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Healthy Start Implementation Survey Report of Findings

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Executive Summary

The Healthy Start Implementation Survey was a mail survey of key individuals in all 29 Healthy Start sites that are currently operating, representing 31 Oregon counties. Participants included Healthy Start managers and staff, and representatives from hospitals, Health Departments, local Commissions on Children and Families offices, and other collaborative partner agencies. The purpose of the survey was to document the extent to which Healthy Start programs are implementing the 15 Essential Components of Home Visiting, and to provide information for continuous program improvement. Because information about three of the Essential Components is reported in the annual status report (community investment, basic services, and early initiation of service), this report focuses on 12 of the 15 areas.

Overall, it appears that Healthy Start programs are successfully implementing the Essential Components. In most areas, there were very few responses that indicated that Healthy Start was not doing a good job. For this reason, we focus our report on understanding areas in which programs might be able to move from "good" or "very good" implementation to "excellent" implementation. For example, many of the survey items asked respondents whether they strongly disagreed, disagreed, agreed, or strongly agreed that the program was implementing a particular Essential Component. Because so few respondents ever disagreed with these statements, we present the percentage of respondents who *agreed* vs. those who *strongly agreed*. Where a majority of respondents simply agreed, rather than strongly agreed, we suggest that there may be some room for improvement. **However, we emphasize that overall results showed strong levels of successful implementation. "Improvement" in the context of this report suggests fine-tuning and continued pursuit of excellence, rather than implying a program deficit.**

Results did, however, vary by program, so specific program improvement activities at the individual program level should take this variation into account. This report includes areas of particular strength for the overall statewide program, and notes the general areas that might benefit from improvement. Detailed results for individual programs are provided in Appendix A.

Summary of Findings

Universal and Voluntary

Healthy Start is balancing the need to be voluntary for parents with outreach to families using a variety of recruitment techniques. The majority of respondents in over half the programs *strongly agreed* that parents perceived services to be voluntary. Overall, 98.8% of respondents agreed or strongly agreed with this statement; only 2 respondents disagreed with this statement. However, programs in which fewer persons strongly agreed might want to further promote the idea of Healthy Start as a voluntary service. On the other hand, outreach efforts, especially to high-need families, may need to be increased in some programs. Doing this critical outreach, without being intrusive into families' privacy, is important to successfully engaging families in Healthy Start services.

Family Focus

Most Healthy Start programs are doing a good job in tailoring their services to meet the needs of each family. The majority of respondents in almost three-quarters of these programs *strongly agreed* that individualized service planning was happening. Somewhat fewer programs were at the highest level of implementation in terms following the parents' lead in terms of goal-setting and service planning, although all programs were rated as positive in terms of their implementation of this standard. Balancing the need to guide parents into appropriate services while at the same time involving them in service planning can be challenging. Programs in which fewer respondents strongly endorsed these family-driven strategies may want to work with staff on further strengthening family-focused practice.

Diversity is Respected

Most Healthy Start staff members have received at least some cultural competency training, although smaller, more rural, and newer sites are particularly in need of diversity training. Statewide, it may not be unreasonable to expect that the majority of programs would provide this type of training to at least 90% of their staff; currently, only about half of the programs are able to do this. Although it is clear that some culturally appropriate materials are available for Healthy Start families, there is an indication that more materials may be needed. The majority of respondents in only 14% of programs *strongly agreed* that programs were providing these materials, although only a very few respondents (8) felt that programs were not doing this at all.

Collaboration

Healthy Start is still working to coordinate client services with a wide variety of agencies. Only about one-fourth of programs had a majority of respondents who strongly agreed that Healthy Start was effectively coordinating with similar agencies (although only about 10% of respondents *disagreed* with this statement). There is evidence of Healthy Start's successful collaboration with several key agencies [specifically, the Health Department, the Local Commission on Children and Families, and (birthing) hospitals]; however, strong collaboration with an increased number of agencies (more than 4) may be beneficial. Programs may want to consider what other types of agencies could contribute to their program, either by helping with outreach, providing volunteer staff, helping with fund-raising or resource-sharing, or through other types of community involvement. In particular, business, the faith community, local colleges and universities, and libraries appear to be underutilized resources in many communities. Finally, the data suggest two specific areas of collaboration that may need improvement: resource sharing, and coordination of family plans. It may be particularly important, in times of declining revenue, for programs to increase resource sharing among agencies as a part of their collaborative work.

Community Investment

Although it appears as though some Healthy Start programs are doing a good job in leveraging community funds, a substantial proportion of programs could more actively seek financial community support. One route for leveraging funds is through emphasizing strategies for resource sharing within Healthy Start's many collaborative relationships.

Intensive Services

A variety of criteria are being used to determine a family's frequency of home visits, including, but not limited to, the specific guidelines specified by the Healthy Start level system. Respondents in a little more than a third of the programs strongly agreed that their program was making these decisions according to state guidelines, although few respondents disagreed that state criteria were included in their decision-making.

Health Care Services

Healthy Start programs have implemented this Essential Component well, as many families are linked to a primary care provider and children are receiving immunizations and routine screenings. However, there is still room for improvement in this component, particularly in the area of linking families to primary care providers; only about half the programs were rated as having the highest level of implementation in this area. Home visitors were especially likely to indicate that the program could be improved in terms of this standard. At the same time, however, fewer than 10% of respondents indicated that Healthy Start was not linking families with primary health care providers.

Limited Caseloads

These data show overall adherence to caseload limit guidelines. This component had one of the largest numbers of programs in which the majority of respondents strongly agreed that the component was being implemented. However, there is an indication from Healthy Start staff (managers and home visitors) that there are times in which caseload sizes are exceeded. Managers and home visitors should work together to maintain caseload sizes that consistently follow state guidelines.

Staff Characteristics

Hiring Healthy Start program staff members who are already prepared to work with at-risk families is a challenge for most programs. Compared to other Essential Components, this standard had the largest percentage of respondents who indicated disagreement (although still less than 25%). This no doubt reflects the challenging nature of Healthy Start work. This question did not address reasons why programs are facing this challenge; however, it is likely that a combination of factors, including available pay rates and the particular difficulties of direct service work with at-risk families, contribute to this challenge. Also, these responses indicate the importance of the training provided by OCCF and other collaborative partners in preparing new staff hires for their work.

Supervision

There are indications that both the quantity and quality of supervision of Healthy Start program staff are adequate; however, there are also areas in which supervision could be improved, especially from the vantage point of Family Support Workers. In particular, it appears that some programs, or even workers within programs, do not receive the state minimum required amount of supervision (2 hours/week). Further, only one-fourth of FSWs *strongly* agreed that they receive the quality of supervision they need, although only 23% rated the program negatively on this dimension. Workers could also benefit from additional support for career development and professional growth. Finally, it is important to note that FSWs ratings of their relationships with co-workers were, on average, somewhat on the

negative side. Given the high stress working conditions of FSWs, programs may want to attend to providing more support to workers both in terms of professional development, as well in terms of staff wellness activities that can foster positive working relationships.

Training

These data show specific requests for areas of continued training. Although it is evident that Healthy Start provides staff with training, there are many programs in which additional training would be welcomed. One response to this challenge might be for programs and collaborative partners to work together to share training resources.

Results-Based Accountability

Healthy Start services continue to be evaluated by an independent evaluator. These data are being used by local programs to review and monitor program success, to implement specific program change, to obtain resources, and (to a lesser extent) to educate the community. Because many of the Healthy Start programs are newly implemented, it is likely that the proportion of sites that can and will use evaluation data will increase in future years.

Overall Strengths & Areas for Possible Improvement

Statewide, the Healthy Start program is especially strong in the following areas, based on high agreement across participants and programs:

1. *Having a family focus (individualization of services)*
2. *Ensuring the program is voluntary*
3. *Connecting families with health care services*
4. *Use of limited caseloads*
5. *Adequate amount of supervision*
6. *Maintaining results-based accountability*

The following areas, while generally strong, have not achieved the highest possible level of implementation, and therefore are areas in which additional support may be needed (as measured by fewer than 30% of respondents indicating strong agreement):

1. *Staff being well prepared for the job at the point of hiring*
2. *Collaboration with other agencies working with the same families, including community corrections, schools, childcare facilities, and disability services providers*
3. *Under-utilizing potential community resources, such as the business and faith communities, colleges/universities, and libraries*
4. *Community Investment and leveraging of other funding sources*

These findings suggest that the statewide Healthy Start program is doing a good job in implementing the Essential Components of home visiting. Quality implementation is key to successful program outcomes, and individual programs will benefit from careful examination of their site-specific outcomes. State efforts to continue to improve and refine the Healthy Start program are encouraged, so that all programs can reach the highest level of excellence.

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Introduction

NPC Research conducted a Healthy Start Implementation Survey in spring 2003. This survey was a structured, quantitative survey of all 29 operational local Healthy Start programs. The purpose of the survey was to document programs' abilities to implement the 15 Essential Components of Home Visiting, to identify areas of strength and challenges in program implementation, to document collaborative successes and challenges, and to collect data about site-specific variations in implementation that can help inform the outcome study.

The survey was developed to measure the 15 Essential Components of Home Visiting. These components also serve as the organizational structure for this report. Because information about three of the components are reported in the annual status report, this report will focus on 12 of the 15 areas:

- Universal and Voluntary
- Family Focus
- Diversity is Respected
- Collaboration
- Community Investment
- Intensive Services
- Health Care Services
- Limited Caseloads
- Staff Characteristics
- Supervision
- Training
- Results-Based Accountability

Data for each area are discussed at the statewide level in the text; program-specific data can be found in Appendix A. An open-ended question asked respondents for general feedback about the Healthy Start program. A summary of these comments is included in Appendix B.

Methodology

The Healthy Start Implementation Survey was mailed to key individuals in all 29 Healthy Start sites that are currently operating, representing 31 Oregon counties. Healthy Start managers were asked to identify representatives from the following three key partner agencies in their county or region: hospitals, Health Departments, and local Commissions on Children and Families office. The managers were also asked to indicate any individuals or agencies that are important collaborative partners with their Healthy Start program. In addition, the Healthy Start manager and two Family Support Workers[1] were asked to complete the survey.

Surveys were mailed to 225 key Healthy Start individuals with addressed and stamped return envelopes. There was no financial or other tangible incentive for participation. The week following the due date, evaluation team members phoned individuals who had not yet returned the survey. Phone follow-up continued until 184 surveys were completed, for a response rate of 82%. Response rates were 72% for local Commission on Children and Families representatives, 74% for Collaborative Partners, and 92% for Healthy Start staff. Response rates by site varied from 40% to 100%. Only seven programs (24%) had a response rate of less than 75%.

Respondents were categorized into the following groups based on their relationship to Healthy Start:

- Local Commission on Children and Families Chairpersons and Staff;
- Collaborative Partners (including the Department of Family/Health and Social Services, Health Department, Hospitals, Medical Centers and Other);
- Healthy Start Managers/Supervisors; and
- Family Support Workers

Medical Centers were agencies such as the following: St. Charles Medical Center in Deschutes County, Rogue Valley Medical Center in Jackson County, Sacred Heart Medical Center in Lane County, Good Shepherd Health Care System in Umatilla County and Tualatin Valley Centers in Washington County.

For analysis purposes, Healthy Start programs were grouped into categories based on county population: Up to 69,999 (small); 70,000 to 199,999 (medium); and 200,000 and over (large).

This report includes a discussion of any differences that were found in survey responses based on the respondent's relationship to Healthy Start and based on the size of the county(ies) of the local Healthy Start program.

[1] In some sites, there are only one or two Family Support Workers. In sites were there are more than two FWSs, two staff members were selected by the Evaluation Team to be included in the sample.

Healthy Start Implementation Survey Findings

Universal and Voluntary

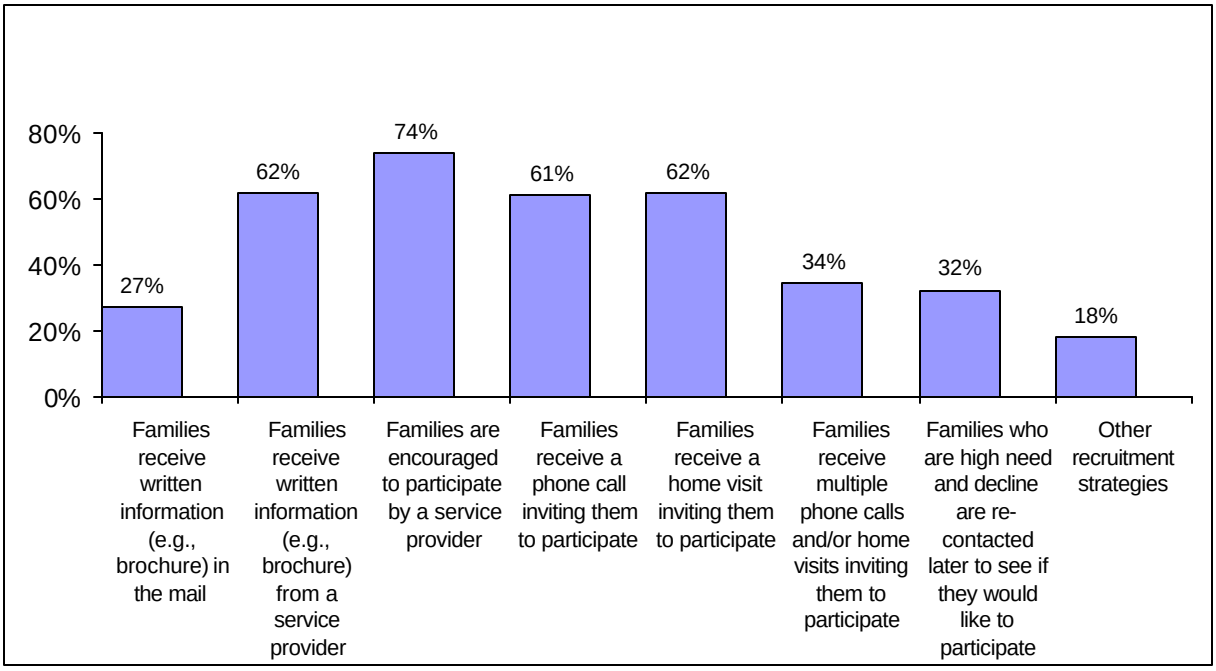
The first Essential Component states that Healthy Start services should be universal and voluntary, specifically that:

> *Healthy Start strives to offer all new parents with a first-born child a range of services from basic to intensive. Participation is voluntary with positive, continuing outreach efforts to ensure that families who would benefit most from the services have an opportunity to become involved.*

Two questions on the survey assessed this component. The first item asked respondents to rate the statement "Parents feel that Healthy Start participation is completely voluntary" on a scale of "strongly agree," "agree," "disagree," and "strongly disagree." Of the 163 respondents, 57.1% (93) strongly agreed, 41.7% (68) agreed, and 1.2% (2) disagreed. One way of measuring the extent to which there was strong agreement in a particular area was to look at the percent of programs where a majority (at least 50%) of respondents strongly agreed. It is always possible that one or two respondents from any program may not have accurate information or may have a dissenting viewpoint. However, using this criterion provides a way to group programs by the trend of their respondents. In almost two thirds of programs (19 of the 29, or 65.5%), at least half of the respondents strongly agreed that parents feel Healthy Start participation is completely voluntary.

The second question related to this component asked respondents to indicate their local Healthy Start program's protocol for recruiting high-need families. Respondents could check off any of a list of recruitment strategies that were provided or write in their own. Figure 1 shows the response options and the percentage of respondents who selected each choice. Note that programs may use multiple strategies.

Figure 1. Protocol for Recruiting High-Need Families



Half (50%) or more of the respondents in 28 of the 29 programs (96.6%) indicated, "Families are encouraged to participate by a service provider." However, only 6 (20.7%) programs had a majority who said, "Families receive written information (e.g., brochure) in the mail." The number of recruitment strategies per program ranged from 2 to 6, with an average of 4.4 recruitment strategies per program (see Appendix A).

Of the "other recruitment strategies" that were specified, 20 respondents identified hospital visits, 5 said that families were recruited through a referral system, and 2 said that families were recruited through parenting classes (see Appendix B).

Summary: The data suggest that Healthy Start is balancing the need for being voluntary to parents with outreach to families using a variety of recruitment techniques. The majority of respondents in over half the programs strongly agreed that parents perceived services to be voluntary. Overall, 98.8% of respondents agreed or strongly agreed with this statement. However, programs in which fewer persons strongly agreed might want to further promote the idea of Healthy Start as a voluntary service. On the other hand, outreach efforts, especially to high-need families, may need to be increased in some programs. Doing this critical outreach, without being intrusive into families' privacy, is important to successfully engaging families in Healthy Start services.

Family Focus

The second Essential Component states that Healthy Start is to be focused on the family, specifically that:

> *The family is the driving force in determining the constellation of supports needed, and in working in partnership with the program to support their child's development. Services are based on supporting positive parent-child interaction and child development, utilizing a holistic approach that recognizes the needs of the child and the parents.*

Three questions were included in the Healthy Start Implementation Survey to assess this component. The first two items were statements rated on a scale of "strongly agree" to "strongly disagree." The first statement was "Families participating in Healthy Start help to determine which services they receive (based on their own needs and interests)." Of the respondents who rated this statement, 50.6% (87) strongly agreed, 48.8% (84) agreed, and 1% (1) disagreed. In 15 programs (51.7%), the majority of respondents strongly agreed.

The second item was, "Information (about parenting, child development, or community resources, for example) provided to Healthy Start intensive service families is individualized and specific to the needs of a particular family." 60.7% (105) of the respondents strongly agreed and 38.2% (66) agreed. Twenty-one (72.4%) programs had a majority of respondents who strongly agreed with this statement. There were only two respondents who disagreed: one was a community partner and one was a home visitor.

The third question assessing Healthy Start's Family Focus asked respondents, "What most often happens when a worker and parent disagree about goals or the best interest of the child?" About half (49.6%, 62) of the respondents to this question said that the worker generally follows the parent's lead; 42.4% (53) said that the worker involves her/his supervisor, and 7.2% (9) said there was some other process that occurred. Only one individual said that the worker generally makes the final decision. However, responses differed depending on the respondents' role. Home visitors were more likely to say that they follow the parent's lead (59.5%, 25) than respondents in other roles. Respondents in all other categories were more likely than the worker to say that the worker involves her/his supervisor.

Respondents used the "other" option to indicate a combination of strategies occurring (see Appendix B).

Summary: These data show that most Healthy Start programs are doing a good job in tailoring their services to meet the needs of each family. The majority of respondents in almost three-quarters of these programs strongly agreed that individualized service planning was happening. Somewhat fewer programs were at the highest level of implementation in terms following the parents' lead in terms of goal-setting and service planning, although all programs were rated as positive in terms of their implementation of this standard. Balancing the need to guide parents into appropriate services while at the same time involving them in service planning can be challenging. Programs in which fewer respondents strongly endorsed these family-driven strategies may want to work with staff on further strengthening family-focused practice.

Diversity is Respected

The third Essential Component of Healthy Start is concerned with the cultural competence of services. Specifically it states:

> *Services are programmatically competent such that the staff understands, acknowledges, and respects differences among participants. Services and materials used reflect the cultural, linguistic, geographic, and ethnic/racial diversity of the population served. Programs will recognize cultural and special needs and make every reasonable effort to address those needs.*

Six questions on the Healthy Start Implementation Survey related to cultural diversity. The first two items were statements rated from "strongly agree" to "strongly disagree." The first statement was, "Healthy Start families receive materials that reflect parents' cultural, linguistic, geographic, or ethnic/racial background." Thirty percent (30.1%, 50) of the respondents strongly agreed with this statement, and an additional 63.9% (106) agreed. A majority of respondents in only four programs (13.8%) strongly agreed with this statement, illustrating that there are more mixed perceptions about this issue within the remaining programs. Collaborative partners were most likely to strongly agree with this statement while home visitors were least likely to strongly agree and most likely to disagree with this statement (16.3% or 8 disagreed or strongly disagreed with this statement).

The second statement was, "Staff in our local Healthy Start program are culturally sensitive, aware, and respectful of differences." Fifty-six percent (55.6%, 99) of respondents strongly agreed with this statement, 42.7% (76) agreed, and 1.6% (3) disagreed. In 18 programs (62.1%), the majority of respondent strongly agreed with this statement.

The other four questions asked respondents for information about their staff's receipt of cultural competency training and the cultural diversity of providers and families (see Table 1).

Table 1. Cultural Competency and Diversity

Question	Average percentage rated
A. What percentage of your program's staff has ever received cultural competency training?	83%
B. What percentage of your program's staff has received cultural competency training within the past year?	58%
C. What percentage of your program's staff is bicultural, bilingual, non-white, openly gay/lesbian, or disabled?	27%
D. What percentage of your program's families has members who are bicultural, bilingual, non-white, openly gay/lesbian, or disabled?	33%

Ratings on all four of these questions ranged from 0% to 100%. Almost half (45%, 13) of the 29 programs reported that more than 90% of staff had (ever) received cultural competency training. At the same time, however, 3 programs (10%) reported that fewer than half of their staff had received this type of training. These three programs were all in

smaller, rural communities. Only four programs (14%) reported that more than 90% of their staff had participated in cultural competency training in the past year; and 12 programs (41%) reported that fewer than 50% had participated. These programs with less training were mostly, but not all, in less populous areas.

Questions C and D related to the diversity of staff and program participants. Three programs reported having no staff with identified differences from the majority population. These three programs were all in small programs and each has relatively small numbers of staff. All of the programs reported having at least some participants who fit this description of cultural diversity. It is also interesting that within some programs, respondents varied widely in their estimates of the percentages on these two questions. For example, one respondent might have reported 25% of staff or participants as being bicultural, bilingual, non-white, openly gay/lesbian, or disabled, while another person from that program might have indicated 50% of staff to fit that category. This finding indicates varying perceptions of the number of minority staff and families in Healthy Start. For detailed information about the range of ratings on these items, please see the table in Appendix A.

Summary: It is evident that most Healthy Start staff members have received at least some cultural competency training, although smaller, more rural, and newer sites are particularly in need of diversity training. Statewide, it may not be unreasonable to expect that the majority of programs would provide this type of training to at least 90% of their staff; currently, only about half of the programs are able to do this. Finally, although it is clear that some culturally appropriate materials are available for Healthy Start families, there is an indication that more materials may be needed. The majority of respondents in only 14% of programs strongly agreed that programs were providing these materials, although only a very few respondents (8) felt that programs were not doing this at all.

Collaboration

The fourth Healthy Start Essential Component focuses on collaboration with community partners:

> *Healthy Start is based on a collaboration of local Commissions on Children and Families, Health Departments and community providers of services that builds on existing perinatal programs and develops an integrated home visiting system. Confidentiality barriers are addressed through information sharing and/or interagency collaboration.*

Information about collaboration was collected in several different ways. Two statements asked respondents to use a scale of "strongly agree" to "strongly disagree." The first item, "Healthy Start is effectively coordinated with other programs in our county serving a similar population," was rated as "strongly agree" by 36.9% (66) of respondents, as "agree" by 52.5% (94), and as "disagree" or "strongly disagree" by 10.6% (19) of respondents. Only 7 programs (24.1%) had a majority of respondents who strongly agreed with this statement. People who *disagreed* with this statement included people from all different roles, (including local CCF representatives, community partners, Healthy Start managers, and home visitors), with the smallest proportion being managers. Over half of the programs surveyed (51.7%, 15) had at least one respondent who disagreed with this statement, which illustrates that there are some individuals who do not perceive that Healthy Start is coordinated with other county programs.

The second statement that was rated was, "For those families involved with multiple agencies/programs, Healthy Start is written into other agencies' family plans." A quarter (25.4%, 32) of respondents strongly agreed with this statement and over half (55.6%, 70) agreed. Only 3 programs (10.3%) had a majority of respondents who strongly agreed with this statement.

Table 2 shows participants' responses to four collaboration questions that asked the extent to which agencies or groups collaborated in different ways (on a scale of 1 = Not at all, 2 = A little, 3 = Some, and 4 = Very much). As can be seen, participants rated Healthy Start as collaborating to a moderate extent across agencies, on average (with responses indicating between "A little" and "Some" collaboration for all items). Participants perceived that there were somewhat less resource sharing compared to other types of collaboration.

Table 2. Collaboration Questions

Question	Across-Agency Average	% of programs averaging 2 or less	% of programs averaging 3 or higher
A. How involved is each of the following agencies/ groups in your local Healthy Start collaboration?	2.6	10.3	72.4
B. Please indicate the extent to which the agencies/ groups in your county(ies) coordinate with Healthy Start for client services.	2.4	24.1	55.2
C. Please indicate the extent to which the agencies/ groups in your county(ies) refer to Healthy Start or receive referrals from your program.	2.4	27.6	48.3
D. Please indicate the extent to which the agencies/ groups in your county(ies) share other resources (such as trainings, transportation, etc.) with your Healthy Start program.	2.1	51.7	20.7

Table 3 presents the collaboration ratings for each agency that was rated, averaged across the four questions. Respondents generally perceived that Healthy Start had the strongest collaboration with Health Departments (3.6), followed by the local CCF (3.1), and the hospital (3.0). Respondents rated Healthy Start's collaboration as weakest with community corrections (1.4), the faith community (1.4), and the business community (1.4).

Table 3. Ratings of Healthy Start Collaboration with Other Agencies

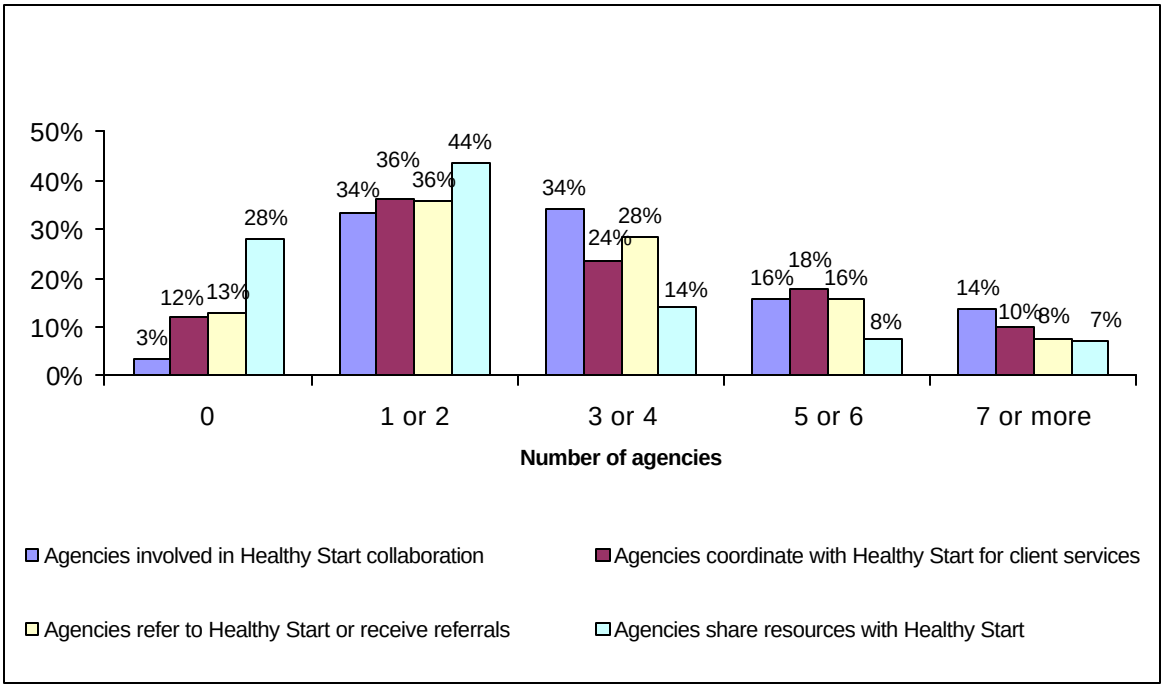
Agency*	Average Collaboration Score (1=low, 4=high)
Health Department	3.6
Local Commission on Children and Families	3.1
Hospital or Medical Providers	3.0
Child Protective Services, Child Welfare	2.8
Early Intervention/ Early Childhood Special Education	2.8
Self-Sufficiency (formerly AFS)	2.6
Head Start/ Oregon Pre-Kindergarten Program	2.6
Mental Health or Alcohol/Drug Treatment Providers	2.4
Disability Services Providers	1.9
Childcare Facilities	1.9
K-12 Schools	1.8
Community Library	1.7
College/University	1.6
Community Corrections	1.4
Faith Community	1.4
Business Community	1.4

*Sample sizes ranged from 147 to 178

Of the types of staff surveyed, collaborative partners and the local CCF representatives gave slightly higher collaborative ratings compared to the ratings given by Healthy Start managers and Family Support Workers.

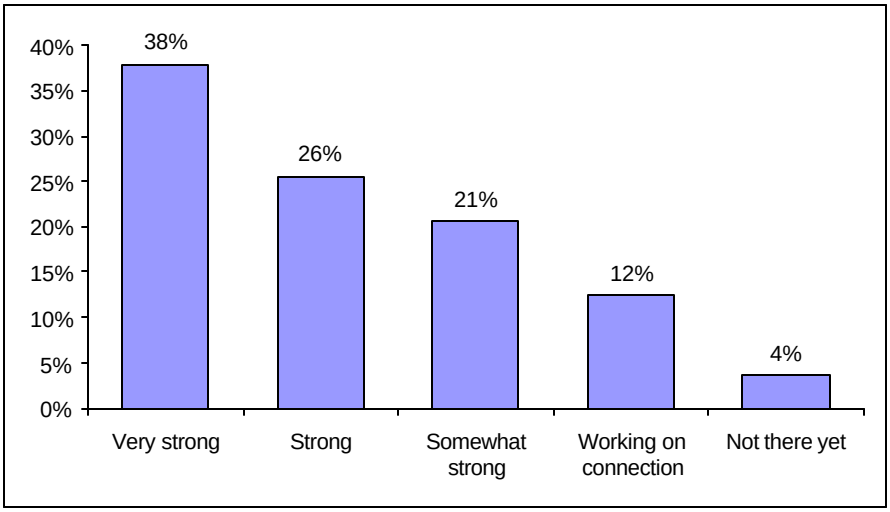
Figure 2 presents the number of agencies that respondents rated as having strong collaboration with their local Healthy Start program. The majority of respondents rated one to four agencies as having "very strong" indicators of collaborative ties with Healthy Start. For example, for the question, "How involved is each of the following agencies in your local Healthy Start collaboration," the majority of respondents (68%) indicated that 1 to 4 agencies had very strong involvement with the local collaboration. Figure 2 again suggests that fewer agencies are involved with sharing resources, compared to other types of collaborative activities.

Figure 2. "Very Strong" Responses to Collaboration Items



Another collaboration question asked respondents to rate the local Healthy Start program's connection with the local birthing hospital. Figure 3 shows that more than one-third (37.9%, 61) of respondents rated their collaboration with local birthing hospitals as "very strong." Eleven programs (37.9%) had a majority of respondents who indicated their relationship with the local birthing hospital was "very strong."

Figure 3. Relationships with Birthing Hospitals



*Sample size = 161

Six respondents felt that the collaboration with local birthing hospitals was not yet established. These respondents were all from different programs. Half of these sites were new Healthy Start programs that began operating in 2002. Of the six respondents, half (3) were local CCF representatives, two were community partners, and one was a home visitor. Given the importance of collaboration with birthing hospitals, especially given recent restrictions on use of public birth record data for recruitment efforts, this may be a particularly important area for program improvement efforts.

Summary: These data show that Healthy Start is still working to coordinate client services with a wide variety of agencies. Only about one-fourth of programs had a majority of respondents who strongly agreed that Healthy Start was effectively coordinating with similar agencies. There is evidence of Healthy Start's successful collaboration with several key agencies [specifically, the Health Department, the Local Commission on Children and Families, and (birthing) hospitals]; however, strong collaboration with an increased number of agencies (more than 4) may be beneficial. Programs may want to consider what other types of agencies could contribute to their program, either by helping with outreach, providing volunteer staff, helping with fund-raising or resource-sharing, or through other types of community involvement. In particular, business, the faith community, local colleges and universities, and libraries appear to be under-utilized resources in many communities. Finally, the data suggest two specific areas of collaboration that may need improvement: resource sharing and coordination of family plans. It may be particularly important, in times of declining revenue, for programs to increase resource sharing among agencies as a part of their collaborative work.

Community Investment

The fifth Essential Component of Healthy Start states that local and federal funding should be sought:

> *The leveraging of community funds (cash and in-kind) and other resources is a valued method for assisting in the process of providing Healthy Start services above targeted levels. These leveraged resources may be accounted for as cash, federal funds (other than OCCF grant streams), private grants and contributions, volunteer services (professional or non-professional), community and organizational participation, service and supply donations, and capital outlay contributions.*

Community investment was assessed by one question on the Healthy Start Implementation Survey that asked respondents to rate, from "strongly agree" to "strongly disagree," the statement, "Our Healthy Start program effectively leverages community funds and resources." Over a quarter of respondents who rated this item (29.6%, 45) strongly agreed with this statement and over half (58.6%, 89) agreed. In only 7 programs (24.1%) did the majority of respondents strongly agreed with this statement. Although it appears as though some Healthy Start programs are doing a good job in leveraging community funds, a substantial proportion of programs could more actively seek financial community support. One route for leveraging funds is through emphasizing strategies for resource sharing within Healthy Start's many collaborative relationships (described above in the section on Collaboration).

Intensive Services

The next Healthy Start Essential Component sets guidelines for intensive service families, specifically that:

> *For families assessed with multiple risk characteristics, long-term services are offered intensively (initially once a week) with well-defined criteria for increasing or decreasing intensity of service over a five-year period. Depending upon needs, services such as information on child development, breastfeeding assistance, positive parenting strategies, community resources and supports, are provided by trained para-professionals and/or collaborative partners with utilization of other available community resources.*

Two items on the Healthy Start Implementation Survey were used to assess components of the Healthy Start model related to Intensive Services. One item asked respondents to rate the statement, "Decisions about the frequency of home visits for intensive service families follow Healthy Start guidelines" from "strongly agree" to "strongly disagree." Over a third (37.1%, 59) of respondents who answered this item strongly agreed with this statement, 59.7% (95) agreed, and 3.2% (5) disagreed. Eleven programs (37.9%) had a majority of respondent who strongly agreed with this statement.

The second item asked respondents to indicate the criteria used for increasing or decreasing the frequency of home visits for participating Healthy Start families. The frequency of home visits is associated with the level of services the family is supposed to be receiving. Healthy Start guidelines list very specific parent achievements for promotion from Level 1 through Level 4. These achievements include such things as maintaining stability in the home with no crisis for 30 days, keeping appointments or calling to reschedule 75% of the time, being able to identify at least one other (besides the FSW) support network/system/person, asking the FSW for help in problem solving as needed, taking the child to all scheduled well-baby care and to the doctor when the baby is sick, and being up to date on immunizations. Most of the criteria are universal for all families and are specified by the program. Of course, because Healthy Start also expects services to be family focused, and for home visitors to create and follow an individualized service plan, the needs of the family certainly enter into the equation for considering moves between levels.

Table 4 shows the percentage of respondents who selected each option, and the percentage of programs in which more than 50% of respondents selected that option. Note that respondents could select multiple criteria.

Table 4. Criteria Used for Healthy Start Home Visits

Criteria	% of respondents	% of programs with a majority using this criteria
Number of months in the program	19.7%	10.3% (3)
Need of the family, as determined by the Family Support Worker	59.0%	72.4% (21)
Need of the family, as determined by the family	63.9%	86.2% (25)
Degree to which the family is progressing in its individualized service plan (and meeting goals)	67.2%	86.2% (25)
Other criteria	11.5%	NA

Twenty-one respondents chose to specify another strategy used by their program to help determine the frequency of home visits. Six people said that they (28.6%) used a supervisor's input, 5 (23.8%) said that the family's schedule and/or availability was an important factor, and 3 (14.3%) indicated that they used the Healthy Start level system.

Summary: It is clear from the survey responses that a variety of criteria are being used to determine a family's frequency of home visits, including, but not limited to, the specific guidelines specified by the Healthy Start level system. Respondents in a little more than a third of the programs strongly agreed that their program was making these decisions according to state guidelines, although few respondents disagreed that state criteria were included in their decision-making.

Health Care Services

This Essential Component sets objectives for promoting the connections between health, health care services, and Healthy Start families:

> *The program promotes the health and well-being of the child and all family members by coaching families on prevention of health problems and ways to appropriately access needed health services, and by advocating for their needs within the health care system. At a minimum, all families receiving intensive services are linked to a primary health care provider so that the child can receive timely immunizations and well childcare. Routine health and developmental screening is done to identify problems and refer for further assessment and early treatment, if needed.*

The Implementation Survey included three items to assess the Health Care Services component of Healthy Start. All three were statements that respondents rated from "strongly agree" to "strongly disagree." The first item, "Our Healthy Start program links all participating families to a primary health care provider," was rated as "strongly agree" by 63 respondents (44.7%), "agree" by 63 respondents (44.7%), and "disagree" or "strongly disagree" by 10.6% (15). Just over half (51.7%, 15) of the programs had a majority of respondents who strongly agreed with this statement. The majority of the respondents who disagreed were home visitors, and of the home visitor respondents, almost a quarter (23.9%) either disagreed or strongly disagreed. The respondents who disagreed came from 14 different programs (42.3%), across small, medium, and large counties, and all but one program had a single person who disagreed.

The second item, "Our Healthy Start program ensures that participating children receive immunizations and preventive care if the family desires them," was rated as "strongly agree" by 55.4% (93) of respondents and "agree" by 41.7% (70) of respondents. This aggregate rate of agreement (97.1% "agreed" or "strongly agreed") is consistent with data from the most recent Healthy Start Annual Status Report (July 1, 2001, to June 30, 2002), which shows that 93% of Healthy Start children are fully immunized by age 2. Eighteen (62.1%) of the programs had a majority of respondents who strongly agreed with this statement. The third item, "Routine health and developmental screening is conducted for all participating Healthy Start families," was rated as "strongly agree" by 51.2% (84) of respondents, "agree" by 44.5% (73) of respondents, and "disagree" or "strongly disagree" by 4.3% (7). Eighteen (62.1%) of the programs had a majority of respondents who strongly agreed with this statement.

Summary: These results suggest that Healthy Start programs have implemented this Essential Component well, as many families are linked to a primary care provider and children are receiving immunizations and routine screenings. However, there is still room for improvement in this component, particularly in the area of linking families to primary care providers; only about half the programs were rated as having the highest level of implementation in this area. Home visitors were especially likely to indicate that the program could be improved in terms of this standard. At the same time, however, fewer than 10% of respondents indicated that Healthy Start was not linking families with primary health care providers.

Limited Caseloads

The next Essential Component of Healthy Start sets limits for intensive service caseload size, specifically that:

> *Intensive service caseloads are limited or weighted for intensity of service to assure that home visitors have an adequate amount of time to spend with each family to meet varying needs, plan for future activities, and accurately document services. Healthy Start uses an established weighted caseload system to ascertain caseloads. This system provides for a review of community and client characteristics in determining caseload size. Limited caseload means, for most communities, no more than 15 families on the most intensive level per home visitor.*

To assess the implementation of the Healthy Start component related to the size of intensive service caseloads, the Implementation Survey asked respondents to rate the statement, "Our Healthy Start home visitors have caseloads within the state guidelines for determining caseload size." Of the respondents who rated this item, 48.6% (72) strongly agreed and an additional 45.9% (68) agreed; only 5.4% (8) disagreed or strongly disagreed. Of the eight respondents who disagreed or strongly disagreed, six (75%) were Healthy Start managers or home visitors. People who disagreed came from programs in both small and large counties. Twenty (69.0%) of the programs had a majority of respondents who strongly agreed with this statement.

Summary: These data show overall adherence to caseload limit guidelines. This component had one of the largest numbers of programs in which the majority of respondents strongly agreed that the component was being implemented. However, there is an indication from Healthy Start staff (managers and home visitors) that there are times in which caseload sizes are exceeded. Managers and home visitors should work together to maintain that caseload sizes consistently follow state guidelines.

Staff Characteristics

This Healthy Start Essential Component focuses on the traits and abilities of Healthy Start Staff, stating that:

> *Program staff are selected because of their education, work and life experiences, ability to effectively communicate and establish trusting relationships, ability to demonstrate interpersonal and helping skills, ability to work with diverse communities, ability to identify and provide access to other services, and appropriate technical skills. Staffs have a framework, based on education and/or experience, for handling the variety of experiences they may encounter when working with at-risk families.*

Respondents were asked to rate the statement, "When Healthy Start program staff are hired, they are well-prepared for the challenges of working with at-risk families." One-quarter of respondents (25.0%, 38) strongly agreed, over half (54.6%, 83) agreed, and 20.4% (31) disagreed or strongly disagreed. Only 6 programs (20.7%) had a majority of respondents who strongly agreed with this statement. The largest percentage of respondents who indicated disagreement was community partners, and they included representatives from Health and Social Service Departments and other agencies (coded as "Community Partner – other" because their agencies were not frequently repeated across programs for use in analyses as their own categories. Almost a third (29.8%) of respondents from this group disagreed or strongly disagreed that staff are well prepared when they are hired. People who disagreed came from 20 (69.0%) different small, medium, and large programs.

Summary: The responses to this item indicate that hiring Healthy Start program staff members who are already prepared to work with at-risk families is a challenge for most programs. Compared to other Essential Components, this standard had the largest percentage of respondents who indicated disagreement (although still less than 25%). This no doubt reflects the challenging nature of Healthy Start work. This question did not address reasons why programs are facing this challenge; however, it is likely that a combination of factors, including available pay rates and the particular difficulties of direct service work with at-risk families, contribute to this challenge. Also, these responses indicate the importance of the training provided by OCCF and other collaborative partners in preparing new staff hires for their work.

Supervision

The next Essential Component of Healthy Start is concerned with effective supervision of program staff, specifically that:

> *Program staff will receive ongoing, effective supervision. The purpose of supervision is to optimize the growth of families and children and accomplish program goals. Effective supervision provides regular feedback, evaluation, guidance, training and support to all Healthy Start staff. The program will demonstrate a plan for effective and ongoing supervision that promotes accountability, quality assurance, skill and professional development, and retention of staff and families. Programs will have written procedures outlining the mechanism for providing supervision for all staff classifications.*

Supervision was measured in several different ways. Two items were rated from "strongly agree" to "strongly disagree." In the first statement, "Family Support Workers receive the amount of supervision that they need," 35.3% (54) of respondents strongly agreed, 55.6% (85) of respondents agreed, and 9.1% (14). Only seven programs (24.1%) had a majority of respondents who strongly agreed.

Respondents indicated that the average number of *individual* supervision hours per month was 8.3; Healthy Start staff (managers and home visitors, who presumably have the most direct knowledge on this topic) stated the average number of individual supervision hours to be slightly less, about 6.5 hours per month. According to all respondents, the average number of hours of *group* supervision, which includes team meetings or group case conferences, was 6.3 per month. These averages exceed the Healthy Start guidelines of 2 total hours of supervision per week for home visitors.

However, there was considerable variation in the amount of reported supervision. Responses ranged from 0 to 160 hours of individual supervision per month and from 0 to 49 hours of group supervision per month. Half of all respondents (50.0%) answering this question (sample size = 114) indicated 4 hours or less individual supervision per month and slightly over half (52.2%) indicated 4 or less hours of group supervision per month. Two respondents indicated that 0 hours of individual supervision was provided per month, and five (from three different programs) indicated that 0 hours of group supervision per month were provided. All of the latter group were from new program sites.

In 19 programs (65.5%), the average number of total (individual and group) supervision hours was 9 or more per month.

The average number of visits shadowed by a supervisor per year was 4.6. Responses (sample size = 103) ranged from 0 to 48 visits per year, with 35% indicating 1 or fewer visits per year, and 19.4% stating that there were 0 visits per year. The 20 respondents indicating no visit shadowing represented 11 different programs, but almost half (45.0%) of the respondents were from 5 new program sites.

Of the respondents who rated the second item, "Family Support Workers receive the quality of supervision they need," 37.8% (59) strongly agreed, 50.0% (78) agreed, and 12.2% (19) disagreed or strongly disagreed. Interesting, only 27.7% (13) of home visitors strongly agreed with this statement, while 45.0% (18) of their supervisors strongly agreed with this

statement. Overall, eight programs (27.6%) had a majority of respondents who strongly agreed with this statement. Most of the respondents who disagreed with this statement were home visitors, with 23.4% (11) of home visitors rating this statement as "disagree" or "strongly disagree." Respondents who disagreed came from 12 different programs (41.4%).

Three measures were included in the survey to assess the extent to which supervisors and Healthy Start programs overall provide different kinds of support to staff. Each measure contained several statements which respondents rated on a scale of "strongly agree" to "strongly disagree."

The first measure asked respondents to rate the Healthy Start supervisor(s) in terms of their supportiveness. Table 5 shows the statements and the average responses on a scale of 1 = Strongly Disagree, 2 = Disagree, 3 = Agree and 4 = Strongly Agree. (Note: Scales on negatively worded items were reversed so that average ratings could be compared across items.)

Table 5. Ratings of Supervisory Support

Item	Average rating (higher scores are more positive)	Number of Respondents
Provides support and helpful feedback	3.4	149
Is very knowledgeable	3.4	151
Is too critical	3.4	139
Is hard to please	3.4	147
Talks down to staff	3.4	142
Is unavailable	3.3	144
Conducts fair evaluations of staff	3.3	108
Compliments and praises staff	3.3	139
Delegates too much	3.1	127
Sets high but realistic standards	3.0	139
Overall	**3.3**	**157**

Table 5 shows supervisory supportiveness strongest in the areas of providing helpful feedback, being a knowledgeable resource, not being too critical or hard to please, and not talking down to staff. Of the various types of respondents surveyed, Healthy Start managers/supervisors perceived overall supervision slightly more positively.

The second measure asked respondents to rate their Healthy Start program in terms of opportunities for professional growth. Table 6 shows the statements and the average response (1 = Strongly Disagree, 2 = Disagree, 3 = Agree and 4 = Strongly Agree).

Table 6. Ratings of Opportunities for Professional Growth

Item	Average rating	Number of Respondents
Encourages staff to share resources with one another	3.4	160
Encourages staff to learn new skills	3.4	154
Provides released time to attend conferences	3.4	150
Has a library of professional books for staff to use	3.2	143
Provides released time to visit other programs	3.1	130
Provides on-site staff development workshops	3.0	140
Provides guidance for professional advancement	2.9	120
Subscribes to several educational journals and magazines	2.5	104
Provides tuition reimbursement to take college courses	2.3	87
Implements a career ladder for professional advancement	2.2	94
Overall	**3.0**	**166**

Table 6 shows that Healthy Start provides most opportunities for professional growth by encouraging staff to share resources, encouraging staff to learn new skills, and providing staff released time to attend conferences. The fewest opportunities for professional growth are apparent in the areas of tuition reimbursement and providing guidance for professional advancement. In general, Healthy Start managers/supervisors believed that there was slightly more opportunities for professional growth (3.1), compared to Family Support Workers (2.9).

The third measure asked respondents to rate the Healthy Start program on items assessing inter-staff relationships. Table 7 shows the statements and the average response on a scale of 1 = Strongly Disagree, 2 = Disagree, 3 = Agree and 4 = Strongly Agree. (Note: Scales on negatively worded items were reversed so that average ratings could be compared across items.)

Table 7. Ratings of Staff Collegiality

Staff members in my Healthy Start program generally:	**Average rating**	**Number of Respondents**
Are cooperative and friendly	3.5	176
Have good team spirit	3.4	166
Are very helpful to new staff	3.3	150
Are competitive	3.1	165
Are reluctant to express their feelings	3.1	173
Are frank and candid	3.1	156
In my Healthy Start program…		
People feel isolated	3.2	136
Morale is low	3.1	152
People complain a lot	3.1	144
People socialize outside of work	2.7	105
Overall	**3.2**	**177**

Table 7 shows that inter-staff relationships are most positive in the terms of program staff being cooperative and friendly, having good team spirit and being helpful to new staff. However, of the types of staff surveyed, Healthy Start managers/supervisors perceived inter-staff relationships to be much more collegial (3.3), compared to Family Support Workers (2.1).

Summary: There are indications that both the quantity and quality of supervision of Healthy Start program staff are adequate; however, there are also areas in which supervision could be improved, especially from the vantage point of Family Support Workers. In particular, it appears that some programs, or even workers within programs, do not receive the state minimum required amount of supervision (2 hours/week). Further, only one-fourth of FSWs *strongly* agreed that they receive the quality of supervision they need, although only 23% rated the program negatively on this dimension. Workers could also benefit from additional support for career development and professional growth. Finally, it is important to note that FSWs ratings of their relationships with co-workers were, on average, somewhat on the negative side. Given the high stress working conditions of FSWs, programs may want to attend to providing more support to workers both in terms of professional development, as well in terms of staff wellness activities that can foster positive working relationships.

Training

This Healthy Start Essential Component states that all program staff shall receive adequate and appropriate training:

> *Local commissions and program staff implementing existing and new Healthy Start efforts will receive research information, technical assistance and training from the State to build local capacity and knowledge. Intensive core training, specific to roles, assures that program staffs understand the essential components of family assessment and home visitation, as adopted by the Oregon State Commission on Children and Families. All program staff and volunteers receive basic training through their local collaboration including information on working with diverse populations, substance abuse, reporting child abuse, domestic violence, drug-exposed infants, and services in their community.*

There were two items on the Healthy Start Implementation Survey that assess training (plus several items previously described under "cultural diversity"). The first statement was, "Our Healthy Start program provides effective training for program staff," rated from "strongly agree" to "strongly disagree." Of the people who responded to this item, 31.7% (52) strongly agreed, 59.1% (97) agreed, and 9.1% (15) disagreed or strongly disagreed with the statement. Only seven programs (24.1%) had a majority who strongly agreed with this statement.

The second question asked respondents to indicate if they had any local program training needs. Slightly more than one-fifth, (21.9%, 40) identified training needs. Healthy Start managers and home visitors were most likely to indicate training needs, with 30.2%, (13) of managers and 26.0% (13) of home visitors answering affirmatively to this question. Table 8 illustrates the types of training needs that were specified and includes any item that was mentioned more than once (for a complete list of suggestions, please see Appendix B).

Table 8. Local Healthy Start Program Training Needs

Training Need	Number of Responses
Cultural or cultural competency	6
Documentation/paperwork	4
Parenting/family skills	4
Drug awareness	3
Outreach	3
Child abuse	2
Child development	2
Curricula	2
Car seats	2

Summary: These data show specific requests for areas of continued training. Although it is evident that Healthy Start provides staff with training, there are many programs in which additional training would be welcomed.

Results-based Accountability

The final Healthy Start Essential Component states that an independent evaluator is to provide an ongoing evaluation of Healthy Start services:

> *The State Commission on Children and Families will contract with an independent evaluator to provide ongoing data collection and evaluation of Healthy Start services. Local Healthy Start programs will work with the contracted evaluator to assure that the provision of program services, implementation, and performance outcomes for children and families are adequately researched and evaluated.*

The State CCF has continued to contract with an independent evaluator to provide ongoing data collection and an evaluation of Healthy Start services, which is evidence of the fulfillment of this Essential Component.

Additionally, the Implementation Survey asked respondents in the local sites to indicate how they use evaluation data, as shown in Table 9. Note that programs may use multiple strategies. There was no apparent pattern of use of data for reviewing program status and/or monitoring program success based on when the site began operating as a Healthy Start program. Programs that were newly implemented were somewhat less likely to use evaluation data to implement changes in practice or to obtain resources. These patterns make sense because these sites have just started implementing their programs, and have not received a great deal of evaluation feedback to date. They also may be relying solely on state funding during the initial period, as they focus on implementation issues, rather than looking for additional resources.

Table 9. Use of Evaluation Data by Local Healthy Start Programs

Type of evaluation use	% of respondents*
For reviewing the status of the program and/or monitoring program successes	66.7%
To implement specific changes in practices	54.1%
To obtain resources (such as grants, donations, or volunteers)	48.6%
For other purposes	8.7%
Not used	6.6%

* Sample size = 183

Healthy Start managers were the group most likely to report using evaluation data for reviewing the status of the program or for monitoring successes (83.7%, 36), though a large proportion of home visitors (72.0%, 36) and local CCF representatives (69.6%, 16) also indicated this use. Twenty-five programs (86.2%) had a majority of respondents who indicated that they used data for reviewing the status of the program or for monitoring successes. This is the largest percentage of programs that showed this high level of implementation.

Healthy Start managers were also the group most likely to use evaluation data for implementing specific changes in practice (74.4%, 32), with local CCF representatives (56.5%, 13) also likely to report this use. Nineteen programs (65.5%) had a majority of respondents who indicated that they used evaluation data for implementing specific changes in practice.

More than half (55.8%, 24) of Healthy Start managers specified that their program used evaluation data to obtain resources. Twelve programs (41.4%) had a majority of respondents who indicated that they used data to obtain resources such as grants, donations, or volunteers.

Local CCF representatives (26.1%) were the group most likely to report use of evaluation data for other purposes; other types of respondents reported less frequent "other" use of evaluation data. The 16 people who indicated some “other” use of evaluation data were from 10 different programs, of different program sizes. The most common “other” use of data was for community education (4 people).

Summary: Healthy Start services continue to be evaluated by an independent evaluator. These data are being used by local programs to review and monitor program success; to implement specific program change; to obtain resources and (to a lesser extent) to educate the community. Because many of the Healthy Start programs are newly implemented, it is likely that the proportion of sites that can and will use evaluation data will increase in future years.

Specific Program Needs

The Implementation Survey solicited specific comments from respondents about their (material and other) needs for their local program.

Respondents indicated, through comments, the (material and other) needs of their local program. Twenty-three percent (42) of respondents said that their local program needed materials and 19.7% (36) indicated other needs. Table 10 illustrates the materials that sites indicated were needed and Table 11 describes the other needs that were specified. (Note: Tables list responses that were made multiple times; for a complete listing of needs, please see Appendix B.)

Table 10. Local Healthy Start Program Needs – Materials

Material Program Needs	Number of Responses
Books for babies	17
Spanish materials	9
Curricula	7
Videos	6
Information for parents	5
Computer/technology needs	4
Toys	3
Resource books	3
Promotional materials	3
Car seats	2

Table 11. Local Healthy Start Program Needs – Other

Other Program Needs	Number of Responses
Funding	21
Additional staff/full-time staff	8
Less paperwork	2

Summary and Conclusions

Overall, it appears that Healthy Start programs are successfully implementing the Essential Components. In most areas, there were very few responses that indicated that Healthy Start was not doing a good job. For this reason, we focused this report on understanding areas in which programs might be able to move from "good" or "very good" implementation to "excellent" implementation. For example, many of the survey items asked respondents whether they strongly disagreed, disagreed, agreed, or strongly agreed that the program was implementing a particular Essential Component. Because so few respondents ever disagreed with these statements, we presented the percentage of respondents who *agreed* vs. those who *strongly agreed*. Where a majority of respondents simply agreed, rather than strongly agreed, we suggested that there may be some room for improvement. ***However, overall results showed strong levels of successful implementation. "Improvement" in this context suggests fine-tuning and continued pursuit of excellence, rather than implying a program deficit.***

Results did, however, vary by program; so specific program improvement activities at the individual program level should take this variation into account. Below, and in Table 12, we note areas of particular strength for the overall statewide program, as well as the few areas where the highest possible quality of implementation have not yet been achieved. Detailed results for individual programs are provided in Appendix A.

Further, it is interesting to note that for many questions, respondents within the same program perceived things quite differently, which may indicate a lack of communication or understanding throughout the partners in the county/program. Some of these discrepancies involve specific program procedures, such as whether caseloads are within state guidelines or if programs are linking families to primary health care providers. These types of items assess what should be consistent program practices, though clearly the degree of knowledge of various components and processes will vary depending on a person's role in the program. For these items, it is important to ensure that clear communication is occurring across all parties, including staff, management, and community partners.

For those items that are potentially different based on a person's role or perspective minority viewpoints point out possible problems that warrant attention. For example, when home visitors say that supervision could be improved, or that families are not receiving materials that reflect the parents' cultural, linguistic, geographic, or ethnic/racial background, that information indicates places where improvements could be made, even if a majority of the other respondents felt that these areas are being adequately addressed.

This Implementation Survey is the first in what is hoped to be a series of annual or biennial reviews of the 15 Essential Components, as part of Healthy Start of Oregon's Quality Assurance plan. Local Healthy Start programs, and the state as a whole, can use this information to identify areas of strength and challenge that they can attend to as they plan for the next biennium.

Healthy Start Statewide Strengths

1. Family Focus (Individualization): Healthy Start programs, overall, appear to be doing a good job in providing information (about parenting, child development, or community resources, for example) to intensive service families that is individualized and specific to the needs of a particular family. Over 75% of programs had a high level of implementation of individualized services. Somewhat fewer programs (about half) were strongly implementing family-driven services.

2. Use of Limited Caseloads: Results suggest that programs are generally doing a good job in adhering to state guidelines for caseload size, and for decision-making around caseloads. 20 programs (69%) had the highest level of implementation possible in this area.

3. Universal and Voluntary: Most staff members report that parents feel that Healthy Start participation is completely voluntary (57.1% of respondents, and 19 (65%) of the programs, strongly agreed with this statement). Healthy Start programs appear to be doing a good job in balancing the need to voluntarily recruit families with doing outreach to higher-risk families.

4. Health Care Services: Local Healthy Start programs doing a good job to ensure that participating children receive immunizations, preventative health care, and developmental screenings. Over half of all programs showed the highest possible level of implementation of this component.

5. Amount of Supervision: Most programs are providing adequate amounts of supervision, exceeding the state guidelines. Nineteen programs (65.5%) appear to provide more than 9 hours of supervision per month (2 hours per week). However, there is variability, with a few programs indicating very low amounts of supervision. This was particularly apparent among new program sites.

6. Results-Based Accountability: The program successfully implements an outcome evaluation, and results indicate that program stakeholders make use of this evaluation information in a number of ways, including program monitoring, program improvement, and to obtain other resources. The majority of respondents in 86% of programs indicated using evaluation information for monitoring program and family status.

Healthy Start Statewide Challenges

The following section describes the three Essential Components in which fewer than 30% of respondents indicated strong agreement. Note, however, that for each of these areas, overall implementation was solid. These were areas in which the program may want to focus attention to move from "good" implementation to "excellent" implementation.

1. Staff Characteristics: Only 25% of respondents (and 6 programs) strongly agreed that when Healthy Start staff members are hired, they are well prepared for the challenges of working with at-risk families. There were only 6 programs in which the majority of respondents strongly agreed that staff members were adequately prepared at the point of hiring. Clearly, continued commitment to provide early, comprehensive training for new staff, and adequate supervisory support for all staff, is essential to providing quality, effective Healthy Start services.

2. Collaboration: Some areas of collaboration were quite strong, such as that with Health Departments, local CCF offices, and hospitals. However, one of the biggest challenges was getting collaboration to occur with other agencies working with the same families, such as community corrections, schools, childcare facilities, and disability service providers. Only about a quarter (25.4%) of respondents strongly agreed that families involved with multiple agencies have Healthy Start written into the other agencies' family plans, and only 3 programs (the lowest for all of the items) had a majority of respondents who strongly agreed with this item. Building bridges between Healthy Start and other direct service agencies would likely be beneficial to the families, and would provide staff of both agencies with the benefits of each other's efforts and expertise. At the same time, however, it is important to note that very few people actually *disagreed* that these kinds of activities were happening. Again, this suggests that improvement from "good" implementation to "excellent" is possible. Finally, data suggest that Healthy Start programs could be more active in collaborative arrangements that involve resource sharing, and may be under-utilizing such potential community resources as libraries, universities/colleges, and the business and faith communities.

3. Community Investment: Less than a third (29.6%) of respondents strongly agreed that their Healthy Start program effectively leverages community funds and resources. Only seven programs (24.1%) had a majority of respondents strongly agreeing with this item. In this climate of diminishing state resources, leveraging funds from other sources is going to be even more important, and perhaps even more difficult. This area may be a place for the state office to provide additional training and suggestions, or for programs to share success stories and strategies with each other, to enhance community investment in local Healthy Start programs.

4. Cultural Competency. Healthy Start appears to be doing a good job in providing cultural competency/diversity training to staff members, although staff from sites that are smaller, more rural, and which began serving families more recently are particularly in need of diversity training. Additionally, it is clear that some culturally appropriate materials are available for Healthy Start families; however, there is an indication that more materials may be needed. The majority of respondents in only 14% of programs strongly agreed that programs were providing these materials, although only a very few respondents (8) felt that programs were not doing this at all.

Table 12. Summary of Results for Indicators of Essential Components

Essential Component	Item	# of programs with majority who "Strongly Agree"	% of programs with majority who "Strongly Agree"
Family Focused (Individualization)	Information (about parenting, child development, or community resources, for example) provided to Healthy Start intensive service families is individualized and specific to the needs of a particular family.	21	72.4%
Limited Caseloads	Our Healthy Start Program home visitors have caseloads within the state guidelines for determining caseload size.	20	69.0%
Voluntary Service	Parents feel that Healthy Start participation is completely voluntary.	19	65.5%
Health Care Services	Our Healthy Start program ensures that participating children receive immunizations and preventive care if the family desires them.	18	62.1%
Health Care Services	Routine health and developmental screening is conducted for all participating Healthy Start families.	18	62.1%
Collaboration	For those families involved with multiple agencies/programs Healthy Start is written into other agencies' family plans (such as Child Welfare, Self-Sufficiency, etc.)	18	62.1%
Health Care Services	Our Healthy Start program links all participating families to a primary health care provider.	15	51.7%
Family Focused (Family Directed)	Families participating in Healthy Start help to determine which services they receive (based on their own needs and interests).	15	51.7%
Limited Caseloads	Decisions about the frequency of home visits for intensive service families follow Healthy Start state guidelines.	11	37.9%
Supervision	Family Support Workers receive the quality of supervision that they need.	8	27.6%
Supervision	Family Support Workers receive the amount of supervision that they need.	7	24.1%
Training	Our Healthy Start program provides effective training for program staff.	7	24.1%
Results-Based Accountability	Our Healthy Start program effectively leverages community funds and resources.	7	24.1%
Staff Characteristics	When Healthy Start program staff are hired, they are well-prepared for the challenges of working with at-risk families.	6	20.7%
Diversity is Respected	Healthy Start families receive materials that reflect parents' cultural, linguistic, geographic, or ethnic/racial background.	4	13.8%
Collaboration	Healthy Start is effectively coordinated with other programs in our county serving a similar population.	3	10.3%

Appendix A

Data Tables for Responses by Program

Table I. Universal and Voluntary
Percent of "Strongly Agree" Responses by Program
(Numbers in parentheses indicate the sample size in that program for that item)

County	Parents feel that Healthy Start participation is completely voluntary.	Families receive written information in the mail.	Families receive written information from a service provider.	Families are encouraged to participate by a service provider.
Baker	20.0% (5)	20.0% (5)	0.0% (5)	40.0% (5)
Benton	40.0% (5)	50.0% (6)	50.0% (6)	66.7% (6)
Clackamas	50.0% (6)	85.7% (7)	85.7% (7)	71.4% (7)
Clatsop	57.1% (7)	28.6% (7)	71.4%(7)	57.1% (7)
Columbia	42.9% (7)	42.9% (7)	71.4% (7)	71.4% (7)
Coos	80.0% (5)	60.0% (5)	80.0% (5)	100.0% (5)
Crook	100.0% (3)	0.0% (3)	100.0% (3)	66.7% (3)
Curry	80.0% (5)	20.0% (5)	60.0% (5)	100.0% (5)
Deschutes	60.0% (5)	16.7% (6)	66.7% (6)	83.3% (6)
Douglas	40.0% (10)	0.0% (10)	40.0% (10)	60.0% (10)
Grant	75.0% (4)	20.0% (5)	60.0% (5)	60.0% (5)
Harney	75.0% (4)	16.7% (6)	83.3% (6)	83.3% (6)
Hood River	83.3% (6)	37.5% (8)	62.5% (8)	75.0% (8)
Jackson	28.6% (7)	28.6% (7)	28.6% (7)	71.4% (7)
Jefferson	100.0% (2)	50.0% (2)	100.0% (2)	100.0% (2)
Klamath	83.3% (6)	0.0% (8)	75.0% (8)	75.0% (8)
Lake	0.0% (3)	25.0% (4)	50.0% (4)	75.0% (4)
Lane	63.6% (11)	15.4% (13)	76.9% (13)	69.2% (13)
Linn	33.3% (6)	28.6% (7)	57.1% (7)	57.1% (7)
Malheur	100.0% (2)	0.0% (2)	50.0% (2)	50.0% (2)
Morrow	80.0% (5)	0.0% (5)	60.0% (5)	80.0% (5)
Multnomah	57.1% (7)	62.5% (8)	50.0% (8)	62.5% (8)
Tillamook	75.0% (8)	22.2% (9)	33.3% (9)	88.9% (9)
Umatilla	50.0% (4)	40.0% (5)	60.0% (5)	80.0% (5)
Union	75.0% (4)	0.0% (5)	60.0% (5)	60.0% (5)
Washington	42.9% (7)	57.1% (7)	57.1% (7)	71.4% (7)
Yamhill	25.0% (4)	0.0% (5)	80.0% (5)	80.0% (5)
Marion/Polk	71.4% (7)	0.0% (7)	85.7% (7)	85.7% (7)
Wasco/Sherman	44.4% (9)	44.4% (9)	66.7% (9)	100.0% (9)

Table Ia. Universal and Voluntary, continued

(Numbers in parentheses indicate the sample size in that program for that item)

County	Families receive a phone call inviting them to participate.	Families receive a home visit inviting them to participate.	Families receive multiple calls and/or home visits inviting them to participate.	Families who are high need and decline are re-contacted later to see if they would like to participate.	Other recruitment
Baker	40.0% (5)	80.0% (5)	60.0% (5)	80.0% (5)	0.0% (5)
Benton	66.7% (6)	50.0% (6)	83.3% (6)	0.0% (6)	0.0% (6)
Clackamas	100.0% (7)	57.1% (7)	57.1% (7)	28.6% (7)	0.0% (7)
Clatsop	71.4% (7)	57.1% (7)	14.3% (7)	0.0% (7)	14.3% (7)
Columbia	57.1% (7)	57.1% (7)	57.1% (7)	71.4% (7)	0.0% (7)
Coos	60.0% (5)	100.0% (5)	20.0% (5)	60.0% (5)	20.0% (5)
Crook	66.7% (3)	100.0% (3)	33.3% (3)	66.7% (3)	0.0% (3)
Curry	60.0% (5)	60.0% (5)	100.0% (5)	80.0% (5)	20.0% (5)
Deschutes	50.0% (6)	83.3% (6)	33.3% (6)	33.3% (6)	66.7% (6)
Douglas	60.0% (10)	60.0% (10)	40.0% (10)	10.0% (10)	0.0% (10)
Grant	60.0% (5)	60.0% (5)	40.0% (5)	40.0% (5)	40.0% (5)
Harney	50.0% (6)	66.7% (6)	33.3% (6)	50.0% (6)	0.0% (6)
Hood River	37.5% (8)	87.5% (8)	12.5% (8)	50.0% (8)	50.0% (8)
Jackson	85.7% (7)	71.4% (7)	14.3% (7)	28.6% (7)	14.3% (7)
Jefferson	100.0% (2)	0.0% (2)	50.0% (2)	50.0% (2)	0.0% (2)
Klamath	25.0% (8)	62.5% (8)	37.5% (8)	50.0% (8)	0.0% (8)
Lake	75.0% (4)	75.0% (4)	25.0% (4)	50.0% (4)	0.0% (4)
Lane	69.2% (13)	7.7% (13)	7.7% (13)	0.0% (13)	30.8% (13)
Linn	42.9% (7)	57.1% (7)	0.0% (7)	0.0% (7)	0.0% (7)
Malheur	50.0% (2)	50.0% (2)	50.0% (2)	50.0% (2)	0.0% (2)
Morrow	60.0% (5)	80.0% (5)	40.0% (5)	60.0% (5)	0.0% (5)
Multnomah	62.5% (8)	62.5% (8)	37.5% (8)	25.0% (8)	25.0% (8)
Tillamook	55.6% (9)	77.8% (9)	11.1% (9)	33.3% (9)	33.3% (9)
Umatilla	60.0% (5)	80.0% (5)	40.0% (5)	0.0% (5)	40.0% (5)
Union	60.0% (5)	40.0% (5)	20.0% (5)	20.0% (5)	40.0% (5)
Washington	71.4% (7)	71.4% (7)	42.9% (7)	28.6% (7)	28.6% (7)
Yamhill	60.0% (5)	40.0% (5)	20.0% (5)	40.0% (5)	20.0% (5)
Marion/Polk	42.9% (7)	28.6% (7)	14.3% (7)	0.0% (7)	14.3% (7)
Wasco/Sherman	88.9% (9)	88.9% (9)	66.7% (9)	44.4% (9)	22.2% (9)

Table II. Family Focus
Percent of "Strongly Agree" Responses by Program
(Numbers in parentheses indicate the sample size in that program for that item)

County	Families participating in Healthy Start help to determine which services they receive (based on their own needs and interests).	Information (about parenting, child development, or community resources, for example) provided to Healthy Start intensive service families is individualized and specific to the needs of a particular family.
Baker	25.0% (4)	50.0% (4)
Benton	60.0% (5)	80.0% (5)
Clackamas	28.6% (7)	85.7% (7)
Clatsop	50.0% (6)	50.0% (6)
Columbia	57.1% (7)	71.4% (7)
Coos	40.0% (5)	40.0% (5)
Crook	66.7% (3)	66.7% (3)
Curry	80.0% (5)	80.0% (5)
Deschutes	100.0% (6)	100.0% (6)
Douglas	33.3% (9)	50.0% (10)
Grant	75.0% (4)	75.0% (4)
Harney	40.0% (5)	50.0% (6)
Hood River	42.9% (7)	42.9% (7)
Jackson	42.9% (7)	42.9% (7)
Jefferson	50.0% (2)	0.0% (2)
Klamath	71.4% (7)	71.4% (7)
Lake	25.0% (4)	50.0% (4)
Lane	69.2% (13)	83.3% (12)
Linn	33.3% (6)	50.0% (6)
Malheur	100.0% (2)	50.0% (2)
Morrow	60.0% (5)	60.0% (5)
Multnomah	42.9% (7)	42.9% (7)
Tillamook	77.8% (9)	88.9% (9)
Umatilla	60.0% (5)	40.0% (5)
Union	50.0% (4)	40.0% (5)
Washington	28.6% (7)	71.4% (7)
Yamhill	20.0% (5)	50.0% (4)
Marion/Polk	14.3% (7)	28.6% (7)
Wasco/Sherman	44.4% (9)	66.7% (9)

Table III. Diversity is Respected
Percent of "Strongly Agree" Responses by Program
(Numbers in parentheses indicate the sample size in that program for that item)

County	Healthy Start families receive materials that reflect parents' cultural, linguistic, geographic, or ethnic/racial background.	Staff in our local Healthy Start program are culturally sensitive, aware, and respectful of differences.
Baker	25.0% (4)	0.0% (4)
Benton	20.0% (5)	75.0% (4)
Clackamas	14.3% (7)	42.9% (7)
Clatsop	40.0% (5)	57.1% (7)
Columbia	42.9% (7)	85.7% (7)
Coos	20.0% (5)	20.0% (5)
Crook	33.3% (3)	66.7% (3)
Curry	40.0% (5)	80.0% (5)
Deschutes	40.0% (5)	66.7% (6)
Douglas	20.0% (10)	40.0% (10)
Grant	25.0% (4)	40.0% (5)
Harney	33.3% (6)	66.7% (6)
Hood River	37.5% (8)	62.5% (8)
Jackson	33.3% (6)	28.6% (7)
Jefferson	50.0% (2)	100.0% (2)
Klamath	14.3% (7)	87.5% (8)
Lake	50.0% (2)	66.7% (3)
Lane	25.0% (12)	53.8% (13)
Linn	28.6% (7)	28.6% (7)
Malheur	100.0% (2)	100.0% (2)
Morrow	60.0% (5)	80.0% (5)
Multnomah	14.3% (7)	28.6% (7)
Tillamook	42.9% (7)	77.8% (9)
Umatilla	20.0% (5)	60.0% (5)
Union	20.0% (5)	40.0% (5)
Washington	42.9% (7)	28.6% (7)
Yamhill	0.0% (0)	40.0% (5)
Marion/Polk	16.7% (6)	57.1% (7)
Wasco/Sherman	42.9% (7)	77.8% (9)

Table IIIa. Diversity is Respected
Minimum and Maximum Percentages

County	What proportion of your program's staff is bicultural, bilingual, non-white, openly gay/lesbian, or disabled?	What proportion of your program's staff is bicultural, bilingual, non-white, openly gay/lesbian, or disabled?
Baker	0% 25%	0% 15%
Benton	0% 25%	5% 55%
Clackamas	0% 40%	5% 60%
Clatsop	20% 25%	25% 33%
Columbia	0% 25%	0% 15%
Coos	1% 33%	3% 26%
Crook	0% 0%	10% 25%
Curry	0% 20%	0% 20%
Deschutes	10% 20%	10% 20%
Douglas	1% 15%	5% 50%
Grant	0% 25%	0% 30%
Harney	0% 5%	5% 33%
Hood River	60% 80%	25% 80%
Jackson	10% 25%	10% 45%
Jefferson	0% 50%	50% 60%
Klamath	33% 66%	15% 40%

Table IIIb. Diversity is Respected , continued
Minimum and Maximum Percentages

County	What proportion of your program's staff is bicultural, bilingual, non-white, openly gay/lesbian, or disabled?	What proportion of your program's staff is bicultural, bilingual, non-white, openly gay/lesbian, or disabled?
Lake	25% 25%	0% 25%
Lane	0% 100%	0% 100%
Linn	25% 50%	25% 50%
Malheur	0% 0%	60% 80%
Morrow	30% 67%	50% 66%
Multnomah	40% 98%	20% 100%
Tillamook	10% 50%	20% 47%
Umatilla	40% 50%	10% 75%
Union	0% 0%	1% 1%
Washington	20% 100%	40% 100%
Yamhill	25% 25%	10% 50%
Marion/Polk	25% 50%	30% 60%
Wasco/Sherman	0% 50%	15% 50%

Table IV. Collaboration
Percent of "Strongly Agree" Responses by Program
(Numbers in parentheses indicate the sample size in that program for that item)

County	Healthy Start is effectively coordinated with other programs in our Program serving a similar population.	For those families involved with multiple agencies/programs, Healthy Start is written into other agencies' family plans (such as Child Welfare, Self-Sufficiency, etc.)
Baker	40.0% (5)	0.0% (1)
Benton	20.0% (5)	25.0% (4)
Clackamas	42.9% (7)	25.0% (4)
Clatsop	14.3% (7)	0.0% (3)
Columbia	28.6% (7)	33.3% (6)
Coos	20.0% (5)	25.0% (4)
Crook	33.3% (3)	0.0% (1)
Curry	40.0% (5)	0.0% (2)
Deschutes	83.3% (6)	33.3% (6)
Douglas	40.0% (10)	44.4% (9)
Grant	80.0% (5)	0.0% (3)
Harney	50.0% (6)	0.0% (4)
Hood River	50.0% (8)	25.0% (8)
Jackson	14.3% (7)	0.0% (6)
Jefferson	100.0% (2)	0.0% (0)
Klamath	28.6% (7)	40.0% (5)
Lake	33.3% (3)	0.0% (1)
Lane	46.2% (13)	25.0% (12)
Linn	0.0% (7)	0.0% (3)
Malheur	50.0% (2)	50.0% (2)
Morrow	60.0% (5)	0.0% (5)
Multnomah	0.0% (8)	0.0% (4)
Tillamook	44.4% (9)	44.4% (9)
Umatilla	40.0% (5)	40.0% (5)
Union	40.0% (5)	0.0% (3)
Washington	28.6% (7)	0.0% (6)
Yamhill	40.0% (5)	66.7% (3)
Marion/Polk	16.7% (6)	0.0% (2)
Wasco/Sherman	44.4% (9)	62.5% (8)

Table V. Community Investment
Percent of "Strongly Agree" Responses by Program
(Numbers in parentheses indicate the sample size in that program for that item)

County	Our Healthy Start program effectively leverages community funds and resources.
Baker	0.0% (3)
Benton	0.0% (5)
Clackamas	33.3% (6)
Clatsop	42.9% (7)
Columbia	33.3% (6)
Coos	25.0% (4)
Crook	33.3% (3)
Curry	25.0% (4)
Deschutes	75.0% (4)
Douglas	16.7% (6)
Grant	60.0% (5)
Harney	75.0% (4)
Hood River	37.5% (8)
Jackson	0.0% (5)
Jefferson	0.0% (2)
Klamath	16.7% (6)
Lake	50.0% (2)
Lane	46.2% (13)
Linn	0.0% (6)
Malheur	50.0% (2)
Morrow	40.0% (5)
Multnomah	0.0% (8)
Tillamook	66.7% (6)
Umatilla	60.0% (5)
Union	25.0% (4)
Washington	16.7% (6)
Yamhill	20.0% (5)
Marion/Polk	0.0% (4)
Wasco/Sherman	12.5% (8)

Table VI. Intensive Service
Percent of "Strongly Agree" Responses by Program
(Numbers in parentheses indicate the sample size in that program for that item)

County	Decisions about the frequency of home visits for intensive service families follow Healthy Start state guidelines.
Baker	0.0% (4)
Benton	20.0% (5)
Clackamas	33.3% (6)
Clatsop	60.0% (5)
Columbia	71.4% (7)
Coos	20.0% (5)
Crook	33.3% (3)
Curry	20.0% (5)
Deschutes	80.0% (5)
Douglas	50.0% (8)
Grant	75.0% (4)
Harney	50.0% (6)
Hood River	57.1% (7)
Jackson	28.6% (7)
Jefferson	50.0% (2)
Klamath	0.0% (4)
Lake	0.0% (4)
Lane	25.0% (12)
Linn	14.3% (7)
Malheur	50.0% (2)
Morrow	75.0% (4)
Multnomah	40.0% (5)
Tillamook	57.1% (7)
Umatilla	20.0% (5)
Union	40.0% (5)
Washington	33.3% (6)
Yamhill	20.0% (5)
Marion/Polk	16.7% (6)
Wasco/Sherman	37.5% (8)

Table VII. Health care services
Percent of "Strongly Agree" Responses by Program
(Numbers in parentheses indicate the sample size in that program for that item)

County	Our Healthy Start program links all participating families to a primary health care provider.	Our Healthy Start program ensures that participating children receive immunizations and preventive care if the family desires them.	Routine health and developmental screening is conducted for all participating Healthy Start families.
Baker	0.0% (5)	0.0% (3)	0.0% (4)
Benton	25.0% (4)	20.0% (5)	40.0% (5)
Clackamas	50.0% (6)	57.1% (7)	50.0% (6)
Clatsop	40.0% (5)	85.7% (7)	71.4% (7)
Columbia	57.1% (7)	85.7% (7)	16.7% (6)
Coos	100.0% (3)	100.0% (4)	50.0% (4)
Crook	50.0% (2)	50.0% (2)	33.3% (3)
Curry	20.0% (5)	80.0% (5)	60.0% (5)
Deschutes	16.7% (6)	66.7% (6)	83.3% (6)
Douglas	37.5% (8)	40.0% (10)	40.0% (10)
Grant	75.0% (4)	75.0% (4)	100.0% (4)
Harney	50.0% (4)	33.3% (6)	66.7% (6)
Hood River	40.0% (5)	57.1% (7)	50.0% (6)
Jackson	33.3% (6)	66.7% (6)	57.1% (7)
Jefferson	50.0% (2)	50.0% (2)	100.0% (2)
Klamath	60.0% (5)	57.1% (7)	57.1% (7)
Lake	0.0% (3)	0.0% (4)	0.0% (3)
Lane	60.0% (10)	61.5% (13)	61.5% (13)
Linn	50.0% (4)	28.6% (7)	28.6% (7)
Malheur	100.0% (2)	100.0% (2)	100.0% (2)
Morrow	80.0% (5)	80.0% (5)	80.0% (5)
Multnomah	33.3% (6)	28.6% (7)	14.3% (7)
Tillamook	62.5% (8)	88.9% (9)	44.4% (9)
Umatilla	20.0% (5)	40.0% (5)	50.0% (4)
Union	50.0% (4)	50.0% (4)	40.0% (5)
Washington	16.7% (6)	42.9% (7)	42.9% (7)
Yamhill	33.3% (3)	20.0% (5)	66.7% (3)
Marion/Polk	20.0% (5)	20.0% (5)	50.0% (4)
Wasco/Sherman	66.7% (6)	85.7% (7)	71.4% (7)

Table VIII. Limited Caseload
Percent of "Strongly Agree" Responses by Program
(Numbers in parentheses indicate the sample size in that program for that item)

County	Our Healthy Start home visitors have caseloads within the state guidelines for determining caseload size.
Baker	0.0% (5)
Benton	50.0% (6)
Clackamas	42.9% (7)
Clatsop	80.0% (5)
Columbia	66.7% (6)
Coos	40.0% (5)
Crook	66.7% (3)
Curry	20.0% (5)
Deschutes	40.0% (5)
Douglas	57.1% (7)
Grant	66.7% (3)
Harney	50.0% (4)
Hood River	57.1% (7)
Jackson	66.7% (6)
Jefferson	50.0% (2)
Klamath	0.0% (5)
Lake	100.0% (1)
Lane	72.7% (11)
Linn	50.0% (4)
Malheur	100.0% (2)
Morrow	80.0% (5)
Multnomah	16.7% (6)
Tillamook	50.0% (6)
Umatilla	50.0% (4)
Union	0.0% (5)
Washington	83.3% (6)
Yamhill	60.0% (5)
Marion/Polk	0.0% (6)
Wasco/Sherman	50.0% (6)

Table IX. Staff Characteristics
Percent of "Strongly Agree" Responses by Program
(Numbers in parentheses indicate the sample size in that program for that item)

County	When Healthy Start program staff are hired, they are well-prepared for the challenges of working with at-risk families.
Baker	20.0% (5)
Benton	40.0% (5)
Clackamas	14.3% (7)
Clatsop	16.7% (6)
Columbia	33.3% (6)
Coos	20.0% (5)
Crook	33.3% (3)
Curry	20.0% (5)
Deschutes	60.0% (5)
Douglas	25.0% (8)
Grant	25.0% (4)
Harney	40.0% (5)
Hood River	16.7% (6)
Jackson	16.7% (6)
Jefferson	50.0% (2)
Klamath	57.1% (7)
Lake	0.0% (4)
Lane	20.0% (10)
Linn	0.0% (4)
Malheur	0.0% (2)
Morrow	50.0% (4)
Multnomah	14.3% (7)
Tillamook	57.1% (7)
Umatilla	50.0% (4)
Union	0.0% (5)
Washington	14.3% (7)
Yamhill	25.0% (4)
Marion/Polk	0.0% (5)
Wasco/Sherman	0.0% (5)

Table X. Supervision
Percent of "Strongly Agree" Responses by Program
(Numbers in parentheses indicate the sample size in that program for that item)

County	Family Support Workers receive the amount of supervision that they need.	Family Support Workers receive the quality of supervision that they need.
Baker	25.0% (4)	25.0% (4)
Benton	40.0% (5)	20.0% (5)
Clackamas	28.6% (7)	42.9% (7)
Clatsop	60.0% (5)	66.7% (6)
Columbia	66.7% (6)	42.9% (7)
Coos	20.0% (5)	20.0% (5)
Crook	33.3% (3)	33.3% (3)
Curry	20.0% (5)	20.0% (5)
Deschutes	80.0% (5)	80.0% (5)
Douglas	37.5% (8)	25.0% (8)
Grant	20.0% (5)	20.0% (5)
Harney	33.3% (3)	25.0% (4)
Hood River	50.0% (6)	50.0% (6)
Jackson	33.3% (6)	33.3% (6)
Jefferson	0.0% (1)	0.0% (1)
Klamath	42.9% (7)	71.4% (7)
Lake	0.0% (2)	0.0% (2)
Lane	72.7% (11)	81.8% (11)
Linn	16.7% (6)	16.7% (6)
Malheur	50.0% (2)	50.0% (2)
Morrow	20.0% (5)	20.0% (5)
Multnomah	40.0% (5)	60.0% (5)
Tillamook	50.0% (8)	37.5% (8)
Umatilla	40.0% (5)	40.0% (5)
Union	40.0% (5)	50.0% (4)
Washington	16.7% (6)	16.7% (6)
Yamhill	0.0% (5)	0.0% (5)
Marion/Polk	0.0% (6)	16.7% (6)
Wasco/Sherman	0.0% (6)	28.6% (7)

Table XI. Training
Percent of "Strongly Agree" Responses by Program
(Numbers in parentheses indicate the sample size in that program for that item)

County	Our Healthy Start program provides effective training for program staff.
Baker	0.0% (5)
Benton	33.3% (6)
Clackamas	14.3% (7)
Clatsop	20.0% (5)
Columbia	66.7% (6)
Coos	20.0% (5)
Crook	33.3% (3)
Curry	20.0% (5)
Deschutes	80.0% (5)
Douglas	25.0% (8)
Grant	60.0% (5)
Harney	50.0% (4)
Hood River	16.7% (6)
Jackson	16.7% (6)
Jefferson	100.0% (2)
Klamath	28.6% (7)
Lake	0.0% (4)
Lane	58.3% (12)
Linn	0.0% (6)
Malheur	0.0% (2)
Morrow	40.0% (5)
Multnomah	28.6% (7)
Tillamook	50.0% (8)
Umatilla	20.0% (5)
Union	40.0% (5)
Washington	28.6% (7)
Yamhill	0.0% (5)
Marion/Polk	33.3% (6)
Wasco/Sherman	28.6% (7)

Table XII. Results-Based Accountability
Percent of "Strongly Agree" Responses by Program
(Numbers in parentheses indicate the sample size in that program for that item)

County	For reviewing the status of the program and/or monitoring program successes	To implement specific changes in practices	To obtain resources (such as grants, donations, or volunteers)	Used for another purpose
Baker	20.0% (5)	20.0% (5)	20.0% (5)	0.0% (5)
Benton	66.7% (6)	33.3% (6)	16.7% (6)	0.0% (6)
Clackamas	85.7% (7)	85.7% (7)	85.7% (7)	14.3% (7)
Clatsop	71.4% (7)	14.3% (7)	85.7% (7)	0.0% (7)
Columbia	71.4% (7)	71.4% (7)	57.1% (7)	14.3% (7)
Coos	80.0% (5)	60.0% (5)	60.0% (5)	0.0% (5)
Crook	66.7% (3)	33.3% (3)	33.3% (3)	0.0% (3)
Curry	60.0% (5)	60.0% (5)	20.0% (5)	0.0% (5)
Deschutes	66.7% (6)	50.0% (6)	66.7% (6)	0.0% (6)
Douglas	60.0% (10)	50.0% (10)	40.0% (10)	0.0% (10)
Grant	60.0% (5)	40.0% (5)	60.0% (5)	0.0% (5)
Harney	50.0% (6)	33.3% (6)	16.7% (6)	16.7% (6)
Hood River	87.5% (8)	75.0% (8)	87.5% (8)	37.5% (8)
Jackson	71.4% (7)	71.4% (7)	28.6% (7)	0.0% (7)
Jefferson	100.0% (2)	50.0% (2)	50.0% (2)	0.0% (2)
Klamath	62.5% (8)	37.5% (8)	25.0% (8)	0.0% (8)
Lake	25.0% (4)	25.0% (4)	25.0% (4)	0.0% (4)
Lane	84.6% (13)	61.5% (13)	76.9% (13)	15.4% (13)
Linn	28.6% (7)	57.1% (7)	42.9% (7)	0.0% (7)
Malheur	50.0% (2)	50.0% (2)	50.0% (2)	0.0% (2)
Morrow	60.0% (5)	20.0% (5)	40.0% (5)	0.0% (5)
Multnomah	75.0% (8)	62.5% (8)	25.0% (8)	0.0% (8)
Tillamook	88.9% (9)	77.8% (9)	77.8% (9)	44.4% (9)
Umatilla	60.0% (5)	60.0% (5)	40.0% (5)	0.0% (5)
Union	60.0% (5)	80.0% (5)	0.0% (5)	20.0% (5)
Washington	85.7% (7)	71.4% (7)	28.6% (7)	14.3% (7)
Yamhill	100.0% (5)	100.0% (5)	100.0% (5)	20.0% (5)
Marion/Polk	57.1% (7)	57.1% (7)	42.9% (7)	0.0% (7)
Wasco/Sherman	44.4% (9)	22.2% (9)	44.4% (9)	11.1% (9)

Appendix B

Complete listing of qualitative responses

What is your program's protocol for recruiting high-need families?
The following responses were provided to supplement the response choices that were provided:

Hospital visit
Referral system
Parenting classes
Word of mouth
Information offered once a family has voluntarily expressed interest
Mutual community settings
Information given by agency in person
Families receive a Welcome Baby Bag with information
Home visiting network
Varies with available resources
Families who decline still receive child development information by mail

What most often happens when a worker and parent disagree about goals or the best interest of the child?
The following responses were provided to supplement the response choices that were provided:

Compromise
Collaboration with staff
Situation has not occurred
Depends on the goal
Refer if needed
Varies depending on the level of professionalism
Worker can have separate goals from parents

Which of the following criteria are used for increasing or decreasing the frequency of home visits for participating Healthy Start families?
The following responses were provided to supplement the response choices that were provided:

Supervisor input
Family schedule/availability
Level system
To allow more room in program for new families and avoid creating dependencies
Family assessment worker
Have not done this yet
Some choice based on family need
When family has a crisis
Not sure how each collaborator handles this

How does your site use evaluation data?
The following responses were provided to supplement the response choices that were provided:

Shared with community
Assist staff to set goals
Contract monitoring
Families' satisfaction with program
Peer review
Prepare reports and presentations
Resolving internal program conflicts

Please indicate any needs your program may have.
Training:
The following responses were provided to supplement the response choices that were provided:

Cultural skills
Documentation and paperwork
Parenting and family skills
Outreach
Drug awareness
Child abuse
Child development
Curriculum
Car seats
Training closer to home or onsite
Working with poor families
Evaluation tool training for new hires
Grant writing
Language courses in Spanish
Stress management
Safety awareness
Refresher courses

Please indicate any needs your program may have.
Materials:
The following responses were provided to supplement the response choices that were provided:

Books for babies
Spanish materials
Curriculum
Videos
Information for parents
Computer/technology needs
Resource books
Promotional materials
Toys
Car seats
Forms in other languages
Statewide brochure for all hospital information
Permission to copy from "Partners for Healthy Baby"
Planners
Glue sticks
Vehicles
Curriculum spoken about in the evaluation manual

Please indicate any needs your program may have.
Other:
The following responses were provided to supplement the response choices that were provided:

Funding
Additional staff/full-time staff
Less paperwork
Current updates on OHP changes
Assistance in developing links to hospitals outside the county
Assistance with data collection
Better space
Consistent resources
Mother support groups in English and Spanish
Positive reinforcement for work well done
Reviewing clinical supervisor requirements to ensure our staff are receiving allotted time

Final Comments:

Funding

- I am concerned about loss of General Fund dollars and downsizing the program.
- I think we have a good program with good leadership. Everyone is working hard to increase coordination and cooperation between agencies given the tough times the region faces.
- Morale is low due to funding-related job insecurity. Frustration among staff arise from … focus on public relation matters rather than families.
- [Healthy Start should] explore other ways for outreach with budget reductions. [For instance,] examine reporting method that determines Medicaid reimbursement.
- We need better compensation for vehicle use and more secure program financial stability.
- We are in the process of laying off workers due to decreased birth rate and anticipated reductions in state funding.
- It is very hard to run the program when we're not sure who will be administering program, unsure about upcoming budget cuts, etc.
- Decreased funding has decreased availability of supervision.

Value of Healthy Start as a resource in the community

- Healthy Start is the go-to-resource in the community for high-risk families; this is an excellent service for the community.
- I think Healthy Start empowers families in self-sufficiency and positive parenting.
- [Healthy Start] is an excellent program. The staff is very helpful and wonderful to work with.
- This is my second year working as a partner with Healthy Start. I find the program and staff warm and friendly and knowledgeable.
- [Our local Healthy Start] is an excellent program. The staff are very helpful and wonderful to work with.
- Healthy Start is working well in our county, despite state and federal legislation affecting screening.

Relationship with hospital and medical professionals

- One hospital in the county is parent agency; we have a very strong working relationship. Working to establish agreement with out-of-county hospitals.
- The medical professionals in our community are thankful to have one place where new families can be referred and supported.
- [Our] connection with local hospital is very strong; we are working on connection with out of county hospitals, which serve our families.
- I know this program from the hospital perspective and it is an exceptional program.

- We have no hospital in the county. [Some] health care systems are cooperative. Other hospitals … are not.
- We have a Healthy Start Program in our county, but they are not visible at our hospital. They rely on hospital staff to contact participants – the program does not work well.

Reactions to the Implementation Survey

- This questionnaire doesn't fit the needs of programs using multiple agencies.
- The only way you are going to get a valid picture of Healthy Start is by asking the right questions and ensuring strict confidentiality – that means no identifiers (including numbered surveys).
- Don't know the answers to numbers 9 and 10.
- Number 13 is confusing. The number of hours are what I received.
- Number 14 – Although very strong in the past, HIPAA has changed this dramatically, it's more difficult to find families.
- On questions G and H, we refer, but due to insurance issues, clients can't get care.
- Difficult survey! Took more than 30 minutes to fill out.
- My agency is a Relief Nursery. The families we share are few, but I tried to answer these questions as best I could!
- As commission director, some of these questions are difficult to answer because we are not involved in the day to day operation.
- Define "cultural competency" training and what constitutes competency. I feel that staff are competent in this area.
- I was really only able to answer questions around collaboration.
- I am unable to answer some of these more detailed questions about the program.

Additional program needs

- Our Healthy Start program really needs 3-5 child development curriculum.
- More training to be able to stay information and have more ideas to keep our clients going.
- Biggest frustration for workers: not being able to communicate/advocate for our clients with OHP.
- Better communication between OCCF, LDDF, and Healthy Start programs.
- Healthy Start needs to refine home visitor training and follow through trainings. Home visitor caseload and responsibilities are greater than the guidelines.

Other

- This is a two county program.
- The program has only been operating since July 2002. Our county has a very low diverse population.
- One staff member is in the process of becoming bilingual (English-Spanish).
- We are just starting and are very small. Our RN is doing all the visits currently.
- We are just getting started in our second month of implementation, so most of this information will change.
- We had a mix up with data input so we haven't seen any data to review.

- Data collection is time consuming and getting lost somewhere.
- I'm an RN and do the referrals from the only OB caregiver's office in the two county area.
- The families we serve have revealed to individual FSWs that they do not enjoy it when our supervisor shadows our visits. It creates mistrust, an invasive nature and our families feel "put on the spot."
- Our program is very new. First client was seen in April of 2003. I am not a direct Healthy Start provider.
- Overall I feel our program is running well, but I see areas for improvement.
- I responded to most of the questions based on my agency, not the county as a whole (we have several non-profits providing Healthy Start).
- I just started with the Healthy Start program, which has only been in our community for one year, so my percentages, are probably off.
- I don't know how much supervision FSWs have in my division. NFP has lots of supervision and support.
- I am the local Babies First/Cacoon Coordinator. I work in collaboration with our local Healthy Start.
- I am responding from the perspective of social work in hospital (OB/NICU).
- I am not directly involved in implementing the program. Was on a committee to help get it started and did take FSW and FAW training.
- Evaluation not pertinent to me. I am the manager at a hospital, which refers to Healthy Start eligible clients.
- Active competition for families by public health has weakened the program.
- Unless new staff have already worked with at risk families, they are often not prepared. Following the training provided, they are more prepared.