TYRO Champion Dads

Study Protocol

12/9/2024

ClinicialtrialI.gov ID:
NCT05256992

PROGRAM BACKGROUND

1. PROGRAM SUMMARY

Please provide a brief summary of your grant project including the needs to be addressed, the services provided, and the population served.

Services delivered by the TYRO Champion Dads (TCD) Project are designed to address the skills fathers may need to promote healthy relationships and economic stability in their families. The target population for this project is low-income fathers who identify as Hispanic or Latino, are 18 years of age or older, have no open criminal cases (can be deferred), and have at least one child up to 24 years of age. The primary components of the TCD project are:

1. **Education-based curricula**—TYRO Dads and Core Communication—are delivered as primary services to improve the parenting, co-parenting, partner relationship, and financial skills of all TCD participants. Participants assigned to the treatment group also receive the Ray of Hope curriculum to mitigate risk factors for domestic violence.
2. **Support services** are offered through case management and Anthem's Mini Clinic workshops to increase the likelihood that TCD participants benefit from primary services. Participants can walk in during normal business hours without an appointment to address an array of additional self-perceived needs not met by primary services with a menu of classes delivered on site or referrals.
3. **Cycles of Continuous Quality Improvement (CQI)** are carried out by the CQI Team to ensure that program and evaluation target goals are being met.

2. EVALUATION GOALS

Please briefly describe key goals of your evaluation and what you hope to learn below.

This impact evaluation aims to determine if the addition of the Ray of Hope curriculum is effective at improving outcomes among those program participants who are randomly assigned to the treatment group. Both treatment and control groups will receive standard TCD services under a shared condition, but only treatment group participants will be offered the additional Ray of Hope curriculum focused on mitigating risk factors related to domestic violence.

Standard TYRO Champion Dads (TCD) services deliver TYRO Dads and Core Communication curricula to help fathers build the skills necessary to engage in behaviors that promote healthy relationships and economic stability in their families. Standard TCD services were adapted from the TYRO Suite of curricula—TYRO Dads, Couples Communication I, and Couples Communication II –- which were developed by a Christian, non-profit organization in Ohio called The RIDGE Project, for delivery in a classroom setting, as part of their mission to improve functioning of families affected by the incarceration of a father.

Standard TCD services use facilitators trained by the RIDGE Project to deliver TYRO Dads curriculum in its standard form and the Core Communication curriculum which is adapted from the Couples Communication I curriculum (participants do not receive any form of Couples Communication II). The TYRO Dads curriculum uses cognitive restructuring to present life

lessons to help participants understand, accept, and implement a healthy model of parenthood by resolving key issues—emotional, employment, financial, relationship, and others—that prevent them from meeting their familial obligations. The Core Communication curriculum helps participants develop the basic communication, cooperation, and conflict management skills necessary for successful relationships of all types, such as work, family, and others.

Standard services in the TYRO Champion Dads (TCD) Project directly address healthy relationships and economic stability for the families of participants, but not the dynamics of domestic violence that might be present in families. As a result, fathers in the target population may benefit from additional curriculum focused on attitudes and behaviors associated with domestic violence and risk-related factors. Because family trauma is traditionally considered a private matter in the Latino community, domestic violence or related risk factors may not be adequately detected or addressed by the social service system among this population in particular (Cabrera et. al, 2015).

Anthem Strong Families (ASF) is offering the Ray of Hope curriculum as a supplement to standard TCD services to better meet the needs of populations that may have unmet needs to address domestic violence in their families. The *Ray of Hope* curriculum is designed to help participants develop communication and conflict management skills like *Core Communication* and *Couples Communication I* but is also evidence-based and adds a sharp focus on the dynamics of domestic violence and related risk factors.

This impact evaluation will compare outcomes between study groups related to co-parenting behaviors, parenting behaviors, parenting attitudes, and partner relationship behaviors (study goals 4-7 below). This evaluation will also include an implementation study (study goals 1-3 below).

Goal 1: determine if enrollment targets for the TCD Project were achieved for the treatment and control groups.
Goal 2: determine if the intended amounts of standard TCD services (*TYRO Dads, Core Communication*) were offered to and received by the control group.
Goal 3: determine if the intended amounts of enhanced TCD services (*TYRO Dads, Core Communication, Ray of Hope* curricula) were offered to and received by the treatment group.
Goal 4: determine if treatment group participants who receive enhanced TCD services report **healthier parenting attitudes** compared to control group participants who receive only standard TCD services immediately following TCD program completion. .
Goal 5: determine if treatment group participants who receive enhanced TCD services report **healthier partner relationship behaviors** compared to control group participants who receive only standard TCD services 6 months after TCD enrollment.
Goal 6: determine if treatment group participants who receive enhanced TCD services report **healthier parenting behavior** compared to control group participants who receive only standard TCD services 6 months after TCD enrollment.

Goal 7: determine if treatment group participants who receive enhanced TCD services report **healthier co-parenting behavior** compared to control group participants who receive only standard TCD services 6 months after TCD enrollment.

3. EVALUATION ENROLLMENT

Please provide the expected start and end dates for program and evaluation enrollment using the tables below. For impact studies, please indicate expected start and end dates for each study group.

IMPLEMENTATION EVALUATION *Please leave blank if not conducting an implementation study.*		
	Program Enrollment	**Study Enrollment**
Start Date	04-01-2021	05-20-2022
End Date	03-01-25	03-01-25
Definition	*Fathers who are 18+ years of age, have no open criminal cases (can be deferred), with children up to 24 years old*	*Fathers who are 18+ years of age, have no open criminal cases (can be deferred), with children up to 24 years old AND agree to participate in the study after informed consent*

IMPACT EVALUATION *Please leave blank if not conducting an impact evaluation.*			
	Program Enrollment	**Study Enrollment**	
		Treatment Group	**Comparison Group**
Start Date	04-01-2021	05-20-2022	05-20-2022
End Date	06-30-2025	11-30-2024	11-30-2024
Definition	*Fathers who are 18+ years of age, have no open criminal cases (can be deferred), with children up to 24 years old*	*Fathers who are 18+ years of age, have no open criminal cases (can be deferred), with children up to 24 years old AND agree to participate in the study after informed consent AND were not referred to the program due to involvement in a domestic violence case*	*Fathers who are 18+ years of age, have no open criminal cases (can be deferred), with children up to 24 years old AND agree to participate in the study after informed consent AND were not referred to the program due to involvement in a domestic violence case*

4. EVALUATION TIMELINE

Please include a timeline for key activities of the evaluation below. Example of activities may include IRB submission, staff training, waves of data collection, analysis period, and report writing and submission.

Evaluation Activity	Start Date	End Date
Hire Evaluation Staff: Project Manager (Senior Consultant), CQI Data Manager (CQI-DM)	1/15/2021	2/15/2021
Evaluation Staff Training: Performance Data Measurement and Management (PDMM), CQI Process, Study Activities, Evaluation Plans	1/22/2021	3/12/2021
Kickoff Meeting: introduce evaluation team to project staff and orient them to study activities	2/3/2021	2/28/2021
IRB Certification: evaluation and project staff complete human subjects training	10/1/2020	2/28/2021
Evaluation Plan: evaluation and project staff develop and submit evaluation plan	1/15/2021	2/19/2021
Survey Tools: evaluation staff develop OLLE Pre/Follow-up Surveys (nFORM items at baseline included on OLLE Follow-up)	10/1/2021	2/28/2021
IRB Approval: evaluation staff develop and submit relevant documents to Solutions IRB	3/1/2021	3/15/2021
CQI Team: form team and conduct ongoing bi-weekly meetings to start CQI Process	3/15/2021	7/1/2025
CQI Training: train the CQI-DM and CQI Team about PDMM and the CQI Process	1/22/2021	3/19/2021
Study Activities Training: present to project staff an IRB approved study protocol for consent, enrollment, and data collection.	3/1/2021	3/28/2021
Implementation Evaluation: collect nFORM data to track delivery of intended service amounts	05/1/2021	*05/01/25*
Baseline Surveys: ACS, nFORM Entrance, OLLE Pre	5/1/2021	*05/31/24 for local evaluation surveys; nFORM surveys will continue as required by*

		federal funder until conclusion of program services
Exit Surveys: nFORM Exit, OLLE Post	8/1/2021	*08/01/24*
Follow-up Surveys: OLLE Follow-up (with items from nFORM Entrance)	5/1/2022	*05/31/25*
Preliminary Implementation Report Submitted	5/31/2022	6/31/2022
1st Manuscript submitted for publication	*7/1/2025*	*12/31/2025*
Final Report Submitted	*04/1/2024*	*06/01/2025 for first draft with final report to be submitted before the conclusion of the grant cycle*

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EVALUATION PLAN

1. RESEARCH QUESTIONS

1.1. OVERVIEW OF RESEARCH QUESTIONS

Please state the research questions(s) that the evaluation intends to answer and for each research question indicate the type: implementation or outcome.

- *Implementation Questions: Identifying whether a program has been successful in attaining desired implementation goals (e.g., reaching intended target population, enrolling intended number of participants, delivering training and services in manner intended, etc.)*
- *Outcome Questions: Identifying whether program is associated with intended outcomes for participants (e.g., do participants' knowledge, attitudes, behaviors, or awareness change?)*

Research questions in this study are framed by a Random Control Trial (RCT) design that will be used to determine if *TCD Project* participants who receive *enhanced TCD services* (treatment) derive more benefits than those who receive only *standard TCD services* (control), and they guide two types of analyses in this study—impact and implementation (see Table 1.1 below). Impact analyses estimate the primary benefits of participation for different service conditions six months after TCD enrollment. Primary benefits refer to outcomes that indicate improved attitudes and behavior for healthy

family relationships (parent, co-parent, and partner). However, strong conclusions can only be drawn about the benefits of participation when impact estimates are made after full or nearly full implementation of TCD services. Conclusions are more difficult to draw for impact estimates that are made when participants do not receive the intended service amounts. Consequently, implementation analyses place impact estimates in the appropriate context for interpretation by considering the extent to which TCD services are fully implemented for participants in both study groups.

Table 1.1: Research questions by type for the impact study, implementation and outcome

No	Research Question	*Implementation or Outcome?*
I1	To what extent were the enrollment targets for the TCD Project achieved for the treatment and control groups?	*Implementation*
I2	To what extent were the intended amounts of standard *TCD services* (*TYRO Dads, Core Communication curricula)* offered to and received by the control group?	*Implementation*
I3	To what extent were the intended amounts of *enhanced TCD services* (*TYRO Dads, Core Communication, Ray of Hope curricula)* offered to and received by the treatment group?	*Implementation*
I4	To what extent did the CQI Team carry out the steps in the CQI Plan each program year?	*Implementation*
R1	What is the impact of *enhanced TCD services* (treatment) compared to *standard TCD services* only (control) on **healthy parenting attitudes** immediately following program completion?	*Outcome*
R2	What is the impact of *enhanced TCD services* (treatment) compared to *standard TCD services* (control) only on **healthy partner relationship behaviors** 6 *months* after TCD enrollment?	*Outcome*
R3	What is the impact of *enhanced TCD services* (treatment) compared to *standard TCD services* only (control) on **healthy parenting behavior** 6 *months* after TCD enrollment?	*Outcome*
R4	What is the impact of *enhanced TCD services* (treatment) compared to *standard TCD services* only (control) on **h*ealthy* co-parenting behavior** 6 *months* after TCD enrollment?	*Outcome*
R5	D*oes the impact of the Ray of Hope hours vary by ethnicity?*	*Secondary outcome*

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1.2. OUTCOME RESEARCH QUESTIONS

For each outcome research question listed above, whether a descriptive or impact design, summarize the inputs (e.g., program components, program supports, implementation features, etc.), target population (e.g., the population for which the effect will be estimated) and the outcomes (e.g., child well-being, father-child engagement, etc.) that will be examined to answer the research question(s). Comparisons for descriptive evaluations may reflect circumstances before the grant, pre-treatment, or pre-determined benchmark from other studies with similar interventions.

Research Question Number	Intervention	Target Population	Comparison	Outcome	Confirmatory or Exploratory?
R1	*Ray of Hope* curriculum (10 hours) that focuses on domestic violence and related risk factors	Latino fathers: low-income, 18+ years, no open criminal cases (or deferred), children up to 24 years	**Parenting attitudes** for the treatment group to the control group immediately after completing TCD program.	**Healthier parenting attitudes** for the Treatment Group that receives enhanced services.	Confirmatory
R2	*Ray of Hope* curriculum (10 hours) that focuses on domestic violence and related risk factors	Latino fathers: low-income, 18+ years, no open criminal cases (or deferred), children up to 24 years	**Partner relationship behaviors** for the treatment group to the control group 6 months after TCD enrollment.	**Healthier partner relationship behaviors** for the Treatment Group that receives enhanced services.	Confirmatory
R3	*Ray of Hope* curriculum (10 hours) that focuses on domestic violence and related risk factors	Latino fathers: low-income, 18+ years, no open criminal cases (or deferred), children up to 24 years	**Parenting behavior** for the treatment group to the control group 6 months after TCD enrollment.	**Healthier parenting behavior** for the Treatment Group that receives enhanced services.	Confirmatory
R4	*Ray of Hope* curriculum (10 hours) that focuses on	Latino fathers: low-income, 18+ years, no open criminal	**Co-parenting behavior** for the treatment group to the	**Healthier co-parenting behavior** for the Treatment	Confirmatory

	domestic violence and related risk factors	cases (or deferred), children up to 24 years	control group 6 months after TCD enrollment.	Group that receives enhanced services.	

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2. BACKGROUND

For each outcome research question listed in 1.1, whether descriptive or impact design, briefly summarize the previous literature or existing research that informs the stated research question and how the evaluation will expand the evidence base. Explain why the research questions are of specific interest to the program and/or community. Only a short summary paragraph description is needed below. Additional documentation, such as a literature review, may be appended to this document.

Research Topic	Existing Research	Contribution to the Evidence Base	Interest to Program and/or Community
R1: Healthy Parenting Attitudes	Participants in fatherhood programming, particularly those in the target population, may not be receiving sufficient supports to address domestic violence and related risk factors in their families	Determine whether using curriculum to directly address the negative attitudes, expectations, and behaviors associated with domestic violence can enhance program participation benefits related to parenting attitudes among the target study population	Inform practitioners about whether the dynamics of domestic violence can be addressed directly with curriculum when trying to build parenting skills among program participants
R2: Healthy Partner Relationship Behaviors	Participants in fatherhood programming, particularly those in the target population, may not be receiving sufficient supports to address domestic violence and related risk factors in their families	Determine whether using curriculum to directly address the negative attitudes, expectations, and behaviors associated with domestic violence can enhance program participation benefits related to partner relationship behaviors among the target study population	Inform practitioners about whether the dynamics of domestic violence can be addressed directly with curriculum when trying to build healthy partner relationship skills among program participants
R3: Healthy Parent Behavior	Participants in fatherhood programming, particularly those in the target population, may not be receiving sufficient supports to address domestic	Determine whether using curriculum to directly address the negative attitudes, expectations, and behaviors associated with domestic violence can enhance program participation	Inform practitioners about whether the dynamics of domestic violence can be addressed directly with curriculum when trying to build healthy

	violence and related risk factors in their families	benefits related to parenting behaviors among the target study population	parenting skills among program participants
R4: Healthy Co-parent Behavior	Participants in fatherhood programming, particularly those in the target population, may not be receiving sufficient supports to address domestic violence and related risk factors in their families	Determine whether using curriculum to directly address the negative attitudes, expectations, and behaviors associated with domestic violence can enhance program participation benefits related to co-parenting behaviors among the target study population	Inform practitioners about whether the dynamics of domestic violence can be addressed directly with curriculum when trying to build healthy co-parenting skills among program participants

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3. LOGIC MODEL

Clearly demonstrate how the research question(s) (and the related implementation features and/or participant outcomes) link to the proposed logic model and the theory of change for the program. You may append a copy of your logic model to this document.

MER and Anthem Strong Families worked together to create a logic model to specify a theory of change for delivering *standard* and *enhanced TCD services*. Service delivery processes specified in the model are linked to the desired outcomes that promote healthy family relationships and economic stability. Model specification incorporates an RCT study design to conceptualize service delivery to make impact estimates for the TCD Project by comparing primary and secondary participant outcomes between study groups after random assignment. Treatment group participants receive *enhanced TCD services* and control group participants receive *standard TCD services*.

Service delivery processes: Key aspects of service delivery processes in the theory of change—goals, inputs, activities, and outputs—articulate the experiences that are designed to solve specific problems for those who agree to participate in the TCD Project. Solving each problem identifies three broad service delivery goals to maximize participation benefits for study groups as explained below:

- **Goal 1** - **Deliver *standard TCD services* to the Control Group**: Candidates randomly assigned to the control group will understand they receive *standard TCD services* to develop their skills to engage in healthy behaviors for parenting, co-parenting, partner relations, employment, and financial management but only after receiving an orientation about the TCD Project and giving project staff informed consent to participate in study activities. Then, *TYRO Dads* and *Core Communication* will be delivered to the control group as well as support services through case management and the *ASF Mini-Clinic*, as needed

- **Goal 2** - **Deliver *enhanced TCD services* to the Treatment Group**: Candidates randomly assigned to the treatment group will understand they receive *enhanced TCD services* to develop their skills to engage in healthy behaviors for parenting, co-parenting, partner relations, employment, financial management and address the dynamics of domestic violence, but only after receiving an orientation about the TCD Project and giving project staff informed consent to participate in study activities. Then, the *Ray of Hope* curriculum will be delivered only to the treatment group as well as the *TYRO Dads* and *Core Communication* curricula and support services through case management the *ASF Mini-Clinic,* as needed, under a shared condition with the control group.
- **Goal 3** - **Conduct Continuous Quality Improvement (CQI) to ensure full implementation of *standard* and *enhanced TCD services* for study groups**: Reports prepared and presented to the CQI Team by evaluators will use a series of performance indicators to track key outputs over time to identify any *TCD services* delivered to study groups that might fall short of the intended amounts to be offered (i.e., fidelity standards) and received (i.e., dosage thresholds) by them. The CQI Team will then work with project staff to develop and implement performance interventions to address any outputs that need improvement to ensure the services offered to and received by participants meet the intended amounts by the end of each program year.

Desired Outcomes: Outcomes specified in the logic model theorize the primary outcomes that are desired for participants in each study group after they receive either *standard* or *enhanced TCD services*. All outcomes specified in the logic model are theorized to be more positive for parents assigned to the treatment group because they receive *enhanced TCD services*, whereas the control group receives *standard TCD services*.

4. HYPOTHESES

For each specified research question, state the hypothesized result(s) and briefly describe why these results are anticipated.

Research Question	Hypothesized Result
R1	The treatment group will report **healthier parenting attitudes** than the control group immediately after completing the TCD program. Both study groups receive *TYRO Dads* and *Core Communication* curricula under a shared condition to build healthy parenting skills, but only the treatment group receives the *Ray of Hope* curriculum, which directly addresses the dynamics of domestic violence and related risk that can negatively impact healthy family relationships.

R2	The treatment group will report **healthier partner relationship behaviors** than the control group six months after TCD enrollment. Both study groups receive *TYRO Dads* and *Core Communication* curricula under a shared condition to build healthy communication skills, but only the treatment group receives the *Ray of Hope* curriculum, which directly addresses the dynamics of domestic violence and related risk that can negatively impact healthy family relationships.
R3	The treatment group will report healthier **parenting behavior** than the control group six months after TCD enrollment. Both study groups receive *TYRO Dads* and *Core Communication* curricula under a shared condition to build healthy parenting skills, but only the treatment group receives the *Ray of Hope* curriculum, which directly addresses the dynamics of domestic violence and related risk that can negatively impact healthy family relationships.
R4	The treatment group will report healthier **co-parenting behavior** than the control group six months after TCD enrollment. Both study groups receive *TYRO Dads* and *Core Communication* curricula under a shared condition to build healthy co-parenting skills, but only the treatment group receives the *Ray of Hope* curriculum, which directly addresses the dynamics of domestic violence and related risk that can negatively impact healthy family relationships.

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5. RESEARCH DESIGN

For each research question, briefly describe why the research design proposed will answer each research question(s). State whether the proposed evaluation is a descriptive or impact evaluation and justify why the proposed research design is best suited to answer the research question(s).

Research Question	Design	Justification
R1	Random assignment will isolate the effect on **parenting attitudes** from the *Ray of Hope* curriculum delivered to the treatment group.	**Healthy parenting attitudes** are compared between study groups where the only difference between them is whether participants receive the *Ray of Hope* curriculum because both groups will receive *TYRO Dads*, *Core Communication*, and support services under a shared condition.
R2	Random assignment *will* isolate the effect on **partner relationship behaviors** from the *Ray of Hope* curriculum	**Healthy partner relationship behaviors** are compared between study groups where the only difference between them is whether participants receive the *Ray of Hope* curriculum because both groups will receive *TYRO Dads*, *Core*

	delivered to the treatment group.	*Communication*, and support services under a shared condition.
R3	Random assignment will isolate the effect on **parenting behavior** from the *Ray of Hope* curriculum delivered to the treatment group.	**Healthy parenting behavior** will be compared between study groups where the only difference between them is whether participants receive the *Ray of Hope* curriculum because both groups will receive *TYRO Dads*, *Core Communication*, and support services under a shared condition.
R4	Random assignment will isolate the effect on **co-parenting behavior** from the *Ray of Hope* curriculum delivered to the treatment group.	**Healthy co-parenting behavior** are compared between study groups where the only difference between them is whether participants receive the *Ray of Hope* curriculum because both groups will receive *TYRO Dads*, *Core Communication*, and support services under a shared condition.

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6. ONGOING GRANTEE AND LOCAL EVALUATOR COORDINATION

Describe how the grantee and local evaluator collaboratively worked together to identify the research question(s) and research design to ensure its feasibility and relevance. Describe how the grantee and local evaluator will continue to work together throughout the evaluation to proactively address unforeseen challenges as they arise and ensure the rigor and relevance of the evaluation and its findings. Describe how the grantee and local evaluator will coordinate dissemination efforts. Describe how these processes will occur while maintaining the independence of the evaluation.

The basis for ongoing coordination between ASF (the grantee) and MER (the local evaluator) is regular, systematic communication through a structure comprised of recurring meetings and daily interactions with embedded staff. Throughout the original proposal process, and now during the evaluation planning phase, MER worked in consort with ASF to design a study with research questions that are appropriate to the intervention. MER guides the process, given our experience designing and running evaluations, and ASF provides expertise on their community, target population, and program/curricula specifics.

Recurring meetings will include a bi-weekly project CQI team meeting. Under the leadership of the Data Manager and Lead MER Evaluator, the CQI team reviews data from the nFORM and local evaluation systems to identify and mitigate implementation or data issues, and closely examine trends and accomplishments. This team includes ASF organizational and project leadership, the MER Evaluation team, and front-line staff representatives (e.g., Facilitators, Case Managers).

In addition to CQI team meetings, overall project team meetings occur monthly (at a minimum), with project leaders across MER and ASF in attendance, to ensure the partnership remains strong and that coordination across organizations is on track. This

recurring, ongoing meeting structure is conducive to close coordination, ensuring that challenges can be quickly addressed, and promising strategies can be efficiently maximized.

One of the key components of this coordination effort is the CQI Data Manager, who is a MER employee embedded with ASF The Data Manager functions to bridge the gap between organizations. They will interact with ASF staff daily while completing their job duties and play a leadership role in the recurring meetings outlined above. See Section 8 below for more details about this role and others. Both the meetings and the roles outlined above will continue throughout the entire project period, providing opportunities to ensure the rigor and relevance of the evaluation and its findings, and to discuss and coordinate dissemination efforts (which will also be shared across MER and ASF.

MER has a great deal of experience conducting impact studies with RCT designs using this exact process for other projects funded by the OFA. Clearly outlining roles and responsibilities maintains the independence of the evaluation. That is, the evaluation team helps identify and illuminate areas of concern or improvement (for the program and the evaluation), but the program staff have responsibility for implementing improvements and providing direct services to participants. In this way, ASF and MER acknowledge our shared interest in and responsibility for a well-executed project and evaluation, but that MER is also an independent and external organization with a high level of integrity and is not responsible for nor invested in the specific outcomes of the program. This allows for close coordination without allowing for co-dependence, or for personal interests to influence evaluation findings.

7. *IMPACT EVALUATIONS ONLY:* METHODS TO DEVELOP STUDY GROUPS

If the research design includes the comparison of two or more groups (e.g., a program group and a comparison group), please specify how the groups will be formed and describe the programming for which each will be eligible and how they differ below. The control/comparison group and the program/treatment group should be assigned using a systematic approach appropriate to the research design. Note: If the research question(s) and study design do not necessitate comparisons, this issue does not need to be addressed.

Specify how the groups will be formed.	Study groups will be formed using IRB approved procedures for random assignment after enrollment into the TCD. After soliciting informed consent, participants who agree to participate in the study provide case managers with signed consent forms. After documenting consent, the CQI Data Manager randomly assigns participants to achieve an even distribution across the treatment and control groups. *Assignments are made* and then recorded onto the nFORM data collection system by selecting cards

	that are organized into a stack that equals the number of parents who attended an orientation and now wish to receive TCD services and participate in the impact study. Cards in the stack have equal amounts of even and odd numbers depicted on them and one is drawn for each study participant. Selections into either the treatment or control group depended on whether a participant receives an even or odd number.
Please describe the comparison/control group experience – that is, the types of services available to the comparison/control group.	Fathers assigned to the control group do not receive enhanced TCD services. Instead, they receive the same standard services—TYRO Dads and Core Communication—and support services as treatment group parents under a shared condition (see the theory of change logic model mentioned above). Standard TCD service experiences for the control group should be the same as the treatment group. Parents assigned to both groups are offered the same number, schedule, and duration of workshop offerings for TYRO Dads and Core Communication curricula and attend them together, so they experience the same instructional practices that deliver the same curricula content.
How will the control/comparison group experience differ from the program group's experience?	Only the treatment group receives the *Ray of Hope* curriculum as a service enhancement to directly address the dynamics of domestic violence and related risk in families (see the theory of change logic model for dosage and schedule).
Please list any other services that are similar to the services your program offers and are available in the areas where your program will operate.	Anthem Strong Families (ASF) is the only non-profit in its designated service area offering a complete level of extensive fatherhood education and support services to community fathers and spouses of children up to 24 years old free of charge. There are other smaller ministries or service providers that target fathers of newborns offering periodic workshops for new dads but none on a continuous basis as ASF. The service area for ASF is adjacent to Tarrant County/Ft. Worth, TX., home of the longest existing fatherhood coalition in Texas that provides services to Tarrant County and DFPS Region 3-W.
Are there plans to offer the program to individuals in the control/comparison group in the future? If so, please indicate when they will be offered to participate in the intervention.	No.

7.1. RANDOM ASSIGNMENT TO DEVELOP STUDY GROUPS

If groups will be constructed by random assignment, please describe the process of random assignment and how random assignment will be monitored to prevent crossover of those assigned to specific study groups (e.g., individuals assigned to the comparison group who receive treatment) by addressing the questions below.

Who will conduct random assignment?	Eligible fathers who wish to participate in the study are randomly sorted into a treatment or control group by the CQI data manager or by case managers under supervision of the CQI Data Manager. The CQI Data Manager is trained by Senior staff and overseen by a Senior Consultant from MER.
When does random assignment occur *(e.g., before or after enrollment)*?	Orientation attendees who express interest in TCD services return the following week to enroll at their respective recruitment sites. Those who are also willing to participate in the impact study provide signed consent forms before they are assigned to study groups. After consent is documented, parents are randomly sorted into either a treatment or control group.
How and when are study participants informed of their assignment status?	Participants will be informed of their assignment status immediately after randomization.
Will groups be stratified in any way to ensure balance between treatment and control? If yes, what characteristics or methods will be used?	No.
What strategies will be used to ensure there is no re-assignment or non-random assignment to the treatment group?	A C2 (i.e., client profile) is entered onto nFORM to create a client profile for eligible parents who attend orientations for the TCD Project. Parents who return to participate in the study have their study group assignment entered onto nFORM. Only parents assigned to the treatment group as noted on nFORM can register and attend *Ray of Hope* workshops. Study group assignment cannot be changed once it has been noted on nFORM.

What strategies will be used to minimize crossovers?	The nFORM system produces an operational report that specifies study group assignment for all parents who agree to participate in the study. Study group assignment as noted on nFORM will be examined with the relevant operational report during CQI-Team meetings to make sure participants receive the services specific to their study group.
Who will be responsible for monitoring random assignment compliance?	The CQI Data Manager is responsible for monitoring random assignment compliance by case managers during study enrollment under the guidance of other CQI Team members. The distribution of participants across study groups will be monitored by the CQI Team using the relevant operational reports on nFORM.
What methods will be used to monitor the comparability of the study groups?	nFORM data will be used to produce enrollments into study groups to assess their comparability. Baseline equivalency analyses will determine whether there are statistically significant differences between study groups.

8. LEAD STAFF

Define the roles of lead staff for the evaluation from both organizations below.

Name	Organization	Role in the Evaluation
Dr. Matthew Shepherd	Midwest Evaluation and Research	Principal Investigator
McKenna LeClear	Midwest Evaluation and Research	Lead Evaluation Consultant/ Evaluation Project Manager
Shuntay Ward	Midwest Evaluation and Research	CQI Data Manager

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Articulate the experience, skills, and knowledge of the staff for the evaluation (including whether they have conducted similar studies in this field), as well as their ability to coordinate and support planning, implementation, and analysis related to a comprehensive evaluation plan.

Dr. Matthew Shepherd will serve as the Principal Investigator for this grant. As such, he has corporate responsibility for all evaluation activities. Dr. Shepherd has over 25 years' experience in program design and implementation, applied research, program evaluation, policy analysis, and evaluative technical assistance.

McKenna LeClear will serve as the Lead Evaluation Consultant and Evaluation Project Manager to provide day-to-day oversight for the HMRF evaluation activities. McKenna has five years of program evaluation research experience and has served as the lead evaluation consultant for seven other HMRE evaluations in the current grant cycle. She will lead the effort to conduct an impact study and a Continuous Quality Improvement (CQI) process for the grant.

Shuntay Ward will serve as the CQI Data Manager. The CQI Data Manager will be responsible for accurate and timely data collection, report generation, and assistance with Continuous Quality Improvement (CQI) throughout the process of the grant. Shuntay Ward served as the CQI Data Manager for an HMRF project in the previous funding cohort called the TYRO Champion Dads Project.

9. SAMPLE

9.1. TARGET POPULATION(S)

For each target population identified in Section 1.2, please describe the target population(s), and explicitly state whether the population(s) differs from those who will be broadly served by the grant. Describe how the target population will be identified. Explicitly state the unit of analysis (e.g., non-residential father, unmarried couple).

Description of Target Population	How is the population different from those who will be broadly served by the grant?	How will the target population be identified?	Unit of Analysis
Target population is Latino fathers who are low-income, 18+ years of age, have no open criminal cases (can be deferred), with children up to 24 years old	No difference, all program participants will be study participants.	The sample will be identified and recruited by community partner referrals and program staff.	Individual father

9.2. *IMPACT EVALUATION ONLY:* SAMPLE SIZE

If an impact evaluation is proposed, state the intended sample size (overall and by year), estimated attrition, and the anticipated size of the analytic sample (for both program/treatment and control/comparison groups). If the estimated analytic sample is expected to vary by outcome measure (e.g., outcomes measured using administrative records vs. survey data), you may copy the table below and label accordingly.

Year	**Estimated Sample Size** *(# of individuals randomly assigned)*		**Estimated Size of Analytic Sample** *(# of individuals at analysis)*	
	Treatment	**Comparison**	**Treatment**	**Comparison**
Year 1	*N/A*	*N/A*	*N/A*	*N/A*
Year 2	70	70	49	49
Year 3	162	162	113	113
Year 4	162	162	113	113
Year 5	50	50	35	35
TOTAL	443	443	310	310

9.3. *RCTS ONLY:* POWER ANALYSIS

For each confirmatory outcome, please provide power analyses demonstrating proposed sample sizes will be able to detect expected effect sizes for the outcomes targeted. Refer to previous studies of similar interventions for estimates of the required sample to inform power analyses. Note: If an impact evaluation is not proposed, this issue does not need to be addressed. You may use the table below to report the assumptions used in your power calculations, as well as the resulting minimum detectable impact for your confirmatory outcomes ***or*** *provide them in the space below.*

	Outcome 1	**Outcome 2**	**Outcome 3**	**Outcome 4**
Outcome Name	**Healthier Parenting Attitudes**	**Healthier Partner Relationship Behavior**	**Healthier Parenting Behavior**	**Healthier Co-Parenting Behavior**
Continuous or binary?	continuous	continuous	continuous	continuous

Level of significance (e.g., 0.05 percent)	0.05	0.05	0.05	0.05
Number of sides of test (one- or two-tailed)	One-tailed	One-tailed	One-tailed	One-tailed
Power (e.g., 80 percent)	80%	80%	80%	80%
Total number of individuals in analytic sample	620	620	620	620
If binary, enter mean of outcome variable				
If continuous outcome, enter the standard deviation of the outcome (>0)				
Proportion of individual-level (or within-group) variance explained by covariates				
For cluster RCTs: intraclass correlation coefficient	N/A	N/A	N/A	N/A
For cluster RCTs: proportion of group-level variance of	N/A	N/A	N/A	N/A

outcome explained by covariates				
Minimum detectable impact				
Minimum detectable effect size	0.2	0.2	0.2	0.2

If you did not provide report your assumptions using the table above, please enter them here.

9.4. METHODS TO PROMOTE SUFFICIENT PROGRAM PARTICIPATION

Please describe methods to promote sufficient program participation in the table below.

What methods will you use to ensure sufficient sample is recruited, enrolls, and participates in the program?	Recruitment into TCD services and the study relies heavily on referrals from community partners who serve eligible parents. However, referrals also result from walk-ins to the ASF mini clinic, the ASF website that presents available services, advertising by ASF about the TCD Project, and word of mouth from TCD participants. Recruitment targets fathers but also accepts mothers who are: at least 18 years of age with no open criminal cases (can be deferred), largely low-income, interested in TCD services, and willing to be randomly assigned to either study group after informed consent.
Who will be responsible for recruiting the evaluation sample?	Case Managers under the supervision of the CQI Data Manager through community partnerships formed by Charles Dillon, Project Director.
Please describe any incentives to be offered for program participation and/or completion and/or data collection and/or participation in the evaluation.	*Attendance Incentives:* *• $25.00 e-gift card for attendance at workshops 1 – 3.* *• $25.00 e-gift card for attendance at workshops 4 – 6* *• $25.00 e-gift card for attendance at workshops 7 – 9* *• $25.00 e-gift card for attendance at workshops 10 – 12* *Program completion incentives:* *• $150.00 e-gift card for program completion plus TYRO Champion T-shirt, Champion Dad T-shirt, TYRO Pin and Certificate of Completion*

	• ASF also offers various wristbands displaying positive personal characteristics at various times based on participant engagement and group input. *Survey Completion Incentives:* *• $50.00 Giftogram gift card for OLLE Follow-up Survey*

10. DATA COLLECTION

10.1. CONSTRUCTS AND MEASURES

Clearly articulate the constructs of interest, measures to evaluate those constructs, and specific data collection instruments. Provide any information on the reliability and validity of the data collection instruments. For standardized instruments, you may provide the citation for the instrument.

Measure	Sample	Variable Type	Data source(s)	Variable Name	Definition
Co-parenting relationship behaviors	Has at least one child age 24 or younger	Continuous (range from 1 to 5 where 1 is strongly disagree and 5 is strongly agree)	nFORM entrance, OLLE follow-up	Copar_Beh	Average of 11 survey items that relate to positive interactions with the mother of participant's youngest child
Parenting relationship behaviors	Has at least one child age 24 or younger, saw child within past month	Continuous (range from 1 to 5 where 1 is never and 5 is every day or almost every day)	nFORM entrance, OLLE follow-up	Par_Beh	Average of 10 to 11 survey items (depending on child age) that relate to frequency of positive interactions with participant's youngest child
Parenting relationship attitudes	Has at least one child age 24 or younger, saw child within past month	Continuous (range from 1 to 5 where 1 is always and 5 is never)	nFORM entrance, nFORM exit	Par_Att	Average of 6 survey items that relate to frequency of feelings about participant's youngest child
Parenting relationship behaviors	Has at least one child age 24 or	Continuous (range from 1 to 5 where 1 is	nFORM entrance, ,	Parent_Fight	Reported frequency of

	younger, saw child within past month	never and 5 is every day or almost every day)	OLLE follow-up		fighting with child
Partner relationship behaviors	All survey respondents	Continuous (range from 1 to 5 where 1 is never and 5 is always)	OLLE pre-survey, OLLE post-survey, OLLE follow-up	Partner_Fight	Reported frequency of fighting with partner
Partner relationship behaviors	All survey respondents	Continuous (range from 1 to 5 where 1 is never and 5 is always)	OLLE pre-survey, OLLE post-survey, OLLE follow-up	Partner_Disagree	Average of 7 survey items related to frequency of disagreement with partner on different topics

** you may add rows by hitting the tab button, or right click and select insert row below*

10.2. CONSENT

Describe how and when program applicants will be informed of the study and will have the option of agreeing (i.e., consenting to) or declining to participate in the study.

Staff present the purpose and benefits of standard and enhanced TCD services at orientations held at partner sites and the ASF mini clinic to recruit eligible fathers. Orientations also discuss the impact study and explain informed consent before soliciting participation. Participant responsibilities are clarified at the orientation, such as providing contact information and responding to surveys.

Program staff follow a protocol approved by IRB Solutions, Inc to solicit informed consent. Candidates are informed about study specifics and afterward can ask questions and seek clarification before documenting their consent. Candidates are made aware of their responsibilities to attend TCD service workshops and fulfill important requests, such as providing contact information and responding to surveys. In return, potential study participants are assured that receiving TCD services does not depend upon consent to participate in the study, their identifying information is kept confidential, and study results are reported at the group level to protect their anonymity. Project staff also inform candidates that incentives are offered for participating in TCD services and the study as follows:

Attendance Incentives:

- *$25.00 e-gift card for attendance at workshops 1 – 3.*
- *$25.00 e-gift card for attendance at workshops 4 – 6*
- *$25.00 e-gift card for attendance at workshops 7 – 9*

• $25.00 e-gift card for attendance at workshops 10 – 12

Program completion incentives:

• $150.00 e-gift card for program completion plus TYRO Champion T-shirt, Champion Dad T-shirt, TYRO Pin and Certificate of Completion

• ASF also offers various wristbands displaying positive personal characteristics at various times based on participant engagement and group input.

Survey Completion Incentives:

*• $50.00 G*iftogram *gift card for OLLE Follow-up Survey.*

10.3. METHODS OF DATA COLLECTION

If the evaluation will collect multiple waves of data, describe the timing of these waves below. When describing follow-up periods, specify whether the follow-up period will be post-baseline, post-random assignment, or post-program completion.

Wave of Data Collection (e.g., baseline, short-term follow-up, long-term follow-up)	**Timing of Data Collection**
Baseline	Collected immediately following informed consent and enrollment – during orientation or before first primary workshop session
Post-test	Collected after the completion of the primary services programming – during or following the last workshop or session
Follow-up (6 months after enrollment)	Collected approximately six months after program enrollment

For each measure, describe how data will be collected detailing which data collection measures will be collected by which persons, and at what point in the programming or at what follow-up point.

Measure	**Timing of Data Collection** (baseline, wave of data collection)	**Method of Data Collection**	**Who Is Responsible for Data Collection?**	*Impact Evaluations Only:* **Will Methods or Collection Procedures Differ by Study Group?**	*Administrative Data Only:* **Will data access require data sharing agreement?**
On-line Local Evaluation (OLLE) and nFORM Baseline Survey	Baseline	Participant self-enters survey using online data collection program or on paper surveys if necessary	CQI Data Manager will proctor data collection and assist participants as necessary	No	
OLLE and nFORM Post-Test Survey	Post-Test (approx. 12 weeks after enrollment during last workshop session)	Participant self-enters survey using online data collection program or on paper surveys if necessary	CQI Data Manager will proctor data collection and assist participants as necessary	No	
OLLE Six Month Follow-up Survey	Six months after enrollment / baseline	Participant self-enters survey using online data collection platform and link – or – Phone interview data collection	MER Research Staff/ participant tracking team	No	

* *you may add rows by hitting the tab button, or right click and select insert row below*

10.4. ENSURING AND MONITORING DATA COLLECTION

Describe plans for training data collectors and for updating or retraining data collectors about procedures. Detail plans to regularly review data that have been submitted and to assess and swiftly address problems.

This evaluation will utilize both post-program surveys (completed at the completion of core programming) and follow-up surveys collected six months after enrollment. The methods for these data collections differ. The primary driver for post-program survey completion is high rates of program retention. This data point will be collected during the last workshop session. As such, only those individuals who complete the program and who are at the data collection session will be likely to participate in the post-program data collection.

All program staff and evaluation staff will undergo a rigorous set of trainings to prepare for the evaluation. All staff receive an overview and introductory training to present the goals and objectives of the evaluation effort and its importance to the overall project. Next, all staff receive training on human subject protection and are required to pass a certification test on the subject matter. All staff will also receive a detailed training on the evaluation, including the evaluation tools, timing and data collection process, and the role and importance of randomization of participants.

In addition, the data manager and the primary local evaluation staff will undergo a rigorous training process to better understand the context of HMRF research, training on data collection procedures they will be responsible for, and training on the nFORM system and use of nFORM data in a CQI process. MER is creating networks of CQI data managers and Evaluation Project Managers across the 12 projects that we are evaluating so that all staff have access to experienced data managers and evaluation staff who have done this work previously. This training takes the form of weekly training sessions that are currently underway.

Members of the CQI team will also receive specific training on the MER CQI process that has been developed prior to the launch of data collection or program services. As described elsewhere, MER is assisting the program staff in implementing a robust CQI process that will focus on retention as one of the primary areas of program improvement, and as such, we are anticipating relatively modest levels of attrition for this data collection.

On a bi-weekly basis, the data manager, the local evaluation staff, and MER technical specialists will be responsible for downloading data from the nFORM and MER On-Line Local Evaluation (OLLE) systems for processing and presentation to the CQI team for tracking and monitoring performance measurement outcomes (recruitment, enrollment, dosage, completion, referrals, etc.) so that near real-time adjustments can be made to program implementation to ensure compliance with program goals and objectives.

All MER training is currently being recorded, and as new staff come on board with projects or project staff turnover (or need refresher training), recorded training material can be shared and accessed with follow-up one on one training with the primary local evaluator and the MER Line of Business Lead.

11. IRB/PROTECTION OF HUMAN SUBJECTS

Please describe the process for protection of human subjects, and IRB review and approval of the proposed program and evaluation plans. Name the specific IRB to which you expect to apply.

Solutions IRB, a private commercial Association for the Accreditation of Human Research Protection Programs Inc. (AAHRPP) fully accredited Institutional Review Board, will ensure that this study is approved before any research activities take place. MER has had 14 research studies approved by Solutions IRB over the past four years, has completed over 15 annual check-in reports, and has submitted timely amendments when changes to studies needed to take effect.

All submissions are completed online, so turnaround for a new study approval is between 24 to 72 hours, though the full approval process can take approximately one to two weeks depending on the number of questions and requested revisions that the IRB makes. In the IRB application submission, we will include descriptions of project staff, locations of study sites, the funding source, incentives, summary of activities, participant population, recruitment plans, risks and benefits, confidentiality of data, and the informed consent process along with all materials to be used in the study such as participant forms and surveys.

This project will be submitted for IRB approval in early March 2021 to receive official approval to begin enrollment and data collection that begin on April 1, 2021.

12. DATA

12.1. DATABASES

For each database used to enter data, please describe the database into which data will be entered (i.e., nFORM and/or other databases), including both performance measure data you plan to use in your local evaluation and any additional local evaluation data. Describe the process for data entry (i.e., who will enter the data into the database).

Database Name	Data Entered	Process for Data Entry
nFORM	Participation Data, Participant Outcomes (nFORM Surveys-ACS, Entrance, Exit), Workshop attendance, case management	Entered directly by TCD participants and TCD Project staff
Qualtrics	Participant outcomes (OLLE survey)	Entered directly by participants and MER staff

* *you may add rows by hitting the tab button, or right click and select insert row below*

12.2. DATA REPORTING AND TRANSFER

For each database provided in the table above, please indicate the ability to export individual-level reports to an Excel or comma-delimited format and whether identifying information is available for linking to data from other sources.

Database Name	Ability to Export Individual Reports?	What identifying information is available to facilitate linking to other data sources?
nFORM	Yes, pre-packaged operational reports, excel, cvs, tab delimited	Name, DOB, nFORM ID
Qualtrics	Yes, Excel, cvs, tab delimited, others	Name, DOB, nFORM ID

* *you may add rows by hitting the tab button, or right click and select insert row below*

12.3. CURRENT SECURITY AND CONFIDENTIALITY STANDARDS

For each database provided in Section 11.1, please Indicate the ability to be able to encrypt data access during transit (for example, accessed through an HTTPS connection); be able to encrypt data at rest (that is, when not in transit), have in place a data backup and recovery plan; require all users to have logins and passwords to access the data they are authorized to view; and have current anti- virus software installed to detect and address malware, such as viruses and worms.

Database Name	Ability to encrypt data during transit?	Ability to encrypt at rest?	Data Backup and Recovery Plan?	Require all users to have logins and passwords?	Current Anti-Virus Software Installed?
n*FORM*	Yes	Yes	Yes	Yes	Yes
Qualtrics	Yes	Yes	Yes	Yes	Yes

* *you may add rows by hitting the tab button, or right click and select insert row below*

Please describe any plans for study registration with an appropriate registry (e.g., clinicaltrials.gov, socialscienceregistry.org, osf.io, etc.).

This study will be registered with clinicaltrials.gov.