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# **Healthy Start of Oregon 2001 – 2002 Status Report**

**July 1, 2001 – June 30, 2002**

*prepared for:*

**Oregon Commission on  
Children and Families**

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Special thanks go to the staff, volunteers, and families at the 34 Healthy Start sites:

Healthy Start of Baker County	Healthy Start of Lincoln County
Healthy Start of Benton County	Healthy Start of Linn County
Healthy Start of Clackamas County	Malheur County Healthy Start
Clatsop Healthy Families	Marion/Polk Healthy Start
Columbia County Healthy Start	Healthy Start of Morrow County
Coos County Healthy Start	Healthy Start of Multnomah County
Healthy Start of Crook County	Tillamook Healthy Families
Healthy Start of Curry County	Healthy Start of Umatilla County
Deschutes County Ready, Set, Go	Union County Healthy Start
Douglas County Healthy Start	Healthy Start of Wallowa County
Grant County Healthy Start	Families First of Wasco/Sherman Counties
Harney County Healthy Start	New Parent Network of Washington County
Families First of Hood River County	Healthy Start of Gillam County
Jackson County Healthy Start	New Parent Network of Yamhill County
Jefferson County Healthy Start	Healthy Start of Wheeler County
Josephine County Healthy Start	
Klamath Healthy Start	
Lake County Healthy Start	
Lane County Healthy Start	

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### **Parents Speak About Healthy Start**

“They have been helpful in answering questions...every month it is something new and something different that I have questions about. If they don't know the answer, they find the answer for me. The most helpful thing is that they are very compassionate and listen to my concerns and reassure me that my son is progressing as normal. They've just been awesome all the way through”.

# Healthy Start of Oregon 2001– 2002 Status Report

## Executive Summary and Recommendations

Healthy Start recognizes that every new family can use support when a baby is born. Yet every new family does not need the same degree of support. Thus, Healthy Start of Oregon strives to offer all new parents with a first-born child a range of home visitation services from short-term during the period directly after birth to longer-term services sometimes beginning prenatally and continuing throughout the early childhood years.

After nine years of providing home visitation to families with young children, Healthy Start of Oregon has experienced many successes and faced some challenges. Using a performance measurement strategy, the 2001–02 Status Report describes findings relating to implementation, service participation, child and family outcomes, and system outcomes.

### ***Findings: Program Implementation, 2001–02***

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Program implementation and service delivery processes are evidenced by a series of indicators that measure the success of the comprehensive assessment system, the number of families served, and the type and length of service received.

Fifteen essential components provide a blueprint for Healthy Start's wellness approach. The flexibility of the framework ensures that communities can meet specified quality assurance standards yet also address local needs and utilize local resources.

**1. Healthy Start was funded in all 36 Oregon counties during FY 2001–02.** For the first time in its 9-year history, Healthy Start of Oregon served families in all 36 counties.

- Sixteen new Healthy Start programs received State funding in 2002. These programs began serving families between May 2002-Jan 2003. Yamhill County had been providing services since 2000 with Spirit Mountain Community funds.
- Because not all programs served families during all of the FY 2001–02 fiscal year, data are only reported here for the 19 sites that were serving families for this entire period. Descriptive summaries of all 34<sup>1</sup> programs are in Appendices A & C.

**2. Oregon's statewide system for screening and identifying first-birth families has faced challenges this year.** The Healthy Start model calls for universal, non-stigmatizing supports to be offered to all families with newborns, targeting first-birth families through a comprehensive screening and assessment system. This year, considerably fewer first-births received screening, compared to previous years. This decrease began last year, due to a change in the process for identifying families who could benefit from Healthy Start. With the passage of HB 3659 in 2001, and concern over ensuring strong protection for families' confidentiality, a policy decision was made to

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<sup>1</sup> Two programs are partnerships between two counties.

require parents' express written consent prior to screening. This has reduced counties' ability to identify at-risk families, and counties have had to spend additional resources creating new identification systems and screening procedures. Some counties were more impacted by this policy than others. In addition to this change in screening procedures, the reduction is also likely related to issues involved in changing the screening tool from the Hawaii Risk Indicators instrument to the Oregon Children's Plan Screen (which incorporates the same indicators, but uses a different format and approach).

Overall, 37% of the first-born children across the 19 Healthy Start sites were screened for risk characteristics during FY 2001–02 and offered appropriate services. This percentage was considerably lower than in previous years (80% in 2000–01). However, Washington County was not fully funded in FY 2001–02, and was, therefore, unable to serve all eligible families. When Washington County numbers are excluded, the rate increases to 47%. Finally, it is worth noting that significant drops in several large counties that were particularly impacted by policies requiring parents' express written consent for screening (and thus had screened over 85% of first-births in prior years) account for the majority of this reduction. For example:

- Clackamas County screened only 419 out of 1,620 first-births (26%, compared to 84% in 2000–01).
- Jackson County screened only 476 out of 865 first-births (55%, compared to 94% in 2000–01).
- Marion and Polk (a joint Healthy Start site) screened only 908 out of 1,922 first-births (47%, compared to 82% in 2000–01).
- Union County screened only 38 out of 111 births (34%, compared to 59% in 2000–01).

When Clackamas, Jackson, Marion/Polk, and Union counties (in addition to Washington) are excluded, the reach rate increases to 53%, close to the average for the remaining counties in prior years.

**3. In other areas, Healthy Start has improved its screening and assessment procedures.** Despite the lower number of first-birth families screened, Healthy Start sites improved their screening and assessment process in other areas:

- More families who were screened at higher risk were assessed using the Kempe Stress Interview (53% vs. 45% in 2000–01)
- More families were screened prenatally or at birth (78% vs. 57% in 2000–01)
- In general, a greater proportion of families screened at higher risk, compared to previous years (68% vs. 56%). This finding may reflect changes in counties' strategies for identifying families. Because of new policy requiring parents' express written consent, counties needed to rely more heavily on referrals from medical professionals and other providers serving families. It is possible that providers were more likely to refer families to Healthy Start if they viewed them as higher risk and more in need of home visiting services.



While Healthy Start still aspires to be a universal service, it has been able to maintain services to higher need families despite some of the recruitment challenges it has faced.

### ***Findings: Service Participation, 2001–02***

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**1. Fewer families participated in Healthy Start during 2001–02 than in the previous year; however, the drop is in the number of families screened and provided basic service, not in the number of families receiving Intensive Services.** Participation decreased from 8,912 families in FY 2000–01 to 6,581 in FY 2001–02 (this number increases to 6,776 when counties that were new this year are included). 46.0% (3,044) received short-term Basic Service, 45.9% (3,027) were involved in the long-term Intensive Service, and 8.0% (510) declined any further service beyond screening and community information. The decrease in overall participation is due to the smaller number of families being screened and provided Basic Services. Because Healthy Start is voluntary, families are offered services, including the screening, but are free to decline them. Families are not tracked by the data system unless they have been screened, so data are not available on the number of families that Healthy Start contacted who declined to be screened. Further, some of these families, although they decline the screen, do request and receive Basic Services.

The number of families receiving long-term Intensive Service was approximately the same as in previous years (3,027 in FY 2001–02 compared to 3,220 in FY 2000–01).

**2. Families who chose to participate in Intensive Services appear to be more successfully engaged this year, compared to prior years.** Healthy Start is retaining higher need families for a longer period of time than in previous years (16.7 months vs. 13.9). This is important, as research shows that home visiting is most effective when frequent (at least monthly) visits are provided over an extended period of time (at least one year)<sup>13</sup>. Further, 94% of higher-risk families who accepted Intensive Services received at least 3 months of service, compared to 87% in FY 2000–01.

**3. The comprehensive screening and assessment system effectively identified families at greatest risk for poor outcomes, including child maltreatment.**

Healthy Start uses a targeting approach, which clearly provides an effective means to focus scarce resources on families at greatest risk for poor outcomes, including child maltreatment.

- The likelihood of maltreatment occurring is 2.4 times greater for families with any one risk characteristic in comparison to families with no risk characteristics. With two risk characteristics, the odds for abuse *more than triple* to 11.2 times greater. The probability for maltreatment continues to increase dramatically with the addition of more risk characteristics.
- Families who screen as high risk are then assessed for their level of family stress, using the Family Stress Inventory (KFSI). Ten areas of potential stress are explored in depth, including issues relating to family supports and social isolation, expectations for infant behavior, provides early identification of

families facing pervasive stress that erodes family stability and puts children at risk. The rate of child abuse and neglect is 12 per 1,000 children for families with moderate stress. This rate climbs to 40 per 1,000 children for families with high stress, and to 108 per 1,000 children for families with the most severe levels of stress (see Table 23, Appendix B). and parent-child bonding. This assessment

#### **4. Healthy Start is successfully identifying and serving higher-risk families.**

Families receiving Intensive Service tend to be single parents who are significantly younger, less educated, and poorer than Basic Service families.

- 73% of the Intensive Service mothers have never been married compared to 0% of the lower risk Basic Service mothers.
- 49% of the Intensive Service mothers have less than a high school education compared to 3% of the lower risk Basic Service mothers.
- 82% of the Intensive Service mothers are income-eligible for the Oregon Health Plan compared to 13% of the lower risk Basic Service mothers.
- Approximately 33% of the Intensive Service mothers and 49% of the fathers have a history of alcohol or substance abuse.

### ***Findings: Outcomes for Children and Families, 2001–02***

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A series of outcome indicators measure Healthy Start's statewide progress toward Oregon Benchmarks and the wellness goals of healthy, thriving children and strong, nurturing families for Healthy Start's Intensive Service families.

**1. Most of Healthy Start's young children are free from maltreatment.** A child victimization check by DHS Child Welfare of Healthy Start children aged 0–2 in 2001 showed:

- 98.8% of all Healthy Start children, regardless of family risk characteristics, were free from maltreatment. Only 1.2% (12 per 1,000 children) had confirmed cases of child maltreatment. In comparison, 97.0% of the non-served children aged 0 – 2 years in the same counties were free from maltreatment. The child abuse rate for non-served children (30 per 1,000 children) is **more than double the rate** than among Healthy Start children and is similar to recent national statistics that show an incidence rate of 26 per 1,000 children for this age group, regardless of family risk level.
- 97.5% of higher-risk Intensive Service families with children aged 0 – 2 were free from maltreatment. This percentage is somewhat higher than in other programs providing home visiting services to higher-risk families, including the David Olds nurse home visitation program (96% free from maltreatment) and Hawaii Healthy Start (96.6% free from maltreatment).

**3. Children living in higher-risk families show healthy growth and development, and are receiving regular health care and immunizations.**

- 88% of the children whose families have received Intensive Service during the past three years are developing normally.
- 97% of Healthy Start’s children from families receiving Intensive Service have a primary health care provider and 91% are receiving regular well-child checkups.
- 93% of Healthy Start’s two-year-olds have completed the immunization sequence. In contrast, only 76% of all Oregon two-year-olds were adequately immunized in 2001, as reported by the U. S. National Immunization Survey.

**4. Pregnant women received better prenatal care for subsequent births.**

- Pregnant women are receiving early, comprehensive prenatal care for second pregnancies. 80% of Intensive Service mothers received early comprehensive prenatal care for second pregnancies. Only 68% had received early comprehensive prenatal care for their first pregnancies.

**5. Families promote children’s school readiness.** Family literacy activities are strong predictors of school readiness. The majority of Intensive Service families are effective in their role as their child’s first teacher. After 12 months of Intensive Service:

- 74% of Healthy Start’s higher-risk families are creating learning environments for their young children that are rated as “well above average” by their home visitor.
- By age 2:
  - 93% of higher-risk Intensive Service families regularly read to their children.
  - 99% of the children have 3 or more books of their own.

**6. Healthy Start supports positive parenting.** Positive, supportive interactions increase children’s well-being and are related to reductions in child maltreatment. By the time their child is 6 months of age:

- 73% of Healthy Start’s higher-risk families *consistently* engage in positive, supportive interactions with their children.
- 75% of higher-risk families report improved parenting skills.

**7. Healthy Start successfully connects higher-risk families with needed services and resources.** After 12 months of service:

- 87% of Intensive Service families report their needs are usually met for basic resources, a 12% increase from when their children were born.
- 77% of the families have a primary health care provider, 61% have dental care, and 78% *never* use costly emergency room services for routine health care.

- Only 3% of Intensive Service families report regular use of emergency room services for routine health care.
- 96% of Intensive Service families had health insurance, and 82% were enrolled in the Oregon Health Plan.

**8. Families find Healthy Start of Oregon very helpful.** As one parent remarked about her participation, “Healthy Start is a great resource.”

- 92% of the Intensive Service parents reported that Healthy Start helped them meet the needs of their child, better understand their child's behavior and feelings, and find positive ways to teach and discipline their child.
- 89% reported Healthy Start helped to provide access to other needed community resources; and 81% said the Healthy Start helped with serious family problems.
- Parents reported that the emotional support provided by home visitors helped them improve their relationships with others. By developing a family support plan, they were able to set and achieve goals for themselves. Many parents accomplished things they never thought were possible, such as getting a high school diploma.

### ***Findings: Systems Outcomes, 2001–02***

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Healthy Start is designed to provide collaborative, community-based services. Thus, it is important to document the extent to which Healthy Start is effectively bringing providers together to create a coordinated and integrated early childhood program.

**1. Healthy Start’s collaborative partnerships have been developed and maintained.** Over the 19 sites described in the report:

- 108 different programs and agencies collaborate to create the core of the Healthy Start effort under the leadership of local Commissions on Children and Families (average of 6 per site). Core collaborators include local Health Departments, hospitals, health care providers, local Department of Human Services (DHS) offices, Educational Service Districts, community colleges, Head Start and Early Head Start, and teen parent programs.

**2. A variety of resources are leveraged and mobilized in support of families.**

Healthy Start sites have successfully leveraged a variety of resources, including space, materials, staff, and money.

- During the 2001–03 biennium, the Oregon legislature appropriated funds to support Healthy Start in all 36 counties. The program was funded at 80%, which with a 20% local match requirement would have made it possible to serve all of Oregon’s first-birth families. By the end of the fifth Special Session, the funding level had been reduced to 65% in all 36 counties. During FY 2001–02, reimbursement from federal Title XIX Administrative Case

Management funds yielded approximately \$2.4 million. Additionally, the Oregon Commission on Children and Families allocated approximately \$525,000 in federal Family Preservation and Support monies to the Healthy Start effort.

- Communities invested local resources to support, at a minimum, 20% of the local program costs. Further, communities utilized 312 volunteers to support Healthy Start services.
- The Oregon State Library and the Spirit Mountain Community Development Fund both provided funds for children's books to be distributed to Healthy Start families across the state. Many local sites also received funds through First Books to distribute books to families.

### ***Recommendations: 2001–02***

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The outcome evaluation shows clearly that many children and families benefit from Healthy Start services. Healthy Start appears to be especially effective in helping to link families to needed basic resources, supporting the development of positive home environments for children, supporting positive parent-child interactions, helping children to become fully immunized, increasing early, comprehensive prenatal care for subsequent pregnancies, and, perhaps most importantly, reducing the incidence of child abuse and neglect.

Despite many successes, a proportion of Healthy Start's higher-risk families continue to struggle, experiencing conditions that place both adults and children at risk for poor outcomes. Further, this year brought significant changes to Healthy Start screening and identification systems, resulting in fewer families being served. However, while changes in screening procedures reduced the number of families who were screened this year, services to higher need families were expanded. Though approximately the same number of families received Intensive Services this year, those families received services for a longer period of time. Further, more families were screened early in the child's development, allowing services to begin during the critical early infancy or prenatal periods. In addition, this year brought expansion of Healthy Start to new counties, which required local and state coordination and implementation efforts and will contribute to a broader availability of Healthy Start services in coming years. Based on the findings from this fiscal year, we make the following recommendations.

1. **Continue to work to provide a continuum of non-stigmatizing Healthy Start service to all Oregon families with newborn children.** Healthy Start builds on family strengths, implementing a legislative philosophy designed to create wellness for all Oregon children and families. Information from participating counties shows family interest and need for Healthy Start service is substantial. It is important for Healthy Start to continue to provide *a continuum of service*, ranging from short-term, basic service during the period after birth to long-term support service beginning prenatally and continuing through the early childhood years, so that *all* families with newborn children may benefit from this important community support. More families have

begun to be served prenatally, a trend that appears to be positive in terms of providing early screening and successfully engaging families.

Additionally, new sites that began to serve families during FY 2001–02 may have particular challenges. Some serve particularly small, isolated rural Oregon communities. Others (especially Multnomah County) involve implementing Healthy Start within a complex pre-existing system of home visiting programs in a way that augments, rather than duplicates, existing services. Intensive, ongoing support is needed to ensure that these sites implement high quality Healthy Start services.

2. **Refine the comprehensive screening and assessment system to ensure that all families are offered service.** Healthy Start of Oregon’s comprehensive screening and assessment system went through significant changes during the past year. Sites clearly face challenges in developing new strategies for effectively identifying and screening all first-birth families. Strategies employed in those counties that have been successful in reaching a large proportion of first-born children should be shared with other counties. Further, it may be important to develop ways of documenting the Basic Services provided to families who decline to participate in the screening process.
3. **Continue to provide high quality long-term Intensive Service for higher-risk families throughout the early childhood years.** Higher-risk families have stressful lives that put parents and children at risk for poor outcomes. Multiple risk factors create an “environment of risk” that substantially reduces the chances for children’s healthy development and school success. Although this year there appeared to be a significant increase in the length of time that families remained enrolled in Intensive Services, continued efforts should be made to reduce the attrition rate among higher-risk families. When families do leave before graduation, they should be linked to other quality services within the early childhood system of supports to ensure the best outcomes for themselves and their children.
4. **Maintain and expand quality assurance mechanisms to ensure high quality service throughout the system.** Healthy Start’s impact on the Oregon Benchmarks will depend ultimately on maintaining the quality and integrity of the Healthy Start services. Healthy Start of Oregon uses a framework of research-based essential components to guide supports and services. In addition, quality assurance standards have been developed for Oregon’s Early Childhood System of Supports and Services. Healthy Start has embarked on a systematic Quality Assurance initiative during FY 2001–02; the results of these efforts should be evaluated in next year’s report. Further, quality assurance efforts should draw on the county-specific data contained in this report to target technical assistance in counties whose outcomes are not meeting state expectations. Integration of quality assurance efforts into all aspects of service will help to insure that Healthy Start supports families in achieving positive outcomes.
5. **Continue to provide quality statewide training.** Resources have been used this year to develop statewide training and networking for Healthy Start staff and their supervisors. A statewide training committee comprised of local staff and program partners has been established and used as a vehicle to plan several training initiatives. For example, OCCF and Linn-Benton Community College have collaborated to

provide on-line training in infant-toddler development to staff from Healthy Start and its collaborative partners. Although not a focus of evaluation this year, continuing emphasis on accessible, regular training is likely will help ensure that Healthy Start staff provide high quality services to families.

6. **Continue tracking Healthy Start activities, outputs, and outcomes through a common performance measurement system.** Performance measurement allows managers to be accountable for results. The Oregon Commission on Children and Families is to be commended for its leadership in establishing a standard system for data management that allows the effective tracking of Healthy Start activities and outcomes for sites across the state. Special commendation also goes to the Department of Human Services for its support and participation. Many improvements have been made in the performance measurement system over the past nine years. Nevertheless, the system continues to need refinement to focus on the data elements that are the most powerful indicators of progress. In particular, Healthy Start should consider developing specific benchmarks it would like each site to achieve based on each site's current level of performance. For example, a Healthy Start site could work toward increasing its county reach rate from 60% to 70% the following year. Specific outcome targets are helpful in focusing programs on particular goals and in measuring achievement of those outcomes.





## Overview of Healthy Start's Performance Measurement System

Healthy Start seeks to insure healthy, thriving children and strong, nurturing, families by offering both short and long term support and assistance to families with newborn children, and at a minimum, targeting those with first-borns. Healthy Start service begins during pregnancy or at the time of birth.

Through a comprehensive assessment process, families are screened for characteristics that potentially place them at risk for poor child and family outcomes.

- Families with few, if any, risk characteristics are offered short-term service that may include a welcome-home visit, parenting newsletters about child development, and information about community resources and supports.
- Using a home visitation model, longer-term family support services extending through the early childhood years are offered to families whose characteristics place them at higher risk for poor child and family outcomes. These services include developmental screening for children, parent education and support, and linking families to needed community resources such as health care, food or housing.

### **Healthy Start of Oregon**

Is designed to offer community support through home visiting to every new family as each begins parenting.

## **Goals**

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Under Oregon House Bill (HB) 2008 passed in 1993, reconfirmed under Senate Bill (SB) 555 in 1999, and under HB 3659 in 2001, Healthy Start of Oregon was established as a primary prevention program dedicated to creating wellness for Oregon children and their families. Under this legislation, Healthy Start's goals are to:

1. Provide information and short-term support services to all first-birth families.
2. Systematically identify higher-risk families and offer long-term support services.
3. Enhance family functioning in higher-risk families by:
  - a. building trusting relationships,
  - b. teaching problem solving skills, and
  - c. improving the family's support system.
4. Encourage positive parent-child interaction in higher-risk families.
5. Promote healthy growth and development for children in higher-risk families. By enhancing family stability and supporting positive parenting practices, Healthy Start of Oregon addresses critical Oregon Benchmarks including:
  - a. promotion of school readiness,

- b. health care utilization with an improvement of health outcomes for children and families,
- c. immunization rates, and
- d. reduction in the incidence of child maltreatment among higher-risk families.

## ***Performance Measurement***

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The effectiveness of Healthy Start of Oregon is assessed using a performance measurement strategy. This strategy is the primary tool for accountability in both government and not-for-profit programs, having expanded over the past 40 years from mainly financial accounting to a more comprehensive tracking system of inputs, activities and outputs, and outcome results.

Performance measurement and program evaluation are related but not identical processes.<sup>1</sup> Program evaluation typically involves the use of a comparison group that does not receive the program services. Outcomes are measured for both groups in order to prove that any effects are, in all probability, caused by the intervention.

**PERFORMANCE MEASUREMENT**

Shows the extent to which:

- Planned activities were conducted
- Expected outputs were produced
- Anticipated results were achieved

Performance measurement is less concerned with establishing causality. Scarce resources are not invested in tracking outcomes for a no-treatment group in order to prove the effectiveness of an intervention. Instead, performance measurement seeks to establish the extent to which:

- planned activities were conducted,
- expected outputs were produced, and
- anticipated results were achieved.

The 2001–02 Healthy Start of Oregon Status Report assesses the successes and challenges experienced in the pursuit of Healthy Start’s goals. Two sets of indicators were used:

1. Implementation and Service Indicators
2. Outcome Indicators

One of the keys to performance measurement is the ability to link key implementation and service variables to outcomes. The Healthy Start of Oregon project has developed a logic model that shows how program services are linked to intermediate outcome indicators and to key Oregon Benchmarks. This logic model is presented in Figure 1. Implementation and service indicators are listed in Table 1. Outcome indicators are listed in Table 2.

**Table 1. Healthy Start of Oregon Implementation and Service Indicators**

<b>IMPLEMENTATION AND SERVICE INDICATORS</b>
<ul style="list-style-type: none"><li>• Development of collaborative partnerships</li><li>• Resource acquisition and mobilization to support families</li><li>• Establishment of a comprehensive risk assessment system</li><li>• Number of first-birth families reached by Healthy Start</li><li>• Type, duration, and amount of services received by families</li><li>• Family satisfaction</li></ul>

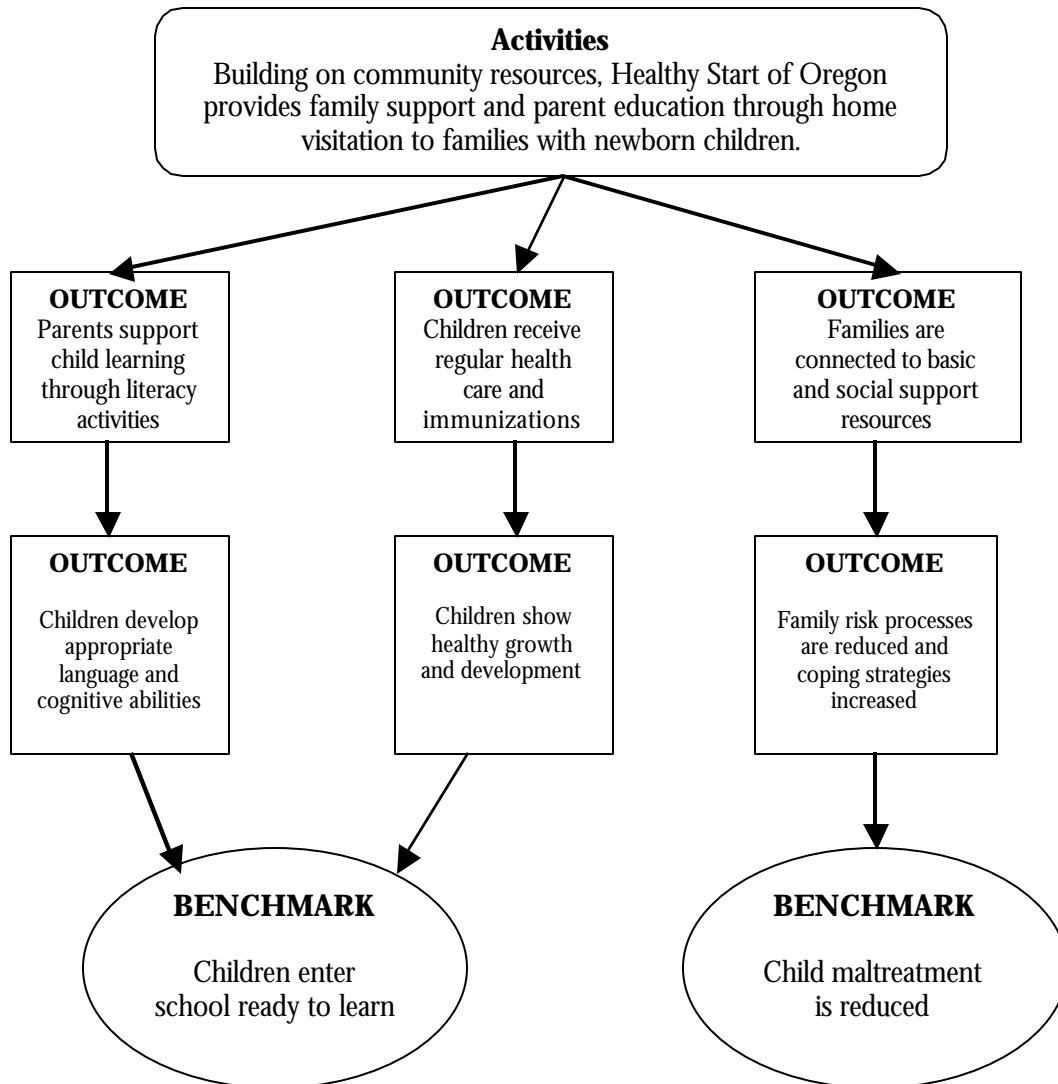
**Table 2. Healthy Start of Oregon Goals, Benchmarks, and Child and Family Outcome Indicators**

<b>Wellness Goal</b>	<b>Oregon Benchmarks Measured</b>	<b>Healthy Start Program Outcome</b>	<b>Outcome Indicators Measured</b>
HEALTHY THRIVING CHILDREN	<b>Pregnant mothers receive early prenatal care</b>	Quality Prenatal Care	<ul style="list-style-type: none"> <li>▪ Early, comprehensive prenatal care</li> </ul>
	<b>Children are adequately immunized</b>  <b>Children enter school “ready-to-learn”</b>	Healthy Growth and Development	<ul style="list-style-type: none"> <li>▪ Normal growth and development</li> <li>▪ Early intervention for all children falling outside normal developmental ranges</li> <li>▪ Adequacy of health care</li> <li>▪ Adequacy of immunizations</li> </ul>
		Nurturing and Supportive Home Environments	<ul style="list-style-type: none"> <li>▪ Family effectiveness as child’s first teacher</li> <li>▪ Family literacy activities</li> </ul>
STRONG, NURTURING FAMILIES	<b>Children free from abuse or neglect</b>	Self-Sufficiency and Access to Essential Resources	<ul style="list-style-type: none"> <li>▪ Adequacy of basic resources: food, housing, transportation, health and dental care</li> <li>▪ Utilization of appropriate health care</li> </ul>
		Family Emotional Climate	<ul style="list-style-type: none"> <li>▪ Reduction in family risk processes</li> <li>▪ Coping strategies</li> </ul>
		Positive Parent-Child Relationships	<ul style="list-style-type: none"> <li>▪ Parenting skills</li> <li>▪ Quality of parent-child interactions</li> <li>▪ Children free from confirmed incidents of maltreatment</li> </ul>

Research linking these outcome indicators to the broader wellness goals and Benchmarks are reviewed in the Oregon Commission on Children and Families publication, *Building Results I.* <sup>2</sup>

Performance measurement begins with the creation of a logic model detailing the “chain” of services, activities and outcomes that is intended to lead to longer-range results. The logic model for Healthy Start of Oregon is shown here as a series of linkages between program activities, outcome indicators, and two key Oregon Benchmarks.

**Figure 1. Logic Model for Healthy Start of Oregon**



## ***Accountability and Data Collection System***

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Accountability means tracking how programs perform. This includes tracking changes in support systems, the numbers and types of families served, and the results of services. Under legislation, Healthy Start is specifically mandated to develop a data system to document the results of comprehensive assessment and the outcomes for families as these relate to Oregon's Early Childhood Benchmarks.

All 34 Healthy Start sites participated in a single statewide performance measurement system during FY 2001–02. However, because 14 of these sites did not begin serving families until Spring 2002 or later, data from these sites are not included in this report. One additional site, Benton County, did not receive state funding until this year, and therefore did not participate in the evaluation until Spring 2002. Thus, a total of 19 sites are included in this report. Descriptive summaries of all 34 sites are included in Appendices A & C.

The system used in 2001–02 was developed by the Oregon State University Family Policy Program (OSU) in collaboration with representatives of the Oregon Commission on Children and Families (OCCF), the Department of Human Services, Office of Family Health (DHS, OFH), Oregon Department of Human Services, Child Welfare Division, and local Healthy Start programs. In March 2002 NPC Research, Inc., became the lead evaluators, replacing the OSU team. NPC Research collected data through the following procedures:

- *If families agree to release of information*, screening and service delivery information for all babies screened through the Healthy Start collaboration is entered at the local level into the OFH Women and Children's Data System.
- OFH regularly transmits service delivery information to NPC Research for evaluation purposes, using identification numbers for Healthy Start babies and their families to insure privacy. Neither children's names nor those of their parents or guardians are included in the data files at NPC Research.
- Outcome information on child and family progress is collected at the local level by Healthy Start programs *only for families receiving Intensive Service*. This information is transmitted on a monthly basis to NPC where, using identification numbers, it is merged with service delivery data from the OFH Women and Children's Data System.

### **Outcome Methodology**

The Healthy Start home visitor collects outcome information on Intensive Service families to use for the evaluation. The worker completes a Family Intake form when the family begins service.<sup>2</sup> The home visitor then completes a Family Update form every 6 months and at the completion of service. The Family Intake and Updates cover demographic information about the family, access to basic services and resources, health and health care, family stress and strengths, parent-child interaction, and family progress.

The participating parent completes a baseline survey at intake and follow-up surveys at 6 and 12 months after the birth of the child, and annually thereafter until completion of services.

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<sup>2</sup> For families who receive services prenatally, the Family Intake is started at the beginning of service, with the remaining information about the child being completed upon the child's birth.

The Parent Surveys gather information from the parent's perspective about what is enjoyable and what is difficult about being a parent and how their life is going.

The Healthy Start home visitor also completes two standardized measures that provide data for the evaluation. Workers conduct a Home Observation of the Environment (HOME) annually starting at the baby's first birthday. The 12- and 24-month HOME is for infants and toddlers. The preschool HOME is used for measures starting at age 3. Home visitors also complete a developmental screening called the Ages and Stages Questionnaire (ASQ) at various points in the baby's life. The ASQ is completed three times the first year, at 4, 8, and 12 months of age. Thereafter, the ASQ is completed every six months until the child reaches 4 years of age. The ASQ has a specific version for each time point. Table 3, below, summarizes the instruments collected.

- On an annual basis, DHS Child Welfare reviews Healthy Start children for victimization reports to assess the rate of child maltreatment. Information about abuse and neglect is submitted to NPC in aggregate form by identification number. ***Names of children or families are never released by DHS Child Welfare.***

Confidentiality procedures have been collaboratively developed to protect the rights of participants and allow for the sharing of critical program and outcome information. Throughout the evaluation, *family privacy is respected*. Families must agree to a release of information in order for initial screening data to be entered into the OFH Women and Children's Data System.

If families do not agree to a release of information, they may still choose to receive Healthy Start services, but are not included in the evaluation. Families also are informed that they are free at any time not to answer evaluation questions without affecting the services they are receiving.

**Participation in the evaluation is voluntary.**

Although families are given the opportunity NOT to provide information for the evaluation, sites report that almost all families agree to participate.

Implementation and outcome data are analyzed and reported by NPC Research on an annual basis. Participation rates are reported to local programs quarterly.

Quarterly and annual reports form the basis for state and local decision-making. For example, evaluation information has led to refinement of the risk screening and assessment procedures. Information has also informed the development of advocacy efforts for early childhood initiatives.

**Table 3. Measurement Tools and Data Collection Timeline**

	<b>1 Month</b>	<b>4 Months</b>	<b>6 Months</b>	<b>8 Months</b>	<b>12 Months</b>	<b>18 Months</b>	<b>24 Months</b>	<b>30 Months</b>	<b>36 Months</b>	<b>42 Months</b>	<b>48 Months</b>	<b>54 Months</b>	<b>60 Months</b>
<b>Family Intake</b>	X												
<b>Parent Survey I</b>	X												
<b>Family Update</b>			X		X	X	X	X	X	X	X	X	X
<b>Parent Survey II</b>			X		X		X		X		X		X
<b>HOME</b>					X		X						
<b>Preschool HOME</b>									X		X		
<b>ASQ</b>		X		X	X	X	X	X	X				



# The Healthy Start of Oregon Initiative: History and Approach

## HISTORY

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With HB 2008, the 1993 Oregon Legislature established Healthy Start/Family Support pilot projects to assist families in giving their newborn children a “healthy start” in life. Under this legislation, the Oregon Commission on Children and Families (OCCF) was charged with establishing pilot projects in selected counties throughout Oregon.

*First wave.* On July 1, 1994, a first wave of projects was funded in eight counties: Clackamas, Clatsop, Deschutes, Jackson, Josephine, Marion, Polk, and Tillamook. After a startup period for hiring and training staff, these projects were screening and working with families by October 15, 1994.

*Second wave.* In late 1994, a second wave of projects was initiated in four more counties. Lane County Healthy Start began service on February 8, 1995 and Healthy Start of Linn County started serving families on April 10, 1995. Families First of Hood River County and Union County Healthy Start initiated service in May 1995.

### **Counties joining 1996–2001**

Local Commissions on Children and Families (CCFs) also have worked to initiate service. Washington County’s New Parent Network began in January 1996 using local resources. Similarly, screening and home visitation services were initiated in Sherman County in September 1996, in Benton County in March 1997, in Harney and Wasco Counties in September 1997, and in Douglas County in January 1999.

With the passage of SB555 in 1999, state-supported Healthy Start services were initiated in seven more counties: Coos, Douglas, Lincoln, Sherman, Umatilla, Wasco and Washington. Under funding from the Spirit Mountain Community Fund, Healthy Start services were also started in Yamhill County.

### **Sites new in 2001–02**

With the passage of HB 3659 during the 2001 legislative assembly, the Healthy Start program has met its goal of implementing a statewide program of home visiting services for newborns. Healthy Start services were initiated in the remaining 14 counties in the state during the spring and summer of 2002. Two sites that had been using the Healthy Start model (Benton and Yamhill Counties) received state funding for their programs for the first time this fiscal year.

#### ***FY 01-02 Counties with State Funding***

##### First Wave

Clackamas  
Clatsop  
Deschutes  
Jackson  
Josephine  
Marion/Polk  
Tillamook

##### Second Wave

Hood River  
Lane  
Linn  
Union

##### Third Wave

Coos  
Douglas  
Harney  
Lincoln  
Umatilla  
Wasco/Sherman  
Washington\*

##### Fourth Wave

Baker  
Benton\*  
Columbia  
Crook  
Curry  
Gillam  
Grant  
Jefferson  
Klamath  
Lake  
Malheur  
Morrow  
Multnomah  
Wallowa  
Wheeler  
Yamhill\*

\*Washington, Benton, and Yamhill counties were in operation prior to 2001–02; however they did not receive state funding until this year.

## ***Healthy Start is Research Based***

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The Healthy Start of Oregon initiative combines comprehensive assessment and early intervention with intensive home visitation for families at risk for poor child and family outcomes. Healthy Start includes all of these program elements that have proven to be effective in increasing positive child outcomes and decreasing child maltreatment among higher-risk families:

- **Early and comprehensive assessment** of families can accurately establish the risk for poor child outcomes, including the risk for child maltreatment.<sup>3</sup>
- Compared to shorter-term home visitation, **regular contact during the first three years of the child's life** produces the greatest reductions in child abuse potential and the greatest benefits for children and their parents.<sup>4</sup>
- **Support is most effective during periods when stress is high, resources are few and parenting practices are being established.** Preventive efforts show greatest effects for children and families who are at greater social risk by virtue of their poverty and single parent status.<sup>5</sup>
- **Recent research shows that early interactions and experiences directly affect the way the brain develops.** Early and ongoing intervention effectively supports families in their role as the child's first teacher during the time when children's most rapid physical, cognitive and social development occurs.<sup>6</sup>
- **Training and supervision are essential.** Home visitation is most successful when visitors are "well-trained to promote positive health-related behaviors and qualities of infant care-giving, and to reduce family stress by improving the social and physical environments in which families live."<sup>7</sup>

**Healthy Start of Oregon is based on proven strategies for:**

- increasing number of children ready for school
- decreasing child maltreatment among higher-risk families.

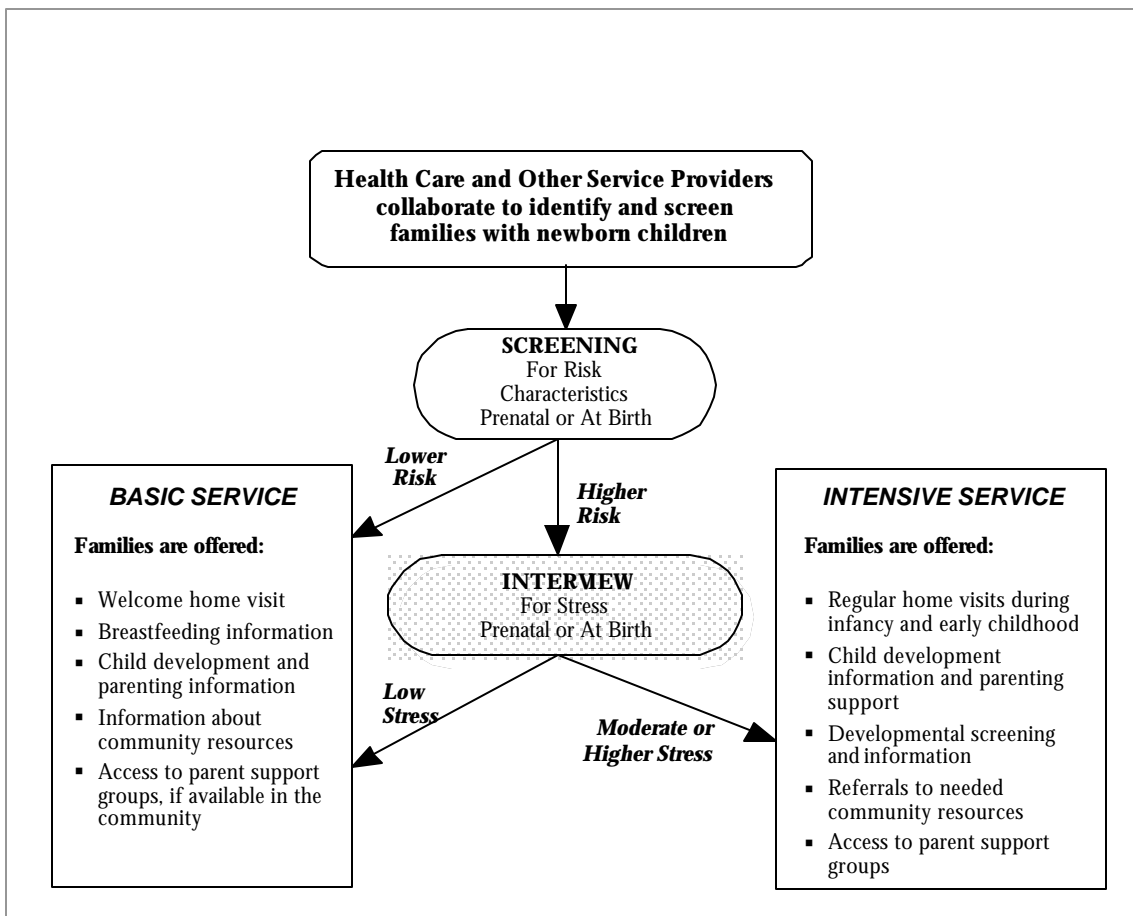
Home visitation pays off. Eight of the ten model programs recently reviewed by the RAND Corporation in their study of the efficacy of early intervention programs included a home visitation component. The RAND study concluded that these programs provided significant benefits both for children and for their families. Funds invested early in the lives of children can result in compensating decreases of government expenditures in later life.<sup>8</sup> Healthy Start of Oregon strives to deliver high quality, targeted home visiting services, and engages in ongoing evaluation to determine the impacts of these services.

## ***The Healthy Start Approach: A Universal Service***

Healthy Start of Oregon is a voluntary service. The model calls for services to be offered to all new families either during the prenatal period or at the time of birth. Families with few, if any, risk characteristics are offered short-term assistance, typically in the form of a welcome-home visit. During this visit, a family support worker, trained community volunteer, or nurse provides information on child development, positive parenting strategies, and community resources and supports. More costly intensive family support services extending through the early childhood years are reserved for families whose multiple characteristics place them at risk for poor child and family outcomes.

The first step in Healthy Start's service (see Figure 2) is the comprehensive family screening and assessment system. In each county, this system results from the collaboration of health care and other providers of perinatal services.

**Figure 2. Healthy Start of Oregon Family Assessment and Service Delivery System**



*Screening.* The comprehensive family assessment process begins with voluntary screening of first-birth families for global characteristics associated with poor child and family outcomes. During the past 1½ years, the screening process used by Healthy Start sites has changed considerably. These changes have resulted in a decrease in the number of families screened. As counties strengthen their new screening processes, the number of families reached should rise. With the passage of HB 3659, Healthy Start now requires the express written consent of parent(s) before preliminary screening can occur.

The second major change has been the transition from the Hawaii Risk Indicators (HRI) screen, a 15-item tool that can be completed by nurses, home visitors, or others after an initial fact-finding interview, to the Oregon Children's Plan (OCP) Screen, a self-report instrument completed by parents. Items included on the OCP screen include slight modifications of the 15 items previously obtained through the HRI, plus additional questions. Sites began using the OCP screen in Spring 2002; the number of first-birth families screened statewide during May and June 2002 was 7–9% lower than in previous or subsequent months.

Anecdotal evidence suggests that some providers, especially hospitals, have concerns about the nature of some of the questions on the OCP, as well as discomfort in asking parents to complete it. These concerns may be creating additional barriers in the screening process; for example, some hospitals have indicated they are more reluctant to do the screens themselves or to allow Healthy Start visitors easy access to parents following the child's birth. The screening tool will be evaluated and modified as needed in early 2003.

If screening shows the presence of risk characteristics, such as the mother being single, or having little or no prenatal care, Healthy Start moves to the second tier of risk assessment to determine the need for longer-term family support services.

*Assessment interview.* Highly trained family assessment workers interview higher-risk families, using the *Kempe Family Stress Inventory (KSFI)*.<sup>9</sup> Ten areas of potential stress are explored in depth, including issues relating to family lifestyle and supports, social isolation, expectations for infant behavior, and parent-child bonding. This two-tier screening and assessment process promotes early contact with first-time parents. It also allows for the early identification of families facing pervasive stress that erodes family stability and puts children at-risk.

**HEALTHY START  
is voluntary**

Families are free to decline assessment and/or service at any time.

**Basic Service**

Families who have few, if any, characteristics that place them at risk for poor outcomes, are offered short-term Basic Service. This short-term assistance usually occurs during the first month after the birth of the child.

Depending on available resources, Basic Service typically includes a home visit to welcome the child to the community, a packet of child development and parenting information, or a telephone call with information about community resources such as parenting support groups or breast-feeding assistance. Oregon State University Extension newsletters on *Parenting the First Year* also are often included.

## **Intensive Service**

The Healthy Start model offers long-term, home visitation assistance to families who have multiple characteristics that place them at risk for poor child and family outcomes. Home visits begin on a weekly basis and continue throughout early childhood. Services are available until age 5 in most sites; a few limit participation to children 3 and younger.

Visits are made by well-trained Healthy Start home visitors who provide child development information, parenting support, and link families to needed services, such as medical care, food and housing resources, job training, or crisis services. Emphasis is placed on insuring that services are coordinated, not only for children but for parents as well.

Visits gradually decrease in frequency as families gain parenting skills, develop coping strategies, and become linked to appropriate community resources. Opportunities for participation in parent support groups, parent-child playgroups, and family-oriented social events are also available in most counties.

## **Staffing of Basic and Intensive Service**

Nurses, family support workers or trained volunteers typically furnish the shorter-term Basic Service. Intensive Service home visitors are well-trained parent educators, social service workers and/or nurses. Periodically, nurses and other supervising professionals conduct supplementary visits as needed. At most sites, multi-disciplinary teams of professionals, drawn from collaborating partners, provide additional case review, training and consultation services.

**Quality assurance.** An established framework of Fifteen Essential Components (see appendix D) provides a blueprint for Healthy Start's wellness approach and identifies quality assurance standards. The essential components are based on research and proven strategies. The Oregon Commission on Children and Families in collaboration with local Healthy Start sites began development of a comprehensive quality improvement process in March 2002, to support continuous improvement in the outcomes for parents and children in each community.

While all 15 components are present in each of the 19 Healthy Start sites described in this report, communities have tailored local operations to address local needs and build on local resources (see site descriptions in Appendices A & C).

**Table 4. Framework of 15 Essential Components**

<b>Guiding Principles</b>	<b>Service</b>	<b>Quality Assurance</b>
<ul style="list-style-type: none"><li>• Universal and voluntary</li><li>• Early initiation of service</li><li>• Family focus</li><li>• Respect for diversity</li><li>• Collaboration</li><li>• Community investment</li></ul>	<ul style="list-style-type: none"><li>• Comprehensive assessment system</li><li>• Basic service for lower risk families</li><li>• Intensive Service for vulnerable families</li><li>• Access to health care services</li></ul>	<ul style="list-style-type: none"><li>• Limited caseloads</li><li>• Skilled staff</li><li>• Comprehensive training</li><li>• Ongoing supervision</li><li>• Results-based accountability</li></ul>

Flexibility of the framework allows communities to select the best procedures for the local Healthy Start, but has not compromised their capacity to meet standards specified in the 15 essential components.

## Findings: Implementation and Service 2001–02

Under House Bill 2004 and Senate Bill 555, the Oregon Commission on Children and Families, together with local Commissions on Children and Families and other partners, is mandated to create a responsive, accessible, comprehensive, and sustainable continuum of supports that promotes wellness among all of Oregon’s children, youth, and families. Healthy Start of Oregon’s home visiting/family support services are a key element of the support system that serves children and families from the prenatal period through the early childhood years.

**Table 5. Implementation Indicators for Healthy Start of Oregon**

<b>Goal</b>	<b>Program Activity</b>	<b>Output Indicators Measured</b>
CARING COMMUNITIES AND SYSTEMS	<p>Community collaboration and decision-making</p> <p>Resource acquisition and mobilization to support families</p> <p>Systematic identification of first-birth families</p> <p>Information and short-term support services provided to lower risk families</p> <p>Long-term family support services and home visitation provided to higher-risk families</p>	<ul style="list-style-type: none"> <li>▪ Number and type of community collaborators</li> <li>▪ Amount and type of resources</li> <li>▪ Number of first-birth families reached by Healthy Start</li> <li>▪ Number of families screened/served by Healthy Start</li> <li>▪ Type of service received by families</li> <li>▪ Length of service for Intensive Service families</li> <li>▪ Number of services for Intensive Service families</li> <li>▪ Family satisfaction for Intensive Service families</li> </ul>

## ***Community Collaboration & Decision-Making***

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Healthy Start was never designed to be a “stand alone” program, but rather to link and build upon existing programs to create a seamless system of support for young children and their families. Collaborating partners participate both by providing direct services and by supporting the effort with resources and ancillary services.

<b>Indicator measured</b>	<b>Finding</b>
<b>Number and type of community collaborators</b>	<p>108 agencies and organizations across 19 sites participate directly in providing Healthy Start home visiting/family support services</p> <p>272 other public and private partners across 19 sites participate in Healthy Start collaborations</p>

See Site Descriptions in Appendices A & C.

**Core collaborators.** Core collaborative partners are agencies and organizations that participate directly in the Healthy Start program. Participation may be through service delivery, administration and supervision, funding, or training. While core collaborators vary, most sites include local health departments (including Babies First!, WIC, and CaCOON), area hospitals and other health care providers.

- Over the 19 sites described in this report, 108 core collaborative partners are directly involved in providing Healthy Start services. The number ranges from 2 core collaborators to 13. The average number is 5.7 core collaborators.
- Local Commissions for Children and Families are core collaborators at all 19 sites. Members participate in governance groups and program planning and provide budget monitoring and program oversight.
- Public health departments are core collaborative partners at 18 of the 19 sites. The public health department is an “other” partner in Union County, but does not provide direct Healthy Start services.
- Hospitals are core collaborative partners at 11 of the 19 sites. Area hospitals are partners in the Clackamas, Jackson, Josephine, Lincoln, Linn, Umatilla, Washington and Yamhill collaborations, but do not provide direct services.
- Other core collaborators include clinics and other health care providers (9 sites), colleges and educational service districts (4 sites), Oregon Department of Human Services branch offices for Child Welfare and Self-Sufficiency and Employment (4 sites), Head Start and early childhood programs (6 sites), social service organizations (13 sites), and teen parent programs (3 sites).

**Other partners.** In addition to the 109 core collaborators, other partners provide a variety of resources, expertise and ancillary services. Statewide, 271 other partners participate in the Healthy Start effort. These partners often make referrals, or serve on service integration teams or governance committees. Other examples of ways these partners support the Healthy Start effort include the following:



- Agency personnel participate in case conferencing to ensure integrated services
- Childbirth education nurses conduct screening during classes
- Local churches and service groups provide donated goods and services, such as baby quilts or diapers
- Local businesses “adopt” families for the holidays

### **Building Effective Collaborations**

In spring 2002, key stakeholders at 12 Healthy Start sites were asked to describe those parts of the collaboration that had worked well in their counties. Several key areas of success emerged across the interviews, including:

- Providing coordinated services,
- Having successful communication,
- Building positive relationships, and
- Developing shared vision.

**Governance.** Over the past eight years, communities have developed a variety of governance structures to engage in comprehensive long-range planning and establish policies for Healthy Start programs. Governance groups typically include members from families, collaborating agencies, service providers, and interested citizens. Governance mechanisms vary widely and are described for each Healthy Start site in Appendices A & C.

**Contracts.** Three sites, Clackamas, Lane and Washington provide Healthy Start services by contracting with local service providers, rather than establishing a single collaborative group. Sites using the contract method employ a system administrator who coordinates services provided under the contracts and assures quality and adherence to the Healthy Start framework of essential components.

### **Addressing the challenges of collaboration**

Key stakeholders were asked to describe which parts of the collaboration had been most challenging in their counties. These challenges included:

- Funding/fiscal issues,
- Communication,
- Territorial concerns,
- Philosophical and procedural differences between collaborating agencies,
- Confidentiality and information sharing concerns among partners, and
- Difficulties involving specific partners, especially the medical community.

***Healthy Start sites enhance collaboration by:***

- *Sharing all types of information across agencies*
- *Integrating services at the family level*

To address these challenges, stakeholders mentioned a variety of strategies that they used to foster effective collaboration, including:

- **A variety of cross-agency meetings, such as:**
  - Regular (quarterly or monthly) partners meetings, focused on such topics as sharing policies and procedures and trying to develop standardization and consistency;
  - Regular all-staff (cross-agency) meetings;
  - “Supervisor’s roundtables” where supervisors from different agencies come together to discuss issues, share client information, etc.;
  - Having staff from different agencies attend other programs’ staff meetings; and
  - Joint case staffings.
- **Strategies for facilitating family-level service integration:**
  - Having staff introduce staff from agencies to families if another agency becomes involved with a family;
  - Having quarterly “peer” chart reviews;
  - Setting up standard procedures so that all agencies collect release of information forms and confidentiality agreements from families;
  - Developing joint case plans; and
  - Developing shared intake and referral forms.
- **Strategies for facilitating effective interagency collaboration:**
  - Learning about the needs of other agencies (one program surveyed all involved agencies to learn about their pressing needs in terms of trainings, service gaps, etc.);
  - Developing a shared vision statement;
  - Having written guidelines for each partner’s role;
  - Making sure to share resources and resource information; and
  - Integrating meetings between existing collaborative groups, so there are fewer meetings overall—e.g., have only one collaborative group vs. several with many of the same partners.
- **Other suggestions:**
  - Hiring staff who value collaboration;
  - Ensuring frequent and ongoing communication via telephone, email, and face-to-face; and
  - Co-locating staff from different agencies.

**Service integration.** Several Healthy Start sites are developing integrated services through their collaborative efforts. When services are integrated, families receive whatever services might be appropriate through a single source. Community agencies and organizations work together to assure coordination and avoid duplication of efforts.

In Jackson County, ACCESS Community Action Agency, Adult and Family Services, Job Council, Mental Health, On Track Substance Abuse Treatment Center, Public Health, and Services to Children and Families offer integrated services at 4 sites within the county. Healthy Start home visitors are co-located at each of these sites where they both receive direct referrals and participate in joint staffings and combined case management.

Other sites, including Hood River, and Wasco/Sherman approach service integration at the family's point of entry into the system. A team of service providers meets to review cases and to determine how services will be managed and integrated.

## ***Resource Acquisition & Mobilization to Support Families***

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Healthy Start has successfully leveraged local, state, federal and private resources to create a system of supports for young children and their families. These resources include space, staff, and materials as well as money.

<b>Indicator measured</b>	<b>Finding</b>
<b>Amount and type of resources</b>	<p>Over \$2.4 million was generated for Healthy Start through services leading to the utilization of health care services by eligible families</p> <p>Approximately 312 volunteers and student interns provided support to families</p> <p>Children's books were provided for Intensive Service families through a grant from the Spirit Mountain Community Fund, First Books, and the Oregon State Library Association.</p>

See Site Descriptions in Appendices A & C.

The Oregon legislature appropriated funds to support Healthy Start in all 36 counties at the beginning of the '01 – '03 biennium. The program was funded at 80%, which with a 20% local match requirement would have made it possible to serve all of Oregon's first-birth families. By the end of the fifth Special Session, the funding level had been reduced to 65% in all 36 counties.

Oregon reimburses Healthy Start with federal Title XIX Administrative Case Management dollars for services that lead to appropriate outreach, access and utilization of health care services for eligible families. During FY 2001 – 02, Healthy Start of Oregon was reimbursed \$2,417,032 for these services.

Communities also invest local resources to support approximately 20% of local Healthy Start costs. Local dollars are allocated through local commissions, other core collaborators, United Way, and a variety of local fund-raising initiatives.

Grants from foundations including Children's Trust Fund (6 sites), Meyer Memorial Trust (2 sites), Northwest Health Foundation (1 site), Oregon Community Foundation's Ready to Learn Initiative (4 sites), United Way's Success By Six Initiative (3 sites) and the Spirit Mountain Community Development Fund (1 site) have also supported Healthy Start services.

The Oregon State Library through LSCA funds and the Spirit Mountain Community Development Fund both have provided money for children's books to be distributed to Healthy Start families across the state. In addition, three sites also received grants for children's books from private entities, including First Book and local bookstores.

Other funds come from local service organizations such as the Lions or the Rotary. Volunteers also provide resources both in the form of material goods such as infant supplies and fundraising. For example, Tillamook County volunteers have formed a non-profit group

that sponsors, among other activities, an annual golf tournament to raise money for the local Healthy Start program.

Under SB 555, Healthy Start programs are specifically mandated to maximize the use of paraprofessionals, volunteers, and other informal community resources:

- Highly trained parent educators are the primary home visitors for higher-risk families at 19 Healthy Start sites described in this report. Approximately 90% have attended college, 60% having a Bachelor's degree or higher. College degrees are in fields such as child development, community health, nursing, psychology, and social work.
- Approximately 312 volunteers and student interns provided support to families through the Healthy Start programs during FY 2001–02. Many of these volunteers are supported through local Department of Human Services (DHS) Volunteer Services or other community-based volunteer programs.

Responses from key stakeholder interviews in spring 2002 indicated that the most common challenges facing management were financial constraints on the program. Specifically, managers were often spread too thinly in their responsibilities, and were perceived as spending too much time easing tensions over budget problems, writing grants to seek external funding, and making decisions about how to allocate reduced program dollars.

## ***Reaching First-Birth Families***

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The Healthy Start model calls for a voluntary, comprehensive risk screening and assessment system that allows services to be accessible to all first-time parents. The system includes a two-tier process. First, first-birth families are screened on the Oregon Children’s Plan Screening Tool (OCP Screen), described previously. When families are screened as potentially at risk for poor outcomes, a subsequent assessment interview using the Kempe Family Stress Inventory (KFSI) is conducted to evaluate the severity of risk, and identify service and support needs among these vulnerable families.

<b>Indicator measured</b>	<b>Finding</b>
<b>Number of first-birth families reached through Healthy Start</b>	<p>37% of all first-birth families in sites existing before FY 2001–02 were reached for screening; this figure increases to 53% when counties particularly effected by screening changes are excluded<sup>3</sup>.</p> <p>53% of first-birth families who had a screening that indicated high risk were successfully reached for Kempe assessment interviews, an increase from 45% last year.</p>

See Tables 1 and 2 in Appendix B.

**Screening among existing programs.** Reaching all first-birth families in a county is an ambitious undertaking. Using data provided by the Office of Family Health for calendar year 2001, we estimate that in FY 2001–02, 37% of eligible families were screened by Healthy Start in counties where programs had been in operation for more than one year. As shown below, the reach rate in these counties decreased considerably from previous years (also see Table 1 in Appendix B).

However, Washington County was not fully funded in FY 2001–02, and was, therefore, unable to serve all eligible families. When Washington County figures are excluded, the rate increases to 47%.

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<sup>3</sup> Excluded were: Clackamas, Jackson, Union, Marion/Polk, and Washington counties. Washington county was excluded because it was not fully state funded, and therefore not subject to the same program requirements during the reporting period.

**Table 6. Reach Rate for First-Birth Children by Birth Year. Note that statistics only describe sites existing before FY 2001-02**

<b>FIRST-BIRTH CHILDREN</b>	<b>1997-98</b>	<b>1999-00</b>	<b>2000-01</b>	<b>2001-02</b>
First-births from OFH statistics in counties with Healthy Start sites, existing before FY 2001-02	8,095	8,149	7,996	12, 653
Screened by Healthy Start sites, existing before FY 2001-02	6,359	6,984	6,420	4,620
Percent of first-birth children reached in sites existing before FY 2001-02	79%	86%	80%	37%

Higher screening rates had occurred in the past when Healthy Start sites used different procedures for doing preliminary screening of first-birth families. However, with the passage of HB 3659 during the 2001 legislative session, and concern over ensuring strong protection of families' confidentiality, Healthy Start implementing screening procedures that required parents' express written consent.

Because of these changes, several large sites that had previously reached over 85% of families struggled this year to identify families. Significant drops in these counties account for the majority of the decrease in the statewide rate. For example:

- o Clackamas County screened only 419 out of 1,620 first-births (26%, compared to 84% in 2000-01).
- o Jackson County screened only 476 out of 865 first-births (55%, compared to 94% in 2000-01).
- o Marion and Polk (a joint Healthy Start site) screened only 908 out of 1,922 first-births (47%, compared to 82% in 2000-01).
- o Union County screened only 38 out of 111 births (34%, compared to 59% in 2000-01).

When Clackamas, Jackson, Marion/Polk, and Union counties (in addition to Washington) are excluded from analysis, the reach rate increases to 53%, close to the average for the remaining counties in prior years.

Additionally, this year was the first year that a new screening tool, the Oregon Children's Plan screening tool, was implemented instead of the Hawaii Risk Indicators tool used previously. In several sites, some collaborative partners had concerns about some additional sensitive questions included on the OCP

**This year, Healthy Start:**

- Screened families earlier in their child's development.
- Successfully completed Kempe Stress Assessments on a larger proportion of high-risk families.
- Engaged families in service for longer periods of time.

screen, as well as concerns over how it was implemented (as a parent self-report survey, rather than an interview). There has been some reluctance to allow Healthy Start screeners the easy access to families they had enjoyed previously because of these concerns about the screening tool.

Together, these two factors results in a considerably lower success rate in screening first-birth families. Sites are clearly being challenged to develop new strategies for comprehensive screening that will allow more families to be screened. However, as counties strengthen their new screening procedures, the reach rate should rise. Further, there have been improvements in screening and service delivery processes in some areas, as described below. Specifically, counties have screened more families prenatally as well as at or just after birth, have reached a larger proportion of higher-risk families for assessment, and have served higher need families for a longer period of time. Further, sites have continued to serve about the same number of Intensive Service families as in previous years, and have been able to identify more than enough high-risk families to fill available Healthy Start Intensive Service slots.

**Screening procedures.** A large proportion of Healthy Start's first-birth families participate in voluntary screening at birth through collaborative arrangements with area hospitals. However, referrals from health care providers also make up a large proportion of screenings conducted. Over half of the screening takes place either prenatally or at birth. For example, during FY 2001–02:

- 14% were conducted during prenatal period,
- 64% were conducted at the time of birth, *and*
- 21% were conducted after birth

Healthy Start sites screened considerably more families during the prenatal period or the time of birth this year, compared to previous years (in 2000–01, only 57% were screened during these very early phases of the child's life). Given the importance of early support during the prenatal and newborn period, this is an important improvement.

Screening is conducted by nurses and/or Healthy Start staff trained in screening procedures. In addition, several counties utilize self-screening forms that are completed by pregnant women when they visit their health care providers. The system for screening differs among communities, but may include:

- ✓ talking to families in hospitals
- ✓ telephoning families at home
- ✓ review of clinic and/or hospital records (with expressed written consent from families)
- ✓ referrals from physicians, clinics and hospitals
- ✓ mailing invitational letters to new families

Families who indicate they are not interested in Healthy Start are neither screened nor is any of their family's information entered on the statewide Healthy Start database.

**Assessment interviews.** After screening, assessment interviews are conducted among higher-risk families by trained family assessment workers to determine family needs and stresses.



- Healthy Start sites assessed 53% of those first-birth families who were screened at higher risk (see Table 2 in Appendix B). This was a substantial increase over FY 2000–01 when 45% of the total first-birth families screened at higher risk had assessment interviews. Healthy Starts have steadily increased their rates of successfully assessing those families whose screening results indicate they are at higher risk.
- Of the higher-risk, first-birth families not assessed, 35% received basic or minimal service, 19% refused assessment after screening, 16% could not be located, 11% received Intensive Service, 11% received “creative outreach” (a variety of strategies to locate and/or engage families) and 9% did not receive follow-up after the initial screening.

Assessment rates depend heavily on the processes sites have adopted for reaching families. Sites who interview parents at home *after the birth of their child* are less successful in locating and connecting with these higher-risk families than sites that conduct assessment interviews in the hospital. Thus, the higher rate of very early risk screening helps to ensure that more families receive the needed assessment.

## ***Characteristics of First-Birth Families***

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### **68% of first-birth families screened at higher risk**

With their consent, families are screened for psychosocial characteristics that put themselves and their children at risk for poor outcomes. Using the OCP screen and standardized HRI criteria, families are considered to be at higher risk if mothers:

- are single when their child is born,
- report an inadequate income,
- have a history of substance abuse,
- received late or no prenatal care,
- are 17 years or younger at the time of the child's birth, or
- have any two other risk characteristics on the screening tool, such as less than a high school education, having an unemployed partner, or reporting marital/family conflicts.

Screening showed that 68% of Healthy Start's first-birth mothers screened at higher risk for poor outcomes as measured on the Healthy Start/OCP screening tool. This is an increase from 56% during 2000–01.

Approximately 58% of the first-birth mothers have two or more of the higher-risk characteristics listed above. The proportions of first-birth families with these characteristics are shown below (also see Table 2 in Appendix B).

**Table 7. Risk Characteristics of Screened Families with First-born Children**

<b>Risk Characteristic</b>	<b>1998–99</b>	<b>1999–00</b>	<b>2000–01</b>	<b>2001–02</b>
Mother is single	43%	43%	44%	48%
Inadequate income	40%	37%	42%	40%
Late or no prenatal care	15%	19%	18%	16%
History of substance abuse	14%	11%	14%	18%
Teen mother, 17 or younger	11%	10%	10%	11%
<b>Total first-birth families screened at higher risk</b>	<b>55%</b>	<b>56%</b>	<b>56%</b>	<b>68%</b>

Approximately 48% of the first-time mothers screened at Healthy Start sites during FY 2001–02 were single. This percentage has increased slightly, compared to prior years, but is consistent with national statistics.

Over the past 60 years, U.S. Census data has shown a steady increase in the number of women who are unmarried at the birth of their first child, with 30% of first-time births between 1999 and 2001 being to unmarried women.

Approximately 40% of the first-time mothers reported inadequate income levels, being Medicaid or WIC participants or having money worries relating to basic necessities such as food, clothing and housing.

### **Parents Speak About Healthy Start**

"I hoped to get some support and ideas and helpful tips...it's actually better than I thought it would be. They don't just check in to see how you live and make sure you're taking care of your kids, but they help and play with your kids and give you papers on how your kids are doing. I got more than I expected."

## **Participation**

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Healthy Start of Oregon recognizes that every new family can use support when a baby is born. Yet every new family does not need the same degree of support. Thus, Healthy Start of Oregon strives to offer all new parents with a first-born child a range of services from short-term during the period directly after birth to longer-term over the early childhood years.

Participation is voluntary with positive, continuing outreach efforts to ensure that families who would benefit most from the services have an opportunity to be involved. Voluntary acceptance of service:

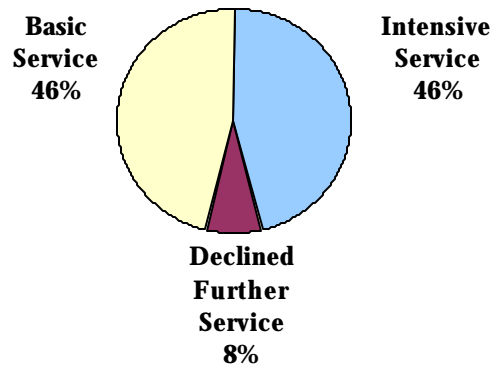
- allows parents to make decisions in their own best interests,
- is respectful of family decision-making, and
- increases service effectiveness.

<b>Indicator measured</b>	<b>Finding</b>
<b>Number of families and type of service</b>	6,581 families were screened or continued to receive services, with 46% receiving short-term Basic Service, 46% receiving longer-term Intensive Service and 8% declining further service after screening. This includes both new births and ongoing Intensive Service families.
<b>Number of higher-risk families receiving Basic Service</b>	53% of the families receiving Basic Service had at least one risk characteristic and were potentially eligible for Intensive Service.
<b>Length of service received by Intensive Service families</b>	On average, higher-risk families with Intensive Service (in sites existing before FY 2001–02) received 16.7 months of home visitation.
<b>Number of home visits for Intensive Service families on Level 1</b>	Families on the most intensive level of service receive an average of 2 visits per month.

See Tables 3, 4, 5 and 10 in Appendix B

During FY 2001–02, a total of 6,581 families from the 19 established Healthy Start counties participated in Healthy Start screening and/or continuing service. Of these families, 46% received short-term Basic Service and 46% were involved in the long-term Intensive Home Visiting services. Only 8% declined any further service (see Figure 3 below and Table 3 in Appendix B).

**Figure 3. FY 2001–02 Participation**



Overall participation for FY 2001–02 decreased by 26% over FY 2000–01 when Healthy Start sites screened and served 8,912 families.

The decrease was felt most sharply in the Basic Service area, which went from 5,083 families in FY 2000–01 to 3,044 in the current year. The proportion of families refusing further service after screening increased slightly (see Table 8 below). Most likely, the decrease in screenings conducted was due to changes in procedures, since March 2001 that required parents' express written consent for screening.

**Table 8. Comparison of Healthy Start Participation Over Last Three Years**

<b>TYPE OF SERVICE</b>	<b>1999-2000</b>	<b>2000–01</b>	<b>2001–02</b>
Basic Service	5,951 (65%)	5,083 (57%)	3,044 (46%)
Intensive Service	2,521 (27%)	3,220 (36%)	3,027 (46%)
Declined Further Service	707 (8%)	609 (7%)	510 (8%)
Total Families, Screened and Served	9,163	8,912	6,581

**The proportion of families receiving Intensive Services increased**

The number of families receiving long-term Intensive Service stayed fairly stable compared to the previous year (3,027 in FY 2001–02 vs. 3,220 in FY 2000–01). However, whereas longer-term home visiting services were provided to only 36% of the FY 2000–01 population, 46% of the FY 2001–02 population received these services. Additionally, several counties did increase the total number of families who were served with Intensive Service, particularly those counties that were new programs during FY 2000-01. For example:

- Douglas County Healthy Start served 135 families with Intensive Service compared to 16 in the previous year.
- Healthy Start of Lincoln County served 74 families with Intensive Service compared to 13 in the previous year.
- Washington County's New Parent Network served 170 families with Intensive Service compared to 151 in the previous year.
- Yamhill County New Parent Network served 76 families with Intensive Service compared to 54 the previous year.

### **Some higher-risk families can only be offered Basic Service**

Healthy Start sites continue to be unable to offer Intensive Service to all the families screened at higher risk *who are potentially eligible* for long-term service. Approximately 53% of the 3,044 families who received Basic Service during 2001–02 were screened as being at higher risk but no further assessment was conducted (see Table 4 in Appendix B).

Of the 1,608 higher-risk families who received Basic Service:

- 53% received a home visit with referrals to needed community resources,
- 19% received some other service such as a telephone call or a mailed packet of information about parenting and community resources, and
- 28% could not be located for further service.

Funding issues continue to be a problem. Many Healthy Start sites lack sufficient resources to offer Intensive Service to all eligible families while at the same time, providing these services to higher-risk families who are already enrolled.

In addition, higher-risk families are often difficult to locate for further assessment and service after the child is born and the mother has left the hospital. Sites who contact families for assessment after the hospital stay are less successful in reaching families screened at higher risk than sites where families are interviewed during the hospital stay.

### **Over half of the Intensive Service families entered during 2001–02**

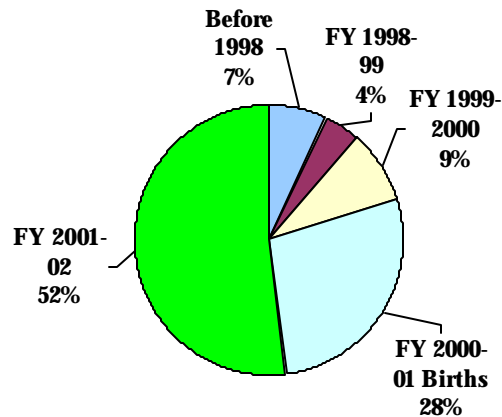
Over half of the 3,027 families (52%) receiving Intensive Service entered during the current fiscal year. The remainder entered the Healthy Start system sometime during previous years (see Figure 4).

Most Healthy Start sites offer home visits and other parenting supports over the early childhood years. However, while long-term support is essential to these families, it further limits the number of newly identified families who can be served.

On average, those families at the highest level of risk tend to receive service longer than families with moderate levels. Stress for higher-risk families tends to be highly episodic. Unforeseen problems can create serious crises.

Increased support during crisis periods is often needed to avert further adversity. In addition, discipline issues become more salient as children grow older and families often need greater support to assure a nurturing environment.

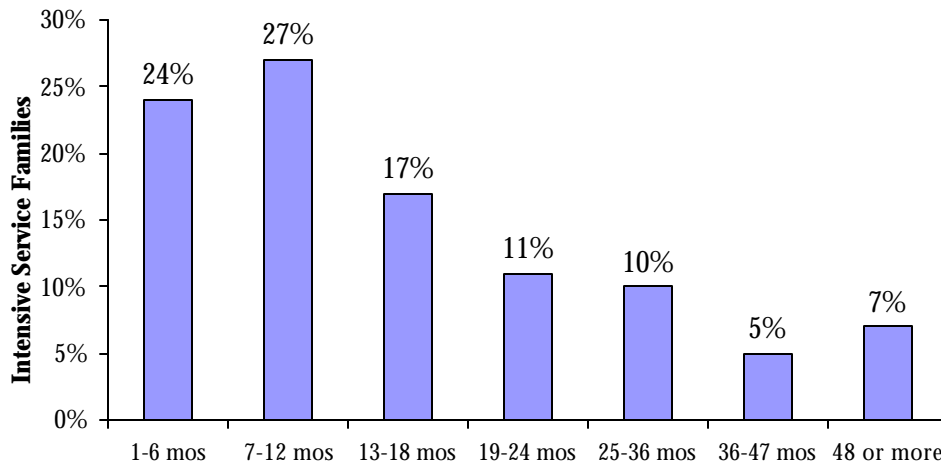
**Figure 4. FY 2001–02 Intensive Service**



**Families average more than 1 year of service**

On average, Intensive Service families received 16.7 months of service in FY 2001–02, more than the average 13.9 months for the previous year (See Figure 5 below and Table 5 in Appendix B).

**Figure 5. Months of Intensive Service**



Over three-fourths of the families (76%) have received 6 or more months of service and 22% received 2 or more years, as shown in Figure 5 (also see Table 5 in Appendix B). The average length of service varied markedly by county, ranging from 10 months to 29 months. This variation is explained by the degree of implementation of the Healthy Start program. Counties that were implemented earliest had the longest service durations and counties that were implemented later had shorter service durations. It is expected that as newer programs become fully established and families have an opportunity to remain in service longer, their average service durations will increase to the level of the seasoned programs.

**Families on the most intensive level receive an average of 2 visits per month**

The Healthy Start model calls for Intensive Service over the early childhood years with visits gradually decreasing in frequency as living situations and/or parenting strategies improve. Initially, families are placed on Level 1 and weekly visits are planned.

On average, families at this most intensive level received 2.2 home visits per month during FY 2001–02 (see Table 9 in Appendix B). The average number of visits per month by county ranged from .8 to 2.9.

During the initial Level 1 period, family life tends to be the most chaotic. Highly stressed families find making plans and keeping to scheduled appointments a difficult task. Further, when appointments are missed, home visitors with large caseloads find it difficult to re-schedule appointments until the following week.

Overall, statistics for participating sites show that, during the most recent six-month period:

- 53% of Level 1 families received more than 12 visits (at least 2 visits per month)
- 31% of Level 1 families received 7–12 visits (1–2 visits per months)



The remaining families (16%) received 6 or fewer visits during the six-month period as home visitors built trust and develop a more regular schedule. These results are consistent with recent evaluations of home visiting programs, showing that across home visiting models, families receive approximately half, on average, of the intended number of visits.<sup>10</sup>

### **Services in addition to home visitation**

Although the primary focus of Healthy Start's Intensive Service is home visitation, most sites also provide other services. In addition to home visitation, parents also participated in the following activities through Healthy Start:

- 28% participated in group activities such as parent support groups and parent education workshops
- 14% participated along with their child in parent-child interaction groups and play groups
- 21% attended family social events, such as holiday parties or field trips
- 17% are in teen parent programs

## ***Who Are Intensive Service Families?***

Families receiving Intensive Service tend to be significantly younger, less educated, and poorer than Basic Service families screened at lower risk (these factors are still true), as shown below (also see Table 6 in Appendix B). Insurance status varies markedly as well. Over 82% of the Intensive Service children are receiving health care through Medicaid/Oregon Health Plan.

Families also vary by levels of maternal employment. At the time of birth, 21% of the Intensive Service mothers have full or part-time employment in contrast to 67% of the lower risk Basic Service mothers.

Ethnic and racial composition mirrors the population in the participating counties. As in previous years, two-thirds of the Intensive Service babies are White/Caucasians (66%). Babies of Hispanic/Latino descent make up a significant minority (30%). Of the remaining families, 1% are African American, 2% are Asian-American, and 1% are Native Americans (also see Table 7 in Appendix B).

**Table 9. Characteristics of Healthy Start Families**

<b>Healthy Start Families FY 00-02</b>	<b>Basic Service screened at lower risk</b>	<b>Intensive Service screened/assessed at higher risk</b>
Average age of mother Percent 17 years or younger	27.6 years 0%	21.1 years 21%
Average years of education Percent with less than high school	14.9 years 3%	11.3 years 49%
Maternal employment, part or full-time	67%	21%
Never married	0%	73%
Oregon Health Plan/Medicaid	13%	82%
Median monthly income	\$1,634	\$906

Counties serving high proportions of Hispanic/Latino families include:

- Hood River (73% of Intensive Service families),
- Washington (60%),
- Marion/Polk (53%),
- Linn (50%), and
- Lincoln (47%).

English is the primary language spoken in 77% of the homes, with Spanish or a Spanish dialect in almost 23%. The remaining families speak a variety of other languages.

### ***Risk Characteristics of Intensive Service Parents***

Many of the Intensive Service families have experienced difficult situations during their own childhood (see Table 8 in Appendix B). Among these Intensive Service families served during FY 2001–02:

- 38% of the mothers and 40% of the fathers were raised by an alcoholic or drug-affected parent
- 35% of the mothers and 38% of the fathers were physically abused or neglected during their childhood; 28% of the mothers and 27% of the fathers experienced neglect during their childhood; and 21% of the mothers and 5% of the fathers experienced sexual abuse during their childhood; 45% of mothers and 42% of fathers experienced one or more of these forms of maltreatment
- 19% of the mothers and 16% of the fathers experienced foster or out-of-home care

A substantial number of the parents also have histories of psychopathology and/or antisocial behavior. Of these Intensive Service families:

- 33% of the mothers and 49% of the fathers had a history of alcohol or substance abuse
- 41% of the mothers and 15% of the fathers have a history of depression or other mental health condition
- 13% of the mothers and 36% of the fathers had a history of criminal activity

Approximately 8% of the families had one or more parents diagnosed with a developmental disability. About 11% had one or more parents with chronic physical health problems needing more than normal levels of health care.

### ***Children's Health Risks at Birth***

A small percentage of the babies whose families received Intensive Service during 2001–02 experienced significant health risks at birth (see Table 7 in Appendix B):

- 9% were born prematurely (36 weeks or less gestation)
- 7% were low-birth weight infants, less than 5 ½lbs.
- 3% were drug-affected at birth
- 1% were medically fragile babies, with a variety of health complications

Healthy Start home visitors provide support services to these families, typically in cooperation with Babies First! nurses from local Public Health Departments and/or CaCOON (Care Coordination) nurses from Oregon State Health Sciences University, Child Development and Rehabilitation Center.

### ***Family Use of Community Resources at Program Intake***

During the first month after the child's birth, the home visitor reports the number of services and other resources used by families receiving Intensive Service. Among the Intensive Service families enrolled during in FY 2001–02:

- 92% were receiving assistance through WIC (Women, Infant, and Child Food Program)
- 82% were on the Oregon Health Plan/Medicaid
- 64% had dental insurance
- 57% were using family planning services
- 43% were using food stamps
- 19% received cash assistance through the welfare system of Temporary Assistance to Needy Families (TANF)

## ***Engagement and Retention***

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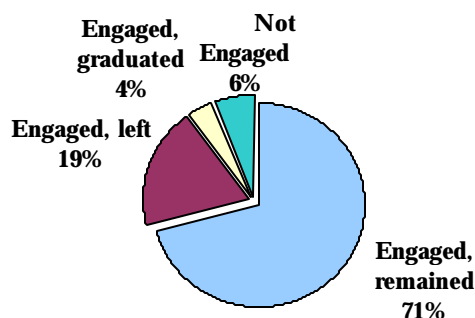
Engagement and retention are critical issues for prevention programs that work with higher-risk families. If families do not take full advantage of the offered services, the potential for beneficial child and family outcomes is decreased.

Successful recruitment is only the first step. Experience has shown that families may accept Intensive Home Visiting initially, but drop out in the first few weeks of service. If families receive at least three months of service and provide some outcome information, they are considered to have engaged, even though service may have been spotty.

### **Most families are engaged and receive 3 or more months of service**

During FY 2001–02, 94% of the higher-risk families who accepted Intensive Service were engaged and received three or more months of service. This is an increase from 87% last year. Approximately 71% remained in Intensive Service at the end of the year and 4% achieved goals and graduated. 48% of the families who graduated had received three or more years of service (see Figure 6 and Table 9 in Appendix B.)

**Figure 6. FY 00–01 Engagement and Retention**



**Attrition.** During FY 2001–02, approximately 19% of the families who engaged but did not graduate left. Engaged families leave for a variety of reasons, including the following:

- 31% moved (13% moved and could not be located, and 18% moved out of the county),
- 17% declined further Intensive Services because they were no longer interested,
- 16% declined further Intensive Services due to work and/or school commitments, and
- 37% left for a variety of other reasons, including not wanting to continue when staff changed.

Moving is the most common reason for dropping out before graduation. If families move to another Oregon county with Healthy Start services, referrals are made but experience has shown that only a small proportion re-connect.

Families commonly decline further services when mothers go to work or go to school and find it difficult to schedule the home visits. Others lose interest or may decline further service when they feel personal goals have been achieved. In addition, if there is a staffing change, families may leave rather than work with a new home visitor.

Other programs report comparable attrition rates. A recent review of home visiting programs found that between 20% and 67% of families enrolled in the programs left before graduation.<sup>11</sup> The authors point out that relatively high rates of attrition have been observed in home visiting programs for years. Much of the attrition is out of the control of home visiting programs as families move away or return to work.

**Supervision affects attrition.** To investigate the specific factors that influence attrition and program retention, researchers examined data from 1,093 families who were receiving home visits from 71 different home visitors.<sup>12</sup> Results revealed that independent of any family characteristics, the likelihood of families remaining in home visiting services beyond one year increased in proportion to the hours of direct supervision that the home visitor received.

Families whose home visitors had weekly supervision for an hour or more were more likely to remain in service than families where home visitors had irregular supervision or supervision on an “as-needed” basis. In structured supervisory sessions, Healthy Start home visitors and supervisors typically review family progress, develop case plans and identify strategies and interventions that will lead to the family achieving goals. This careful planning may improve service quality, leading to higher motivation among families to continue.

### **Non-engagement**

Approximately 6% of Healthy Start’s higher-risk families did not engage after initially accepting Intensive Service (see Figure 7 and Table 9 in Appendix B). This rate of non-engagement is lower than other home visiting programs where from 10% to 25% of families that accept service do not fully engage.<sup>13</sup>

Families did not engage for a variety of reasons. The most common reason for non-engagement (25%) was simply never connected, repeatedly forgetting appointments and/or not being home when the visitor arrived. Approximately 23% declined after initially accepting service, either because they realized they had no time or because they were no longer interested. About 13% could not be located for further service, and an additional 10% did not engage because the family moved out of the county. Caseload limitations prevented 12% of families from having the opportunity to continue participation. Various other reasons account for the non-engagement of the remaining families.

**Maternal isolation affects engagement.** To investigate the specific factors that influence program engagement, researchers examined data from 4,057 mothers with firstborn infants, who enrolled in the Healthy Start of Oregon from 1995 through 1998.<sup>14</sup> Results revealed that mothers facing the challenge of first time parenting in isolation, or with limited family and friendship networks, were less likely to actively engage in home visiting services. Thus, when screening indicates that maternal isolation may be an issue, staff may have to re-double outreach efforts to ensure that families have an adequate opportunity to learn what Healthy Start can do for them.

## **Findings: Outcomes for Children and Families, 2001–02**

Oregon's Healthy Start seeks to insure healthy, thriving children and nurturing, caring families. In addressing these goals, Healthy Start of Oregon contributes to several key Oregon Benchmarks, including reducing child maltreatment and increasing children's readiness for school. A series of outcome indicators have been selected that have been shown empirically to contribute to these goals and Benchmarks. These outcome indicators assess the impact of Healthy Start of Oregon on the children and families who receive long-term Intensive Service. Outcome indicators are shown in Table 2, p. 4.

Research linking these outcome indicators to the broader wellness goals and Benchmarks are reviewed in the Oregon Commission on Children and Families publication, *Building Results I*.<sup>15</sup>

Some program outcome indicators, such as child maltreatment and immunization rates, parallel Benchmark indicators. When direct assessment of a benchmark is not viable among program participants, outcome indicators are assessed that are empirically known to contribute to the benchmark. For example, it is not feasible to directly assess school readiness among the infants and young children served by Healthy Start. Thus, outcomes that contribute to school readiness are assessed, including the child's developmental status and family literacy practices.

## ***Children Free From Maltreatment***

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In cooperation with the Oregon Commission on Children and Families, the Oregon State University Family Policy Program, NPC Research, and the Oregon Department of Human Services, Office of Family Health and, the Oregon Department of Human Services, Child Welfare division checked 2001 victimization records for 14,072 Healthy Start children who were 0–2 years during 2001. This included all children receiving both Basic and Intensive Services who were born between January 1, 2000 – December 31, 2001.<sup>4</sup> Thus, these data reflect a different (larger) sample than the other sections of this report.

<b>Outcome measured</b>	<b>Finding</b>
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<b>Children free from confirmed incidents of child maltreatment</b>	98.8% of all Healthy Start's children aged 0 – 2 years were free from maltreatment during 2001.  The 2001 incidence rate of child abuse was lower for Healthy Start families (12 per 1,000 children, aged 0 – 2 years) than for non-served families in the same counties (30 per 1,000 children, aged 0 – 2 years).
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See Tables 21 & 22 in Appendix B.

### ***In 2001, 98.8% of Healthy Start's children aged 0- 2 years were free from maltreatment***

A comparison of child abuse statistics for four years shows that the vast majority of Healthy Start children, ages 0 – 2 years, are not victims of child maltreatment. The percentage of those free from maltreatment has not varied significantly over the past three years, ranging from 99.1% in 1998 to 98.8% in 2001 as shown below (also see Table 21 in Appendix B).

More children are victimized during infancy and toddlerhood than any other age period. National statistics show a higher incidence rate for this age group than was found for Healthy Start children. The third National Incidence Study of Child Abuse and Neglect (NIS-3) reports that in 1993, 26 per 1,000 children aged 0 - 2 years experienced child maltreatment, compared to 12 per 1000 for Healthy Start children.<sup>16</sup>

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<sup>4</sup> Under this collaborative arrangement, DHS Child Welfare provided information on child abuse and neglect incidents among Healthy Start children for statistical purposes only. It is important to note that names are never released by DHS Child Welfare. To insure confidentiality, children are identified only by number. 2001 is the most recent full year for which data are available.



**Table 10. Confirmed Cases of Child Maltreatment by Year**

	<b>Number</b>	<b>Free from maltreatment</b>	<b>Maltreatment rate per 1,000 children</b>
<b>1998</b> All Healthy Start children, regardless of risk level, ages 0 – 2 years	13,004	99.1%	9/1,000
<b>1999</b> All Healthy Start children, regardless of risk level, ages 0 – 2 years	14,814	98.7%	13/1,000
<b>2000</b> All Healthy Start children, regardless of risk level, ages 0 – 2 years	15,552	98.9%	11/1,000
<b>2001</b> All Healthy Start children, regardless of risk level, ages 0 – 2 years	14,072	98.8%	12/1,000
<b>1993</b> National sample of children, regardless of risk level, ages 0-2 years	N/A	97.4%	26/1,000

***Child maltreatment among families served by Healthy Start is lower than among non-served families in the same counties***

Healthy Start is not able to reach all families with newborns within each county. Hence, non-served families provide a means of comparison for incidence of child abuse. In contrast to these non-served families with similar-aged children, Healthy Start families have lower victimization rates (as shown below and Table 21 in Appendix B).

The incidence rate for families screened and/or served by Healthy Start in participating counties is 12 per 1,000 children aged 0 - 2 years. This group includes both lower and higher-risk families. In contrast, the incidence rate for non-served families (both lower and higher risk) in the same counties is substantially greater, at 30 per 1,000 children aged 0–2 years.

**Table 11. Absence of Confirmed Cases Child Maltreatment Among Served/Non-Served Families**

<b>Children Aged 0-2</b>	<b>2000–01</b>		<b>2001–02</b>	
	<b>Healthy Start</b>	<b>Non Healthy Start</b>	<b>Healthy Start</b>	<b>Non Healthy Start</b>
<b>Number*</b>	15,552	48,918	14,072	50,484
<b>Free from maltreatment</b>	98.9%	97.6%	98.8%	97.0%
<b>Maltreatment rate per 1,000 children</b>	11/1,000	24/1,000	12/1000	30/1,000

\* Healthy Start serves primarily first-birth children. Statistics for non-served families include all children, ages 0 – 2, regardless of birth order.

The difference in incidence rates for served and non-served families also may relate to birth order. Research shows that later born children are at greater risk for child maltreatment than first-born children. Over 85% of Healthy Start's children are first born.

However, Healthy Start also targets families with multiple risks beyond birth order, including poverty, single parenthood, a parent's own history of childhood abuse, and teen parenting. Analysis shows that in the face of these risks, birth order is a lesser factor. Among the non-served population, it is unknown how many families have these multiple risk characteristics.

**Type of maltreatment.** Under Oregon law (ORS 419B.005), child abuse is defined in terms of physical assault, mental injury, sexual abuse or exploitation, neglect, and any threat of harm to the child's health and welfare. Of the Healthy Start children who were confirmed victims in 2001:

- 44% experienced threat of harm,
- 29% were neglected,
- 8% were physically abused,
- 17% were drug-affected at birth,
- 3% suffered mental injury, such as exposure to violence or lack of bonding with a parent, and
- 0% were sexually abused.

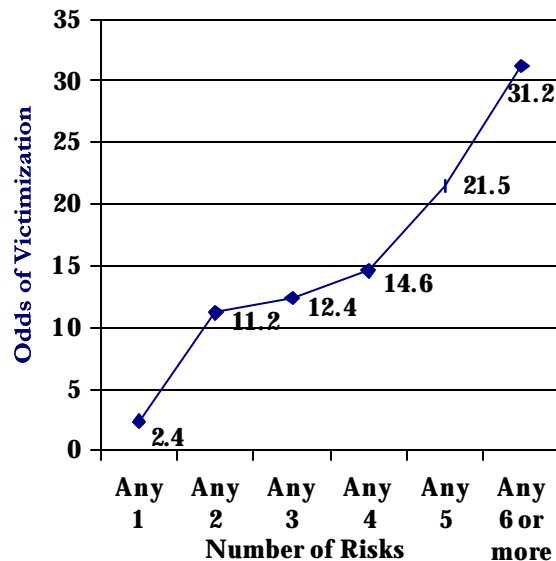
It is important to note that threat of harm accounts for almost half of all abuse/neglect cases. This category, which can be considered the mildest form of maltreatment, includes all activities, conditions, and persons that place a child *at substantial risk* of physical abuse, neglect, or mental injury; for example, if there is domestic violence or sales of illegal drugs in the family's home.

### ***Child maltreatment rates are strongly related to results from risk screening***

The more risks families have, the more vulnerable they and their children are for poor outcomes. For example, the odds of child maltreatment occurring climb precipitously with the absolute number of risks faced by the family, as shown below in Figure 7 (also see Table 24 in Appendix B). Risk characteristics include such factors as:

- ✓ being single at the child's birth,
- ✓ 17 years or younger,
- ✓ experiencing poverty,
- ✓ having a spouse/partner who is unemployed,
- ✓ not receiving early comprehensive prenatal care,
- ✓ unstable housing,
- ✓ experiencing marital or family conflict,
- ✓ a history of substance abuse or mental health problems, and
- ✓ having less than a high school education.

**Figure 7. Likelihood of Maltreatment by Number of Risks on Healthy Start/OCP Screen**



See Table 25 in Appendix B

Regardless of which risk factor, children are more likely to experience abuse when families have risk characteristics than when families are risk free. The odds of abuse occurring are 2.4 times greater for families with any one risk characteristic in comparison to families with none. When families have any two risk characteristics the odds of abuse climb to 11.2 and more than double to 31.2 for families with 6 or more risk factors.

Even though the probability for maltreatment escalates, it should be noted that risk characteristics alone do not create ‘destiny.’ However, they do create situations where barriers to be overcome are greater—and fewer children make it. Coping with any one of the risk factors is a challenge. When these factors are combined, however, an “environment of risk is created that substantially reduces the chances for children’s healthy development and school success.”<sup>17</sup>

Additionally, scores on the Kempe assessment are strongly linked to rates of maltreatment. The rate of child abuse and neglect is 12 per 1,000 children for families who score in the “moderate” stress range. This rate climbs to 40 per 1,000 children for families with high stress, and to 108 per 1,000 children for families with the most severe levels of stress (see Table 23, Appendix B).

**97.5% of Healthy Start’s Intensive Service families were free of maltreatment**

Overall, 97.5% of the higher-risk families receiving Intensive Service with children aged 0-2 years were free from maltreatment during 2001, as shown below (see also Table 21 in Appendix B).

**Table 12. Child Maltreatment by Service Type**

<b>2000 and 2001 Births TYPE OF SCREEN/SERVICE</b>	<b>Number</b>	<b>YR 2001 Free from Maltreatment</b>	<b>Maltreatment rate per 1,000 children, aged 0 – 2 years</b>
<b><u>Basic Service</u></b> Screened at lower risk	5,644	99.0%	1/1,000
Screened as potentially higher risk	3,835	98.4%	16/1,000
<b><u>Intensive Service</u></b> Identified as high risk and high stress, and engaged in services	2,655	97.5%	25/1,000
<b><u>Higher Risk, but Declined or Did Not Engage</u></b> Identified as high risk/high stress, but declined or did not engage in services	1,901	98.5%	15/1,000

The incidence rate for lower risk families who received Basic Service is lower (1/1,000) than for the other families, showing that Healthy Start's comprehensive risk assessment system is highly effective at identifying those at greater risk for poor outcomes. Note that the incidence rate increased to 16/1,000 children aged 0–2 years for families screened as potentially at higher risk.

The incidence rate for higher-risk families who received Intensive Service (25/1,000) is greater than the rate for higher-risk families who declined Intensive Service or who failed to engage, receiving less than three months of service (15/1,000). Both groups were identified as being at higher risk.

**Lower incidence rates among high-risk families who do not receive Intensive Service may simply mean that child abuse is not being reported.**

For those families who were identified as high risk and high stress, but declined or did not engage in services, the lack of regular observation by a home visitor may account for the lower rates of maltreatment, compared to similar families receiving Intensive Service. Because home visitors have regular contact with Intensive Service families, there is a greater chance that child maltreatment will be reported. In short, the lower rate among non-served higher-risk families does not mean that child maltreatment is not occurring, only that it may not be reported.

During 2001, approximately 21% of the confirmed incidents occurred while families were receiving Intensive Service. This same pattern has been observed in other home visitation programs. Home visitors are mandated reporters of child abuse and neglect under Oregon law. Participation in Healthy Start's Intensive Service brings higher-risk families into contact both with Healthy Start home visitors and other mandatory reporters, such as public health nurses, physicians, and other social service providers, thus increasing the likelihood of identification if maltreatment occurs. At the same time, it is important to note that 79% of the incidences of maltreatment occurred after the family's exit from Healthy Start. Certain higher-risk families may be more difficult to engage in Healthy Start services, and be more likely to drop out of the program before receiving a significant amount of service. For example,

families with domestic violence or with substance abuse issues in the home are much more likely to have reports of maltreatment based on “threat of harm” to the child (the most common type of maltreatment). These families may also be less likely to continue to engage in Healthy Start services, because of their desire to hide these kinds of family circumstances from home visitors.

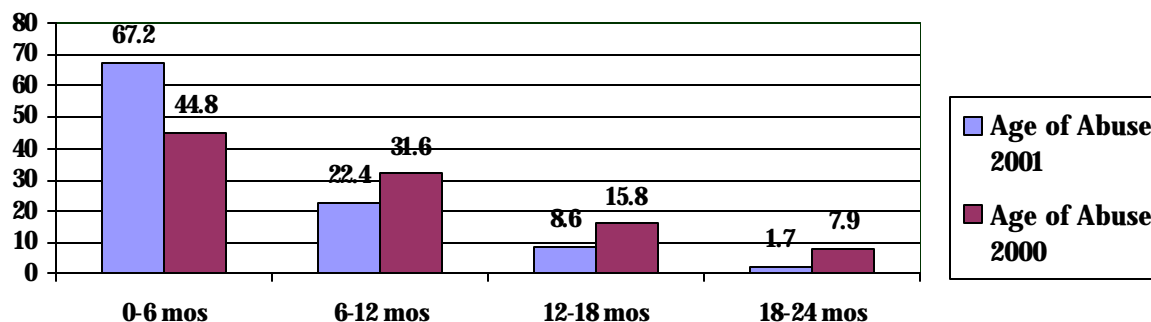
Importantly, in all of the cases in which Healthy Start was working with the family at the time of the child abuse/neglect report, the family continued to receive support services. In this way, Healthy Start can work to help strengthen families and prevent additional instances of maltreatment.

**Risk factors.** Children whose families have issues relating to substance abuse, family violence, and/or criminal involvement were more likely to be victims of abuse than children whose families were free of those issues. While the incidence rate of abuse among families with Intensive Service is 21/1,000 children aged 0–2 years, it climbs to 38/1,000 children if one or more of those risk factors is present in the family as shown below:

<b>1999 and 2001 BIRTHS Intensive Service, Engaged families</b>	<b>Number</b>	<b>YR 2001 Free from Maltreatment</b>	<b>Maltreatment rate per 1,000 children, aged 0 – 2 years</b>
Identified as higher risk, engaged	1,813	97.9%	21/1,000
No substance abuse, domestic violence, or criminal activity	1,446	98.2%	18/1,000
One or more risk factors: substance abuse, domestic violence or criminal activity	352	94.0%	60/1,000

**Timing.** Approximately 90% of the child maltreatment among Healthy Start infants and toddlers in 2001 occurred during the first year of life, with 67% happening during the first 6 months of life, when infants are most vulnerable (see Figure 8). As can be seen, the rates of child maltreatment during 2001 for older children were considerably lower than those for 2000. Healthy Start families were much more likely to be reported for child maltreatment when children were younger (0-6 months) compared to last year. This may reflect two trends: a larger number of infants identified as drug affected at birth (17% this year compared to 6% in 2000), as well as a growing number of older children being served by Healthy Start, especially in programs that have been existence for a number of years.

**Figure 8. Age When Abuse Occurred**

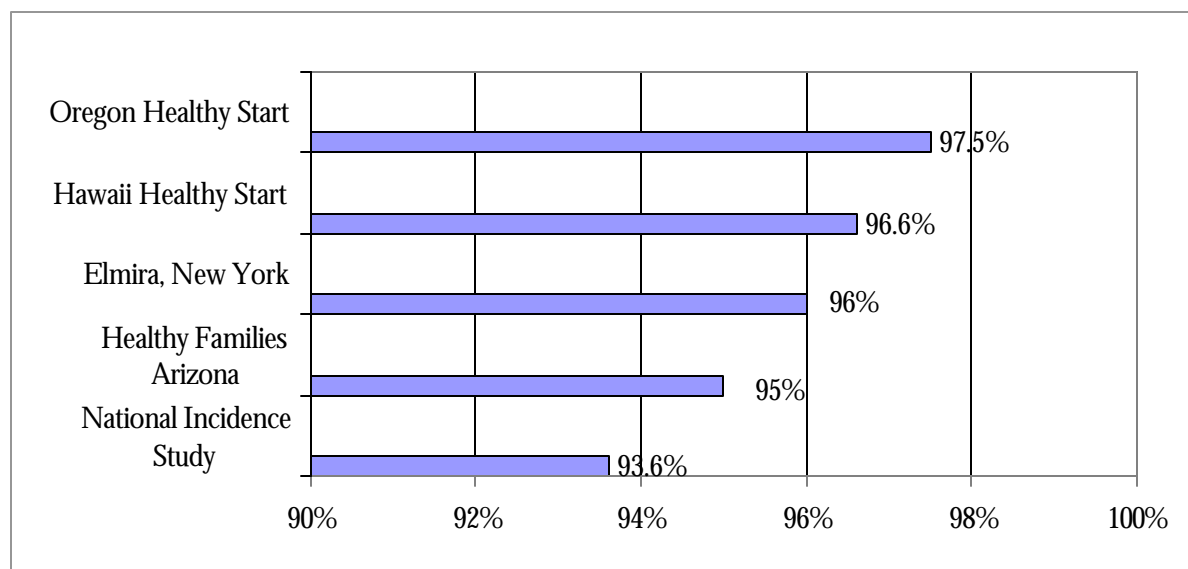


**Perpetrators.** Parents were the most likely perpetrators of the maltreatment. In 72% of the cases, the mother was the individual identified as the source of abuse or neglect by DHS; this is an increase from last year, and again is likely due to the increase in drug-affected infants involved this year. Fathers or live-in partners were the perpetrators in 22% of the cases. Other relatives such as grandparents or step-parents were involved in only 5% of the confirmed cases of maltreatment.

***Percentage of higher-risk families free from maltreatment is comparable to rates found in other home visiting programs***

The finding that 97.5% of higher-risk families who receive Healthy Start’s Intensive Service are free of maltreatment is consistent with other evidence of the effectiveness of home visiting to higher-risk populations (see Figure 9).

**Figure 9. Higher-Risk Families Free of Maltreatment**



From a randomized trial of home visiting conducted in Elmira, New York, David Olds reports that 96% of poor, unmarried teens who were visited by a nurse for two years were free of maltreatment, in comparison to only 79% of poor unmarried teens who received no home visiting.<sup>18</sup>

In a randomized trial of Hawaii's Healthy Start program, 96.6% of the children in higher-risk families served by paraprofessional home visitors were free from maltreatment during the first year of life in contrast to only 93.2% of a control group who were not visited.<sup>19</sup>

The State of Arizona Auditor General's report found that 95% of the Healthy Families Arizona higher-risk families who received at least 6 months of home visitation were free of substantiated reports of abuse or neglect. This figure contrasts with 92% for comparison group families during a similar time period<sup>20</sup>

In Oregon, the 2001 incidence rate among Healthy Start higher-risk families who received at least 3 months of Intensive Service was 21 per 1,000 children, aged 0-2 years. Again, this incidence rate is comparable to those found in other home visitation programs for higher-risk families (see discussion above). Further, this rate is less than half the national rate for higher-risk families (estimated in NIS-3 to be from 52 to 76 per 1,000 children ages 0 – 2).

## ***Early Comprehensive Prenatal Care***

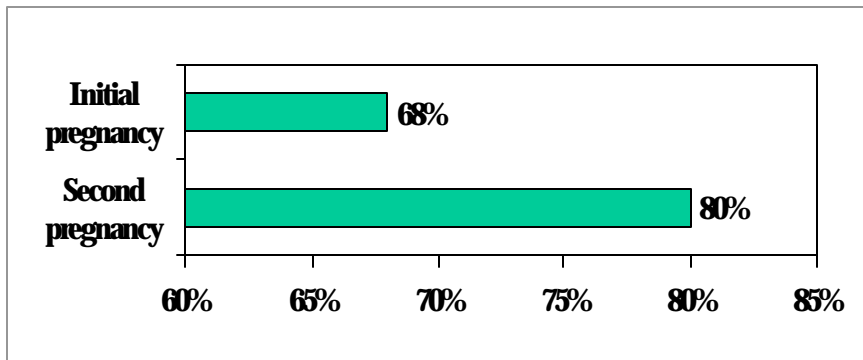
Early comprehensive prenatal care is associated with better developmental outcomes for infants and more positive outcomes for mothers. Early prenatal care begins in the first trimester of pregnancy. Comprehensive prenatal care includes medical, educational, social, and nutritional services.

<b>Outcome measured</b>	<b>Finding</b>
<b>Early comprehensive prenatal care for second pregnancies</b>	80% of the mothers have received early comprehensive prenatal care for second pregnancies in contrast to only 68% for their initial pregnancies.

See Table 11 in Appendix B.

Over two-thirds of Healthy Start's Intensive Service mothers received early comprehensive prenatal care for their first pregnancies. Most sites begin working with families during the last trimester of pregnancy so are not able to have an impact on initial care. However, sites *do* work towards assuring that mothers receive quality care for their second pregnancies.

**Figure 10. Early Comprehensive Prenatal Care for Mothers with a Second Pregnancy**



See Table 11 in Appendix B.

Among higher-risk mothers served by Healthy Start during FY 2001–02, rates of early comprehensive prenatal care increased by 18% for second (or later) pregnancies, compared to rates for their first pregnancies. During Intensive Service, 685 women became pregnant. Of these women, slightly over two-thirds (68%) had received early comprehensive prenatal care for their first pregnancies. As shown above in Figure 10, 80% received early, comprehensive prenatal care for these second or later pregnancies.



## Healthy Growth and Development

Healthy growth and development places children on a positive trajectory leading to readiness for school at age 5. Early and periodic screening for developmental delays and limiting physical and mental conditions is essential if the best possible outcomes for children are to be achieved.

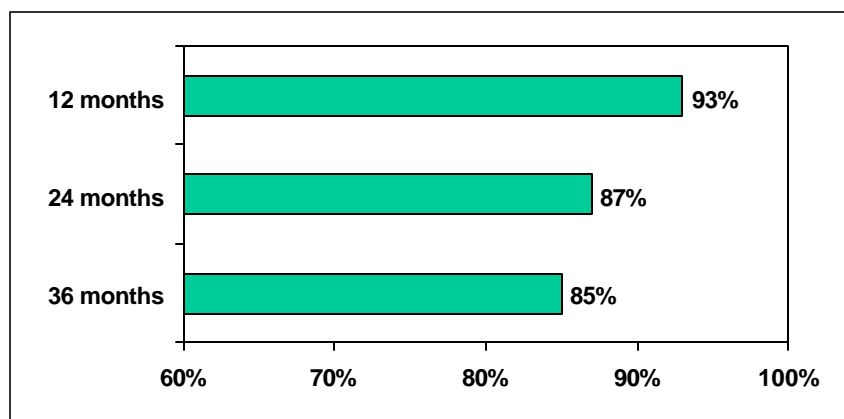
Outcome measured	Finding
<b>Normal growth and development</b>	88% of the children in higher-risk families receiving Intensive Services show normal growth and development when screened with the normed Ages & Stages Questionnaire.
<b>Early intervention for all children falling outside the normal range for development</b>	94% of the children in higher-risk families receiving Intensive Services with <i>diagnosed</i> developmental disabilities are receiving Early Intervention services. Early diagnosis and intervention are critical to achieving the best possible development for these children.

See Table 12 in Appendix B.

Together with parents, home visitors use the Ages and Stages Questionnaire (ASQ)<sup>21</sup> (originally titled the Infant/Child Monitoring Questionnaire) to monitor and screen the developmental progress of children in Healthy Start's higher-risk families. Screening is conducted during the first year at 4, 8, and 12 months, and subsequently at 18, 24, 30, 36 and 48 months of age.

Overall, 88% of the 1,647 Intensive Service children who received a developmental screening during FY 2001–02 were assessed as developing normally. As shown in Figure 11, 93% of the 12-month-olds, 87% of the two-year-olds and 85% of the three-year-olds were within the normal range on the Ages and Stages Questionnaire.

**Figure 11. Normal Child Growth & Development**



See Table 12 in Appendix B.

Most (94%) of the children with developmental disabilities that had been diagnosed professionally, received specialized interventions. For those children with developmental delays, early detection and appropriate specialized intervention

enhances the probability of achieving the best possible outcomes by the time they enter school.

## ***Adequacy of Health Care***

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Access to and utilization of well-child health care is critical to children’s well-being and healthy growth and development. Many common conditions such as ear infections can have long-term consequences for children if left untreated. In the health arena especially, “an ounce of prevention is worth a pound of cure.”

<b>Outcome measured</b>	<b>Finding</b>
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<b>Adequacy of health care</b>	<p>97% of all children in higher-risk families receiving Intensive Services are linked to a primary health care provider.</p> <p>91% of the children in higher-risk families receiving Intensive Services receive regular, well-child checkups.</p>
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See Table 13 in Appendix B.

Healthy Start works with parents to ensure access to health care. Visitors emphasize the importance of children receiving regular well-child care and recommended immunizations. Using a Family Update, visitors report on the adequacy of health care at six-month intervals or when the family leaves the program.

Almost all (97%) of Healthy Start’s children from higher-risk families have a primary health care provider. Linkage to a primary health care provider is an important first step to ensure that children receive regular preventive well-child check-ups and receive appropriate routine health care. Most (91%) of the Healthy Start children from higher-risk families received regular well-child checkups during FY 2001–02. About 82% of higher-risk families who received Intensive Service are enrolled in the Oregon Health Plan.

At six-month intervals, home visitors rate whether or not children are exposed to passive smoke. During the current fiscal year, 63% were not exposed to passive smoke. However, two-fifths of the children lived in a home environment with family members who used tobacco.

*Children who have regular well-child check-ups are rated as having better health than children who receive less health care.*

Overall, home visitors reported that 89% of the children from higher-risk families had good or better health and 84% had good or better nutrition. Further analysis shows that children who had regular well-child checkups were more likely to be rated as having better health than children who received less health care ( $p < .001$ ).

## Adequacy of Immunizations

In 1994, the President's Childhood Immunization Initiative made immunization of preschool children one of the nation's highest health priorities. Priorities include: 1) eliminating indigenous cases of six vaccine-preventable diseases by 1996, 2) establishing a vaccination-delivery system that maintains and improves high coverage levels; and 3) increasing age-appropriate vaccination coverage levels to at least 90% among 2-year-olds by 2001.<sup>22</sup>

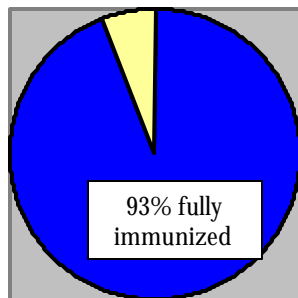
Outcome measured	Finding
<b>Adequacy of immunizations</b>	<p>91% of all the children in higher-risk families receiving Intensive Service are up-to-date with immunizations and another 7% have received some vaccines but are not fully up-to-date.</p> <p>93% of the children in higher-risk families who have received Intensive Services for 24 months or more are fully immunized at 2 years of age.</p>

See Table 13 in Appendix B.

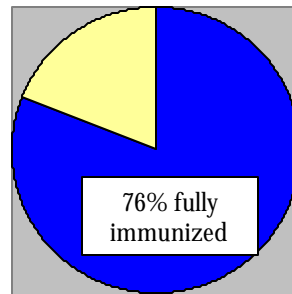
Approximately 91% of Healthy Start babies are up-to-date on their immunizations, and an additional 7% have received some vaccines but are not fully up-to-date. Immunizations are delayed if a child is sick when the vaccine is due. Very few parents (1%) have chosen *not* to immunize their child because of cultural or religious beliefs.

The United States National Immunization Survey,<sup>23</sup> an ongoing survey that provides estimates of vaccination coverage among children aged 19-35 months, shows that 76% of Oregon's two year olds are fully immunized. In comparison, 93% of the two-year-olds from higher-risk families who have received Healthy Start's Intensive Service over a two-year period are fully immunized (see Figure 12).

**Figure 12. Percentage of Children with Immunizations at Two Years**



**Healthy Start Two-Year-Olds from higher-risk Families, 2001-02**



**Oregon Two-Year-Olds, 2001**

Oregon immunization rate for two-year-olds from the National Immunization Survey, 2001

## ***Family Effectiveness As Child's First Teacher***

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A strong relationship exists between children's development and the environments in which they live.<sup>24</sup> Positive learning environments in the home lead to readiness for school. When parents are encouraging, stimulating, responsive, and genuinely enjoy interacting with their children, children gain the skills and confidence to succeed in school when they reach kindergarten.

<b>Outcome measured</b>	<b>Finding</b>
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<b>Family effectiveness as child's first teacher</b>	<p>74% of the children experience well above average home learning environments as measured by the Home Observation for Measurement of the Environment (HOME) at 12-15 months.</p> <p>75% of the parents show well above average responsivity and affection to their child as measured by the Home Observation for Measurement of the Environment (HOME) at 12-15 months.</p> <p>72% of the parents show well above average involvement in child learning activities as measured by the Home Observation for Measurement of the Environment (HOME) at 12-15 months.</p>
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See Table 14 in Appendix B.

At 12 months and again at 24 months, home visitors use a standardized observation tool, the Home Observation for Measurement of the Environment (HOME) Inventory for Infants and Toddlers,<sup>25</sup> to review the home environment from the child's perspective. Numerous studies show the HOME Infant-Toddler Inventory to be a strong predictor of developmental outcomes for kindergarten children, especially in the cognitive and language areas.<sup>26</sup> Raters generate a numeric score, which is then compared to the results for a normed sample of families in the general population. Families are rated as being in "low" (less than the 25<sup>th</sup> percentile), "medium" (from the 25<sup>th</sup> to 75<sup>th</sup> percentiles), or high "75<sup>th</sup> percentile or greater).

**Healthy Start children have supportive home environments.** Over two-thirds (74%) of Healthy Start's higher-risk families were rated as being in the highest quartile, which means they create a better than average learning environment for their young children at 12 months, compared to only 25% of the general population on which the HOME has been normed. Similarly, at 24 months, 75% provide above average learning environments (see Table 16 in Appendix B). HOME scores tend to remain stable over the first two years of life. Parents who are providing a supportive learning environment for their child at 12 months are also likely to be effective as the child's first teacher at 24 months.

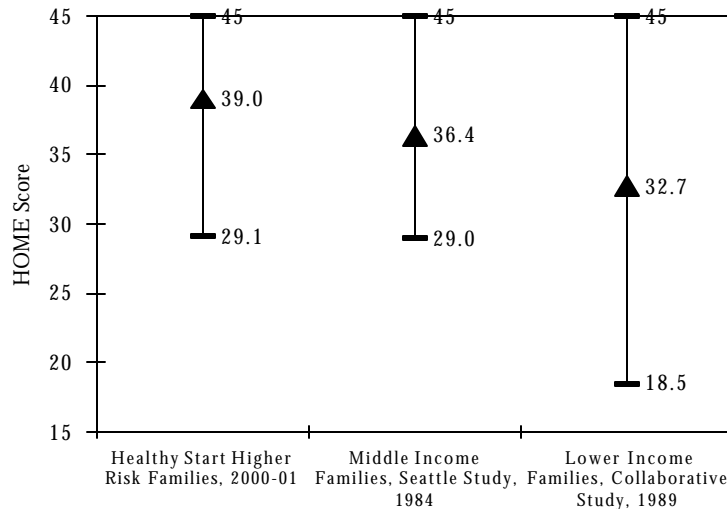
Three sub-scales of the HOME are most highly correlated with children's cognitive development: 1) parent responsivity to the child, 2) parent involvement and encouragement of the child and 3) availability of age-appropriate toys and learning materials. Analysis of the sub-scales shows only minimal variability over the two-year period:

- 75% of Healthy Start’s higher-risk families are well above average in the degree of positive emotional and verbal responsiveness they show to their children at 12 months of age. After 24 months, 81% of the families are well above average.
- 69% of Healthy Start’s higher-risk families are well above the average in providing appropriate toys and learning materials for their children at 12 months of age. After 24 months, 80% are well above average.
- 72% of the higher-risk families are well above the average at encouraging children to develop more mature skills at 12 months of age. At 24 months, 78% of families are well above the average at encouraging children to advance developmentally.

Based on HOME scores when the child is 12 months old, mothers who have at least a high school education tend to create more supportive home environments than mothers who have less education ( $p < .0001$ ). Also at 12 months, the mother’s age is significantly associated with HOME scores. On average, children whose mothers are 18 years or older have intellectually more advantageous home environments than children whose mothers are 17 years or younger ( $p < .0001$ ).

**Home environments of Healthy Start one-year-olds compare favorably to others.** The home environments of Healthy Start one-year-olds from higher-risk homes compare favorably with the home environments of other children, assessed at one year of age, regardless of socioeconomic status (see Figure 13).

**Figure 13. Comparison of 1-Year Healthy Start HOME Means with 1-Year HOME Means from Other Populations**



Note: The range for each study represents the mean plus or minus 2 standard deviations and describes 95% of the distribution.

The home environment of Healthy Start one-year-olds is similar to that provided by middle socioeconomic status (SES) families in the Seattle Study of healthy, normally developing children.<sup>27</sup> On average, Healthy Start higher-risk families provide considerably *more* enriched home environments than those provided by lower SES families not receiving home visitation services.<sup>28</sup>

## Family Literacy Activities

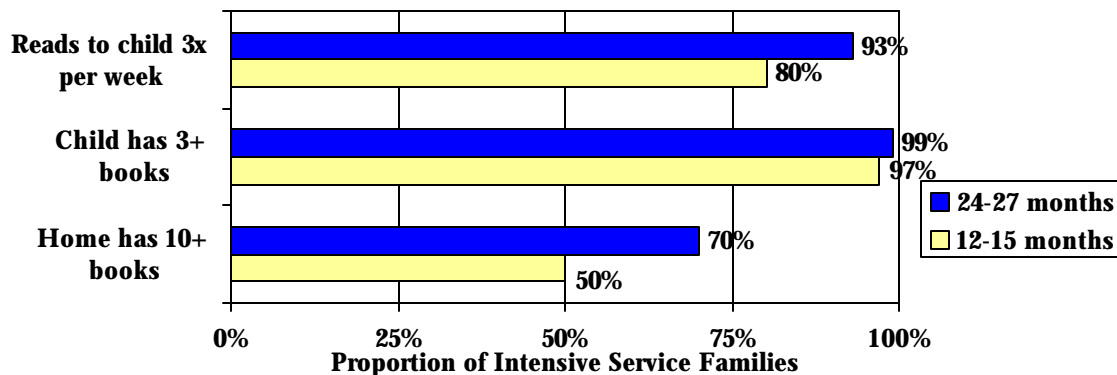
When families introduce children to the world of books early in their childhood, children are more likely to have appropriate language abilities when they enter school.<sup>29</sup> Thus, families who read or tell stories to their young children are giving them a head start toward success in school.

Outcome measured	Finding
Family literacy activities	<p>80% of the higher-risk Intensive Service families read or look at picture books with their 12-month-old child at least 3 times per week. At 24 months, 93% of the families read to their child at least 3 times per week.</p> <p>97% of the children in higher-risk families who have received Intensive Service for 12 months have at least 3 books of their own. By 24 months, 99% of children achieve this goal.</p>

See Table 15 in Appendix B.

**Families are involved in early literacy activities.** Well over three-fourths (83%) of Healthy Start's higher-risk families "read" picture books with their one-year-olds at least three times per week. Reading to a toddler typically involves looking at pictures and naming objects. As shown below in Figure 14, by age two, 93% of the families are regularly involved in reading to their children. In comparison, national statistics indicate that about two thirds (64%) of higher-risk families read to their preschoolers aged 3 – 5 three or more times a week.<sup>30</sup>

**Figure 14. Family Literacy Activities**



See Table 15 in Appendix B

Almost all Healthy Start higher-risk families with one-year-olds (97%) have at least 3 books of their own. Much of Healthy Start's success in encouraging early literacy can be attributed to Oregon State Library and local libraries, which gave books to the children and provided other learning materials to be shared with families through its program, *Reading for a Healthy Start*.

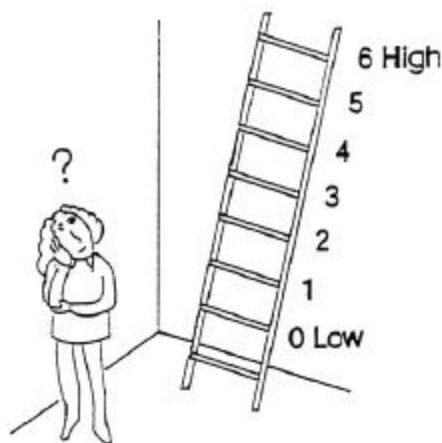
## Adequacy of Parenting Skills

Parenting skills support children’s healthy growth and development. Parent knowledge and skills leads to realistic expectations and developmentally appropriate support for children’s learning and development.

Outcome measured	Finding
Adequacy of parenting skills	<b>After 12 months of Intensive Service:</b> 75% of the parents in higher-risk families receiving Intensive Service have improved parenting skills, as measured on the Parenting Ladder.

See Table 19 in Appendix B.

**Figure 15. Parenting Ladder**



After 12 months of Intensive Service, parents rate their current knowledge and skills on a “Parenting Ladder.” At the same time, they reflect back and rate their knowledge and skills when Intensive Service began. This retrospective pretest methodology produces a more robust assessment of program outcomes than traditional pretest/post-test methodology since parents have shifted their frame of reference about their initial knowledge and skill level as a result of program participation.<sup>31</sup>

**Parenting skills improve.** After 12 months of Intensive Service, 75% of higher-risk families report improved parenting skills over the time when their child was born (see Table 20 in Appendix B). Parents report similar gains for individual skills. After 12 months of Intensive Service:

- 74% report improved knowledge of child development
- 62% report improved ability to help their child learn
- 44% report improved ability to cope with the stress in their lives



## ***Quality of Parent-Child Interactions***

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Supportive, nurturing interactions between a caregiver and an infant are critical to the child's healthy growth and development. Positive patterns are established during infancy when caregivers learn to recognize and accurately interpret the child's signals and to respond appropriately to the child's behavior.

<b>Outcome measured</b>	<b>Finding</b>
<b>Quality of parent-child interactions</b>	73% of the higher-risk families receiving Intensive Service consistently engage in positive parent-child interactions by 6 months, in contrast to 60% during the first month of life, as reported by home visitors, based on regular observation of family practices.

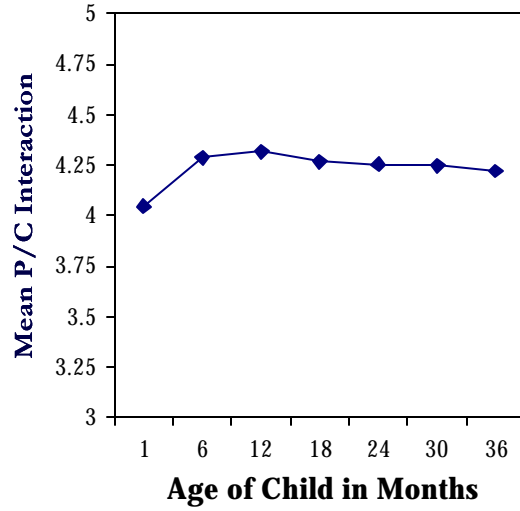
See Table 20 in Appendix B.

**Positive parent-child interactions increase.** Healthy Start workers write up notes and observations on family needs and progress after each home visit. At six-month intervals, home visitors review these case notes and, on a Family Update, report the extent to which parent(s) engage in positive parent-child interactions.

During the first month of life, 60% of Healthy Start's higher-risk families were rated as consistently engaging in positive interactions with their child, such as responding appropriately to the baby's cues. By 6 months, the proportion had increased to 73% (see Table 21 in Appendix B). After 12 months, parent-child interactions continue to be positive and supportive for approximately the same percentage of families (74%).

**Parent-child interactions are affected by children's developmental stage.** The mean ratings of *consistent* positive parent-child interactions is related to the child's age (see Figure 16). Families being served by Healthy Start Intensive Services show an improvement in parent-child interactions from the start of service to the first follow-up point, when the child is about 6 months of age. Data from FY 2001–02 show fairly consistent mean ratings across the other age groups.

**Figure 16. Mean Parent-Child Interaction by Age of Child**



With continued support from Healthy Start, about three-fourths of the higher-risk families maintain positive interactions with their children through the critical and demanding first three years of life.

## Utilization of Appropriate Health Care

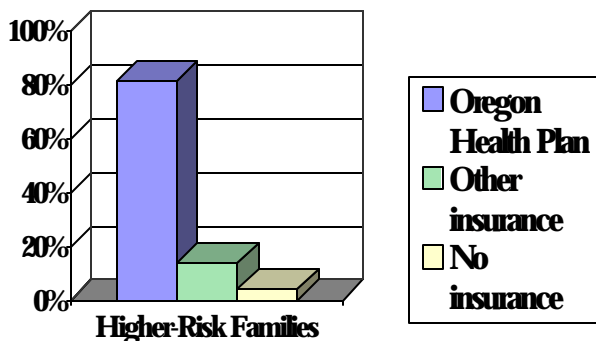
Health care is a basic necessity for all families. Those without access to health care are more likely to have poor health than those who receive regular, preventive care. Health has an impact on a variety of life course outcomes. For example, individuals with poor health are less likely to find and keep stable employment.

Outcome measured	Finding
Utilization of appropriate health care	<p>77% of the parents in higher-risk families receiving Intensive Service are linked to a primary health care provider.</p> <p>61% of the parents in higher-risk families receiving Intensive Service have dental care.</p> <p>78% of the higher-risk families receiving Intensive Service never use emergency services for routine health care.</p>

See Table 16 in Appendix B.

Using a Family Update, home visitors report on the adequacy of health care at six-month intervals or when the family leaves the program. Health care statistics reflect the most recent information on file about each family.

**Figure 17. Health Insurance Status of Intensive Service Families**



Healthy Start works with families to ensure access to the Oregon Health Plan for all those who are eligible. Approximately 82% of the higher-risk families receiving Intensive Service were enrolled in the Oregon Health Plan during FY 2001–02 (see Figure 17). Only 4% have no health insurance.

Approximately 77% of the higher-risk families have a primary health care provider and about 61% have dental care. Although families are eligible for dental services through the Oregon Health Plan, many dental providers do not take Medicaid clients. This may explain the limited access to dental care for some Healthy Start families.

Emergency room services are very costly, but families without a primary care provider often use the emergency room for routine health care needs. Because Healthy Start has been successful in linking families to primary health care providers, 78% of these higher-risk

families have never used emergency room services for routine health care. Another 19% have only used these services once or twice during the past year.

## Adequacy of Basic Resources

Adequate family resources are essential to family well-being, stability and self-sufficiency. Adequate resources act as protective processes that increase the likelihood of positive child and family outcomes and decrease the chances for child maltreatment. Families whose needs for basic resources are met feel less stress.

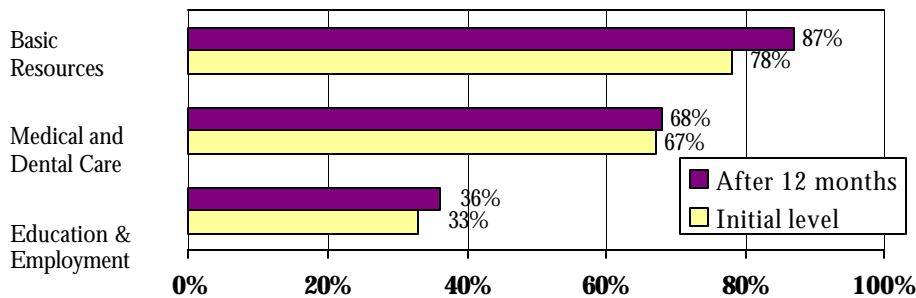
Outcome measured	Finding
<b>Adequacy of basic resources: food, housing, transportation, health and dental care</b>	<b>After 12 months of Intensive Service:</b> A 12% increase in families (from 78% to 87%) who report their need for basic resources such as housing, food, and clothing are usually met. A 9% increase in families (from 33% to 36%) who report need for education and employment opportunities are usually met.

See Table 17 in Appendix B. Percent increase/decrease is the percentage of change from the first level to the second. It is calculated by dividing the difference between the two levels by the first level.

Parents rate the extent to which family needs are met for basic resources such as food, shelter, clothing, transportation, child care, money, and education and employment opportunities during the first month of the child's life and again when the child is six and twelve months of age.

**Healthy Start successfully connects families with community resources.** After 12 months of service, 87% of higher-risk families report their needs usually met for basic necessities, such as housing, food, and clothing, a 12% increase from the time when their children were born (see Figure 18).

**Figure 18. Adequacy of Basic Resources**



See Table 17 in Appendix B

The proportion of families who reported needs usually met for medical and dental care remained approximately static at 67% initially and 68% after 12 months.

The proportion of families with their transportation needs met increased from 74% to 80% from intake to 12 months (an 8% improvement). Child care is a somewhat more challenging need, with 64% of families having this need met at the child's birth, and 66% reporting this need as met by the time the child is 12 months old.

## Reduction in Family Risk Processes

Risk processes such as substance abuse, domestic violence, and criminal activity have a negative impact both on the ability of families to provide physical and emotional care to their children and the children's brain development.

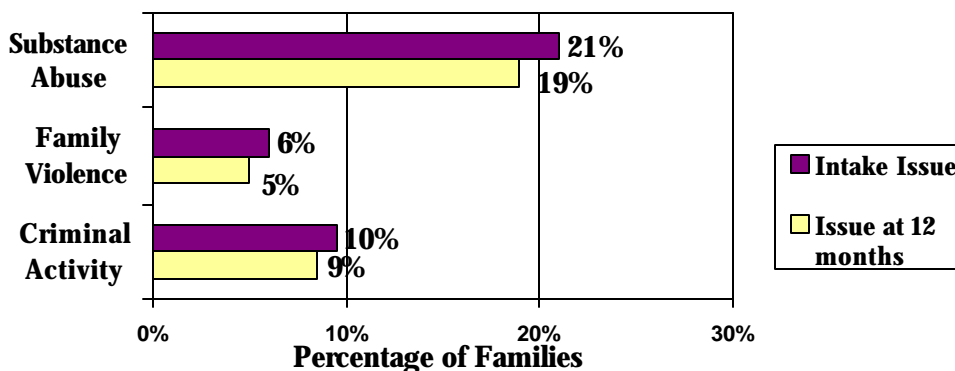
### Reduction in number of risk factors

The number of families with substance abuse, criminal activity, or domestic violence decreased slightly from intake to the baby's first birthday.

See Table 18 in Appendix B. Percent increase/decrease is the percentage of change from the first level to the second. It is calculated by dividing the difference between the two levels by the first level.

**Reductions were observed for Healthy Start's Intensive Service families with risk processes.** A sample of 943 higher-risk families, with information at intake and 12 months was examined for issues relating to substance abuse, family violence, and criminal activity. As shown in Figure 19, there were small reductions in the number of families with these issues over the twelve-month period. However, it should be noted that often, these risk factors are unknown by the home visitor at the time of family intake. Thus, the rates may actually be likely to increase simply based on the home visitor having greater knowledge of the family over time.

**Figure 19. Families with Risk Issues After 12 months of Intensive Service**



See Table 18 in Appendix B.

For the subset of families with data available for each of these indicators, 29% of the families showed one or more of these risk processes at intake, most often substance abuse by a family member other than the mother. By 12 months, only 23% of these families had one or more risks, a percentage decrease of 21% (see Table 18 in Appendix B).

## ***Coping Strategies***

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Healthy Start of Oregon is a strength-based service, designed to facilitate family decision-making, capabilities, and competencies. Family life and parenting are frequently stressful. Even among the strongest families, crises and stresses occur. Among higher-risk families, chronic stress and crisis can strain relationships severely. Family well-being depends on the extent to which families respond to stress effectively and maintain a stable home life, even in adverse circumstances.

<b>Outcome measured</b>	<b>Finding</b>
<b>Coping strategies</b>	After 12 months of Intensive Service, 81% of families are rated as having effective coping strategies.

At 6 month intervals, home visitors report on coping strategies and strengths for each parent, including such attributes as coping effectively with stress, managing anger constructively, understanding and respecting the child's needs, positive problem-solving skills, and the capacity to set realistic personal goals.

**Coping strategies increase with the amount of service received.** For families with ratings at both intake and 12 months, there is a statistically significant improvement in the workers' ratings of parents' use of effective coping strategies. After 12 months of Intensive Service, approximately 81% of Healthy Start's higher-risk families demonstrate effective coping strategies compared to 76% at the time of their child's birth.

After 12 months of Intensive Service,

- 79% of participating mothers cope effectively with stress
- 82% of participating mothers have good problem-solving skills
- 88% of participating mothers are able to set realistic personal goals for education or self-improvement

## ***Family Satisfaction***

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Healthy Start earns uniformly high marks from parents for both the helpfulness of the home visits and the treatment that families receive from the visitors. Intensive Service parents are surveyed about their experience when their child is six months and then annually thereafter.

<b>Indicator measured</b>	<b>Finding</b>
<b>Family satisfaction with Intensive Service</b>	96% of higher-risk families receiving Intensive Service say Healthy Start has helped them better meet their child's needs

See Table 10 in Appendix B.

Families report that they find Healthy Start services helpful<sup>5</sup>. Almost all the parents (96%) reported that Healthy Start has helped them meet the needs of their child and understand their child's behavior and feelings (see Table 10 in Appendix B). About 82% rated Healthy Start as "helping a lot" with meeting their child's needs and 83% rated Healthy Start as "helping a lot" with understanding their child's behavior and feelings. 81% of families felt that Healthy Start had helped them to solve serious problems in their lives.

Families also rated the extent to which Healthy Start has helped meet their needs for community services such as education or childcare. About two-thirds (67%) rated the service as "helped a lot" in this area while 22% said Healthy Start "helped a little." Assistance in this area depends on the availability of resources and the ability of the family to access the resources. For example, childcare may be available, but the family may not be able to afford what is available.

Healthy Start's family-centered services and supports are designed to facilitate family decision-making, capabilities, and competencies. Families are very satisfied with the treatment they receive through Healthy Start (see Table 10 in Appendix B).

More than three-fourths of the families say they are almost always treated well and respectfully:

- 88% feel that their home visitor *almost always* really listens to them
- 81% *almost always* find the information they receive easy to understand
- 75% say that, *almost always*, they can decide what help they receive from their visitor
- 69% say that, *almost always*, the visitor helps them find a solution to a crisis they are experiencing.

### **What Do Parents Say About Healthy Start?**

In order to gain information about parents' experiences with the Healthy Start Program, NPC Research conducted interviews with parents from the 11 original Healthy Start counties (Clackamas, Clatsop, Deschutes, Hood River, Jackson, Josephine, Lane, Linn, Marion/Polk, Tillamook, and Union counties). One additional existing Healthy Start county was included

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<sup>5</sup> It is important to note, however, that this information is collected in a manner that is not confidential; parent answers are known to the home visitor.



(Harney) to broaden representation of Eastern Oregon (and rural) counties. These sites have been in existence for at least 3 years.

A total of 21 parents participated, all female. The racial breakdown of this sample is as follows: 15 White (71%), 4 Hispanic (19%), 1 Asian (5%), and 1 Native American (5%)<sup>6</sup>. Three of the participants (14%) reported having multiple races within their families.

Information from these interviews as well as from open-ended comments included in Parent Surveys was used in compiling the parent feedback below.

### **Reasons for participating**

Most parents interviewed indicated that they agreed to participate in Healthy Start because of the information they believed the program would provide. They either had specific questions or knew questions would arise over time. Several parents indicated that they were a teen parent or that this was their first baby, so they felt they needed information.

*Because I am 15 and don't know much about parenting and I thought some extra help would be helpful and it was there. The most important thing I thought I would get was just someone to talk to about [Baby] besides my parents.*

Another frequent reason for participating was that the worker was kind, thoughtful, or respectful. Several parents also indicated that they were looking for support or help, or someone to talk to. One parent was enticed by the home visiting structure; she was pleased that she did not need to go somewhere to get information.

*She's caring, sincere, seems that she just really cares about how I'm doing and the kids.*

### **Reasons for continuing in the program**

The most common reason parents remained in the Healthy Start program was because they were receiving information that was useful to them. They stated that they were able to get their many questions answered, and they received advice and ideas from their workers. Many parents indicated that the worker or program overall was helpful. Many also stated that they received support or encouragement from their home visitor. Parents remained in the program because the staff was friendly and respectful.

*First because [Baby] is my first baby and I didn't know how to take care of him, I didn't know anything about it, especially when he was crying, with their [Healthy Start] help now I can have better control. [I continue the program] for my child, because he continues to grow and when I have questions she [home visitor] answers them and I still have things I don't know about my child.*

*Because it is really helpful. They help me answer my questions and I can see how much my kids are developing. As long as I am involved I get the information, I can read, and if I have questions my visitor can bring me answers to our next visit.*

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<sup>6</sup> One additional parent indicated being a small proportion Native American. She identifies as White, so she is listed in the White category.

*I like having someone there pat me on the back – telling me I am doing a good job. Given me a lot of information on brain development.*

Many parents shared that the program provided them with direct assistance, such as transportation, formula, and diapers. They also mentioned receiving books and gifts for their children. Several parents appreciated that the program linked them to other services and resources.

*Because they help me a lot, and they help me go to my appointments. They drive me to my appointments. If I don't have a ride, they will come and get me. If I have any questions or if anything is wrong than they try to help me. Every time she brings me a book for my daughters, and she will read to them. Sometimes she takes me to the library.*

*I like the ideas that she gives to me and how she responds to the way I act toward my son.*

*Mostly because I found it really useful. I like knowing what my daughter should be learning and what I should be doing to help my daughter develop. Probably the most was helping me learn what my daughter should be learning. It's been helpful that if I'm stressful about anything I can call my worker*

*I feel like it is helping me to teach my son things that I wouldn't normally have taught him. Show me things to help him grow...*

### **Friend and family perspectives on the program**

None of the parents interviewed for this study had friends or family members who were concerned about or unsupportive of the parent's involvement in Healthy Start. Most of the respondents indicated that their family members or friends were supportive and liked the program. Several parents indicated that their friends or loved ones were not involved or had no opinion of the program. Several others said that the worker had helped a family member in addition to the participating parent and child.

*Actually, she helps my husband to get into new career. [Our] family supported us.*

*They thought it was a really good idea to have some resources, they were supportive of my joining.*

*My husband likes it and my mom was glad to help out. Everyone's happy for me because I've got help and support and information.*

*My family thinks that it is good, when they have questions they can ask her and she (visitor) always answer all the questions they have.*

*I've recommended it to other family members.*

## **What parents like best about their home visitors**

By far the most common response to the question, “what do you like best about your home visitor?” was a personality characteristic. Home visitors were described as nice, friendly, caring, happy, casual, and respectful.

*She always has a smile and is always ready to listen. She always calls before she comes over, and asks if I need anything. Her helpfulness and caring attitude.*

*She is respectful the way her personality is. Sometimes I'm down and in the dumps, and she makes me laugh instead of being grumpy.*

*Probably just that she is a really happy person and I love visiting with her. When she comes over she gives me handouts and sit on the floor with my daughter and goes over things and teaches me games and we talk and stuff.*

*She helped me get through the first three months with the postpartum depression. She'd been through it and helped me.*

Second, but also frequently mentioned, was that the worker provided helpful information or advice. Many parents valued the support they received from their workers and reported them as being good listeners.

*Sometimes I just need someone to talk to or someone to listen to me. She does those things. She is always happy to see my kids. Sometimes she suggests going to the park and playing together. She gives me lots of ideas.*

*I like the workers and they are helpful. My worker provides me with helpful information*

Several specifically mentioned that the home visitor cared about her and her children. Parents also appreciated when workers would “get on the floor with the kids.”

*...she's a very nice, kind lady. She works at the hospital and is very wise. She is a mom too so she can relate, understanding. Gets on the floor with the kids; introduced herself to me the first time I met her. She doesn't try to force the kids to do anything. She gets the kids to do things with out them knowing it.*

## **Home visitor knowledge**

Most of the parents reported that the home visitors knew everything they needed to know. Several parents said that if a worker did not know an answer to a question, she would find out by the next visit.

*My worker brings all the information about children's development so I can read it too. She got me to do community activities, like a playgroup.*

*If we do ask her something she definitely gets it, if she doesn't know the answer she'll go find it.*

*From the first time I met her she made me feel good and I have a lot of confidence in her, she knows almost everything. . . she knows how to listen and understand and she explains things very well.*

### **Biggest benefit of Healthy Start**

Many parents reported that receiving information and educational material was the biggest benefit of their involvement in the Healthy Start program.

*I feel like my son is getting a head start in education and development, he gets a lot of quality time in a healthy learning environment with HS.*

*She [home visitor] explains things to me. I grew up with my parents not knowing what activities to do. She comes out with paperwork for different activities and teaches me songs to sing.*

*Probably seeing my kid go to preschool to learn ABCs. And to see my young one go to play group and get along.*

*Most of the benefits would be towards my daughter and helping her develop normally.*

A large number also mentioned that having support and someone to talk to was a huge benefit. Several parents responded that through the program they learned to be a better parent. Several others noted how much they valued the home visits.

*Just learning how to be a better mom. The home visits, I like that they come to my house and offer support.*

*To be a good mother, and I learn many things. I have learned how to raise my daughter, and how to take care of them. Now I know more information to do a better job being a mother.*

*[I] feel like I have been able to do a better job. Education and support.*

Two parents said that they valued the community activities (such as play group). Other parents noted that getting help finding a job, learning activities to do with her child, and getting a break from the children were benefits of the program that they appreciated.

### **Demonstrating respect for participants and their families**

Respondents were asked what, if anything, Healthy Start staff members do that shows respect for the participant and her family. All of the participants reported feeling that their workers respected them. The examples they provided were varied. Many parents reported that their workers were courteous, polite, nonjudgmental, understanding, supportive, and did not “talk down” to them.

*She was always there to answer questions and be there once a month for visits. That’s a huge thing.*

*They don’t talk down to you. Sometimes at the doctor’s office, they do that. They make you feel dumb. She [home visitor] never does that.*

*They’re understanding. And they want the best for every kid, and they prove that with their work.*

Others said that their home visitors knew their boundaries and were not nosey or interfering. Still others used more concrete criteria: If their workers had to miss an appointment, they called.

*They're not really interfering, they keep their distance, they know their boundaries and are not nosey. This is very important to me.*

*If she can't make a meeting she calls and let's me know. She supports me in my decisions and totally understands my point of view on things, which is so great.*

*When she comes, if I'm down or feel like I don't want to talk then she'll respect my wishes. I talk to her about a lot of things, but she doesn't push me to talk about things that are unnecessary.*

Some respondents had individual examples, such as a situation where the worker maintained the parent's confidentiality or a parent whose worker complimented her parenting. Some respondents had no specific examples, but just felt that respect was evident in the ways the worker talked to the parents or acted with them. One respondent reported that the program was always receptive to her needs, and even when her worker was not available, someone else would help her. As one parent stated, "they want the best for every kid."

*The way they talk to me. The way they do things, and the way they act.*

*She knocks and she calls. She'll wait to make herself at home, she's not impatient, and she's nice to everyone. She let's us know that if we don't want her there all we have to do is ask.*

*I know that when I talk to staff, maybe concerning difficult situations with other parents, I know that confidentiality is kept in highest regards.*

### **Culturally appropriate services**

Because the sample of parents in this study was predominantly White, it is understandable that most respondents did not feel that the questions on culturally appropriate services were applicable to them. Several respondents indicated that the worker never addressed the topics of race or religion. For parents who identified as Hispanic or Asian, the questions seemed more relevant. Hispanic parents in this study provided several examples of ways that Healthy Start provided culturally appropriate services, including bringing books in Spanish, caring about their language, not being racist, and having the worker be Hispanic and speak Spanish.

*She always bring things that help me, and she always explain to me the good and bad of everything. There hasn't been any cultural conflicts." (Hispanic female) No I haven't have any difficulty but sometimes when I need to make use of a service, I can't have it because I don't speak English and that makes things difficult. Then I ask for help of my visitor and she always helps me.*

*They bring books in Spanish and they care about our language too.*

## **Recommending Healthy Start to others**

Not surprisingly, all parents in the sample said that they would recommend Healthy Start to others. In fact, many said they already had. There were many reasons for their endorsement, with by far the most frequent responses relating to how helpful and informative the program is.

*Yes, I do [recommend Healthy Start to others]. Because I feel like it is really important to kids, since the parent is their first teacher. [Healthy Start] gives parents the opportunity to learn new tools. Healthy Start makes learning fun.*

*I am very happy to be in this program because I'm learning many things.*

*Yes, and I do. I think it's a good learning environment for other parents.*

Parents were also in agreement that the program offers fun activities, support and comfort, help to first time mothers, and help with referrals and access to other services. Parents also appreciated childcare during appointments, transportation, free books, and the program's importance to their children. Respondents indicated that parents can trust the Healthy Start staff and that the workers care about them and their families.

*Yes I would, I recommended it to two of my friends already. It is fun for the kids, we get free books, they teach you a lot and they even help you with rides and any help we need.*

*...my home visitor is really cool, she really cares about me, my family and my kids. And I need that right now in my life. If someone were in my same shoes I think they would benefit from that a lot.*

*I think it is really helpful, even my mom thought she knew everything. It is something that can help you, it's a helpful resource. It offers another opinion and voice.*

*I already have [recommended the program to others]. I let them know that Healthy Start is really helpful and that there are all different resources.*

Although this sample represented a small group of Healthy Start parents, their comments and reactions to the program are instructive. Clearly, home visitor characteristics are extremely important to successfully engaging families. Home visitors who are respectful, warm and supportive seem to have good success, at least with some families, in engaging them in Healthy Start services. Parents appear to appreciate and value both the information and resources provided by Healthy Start, as well as the informal support provided.

## ENDNOTES

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- <sup>1</sup> Hatry, H. (1997). Where the rubber meets the road: Performance measurement for state and local public agencies. *New Directions for Evaluation*, 75, (Fall), 31-44. San Francisco, CA: Jossey-Bass.
  - <sup>2</sup> Pratt, C., Katzev, A, Henderson, T., & Ozretich, R. (1997). *Building results: From wellness goals to positive outcomes for children and families*. Oregon Commission on Children and Families, 530 Center Street NE, Suite 405, Salem, OR 97310, August 1997.
  - <sup>3</sup> Gray, J.D., Cutler, C.A., Dean, J. G., & Kempe, C. H. (1979). Prediction and prevention of child abuse and neglect. *Journal of Social Issues*, 35, 127-139. Also see Murphy, S., Orkow, B., & Nicola, R. (1985). Prenatal prediction of child abuse and neglect: A prospective study. *Child Abuse and Neglect*, 9, 225-235.
  - <sup>4</sup> Olds, D. (1997). The prenatal/early infancy project: Fifteen years later. in G.W. Albee & T. P. Gullotta (Eds.) *Primary Prevention Works*, pp. 41-67. Thousand Oaks, CA: Sage Publications.
  - <sup>5</sup> Olds, D.L., & Kitzman, H. (1993). Review of research on home visiting. *The Future of Children*, 3(3), 51-92.
  - <sup>6</sup> Campbell, F.A., & Ramey, C.T. (1994). Effects of early intervention on intellectual and academic achievement: A follow-up study of children from low-income families. *Child Development*, 65, 684-698. Also see Shore, R. (1997). *Rethinking the brain: new insights into early development*. New York, NY: Families and Work Institute.
  - <sup>7</sup> Olds, D.L., Henderson, C. Kitzman, H., Eckenrode, J., Cole, R., & Tatelbaum, R. (1998). The promise of home visitation: Results of two randomized trials. *Journal of Community Psychology*, 26 (1), 5-21.
  - <sup>8</sup> Karoly, L.A., Greenwood, P.W., Everingham, S.S., Hoube, J., Kilburn, M.R., Rydell, C. P., Sanders, M. & Chiesa, J. (1998). *Investing in our children: What we know and don't know about the costs and benefits of early childhood interventions*. Santa Monica, CA: RAND.
  - <sup>9</sup> Korfmacher, J. The Kempe Family Stress Inventory: A review. (1999). *Child Abuse & Neglect*, 24 (1), 129-140.
  - <sup>10</sup> Gomby, D. S., Culross, P.L., & Behrman, R.E. (1999). Home visiting: Recent program evaluations---analysis and recommendations. *Future of Children*, 9.
  - <sup>11</sup> Gomby, D. S., Culross, P.L., & Behrman, R.E. (1999). Home visiting: Recent program evaluations---analysis and recommendations. *Future of Children*, 9, 4-26.
  - <sup>12</sup> McGuigan, W.M., Katzev, A.R., & Pratt, C.C. (2001). Multi-level determinants of retention in a home visiting child abuse prevention program. Manuscript submitted for publication.
  - <sup>13</sup> Gomby, D. S., Culross, P.L., & Behrman, R.E. (1999). Home visiting: Recent program evaluations---analysis and recommendations. *Future of Children*, 9, p. 16.
  - <sup>14</sup> McGuigan, W.M., Katzev, A.R. & Pratt, C.C. (2001). Multi-level determinants of mothers' engagement in home visitation services. Manuscript submitted for publication.
  - <sup>15</sup> Pratt, C., Katzev, A, Henderson, T., & Ozretich, R. (1997). *Building results: From wellness goals to positive outcomes for children and families*. Oregon Commission on Children and Families, 530 Center Street NE, Suite 405, Salem, OR 97310, August 1997.
  - <sup>16</sup> U.S. Department of Health and Human Services. (1996). *The third national incidence study of child abuse and neglect. (NIS-3)*. Washington, D.C.; National Clearinghouse on Child Abuse and Neglect.
  - <sup>17</sup> Annie E. Casey Foundation. (1999). At greatest risk: Identifying America's most vulnerable children. 1999 Kids Count. [www.aecf.org/kidscount/kc1999](http://www.aecf.org/kidscount/kc1999)
-

- 
- 18 Olds, D. (1997). The prenatal/early infancy project: Fifteen years later. In G. W. Albee & T. P. Gullotta, (Eds.) *Primary prevention works*, pp. 41 – 67. Thousand Oaks, CA: Sage Publications.
- 19 Intensive Home Visitation: A Randomized Trial, Follow-up and Risk Assessment Study of Hawaii's Healthy Start Program; Final Report, NCCAN Grant No. 90-CA-1511, June 15, 1996; Prepared for the National Center on Child Abuse and Neglect Administration for Children, Youth and Families, U.S. Department of Health and Human Services, Washington, D.C. by the Center on Child Abuse Prevention Research, National Committee to Prevent Child Abuse, Chicago, IL
- 20 Norton, D.R. State of Arizona Office of the Auditor General Annual Evaluation Health Families Pilot Program. Report to the Arizona Legislature, January 1998, Report No. 98-1.
- 21 Squires, J., Potter, L., & Bricker, D. (1995). *Ages and stages questionnaire: A parent-completed, child-monitoring system*. Baltimore, MD: Paul H. Brookes Publishing Co.
- 22 See Oregon Public Health Services, <http://www.ohd.hr.state.or.us/imm/about.htm>
- 23 National Immunization Survey (2001). Centers for Disease Control and Prevention, United States Department of Health and Human Services. <http://www.dcd.gov/mmwr/preview/mmwrhtml/mm5130a2.htm>.
- 24 Sameroff, A., Seifer, R., Barocas, B., Zax, M., & Greenspan, S. (1987). IQ scores of 4-year-old children: Socioenvironmental risk factors. *Pediatrics*, 79, 343-350.
- 25 Caldwell, B.M., & Bradley, R. H. (1984). *Home Observation for Measure of the Environment*. Little Rock: University of Arkansas at Little Rock.
- 26 Caldwell, B. M., & Bradley, R. H. (1994). Environmental issues in developmental follow-up research. in S. L. Friedman & H. C. Haywood, eds. *Developmental follow-up: Concepts, domains, and methods*. pp. 235-256. San Diego, CA: Academic Press.
- 27 Barnard, K., Bee, H., & Hannond, M. (1984). Home environment and cognitive development in a healthy, low-risk sample: The Seattle study. In A.W. Gottfried, (Ed.), *Home Environment and Early Cognitive Development*, pp. 117-149. Orlando, FL: Academic Press, Inc.
- 28 Bradley, R.H., Caldwell, B.M., Rock, S.L., Barnard, K.E., Gray, C., Hammond, M.A., Mitchell, S., Siegel, L., Ramey, C.T., Gottfried, A.W., & Johnson, D.L. (1989). Home environment and cognitive development in the first 3 years of life: A collaborative study involving six sites and three ethnic groups in North America. *Developmental Psychology*, 25, 217-235.
- 29 Payne, A.C., Whitehurst, G.J., & Angell, A. L. (1994). The role of home literacy environment in the development of language ability in preschool children from low-income families. *Early Childhood Research Quarterly*, 9, 427-440.
- 30 Nord, C.W., Lennon, J., Liu, B., & Chandler, K. (1999). Home literacy activities and signs of children's emerging literacy, 1993 and 1999. Washington, D.C.: National Center for Education Statistics, NCES 2001-026.
- 31 Pratt, C.C., McGuigan, W.M., & Katzev, A.R. (2001). Measuring program outcomes using retrospective pretest methodology. *American Journal of Evaluation*, 21(3), 341-349.