the TNFP intervention.

APPENDIX A: PROGRAM OUTCOME RESULTS

The aim of the TNFP program is to improve the health and self-sufficiency of low-income, first-time parents and their children by improving pregnancy outcomes, improving child health and development, improving family economic self-sufficiency and stability, and reducing child abuse and neglect. TNFP sites gather program outcome data associated with these program goals.

- **Improve pregnancy outcomes.** TNFP sites collect data on preterm delivery and low birth weight rates, neonatal intensive care unit (NICU) use, and incidence of pregnancy complications.
- **Improve child health and development.** TNFP sites collect data on the frequency of emergency room visits, hospitalizations, and well-child check-ups.
- **Improve family economic self-sufficiency and stability.** TNFP sites collect data on the intervals between the first and second child, work force participation, and the use of public assistance.
- **Reduce child abuse and neglect.** TNFP sites collect data on the frequency of hospitalizations (including visits to the emergency room) for injury and ingestion.²²

Limitations

The following limitations may affect the validity of the outcome analysis:

- Program site staff reported some minor discrepancies in the tables reporting outcome data. Although the discrepancies appear to be very small, due to the small sample size and low occurrence of reported measures any discrepancy may impact the interpretation of the results.
- The low frequency of occurrence for some program outcomes makes an interpretation of the data difficult. Program outcomes with very low frequency were not reported.
- No data is presented on the reduction of child abuse and neglect due to limited data. During this reporting period, NFPNSO assessed rates of child abuse and neglect only by the number of children admitted to the hospital or seen in the emergency room because of an injury or ingestion. As of October 2011, new data collection forms have been implemented and these include direct questioning of referrals for child abuse and neglect.

Improve Pregnancy Outcomes

Between September 1, 2008 and June 30, 2011, there were 2,111 babies born to TNFP clients. Of these, 10.1 percent were born before 37 weeks gestation (see Table A-1). This is slightly higher than the NFP national average of 9.7 percent but less than the Healthy People 2020 objective of 11.4 percent.²³ In the same period, 9.1 percent of TNFP babies were born at a low birth weight (less than 2,500 grams or 5 lbs. 8 oz) and 1.6 percent were born at a very low birth weight (less than 1,500 grams or 3 lbs 5 oz.) both similar to the NFP national average of 9.2 percent and 1.5 percent respectively. Between September 1, 2008 and June 30, 2011, 16 percent of TNFP infants were admitted to the NICU. This admission rate is higher than the national average of 14.7 percent.

²² Ingestion is used as a surrogate measure for child abuse and neglect.

²³ Healthy People 2020 provides 10-year national objectives for improving the health of all Americans. (<http://www.healthypeople.gov/2020/default.aspx>)

Table A-1. Goal 1 – Improve Pregnancy Outcomes

	Number of Births*	Preterm Birth (born before 37 weeks)	Low Birth Weight (< 2500g)	Very Low Birth Weight (< 1500g)	Admitted to the NICU
TNFP	2,107	10.1%	9.1%	1.6%	16.0%
National NFP	87,542	9.7%	9.2%	1.5%	14.7%
Healthy People 2010 Objective**		11.4%	7.8%	1.4%	N/A

Time period: September 1, 2008 - June 30, 2011

*In the case of multiple births, one infant is randomly selected for the calculation of premature birth and low birth weight.

**The NFP objectives are the same as the Healthy People 2020 objectives.

Improve Child Health and Development

Breastfeeding

- The proportion of TNFP clients that initiated breastfeeding outnumbered the proportion of NFP clients nationally, 87 percent and 78 percent respectively. The proportion of TNFP clients who initiated breastfeeding is greater than Healthy People 2020 objective of 82 percent.
- At 6 months post-delivery, fewer TNFP clients were still breastfeeding compared to NFP clients nationally, 20 percent and 28 percent respectively. Both the TNFP and national NFP averages were below Healthy People 2020 objective of 61 percent.
- At 12 months post-delivery, only 13 percent of TNFP clients were still breastfeeding compared to 16 percent of NFP clients nationally. Both the TNFP and national NFP averages were below Healthy People 2020 objective of 34 percent.

**Table A-2. Goal 2 – Improve Child Health and Development
Frequency of Breastfeeding***

	Total Number of Clients	Initiated Breastfeeding Percent	Total Number of Clients	Breastfeeding at 6-Months Percent	Total Number of Clients	Breastfeeding at 12-Months Percent
TNFP	2,118	87.1%	1,036	20.4%	645	12.6%
National NFP	62,114	77.7%	32,434	27.7%	22,892	16.4%
Healthy People 2020 Objective**		81.9%		60.6%		34.1%

Time Period: September 1, 2008- June 30, 2011

* Total Number of Clients includes clients who were provided information about breastfeeding.

**The NFP objectives are the same as the Healthy People 2020 objectives.

Immunizations

Between September 1, 2008 and June 30, 2011, 86 percent of 6-month old TNFP babies had received all of their scheduled immunizations and 84 percent of 12-month old babies had received all of their scheduled immunizations (see Table A-3). These figures are similar to the NFP national averages of 86 percent at 6-months, and 85 percent at 12-months.

**Table A-3. Goal 2 – Improve Child Health and Development
Percent of TNFP Children Who Received Scheduled Immunizations**

	Total Number of Children with Immunization Data	Percent with Up-to-Date Immunizations at 6-Months	Total Number of Children with Immunization Data	Percent with Up-to-Date Immunizations at 12-Months
TNFP	1,231	86.4%	770	84.3%
National NFP	25,151	86.2%	20,480	85.1%

Time Period: September 1, 2008- June 30, 2011

Developmental Delays

In order to screen TNFP babies for developmental and social delays, nurse home visitors administer the Ages and Stages Questionnaire (ASQ-3) and Ages and Stages Questionnaire: Social-Emotional (ASQ:SE). These screening instruments are designed to test infants and young children at standardized intervals for developmental delays and social-emotional delays. Only data from the first two screenings (4-months and 10-months for the ASQ-3 screenings and 6-months and 12-months for the ASQ:SE) are reported.

There were 1,038 babies screened with the ASQ at four months of age with five percent requiring additional developmental assessment. At ten months of age, 82 percent of infants were screened and nine percent required additional screening. These levels were slightly lower than the NFP national average for those infants requiring further evaluation of seven percent and 11 percent at 4- and 10- months respectively (see Table A-4).

**Table A-4. Goal 2 – Improve Child Health and Development
Developmental Delays: Ages and Stages Questionnaire (ASQ) Results***

	Number of Infants**	Percent Assessed at 4- Months	Required Additional Assessment	Number of Infants**	Percent Assessed at 10- Months	Required Additional Assessment
TNFP	1,234	84.1%	5.4%	771	81.5%	8.6%
National NFP	28,984	84.6%	6.5%	22,111	83%	10.6%

Time Period: September 1, 2008- June 30, 2011

*ASQ is also assessed at 14- and 20-months

** Number of Infants includes those eligible for an ASQ assessment.

There were 1,069 infants screened at six months of age with the ASQ:SE. Of these, five percent required further evaluation (see Table A-5). At twelve months, 678 children were screened and three percent required further evaluation. These rates are slightly higher than the national NFP totals.

**Table A-5. Goal 2 – Improve Child Health and Development
Developmental Delays: Ages and Stages Questionnaire: Social Emotional (ASQ:SE)
Results***

	Number of Infants**	Percent Assessed at 6- Months	Required Additional Assessmen t	Number of Infants**	Percent Assessed at 12- Month	Required Additional Assessmen t
TNFP	1,234	86.6%	5.3%	771	87.9%	3.4%
National NFP	28,984	72.2%	4.3%	22,104	72.4%	3.0%

Time Period: September 1, 2008- June 30, 2011

* ASQ:SE is also assessed at 18- and 24-months.

** Total Number of Infants includes those eligible for an ASQ:SE assessment

Improve Family Economic Self-Sufficiency and Stability

Employment

As presented in the main body of the report, 50 percent of TNFP clients reported working at 18-months postpartum compared to 35 percent at program enrollment. The percent of TNFP clients employed at 18-month postpartum was three percent higher than the percent of employed NFP clients nationally.

Subsequent Pregnancy

Between September 1, 2008 and June 30, 2011, three percent of TNFP clients were pregnant six months after giving birth and 11 percent were pregnant 12 months after giving birth (see Table A-6). The percent of TNFP clients pregnant after six months was similar to NFP national average and slightly lower than the NFP national average of 13 percent and 22 percent after 12- and 18- months, respectively.

**Table A-6. Goal 3 – Improve Family Economic Self-Sufficiency and Stability
Subsequent Pregnancy**

	6 Months Postpartum		12 Months Postpartum		18 Months Postpartum	
	Number of Clients	Percent of Clients Pregnant	Total Number of Clients	Percent of Clients Pregnant	Total Number of Clients	Percent of Clients Pregnant
TNFP	1,241	3.3%	780	11.3%	402	21.1%
National NFP	53,435	3.7%	39,955	12.5%	27,845	22.4%

Time Period: September 1, 2008- June 30, 2011