Healthy Start of Oregon 2005-2006 Status Report



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Benton County Clackamas County **Clatsop County** Columbia County Coos County **Crook County Curry County** Deschutes County **Douglas County** Gilliam County **Grant County** Harney County **Hood River County** Jackson County Jefferson County Josephine County Klamath County

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Parents Tell Us "The Best Thing About Healthy Start is...."

This year, we received more than 1,500 comments from parents about the Healthy Start program. Here are just a few examples of the "best thing about Healthy Start:"

The personal contact. I am a first-time mother with no family or friends in Oregon.

Meeting with (worker) gives me a chance to get some feedback on whether I am doing a good job as a mom or not. (Worker) has provided me with much needed support and positive feedback.

It gives positive and encouraging help to first time parents who may or may not know much about their child's development and ability to



learn and grow. They are willing to help in any way possible and are friendly and very educational people.

It gives me someone to talk and share all my feelings and problems with.

Everything. My friends told me not to get it, but now I think they were wrong. I enjoy it a lot and so does my baby.

The time I spend learning more things to do with my daughter. We love this time.

I love the fact that someone cares enough to come in our home and go over things with you to make sure that your child is developing the way he/she should be and makes sure that the mother/father is developing the way parents should.

I feel that without the program I never would have the courage to do certain things such as breastfeeding my child.... and thanks to (worker) I now have wonderful memories that I will cherish forever.

EXECUTIVE SUMMARY

ealthy Start is Oregon's largest child abuse prevention program, screening over 7,500 families and providing evidence-based home visiting services to over 3,300 children at risk for maltreatment statewide in FY 2005-06. Outcomes for families receiving home visiting are tracked annually through an ongoing evaluation conducted by an external evaluator, NPC Research. Additionally, during FY 2005-06, Oregon's Healthy Start program continued its efforts to obtain a statewide program credential from Healthy Families America (HFA). This credential involves documenting the use of a comprehensive set of research-based program practices, including evidence-based home visiting procedures, rigorous training and supervision supports, and effective program management and administration processes. As of December 2006, 7 of 13 selected Oregon sites have passed the credentialing process, and the statewide system is ontarget to achieve credentialing in Spring 2007.

Although the evaluation does not provide data that speak to all of the HFA standards, results this year found that at a statewide level, Oregon's Healthy Start program statewide met or exceeded HFA standards in almost every area in which evaluation data were available. Further, Healthy Start has been effectively engaging families with numerous risk factors for child maltreatment. In tandem with the positive outcome findings, these results suggest that Healthy Start programs are providing effective services for Oregon's most at-risk children. Outcome and implementation results from FY 2005-06 are summarized below, and more detailed information is provided in the available full report (also www.oregon.gov/OCCF).



Outcomes for Children and Families

REDUCING RISK FACTORS FOR CHILD MALTREATMENT

Research shows that helping parents to develop skills to better support their children's development and reducing parents' levels of stress are critical to reducing the likelihood of child maltreatment. Healthy Start's results compare favorably to other research with higher-risk families:

- Healthy Start workers report that 73% of Healthy Start's higher-risk families consistently engaged in positive, supportive interactions with their children.
- 86% of higher-risk families report that they have improved their parenting skills.
- 38% of higher-risk parents reported a decrease in parenting-related stress from the time of the child's birth to the 6-month birthday, a time when parents generally experience highly elevated levels of parenting-related stress.



PROMOTING HEALTHY DEVELOPMENT

Oregon's Healthy Start program is highly successful in promoting positive health outcomes for children and adults, and greatly exceeds Healthy Families America standards on these issues. After at least 6 months in Healthy Start:

- 98% of Healthy Start's children from families receiving Intensive Service had a primary health care provider, which greatly exceeds the Healthy Families America standard of 80%. In addition, 78% of caregivers had a primary health provider.
- 91% of Intensive Service mothers received early prenatal care for their second pregnancies, compared to 76% for their first pregnancies.
- 94% of children were receiving regular well-child check-ups, compared to only 84% of young children nationally (Child Trends, 2004).
- 91% of Healthy Start children had health insurance, compared to 85% of low-income children nationally.
- 94% of Healthy Start's 2-year-olds were fully immunized, compared to 72% of all Oregon 2-year-olds (U. S. NIS-3, 2003), and greatly exceeding the HFA standard of 80%. Nationally, about 76% of children from low-income households were fully immunized by age 3 (Child Trends, 2004).
- Almost three-fourths (73%) of Healthy Start Intensive Service children received regular developmental screening during FY 2005-06. Most (88%) of these children showed normal growth and development on their overall assessments, and 86% of Healthy Start Intensive Service children with identified developmental delays were linked to early intervention services.

PROMOTING SCHOOL READINESS

Oregon's Healthy Start program is also extremely successful in helping parents to provide children with supportive early literacy environments, one of the keys to helping children be prepared to enter and succeed in school:

- After 12 months of Intensive Service, 79% of Healthy Start's higher-risk families were creating learning environments for their young children that were rated as "good" or higher by their home visitor, as indicated by The Home Observation for Measurement of the Environment Inventory (Caldwell & Bradley, 1994). This percentage is higher than results found in other, comparable populations.
- By age 2, 86% of Healthy Start Intensive Service parents reported reading to their children three times per week or more; nationally, only about 64% of higher-risk families read to their young children three or more times per week (Nord, Lennon, Liu, & Chandler, 1999).

SUPPORTING FAMILY SELF-SUFFICIENCY

Healthy Start's higher-risk families often need a variety of supports to help them meet their basic needs, and frequently set goals related to improving their selfsufficiency. Last year:

- After 6 months of Intensive Services, many Healthy Start families had been connected to services they needed. Of those families indicating each of the following needs, 87% were connected to housing assistance, 92% were connected to education assistance, 91% were connected to job training and employment services, 95% were connected to Temporary Assistance for Needy Families, and 84% were connected to dental insurance.
- Over one-third (35%) of parents reported their family income situation had

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improved over the past 6 months (only 13% reported a decrease in income), and 9% of families reported that at least one of the primary caregivers gained employment over the first 6 months of their child's life.

Program Implementation & Service Delivery

Healthy Start continues to increase the effectiveness of its system for contacting and offering services to first-time parents:

- A total of 10,336 families (56% of eligible births) were identified and offered Healthy Start services during FY 2005-06 and 40% (7,510 families) agreed to participate in the screening and the program's evaluation.
- Only 6% of families declined to hear about Healthy Start at the initial point of contact. An additional 14% accepted the initial Healthy Start information, but declined to participate in screening. Of those screened, only 1% declined to participate in the evaluation.
- Most screening (87%) took place prenatally or during the first 2 weeks after the baby's birth. Early screening and engagement of families in services is critical to program success.

Healthy Start's screening and assessment system effectively identified families and children at greatest risk for poor outcomes:

- Of those families screened, 72% screened at higher risk.
- Families screened by Healthy Start have more demographic risk factors, compared to Oregon's general population. For example:
 - o 52% of those screened were single mothers, compared to 32% in the general population (KIDS COUNT, 2004)
 - o 9% of those screened were teen mothers, compared to 3% in the

- general population (KIDS COUNT, 2004)
- 26% of mothers screened had less than a high school education, compared to 20% in the general population (KIDS COUNT, 2004)

Healthy Start is successfully engaging higher-risk families with Intensive Services:

- Families receiving Intensive Services are significantly more likely to be single-parent households, teen parents, unemployed, and have financial difficulties than families who were screened but did not participate in the homevisiting component. 92% of Healthy Start Intensive Service mothers and fathers grew up in homes with at least one parent who had problems with substance abuse, mental health, and/or criminal involvement. 97% reported a lack of nurturing parents in their own childhoods, with concerns ranging from use of corporal punishment to more serious abuse and neglect.
- Healthy Start has a very low rate of refusal of Intensive Services: 90% of families who were offered home visiting services agreed to participate. However, as seen in many home visiting programs, long-term retention is a challenge. 41% of Intensive Service families who had enrolled in FY 2004-05 (that is, who the evaluation could follow for at least 1 year) remained in service for longer than 1 year.

The need for Intensive Home Visiting Services may be greater than the capacity of Healthy Start to provide them:

Using the current (FY 2006-07) eligibility requirements, 3,980 families screened last year would have been eligible for Intensive Services. Program capacity allowed enrollment of only 1,231 new Intensive Service families,



about one-third (31%) of potentially eligible higher-risk families.

Finally, it is important to note that parents are extremely positive about the services that Healthy Start provides:

• Close to 100% of Healthy Start Intensive Service parents reported Healthy Start "helped a lot" by providing parenting information. Parents also reported that their home visitor "helped a lot" with obtaining basic resources (90%), dealing with emotional issues (91%), and encouraging the development of positive relationships with family or friends (93%). Parents reported that the services provided by the program are culturally competent (75%) and help them to build on their family's strengths (92%).

Conclusions and Looking Ahead

Outcomes for Oregon's Healthy Start program are consistently positive across a variety of domains known to be important to supporting children's healthy development and reducing the risk for child maltreatment. Further, the program is showing considerable success at the state level in meeting the standards set by Healthy Families America. Meeting these standards will ensure that all programs across the state are implementing high quality home visiting services for families at risk. Currently, the Healthy Start program is on-target to obtain its HFA credential in Spring 2007.

HEALTHY START RESTRUCTURE PROCESS

In addition to credentialing efforts, FY 2005-06 brought other significant quality assurance efforts to the Healthy Start pro-

gram. The data presented in this report reflects services provided in a year of a 20% across the board funding reduction. During this year, a statewide Healthy Start Restructure Committee was formed to address the question of program quality in the face of this budget reduction. This committee made several changes, effective June 2006, designed to strengthen the quality and efficiency of the Healthy Start program, including:

- 1. Developing and implementing databased performance standards for program implementation and outcomes;
- 2. Revising and streamlining the Healthy Start intake and eligibility process;
- 3. Affirming the priority of Healthy Start to serve first-birth families; and
- 4. Revising the way that funds are allocated to better account for program capacity and quality.

As a result of these processes, nine programs implemented state-supervised quality improvement plans, and five programs were required to significantly restructure their service delivery system in order to obtain ongoing funding. OCCF staff and NPC Research continue to monitor program quality using both the HFA standards and the Oregon Healthy Start Service Delivery Performance Standards. Continued technical support and assistance to the local program sites will help ensure consistency in implementing these "best practice" standards so that all of Oregon's children can have a "healthy start." However, additional funds will be needed in order to reach a larger proportion of eligible families with intensive home visiting services.

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HEALTHY START OF OREGON STATUS REPORT 2005-2006

n 1993, the Oregon Legislature created the Healthy Start program with a mandate to provide universal, voluntary services to all first-time parents in the state of Oregon (ORS-417.795). The Healthy Start mission is to "promote and support positive parenting and healthy growth and development for all Oregon parents and their firstborn children." Healthy Start operates on the research-based premise that while all new families can use information, education, and support when a baby is born, individual families differ in the type and intensity of support that is needed. Thus, Healthy Start strives to offer all first-time parents a range of services appropriate to their needs, ranging from ineducational formation materials and (Screened/Referred) to longer-term, more intensive home visiting services (Intensive Services) that continue throughout the early childhood years.

Healthy Start Goals

Healthy Start aims to establish an early child-hood system to nurture all families and children. It accomplishes this objective by systematic identification of all first-birth families, providing information and short-term support to all lower-risk families, and providing family support and long-term home visits to higher-risk families.

The ultimate goals of Healthy Start are to:

- 1. Reduce the incidence of child abuse and neglect among Healthy Start families; and
- 2. Improve the school readiness of children participating in Healthy Start.

To do this, Healthy Start builds on research that shows that home visiting is most effective when services are provided to families most at-risk for negative child outcomes and when high-quality intensive services are provided to families for a period of several years.

Healthy Start works to reduce risk factors associated with increased incidence of child abuse and neglect and to promote the role of parents as the child's first teacher. Family Support Workers (FSWs) coach first-time parents to help them develop warm, sensitive, and responsive parenting styles that establish a foundation for positive child development and school readiness. In doing so, the program aims to reduce incidents of child abuse and neglect and to prevent costly long-term foster care placements.



Healthy Start workers provide information to parents about age-appropriate expectations for children's development, how to deal with developmental and behavioral challenges, discipline and positive guidance, and healthy lifestyles. Additionally, FSWs work with parents to make sure the family is connected with a medical care home, that children are receiving regular well-child check-ups and timely immunizations, and that families have health insurance coverage. These activities promote preventive health care, helping to offset more costly emergency room and acute care services.

Together, the wide variety of services provided by Healthy Start home visitors helps to ensure that children are ready to succeed in school by promoting children's healthy physical, cognitive, and social/emotional development. By empowering and supporting

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parents to be their child's first teacher, the program strives to put the family on a positive trajectory to be able to support their child effectively through the child's school years. Healthy Start's ongoing program evaluation documents this broad array of outcomes to make sure that the program is meeting its intended objectives.

Healthy Families America Credentialing

During FY 2004-05, Oregon's Healthy Start program embarked on the groundbreaking process of being credentialed through the national Healthy Families America (HFA) initiative. This rigorous process will ensure that all of Oregon's Healthy Start programs are implementing programs that align with evidence-based best practices for early childhood home visiting programs. In fact, a recent study of more than 1,100 parents who were randomly assigned to either the HFA program or a control group found the HFA model to be effective in improving parenting and child outcomes (Mitchell-Herzfeld et al., 2005). HFA is now officially considered to be an evidence-based promising practice (Rand, www.promisingpractices.net).



To achieve an HFA credential, all programs must submit extensive documentation showing that they are in alignment with credentialing guidelines. A random sample of 13 sites received 2- to 3-day site visits from HFA credentialing reviewers. Additionally, the

program's central office at the Oregon Commission on Children and Families (OCCF) also received a site visit and a detailed review of their training, technical assistance, evaluation, quality assurance, and administrative systems.

As of November 2006, all 34 program sites had completed site self-assessments and submitted those materials either to HFA as part of the credentialing process or to OCCF as part of quality assurance efforts. Materials submitted to HFA are reviewed by the National Healthy Families America Credentialing Panel, comprised of experts, researchers, and program staff from across the country. Nine of the thirteen selected programs have completed this process. The remaining programs and the state system as a whole are on track to finish in July 2007. At that time, all of the programs in the state will receive the Healthy Families America credential.

Healthy Start Program Restructuring

The 2005 legislature reduced funds to Healthy Start by 20%, requiring OCCF to reexamine the Healthy Start service delivery system. In Fall 2005, the Healthy Start Restructure Committee was established to address the need to implement these budget reductions, as well as to consider proactive changes to continue to improve the overall quality of the Healthy Start program. The Restructure Committee was composed of program managers and local Commission on Children and Families directors representing Oregon's diverse geography. Additionally, researchers with expertise in early childhood, key state agency representatives, and other community members were included. The process was facilitated by Dr. Clara Pratt, Professor Emeritus at Oregon State University. The Committee made a number of recommendations that were adopted by the State Commission on Children and Families and implemented by Healthy Start programs.

PERFORMANCE INDICATORS

First, the Restructure Committee strongly endorsed performance-based decisionmaking and recommended funding and other decisions take into account program performance. A Research Subcommittee was established to review available Healthy Start data and recommend a set of performance indicators. In developing the indicators, a number of factors were considered. First, it was important that the Oregon Healthy Start Performance Standards align with HFA standards as much as possible. Second, it was important that the set of performance indicators be fair and balanced in regards to the ability of counties in different regions of Oregon (rural, frontier, urban) to meet the standards. Third, it was recognized that no single indicator would be necessary or sufficient to judge program quality. That is, the Committee acknowledges that different counties might have different strengths and areas in need of further support. Thus it was important to have a set of indicators that could tap multiple performance areas for programs.

In Spring 2006, after an iterative process of data review, discussion, and feedback from the Restructure Committee, the State Commission on Children and Families approved a set of seven service delivery performance indicators (e.g., the percentage of eligible birth screened, and the percentage of families retained in service for 12 months or more) and six outcome indicators (e.g., the percentage of parents reading to their child regularly, and the percentage of children with upto-date immunizations). These indicators were based on the most currently available Healthy Start data at the time (FY 2004-05), review of Healthy Families America (HFA) standards, and review of comparable information from other similar home visiting programs. "Cut-off" scores for each indicator were set to reflect three levels of performance: (1) Meeting the program goal (highest performance); (2) meeting a minimum acceptable standard (adequate performance); or (3) failing to show adequate performance.

Using data from 2004-05, each program was then evaluated on each indicator as to whether they met the standard (category 1 or 2 above) or not (category 3). Finally, to come up with an overall assessment of the quality of service delivery, programs that were rated as meeting the minimum performance standard for 5, 6, or 7 of the set of 7 service delivery performance indicators were considered "Adequately Performing" (22 programs) and were not required to make any major changes to service delivery. Programs rated as meeting only 3 or 4 of the 7 service delivery performance indicators were required to develop a work plan to address under-performing areas of implementation (9 programs) prior to being funded for FY 2006-07. Finally, programs that were rated as meeting the minimum standards on only 1 or 2 indicators were required to substantially restructure their programs prior to funding for FY 2006-07 (5 programs). However, it should be noted that these "restructure" programs were functional during FY 2005-06 and thus their data are included in this report.

It is important to note that programs were categorized into these groupings based on the service delivery indicators, and not the outcome indicators. Service Indicators were chosen because the committee felt it was most appropriate to gauge program quality using measures that programs would be able to most directly impact.

CHANGES IN ELIGIBILITY AND SCREENING

A second major change in the Healthy Start program was to streamline the determination of eligibility for the program from a two-step screening and assessment process to use of a single screening tool. Prior to this change, families were first screened using a brief instrument (the New Baby Questionnaire) to identify risk factors. Families with any single risk factor were then referred on for more indepth assessment using the Kempe Family



Stress Inventory (Korfmacher, 1999). Kempe assessments involve a semi-structured interview done at the family's home by a trained assessment worker. However, because of reductions in program capacity, Kempe interviews were often completed for families that could not be enrolled in Healthy Start's home visiting component. While this thorough assessment is beneficial for fully understanding families' needs, it was an area that required extensive use of staff resources.

Using data from the Kempe and the NBQ, NPC Research determined that potentially eligible families could be identified with 86% accuracy based solely on the NBQ, if the scoring system were changed. Specifically, families with any two or more positive risk factors on the NBO, or who indicated a substance abuse or depression concern, were extremely likely to be found eligible on the Kempe assessment. The recommendation from the Restructure Committee, therefore, was to eliminate the use of the Kempe for eligibility purposes, and to change the NBQ scoring to the above criteria. This change in program process was begun in July 2006 (the start of the FY 2006-07 fiscal year).



Funding Formula

The third major recommendation of the Healthy Start Restructure Committee was to change the funding structure for the Healthy Start program; specifically to eliminate "tiered minimum grant" funding (for programs with fewer than 100 first births) and to ensure performance criteria were incorporated into the funding structure. The Budget Committee of the OCCF adopted a new formula for FY 2006-07 that included population-based funding allocations, coupled with (1) a "safety corridor" to prevent drastic increases or decreases to budgets that would impede a program's ability to delivery consistent services; and (2) performance factors, which provided additional funds (if available) to be provided to the highest quality programs.

Regionalization

A final major recommendation of the Restructure Committee was to encourage small and/or frontier counties to maximize the efficiency of their programs by regionalizing service delivery. Regionalization was meant to reduce overhead, and allow small counties to pool resources to better serve families. As of January 2007, two regional programs comprising five counties have been established.

Program Delivery Challenges

During FY 2005-06, the Healthy Start program faced several challenges to optimal service delivery. First and foremost, the program sustained an almost 20% budget cut, requiring the elimination of a number of home visiting staff positions and reducing program capacity. At the same time, the statewide economic downturn led to a reduction in other available services for at-risk families, including reduction in health insurance coverage for poor families, elimination of subsidized alcohol and drug abuse treatment slots, increased unemployment, and a general reduction in a variety of other sup-

portive services for poor families. Child abuse rates statewide and nationally were on the rise, due in large part to the increased prevalence of methamphetamine production and use (DHS, 2006). Further, these challenges were occurring at a time when pro-

grams were working intensively to meet best practice standards for quality program implementation, as well as the extensive documentation of program services required for HFA credentialing. Finally, during

the 2005 legislative session, Healthy Start was asked to focus its efforts on the highestrisk families and to work more closely with families involved with child welfare and TANF/self-sufficiency (and therefore, families with more needs). Thus, the context for Healthy Start in FY 2005-06 can best be described as "doing more with less." This year's status report describes Healthy Start's progress in meeting the Healthy Families America performance standards as well as in achieving its legislatively mandated outcomes. This document summarizes statelevel Healthy Start Outcomes. County-level information is presented in Tables 1 through 37. The progress of Healthy Start in meeting select HFA critical elements is described in Table A

Outcomes for Children and Families, FY 2005-06

Over the past 12 years, a set of outcome indicators has been developed to measure Healthy Start's annual progress toward two key Oregon Benchmarks: reduced incidence of child maltreatment and improved school readiness. The analysis of child maltreatment data is scheduled to be released in April 2007. All of the other outcomes are described below for FY 2005-06.

RISK FACTORS FOR CHILD MALTREATMENT

In order to reduce rates of child maltreatment, the Healthy Start program targets several risk factors that have been found to be associated with higher incidence of child

abuse and neglect (Cicchetti & Toth, 2000), including poor parenting skills and parent stress. These results are summarized below (again, actual impacts on child maltreatment rates will be

- Healthy Start Parent

"Healthy Start has helped me get

my life on track, and helped with

the education of my child."

reported in a separate report in April 2007).

Positive Parenting

Positive, supportive interactions increase children's well being and are related to reductions in child maltreatment (Shonkoff & Phillips, 2000). HFA Standards require that the program have a comprehensive approach to promoting parenting skills and positive parent-child interactions (see Tables 32 & 33). Information from Healthy Start's Intensive Service families in FY 2005-06 found that after 6 months of Healthy Start services:

- 86% of higher-risk families reported **improved parenting skills**.
- 70% of higher-risk families reported improved ability to help their child.
- 73% of higher-risk families were rated by their Healthy Start workers as consistently engaging in positive, supportive interactions with their children.
- More than a third (38%) of higher-risk Intensive Service parents reported a decrease in parenting-related stress from the time of the child's birth to the 6month birthday (see Table 36).

SCHOOL READINESS OUTCOMES

Three primary outcomes related to school readiness are tracked: (1) children's health, (2) children's growth and development, and



(3) the ability of parents to provide developmentally supportive environments for their children. These results are presented below.

Health Outcomes

Impressive health outcomes are reported for Healthy Start families. Workers reported that children living in higher-risk Intensive Service families are receiving regular health care and immunizations (see Tables 24 to 27). After at least 6 months of Healthy Start services:

- 98% of children living in higher-risk Intensive Service families of children have a primary health care provider, which greatly exceeds the Healthy **Families** America standard of
 - 80%. In addition, 78% of the parents have a primary health care provider (see Table 24). This is especially important given significant cuts to the Oregon Health Plan during 2005-06.
- 94% of children living in higher-risk Intensive Service families received wellchild check-ups (see Table 24). National data report that only 84% of children under age 6 nationally received a well-child visit during the past year (Child Trends, 2004). For poor children this rate is even lower (81%).
- Healthy Start workers reported that 94% of these children were fully immunized by age 2 (see Table 26). In contrast, only 72% of all Oregon 2-year-olds were fully immunized in 2003, as reported by the U. S. National Immunization Survey (NIS, 2004). A survey by KIDS COUNT, a national organization, indicated that 82% of Oregon's children were immunized by age 2 in 2004 (KIDS COUNT, 2004). Nationally, about 81% of children were found to be fully immunized by age 3, al-

though rates for poor children are lower (76%; Child Trends, 2004). Healthy Start children exceed the HFA Standard of 80% fully immunized by age 2, as well as exceeding comparable national and local immunization rates.

- Only 7% of Intensive Service families reported regular use of emergency room services for routine health care (see Table 25).
- 91% of Healthy Start Intensive Service children had **health insurance**, compared

to 85% of lowincome children nationally (Table 25). In the general population in Oregon, includes which families at considerably lower risk than Healthy Start

families, 93% of children ages 0 to 5 have health insurance.

to 77% for their first pregnancies, see Table 27).

Intensive Service mothers were more likely to receive early prenatal care for subsequent pregnancies (91% compared

Healthy Growth and Development

HFA standards require regular developmental screening using a standardized tool and appropriate documentation and referral for children with identified delays. Healthy Start programs use the Ages and Stages Questionnaire (ASQ), administered at specific agebased intervals, to monitor children's development (see Table 28). The rate of screening of eligible children increased dramatically from 56% of eligible children in FY 2004-05 to 73% of eligible children (1,888 children screened) in FY 2005-06. Recent case file reviews conducted during the credentialing process suggested that even more eligible children may have had a developmental screening, but that some of these screens are

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66% of Healthy Start Intensive

Service parents reported reading

to their children at least daily,

higher than the

national average.

not being reported to the evaluators in a timely fashion.

Of those children whose ASQ results were reported this year, a large majority (88%) of these children showed patterns of normal growth and development.

Further, those children with identified developmental delays were appropriately linked to early intervention. Almost all (86%) of the Healthy Start Intensive Service children with identified developmental delays had been linked to early intervention services.

In addition to the ASQ, programs use the Ages and Stages Social-Emotional Scale (ASQ-SE) to screen children for developmental delays. Families are eligible for the ASQ-SE when the babies reach 6 months of age (see Table 29). Of the 2,577 eligible families, 1,248 or 48% reported ASQ-SE results to the evaluation team, a sizeable increase since FY 2004-05, when only 35% of eligible children were screened using the ASQ-SE. Most screened children (94% or (1,146 children) had normal ASQ-SE scores. Of the 53 children (4%) with delays indicated (not necessarily diagnosed), Healthy Start workers responded appropriately, providing referral to early intervention (16 children, 30%); information and developmental support (11 children, 21%), and other supportive services (2 children, 4%). Six families (11%) declined the FSW's referral to early intervention or other services.

Early Literacy and Learning

Family literacy activities are strong predictors of school readiness, and the absence of these activities is one key reason that children from poor families are at risk of school failure (Shonkoff & Phillips, 2000). Healthy Start families, however, are showing quite positive outcomes in this area.

First, after 12 months of Intensive Service, 79% of Healthy Start's higher-risk families are **creating learning environments** for their young children that their home visitor

rated as "good" or higher, as indicated by the scoring criteria for The Home Observation for Measurement of the Environment Inventory (Bradley & Caldwell, 1984) (see Table 33). This result compares favorably with findings from other, comparable populations (e.g., Caldwell & Bradley, 1994).



Second, by age 2, 86% of higher-risk Intensive Service families report **reading to their children** at least three times per week (see Table 33). This is a key indicator of a positive early literacy environment. Nationally, only about two-thirds (64%) of higher-risk families read to their young children three or more times per week (Nord, Lennon, Liu, & Chandler, 1999).

CONNECTING FAMILIES WITH RESOURCES

HFA Critical Element 7-3.A. states that the program must show evidence that it is successfully **connecting families to appropriate resources and referral sources**. On the Family Intake and Update forms, Family Support Workers report families' need for a variety of services, and whether these needs are met. The most frequently reported needs are listed below, along with the percent of families who were successfully connected to the appropriate service by 6 months (see Table 30).

 Housing Assistance (141 families in need, 87% connected)



- Education Assistance (78 families in need, 92% connected)
- Job Training & Employment Services (79 families in need, 91% connected)
- Temporary Aid for Needy Families (TANF, 59 families in need, 95% connected)
- Dental Insurance (44 families in need, 84% connected)

Healthy Start also appears to be supporting parents in reaching self-sufficiency. Over one third of parents (35%) reported that their family income situation had improved over the previous 6 months (see Table 36), while half (52%) said it stayed the same, and 13% said it worsened. Moreover, 9% of families reported that at least one of the primary caregivers gained employment during the year, not including mothers returning to work after a maternity leave.

DO PROGRAM OUTCOMES DIFFER FOR PARENTS WITH DIFFERENT CHARACTERISTICS?

In addition to the analyses reported above, we examined outcomes for Healthy Start clients with different demographic and risk characteristics. These analyses can help determine whether Healthy Start is doing a better job serving parents with particular characteristics, and/or whether the program needs to strengthen its efforts for certain parents.

Differences were examined for the following outcomes:

- *Parenting*: (1) Reported improvement in parenting skills and (2) reductions in parenting stress;
- Support for School Readiness: (1) HOME (Home Observation for Measurement of the Environment) scores and (2) frequency of parent reading to the child;
- Child Health: (1) Whether the child is connected to a primary health care provider; (2) receipt of regular well-child

check-ups; and (3) whether the child is fully immunized.

Specifically, we conducted analyses to determine whether any of these outcomes differed for parents in the following groups:

- Hispanic vs. White/Caucasian parents¹
- Teenaged (17 and younger) vs. nonteenaged parents
- Unmarried vs. married parents
- Parents at risk for depression vs. parents not at risk for depression (at screening)

Results showed the following.

Outcomes for Hispanic Parents

Hispanic parents had generally more positive outcomes across two of the three domains, compared to White/Caucasian parents, but Hispanic children were less likely to be fully immunized. Specifically²:

Parenting

- Hispanic parents were more likely to report that their parenting skills had improved after 12 months in the program (89% vs. 84% of White/Caucasian parents).
- Hispanic parents were more likely to report a reduction in parenting stress after six months in the Healthy Start program (42% reporting a reduction vs. 35% of White/Caucasian parents).

Supporting School Readiness

• Hispanic parents had significantly more positive scores on the HOME at the child's 12 and 24 month birthdates, indicating that they were providing a more developmentally enriching environment for their children (85% scoring in the

¹ Other racial/ethnic subgroups did not have sufficient sample size to allow for appropriate statistical analysis.

² All Chi-Squared statistics significant, p<.05.

'good or better' range vs. 75% of White/Caucasian families).

 Hispanic parents were more likely to be reading to their child three times per week or more at both the 12 and 24 month assessments (89% vs. 84% of White/Caucasian parents).

Child Health

• Hispanic children were somewhat less likely to be fully immunized at age 2 (91% vs. 96% of White/Caucasian children).

Teenaged Parents

Teenaged parents generally scored similarly to non-teenaged parents, with a few exceptions:

Parenting

- Teenaged parents were less likely to report that their parenting skills had improved after 6 months in the program (79% vs. 87% of non-teenaged parents), although this difference was not significant after 12 months in the program.
- Teenaged parents were *more* likely to report a reduction in parenting stress after six months in the Healthy Start program (48% vs. 38% of non-teenaged parents).

Supporting School Readiness

 Teenaged parents were less likely to be reading to their child three times per week or more at the child's 24 month birthday (82% of parents), compared to non-teenaged parents (89%), although this difference was not significant at the 12 month assessment.

Child Health

 Children of teenaged parents were less likely to be receiving regular well-child check-ups (88%) compared to children of non-teenaged parents (96%).

Marital Status

Results were generally similar for married vs. unmarried parents, specifically:

Parenting: No significant differences on any parenting outcomes.

Supporting School Readiness

• Married parents had significantly more positive scores on the HOME at the child's 12 month birthday, indicating that they were providing a more developmentally enriching environment for their children (84% scoring in the 'good or better' range vs. 80% of single parents); this difference was not significant at the 24 month assessment.

Child Health: No significant differences on any health outcomes.

Risk for Depression:

Intensive Service parents who scored at risk for depression on the screening (NBQ) had generally similar outcomes as non-depressed parents, with a few exceptions (described below).

Parenting

Parents who scored at higher risk for depression on the screening (NBQ) were more likely to report an improvement in parenting skills after 6 and 12 months in the Healthy Start program (89%) vs. parents who were not at risk for depression (83%).

Supporting School Readiness. No significant differences on any school readiness outcomes.

Child Health: No significant differences on any health outcomes.

Summary of Outcome Analyses for Parents with Different Characteristics

Results of these analyses have several implications. First, it appears that the Healthy Start program is generally doing a good job



in working on parenting issues with Hispanic families, both in terms of parents selfreported parenting skill and stress levels, as well as on observable parenting behaviors as measured by the HOME assessment.

However, the lower rates of immunizations for Hispanic families may require additional program attention. Nationally, Hispanic children have been shown to be less likely to be immunized, compared to White/Caucasian children (Larson, 2003), and this gap in immunization rates continues to grow. In Oregon, only about 82% of Hispanic children are fully immunized at age 2 (Wu, Priedeman, Schubert, Lee, Rosenberg, Cieslak, & Fleming, 2000). Although Hispanic Healthy Start

children are immunized at a higher rate than these figures imply might be expected in the absence of Healthy Start, it appears that the program is not yet eliminating the disparity in immunization rates

for Hispanic children in Oregon.

Second, Healthy Start may need to re-double its efforts to improve the parenting skills of teenaged parents. Although teenaged Healthy Start clients were more likely to report reductions in parenting stress (which indicates that the supportive component of the program is working well for these parents) their parenting scores were less positive than nonteenaged parents in several areas.

Third, while results generally do not show that parents at risk for depression have better outcomes, compared to those less at risk, the fact that at-risk parents did as well as nondepressed parents suggests that Healthy Start may play an ameliorative role in reducing the impact of sub-clinical depressive symptomatology on parenting. Depression has widely been shown to negatively impact parenting behavior (Taaffe McLearn, Minkovitz, et al., 2006).

PARENT SATISFACTION

HFA requires that Healthy Start have a mechanism in place for parents to provide input into the program. In fulfillment of this standard, programs request that parents complete a survey that includes questions about their relationship with the Family Support Worker and their satisfaction with program services. During FY 2005-06, NPC Research changed the parent survey procedure to allow parents to provide this feedback anonymously.

Results indicate that parents almost universally indicate they have benefited from the services they receive from Healthy Start (see Table 35). Almost all of the Intensive Service

> parents (close to 100% that Healthy visitor helped home

> of the 1,886 parents responding) reported Start helped them obtain and parenting understand information. Also, parents reported that their

with obtaining basic resources (90%), dealing with emotional issues (91%), education and job assistance (78%) and encouraging the development of positive relationships with family or friends (93%).

Almost all parents responding rated their Healthy Start workers as being culturally competent (75% agreed or strongly agreed) and having a strength orientation (92% agreed or strongly agreed) 3. For individual item percentages see Table 34.

More than 1,500 parents surveyed added handwritten comments describing the benefits of Healthy Start for their families. Parents noted the "invaluable" emotional support and information provided by home visitors. Several parents commented that without

10 March 2007

The best thing about Healthy Start

is..." They help me to realize that I

am a good mom and can do things

that I set my mind to."

- Healthy Start Parent

³ Average percentage across the three cultural competency scale items and five strength orientation items, respectively.

Healthy Start, they would not be making good choices for their children.

Program Implementation & Service Delivery Results

A consistent finding in the research literature is that effective home visiting programs should start early in the life of the child and provide comprehensive and intensive services to at-risk families. Programs that are not well implemented, or which do not successfully engage families are less likely to show positive outcomes (Sweet & Appelbaum, 2004). In Oregon's Healthy Start program, implementation and service delivery achievements are monitored using a series of indicators that measure the success of the as-

sessment system, the number of families served, and the type and length of service received. As described previously, in Spring 2006, the Healthy Start Restructure Committee

contacted over 10,000 families representing 56% of eligible births in FY 2005-06.

Healthy Start successfully

developed and approved a set of service delivery performance indicators to help monitor Healthy Start program implementation. Below, we present data on key performance indicators and HFA standards for Oregon's Healthy Start program.

EFFECTIVE SCREENING TO IDENTIFY HIGHER-RISK FAMILIES

Healthy Start's screening and assessment system strives to identify families and children at greatest risk for negative outcomes, including child maltreatment and poor school performance. Despite an almost 20% overall budget cut to program services in FY 2005-06, Healthy Start maintained a consistent rate of screening of first-time parents during the year. Healthy Start programs successfully identified and contacted 10,336 families, 56% of eligible first births, a rate comparable to previous years. Healthy Start screened 40% of eligible births statewide (7,510 families), also consistent with previous years (FY 2003-04, 40%; FY 2004-05, 41%; see Tables 1 & 2).

Only 6% of all families offered services declined Healthy Start at the initial point of contact (i.e., were not interested in receiving any information about Healthy Start). An additional 14% accepted preliminary Healthy Start information but declined to participate

in screening. Seven percent (7%) could not be located after signing a release form. 73% of those families offered Healthy Start services were successfully

screened (7,510 families, see Table 2).

Healthy Start uses the New Baby Questionnaire (NBQ), to screen for risk and offer appropriate services based on family need (see Table 1). A few families (85, 1% of those screened) were screened but declined to participate in the evaluation or were screened prenatally and declined further services (232 families, 3%), and thus information about the characteristics and status of these families is not included in this report.



Almost all screening (87%) took place prenatally or within 2 weeks of the child's birth (see Table 3). At the county level, 17 out of the 34 counties (53%) met the HFA standard of 80% of screenings occurring during this time frame, with 3 additional counties within 5% of the standard. The median number of days from the baby's birth to when families were screened by Healthy Start was one (1) day (counting prenatal screens as zero days); county medians ranged from 0-17¹.

During FY 2005-06, families were consid-

ered to be at higher risk (and potentially eligible for services) if they screened positive on any single risk factor on the New Baby Questionnaire and assessed as having a score of at least 25 out of 100 on the Kempe Family Stress Inventory for either

parent. As shown in Table 4, out of 7,131 families with risk factor screening data, 72% (5,105 families) were eligible to go on for further assessment using the Kempe Interview.

Families identified as potentially eligible for Healthy Start represent a range of risk levels, with 19% having only a single risk factor, 21% having two risk factors, 15% three risk factors, 10% four risk factors, 5% five risk factors, and 2% six or more risk factors.

One of the key issues for Healthy Start is the ability of FSWs to present Healthy Start services as non-stigmatizing and as beneficial for all new parents. The programs' success in doing this is reflected in their high initial acceptance rate for Intensive Services: 90% of eligible families (1,175) accepted Healthy Start Intensive Services (see Table 9) at the initial point of contact. Counties range from a

high of 100% acceptance to a low of 50% acceptance rates, with most (31 counties) having 80% acceptance or higher.

WHO ARE HEALTHY START FAMILIES?

Screening and Referral

Because program capacity was

limited, Healthy Start was able

to provide Intensive Services to

only 1,231 new families, about a

third of those identified

as in need.

Healthy Start's goal is to provide screening, referrals, and parenting information to all first time parents. Utilizing the New Baby Questionnaire (NBQ) to screen for risk factors, Healthy Start identifies those families

with significant risk factors who may be eligible for more intensive home visiting services ("Intensive Services"). Lowerrisk families (defined, in FY 2005-06 as families with no more than 1 identified risk factor) receive screening, in-

formation, and basic referral services only. Due to program budget restrictions, many program targeted their screening services at health care providers that serve higher-risk populations. Characteristics of families who were screened this year suggest that this targeting of screening service was occurring. Specifically, screened families appear to be higher risk in terms of demographic characteristics than the general Oregon population. For example, of the 7,131 screened families with available risk information in FY 2005-06, 8% of families had both parents unemployed, 30% had neither parent employed full time, 20% of parents reported symptoms of depression, and 14% reported having difficulty most of the time paying for basic living expenses (see Figure 1 and Table 8).

¹ One county, which only screened two families, had a median of 196 days because one family was not identified by the program until the child was almost 6 months old.

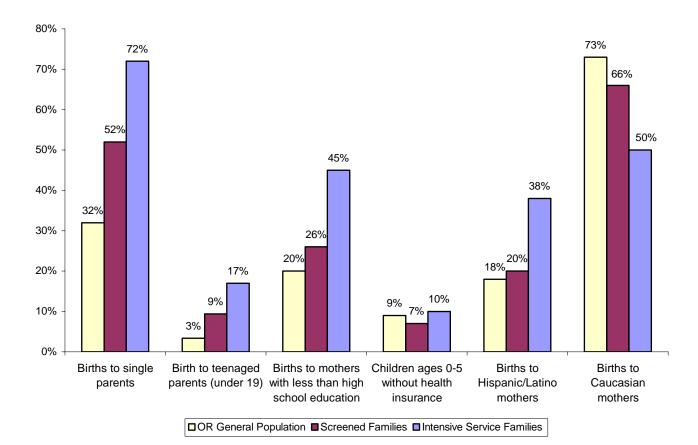


Figure 1. Healthy Start Family Risk & Demographic Characteristics

Intensive Services

In FY 2005-06, 3,332 families received Intensive Services and participated in the evaluation (see Table 10). HFA standards require programs to maintain a description of the current service population that addresses cultural, racial/ethnic, and linguistic characteristics. As shown in Tables 5 through 8 (all families who were screened) and Tables 12 through 15 (Intensive Service families only), families who participated in Healthy Start's Intensive Service component were significantly more likely than the total group of

screened families to be Spanish-speaking (34% vs. 18%), Hispanic/Latino (38% vs. 20%), teen parents (17% vs. 9%), single parents (72% vs. 52%), have less than a high school education (45% vs. 26%), have both parents unemployed (14% vs. 8%), have financial difficulties (26% vs. 14%), have dealt with depression (38% vs. 20%), have serious marital problems (25% vs. 12%), lack health insurance (mothers) (11% vs. 6%), and have had late prenatal care (32% vs. 21%).

Intensive Service families were 50% Caucasian, 38% Hispanic/Latino, 4% Asian/Pacific Islander, 2% African American, 1% Native American, and 4% multiracial. About one-third (34%) indicated Spanish as the primary language spoken at home, while an additional 3% indicated that a language other

serious marital problems $X^2(3)=155.6$, p<.001); no health insurance vs. has health insurance $(X^2(3)=780.7, p<.001)$.

 $^{^1}$ Hispanic/Latino vs. Caucasian ($X^2(2)$ =469.3, p<.001); Spanish vs. English speaking ($X^2(2)$ =373.0, p<.001); teen vs. non-teen ($X^2(2)$ =119.4, p<.001); married vs. single, $X^2(2)$ =455/5, p<.001); less than high school vs. greater than high school, $X^2(2)$ =448.4, p<.001); unemployed vs. employed ($X^2(2)$ =108.6, p<.001); financial concerns vs. no financial concerns ($X^2(3)$ =687.4, p<.001); depression vs. not depressed $X^2(2)$ =279.3, p<.001); serious marital problems vs. no



than English or Spanish was the primary language. A significant number of Intensive Service mothers (17%) were under 18 years of age, and 72% were single mothers.

About 14% of Intensive Service mothers reported that neither she (nor her partner, if applicable) were employed full time, and 38% indicated a risk for maternal depression (see Table 15). About one-third (32%) of Intensive Service mothers indicated they had late or no prenatal care with their first pregnancy. Eleven percent (11%) indicated they had no health insurance (see Table 14) and 65% reported being on the Oregon Health Plan.

Kempe assessments (see Table 16, and Figure 3) showed that a large proportion of the parents in Healthy Start lacked nurturing parents themselves (97%), with concerns ranging from relatively mild use of corporal punishment to more serious abuse and neglect. Ninety-two percent (92%) of Healthy Start children have at least one parent who has at least a mild concern with substance abuse, mental illness or criminal involvement in their family. Forty-one percent (41%) of parents reported having current or previous history with the child welfare system as adults. Almost all parents (98%) reported feeling isolated, having few available social supports, poor coping skills, and/or low selfesteem.

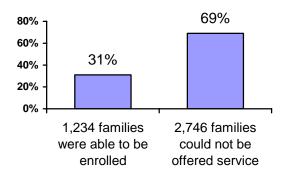
Furthermore, at program enrollment, Healthy Start children often had at least one parent with risk specifically associated with poor parenting skills. For example, 91% had poor understanding of developmental milestones, 95% had concerns about bonding/attachment, and 91% reported plans for using severe discipline techniques (see Table 17). These results illustrate that Intensive Service families

are at very high risk for negative family outcomes including child maltreatment (Shonkoff & Phillips, 2000).

INTENSIVE SERVICE CAPACITY

Of the 7,131 families with risk factor screening data during FY 2005-06, 72% (5,105 families) screened at higher risk, and thus were potentially eligible for Intensive Services. Funding restrictions prevented many of these from being assessed with the Kempe Inventory. Using the new (FY 2006-07) eligibility guidelines of 2 or more risk factors, 53% of those screened, or 3,980 families, would have been eligible for services. Programs were able to provide Intensive Services to only 1,231 new Intensive Service families (see Table 10) or 31% of those eligible, indicating that unmet need for Intensive Services is potentially quite large. It appears that the need for Healthy Start home visiting services greatly exceeds the capacity of programs to enroll families in the Intensive Service component.

Figure 2. Intensive Service Capacity (Out of 3,980 Eligible Families)



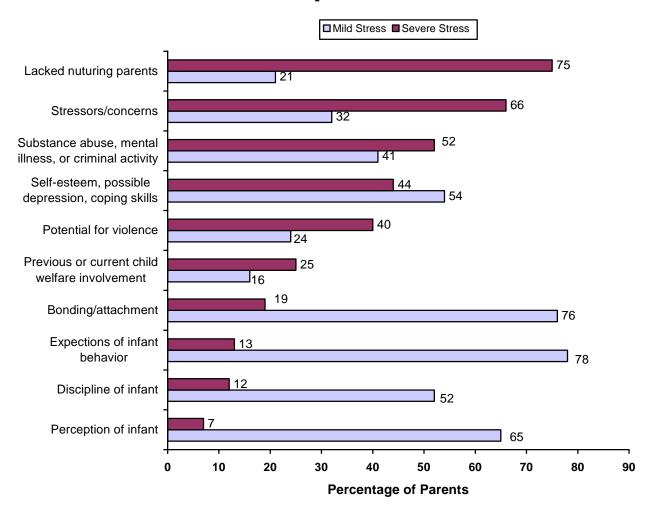


Figure 3. Percentage of Parents with Various Stress Factors Reported on the Kempe Assessment

ENGAGING FAMILIES IN SERVICES

Research shows that engaging and retaining higher-risk families in intensive high-quality home visiting services is the key to positive program outcomes (Sweet & Appelbaum, 2004; Olds et al., 1999). Healthy Start continues to show considerable success with engaging higher-risk families in Intensive Services (see Tables 9 & 11):

- 90% of the 1,299 families who were offered Intensive Services agreed to participate at the initial point of contact.
- 80% of those families who accepted Intensive Services received a first home

- visit and were successful enrolled in the program (940 families)¹.
- Of those who did not receive a first home visit, about one-third (36%, 49 families) declined further services; the remainder moved (9%), were unable to be located (20%) or were unable to be served for other reasons (35%).
- 91% of Intensive Service families received their first home visit within 3 months of the baby's birth, which surpasses the HFA standard.

¹ As shown in Table 10, 1,231 new families received at least some level of Intensive Services during FY 2005-06. A number of these families were missing the Family Intake form, which provides information about the first home visit.



Another HFA credentialing standard requires Healthy Start to analyze differences in acceptance rates for families with different demographic characteristics. NPC Research analyzed whether the acceptance rates were different for the following groups: Hispanic/Latino vs. Caucasian; married vs. single; teen vs. non-teen mothers; mothers with greater than a high school education vs. mothers with less education; and employed vs. unemployed mothers.

There was a strong and significant difference² in terms of racial/ethnic background: Hispanic/Latino families were more likely to accept Intensive Services (96%), compared to Caucasian families (87%). Similarly, Spanish-speaking mothers were more likely (96%) than English-speaking mothers (87%) to accept services. Further, there was a marginally significant trend for mothers with less than a high school education to be more likely to accept services, compared to those with more education (92% vs. 89%). No other groups were significantly different in terms of acceptance rates.

Another key indicator of the quality of Healthy Start is the ability of the program to successfully deliver home visiting services. Beginning in January 2006, the Healthy Start program began an intensive effort to monitor and improve the number of home visits provided to each family by FSWs. The HFA model specifies that families should receive weekly visits from the FSW for at least 6 months after enrollment (known as 'Level 1'). Following this initial period, service levels are adjusted according to a structured system based on family needs. For example, families that are progressing well might move on to Level 2, which requires home visits every other week; families in need of greater support may remain on Level 1.



To monitor whether families are receiving the appropriate number of home visits based on their specified level of service, NPC Research developed an electronic form for programs to complete to document the number of visits provided to each family each month, given the family's service level. This form automatically calculated the percentage of expected visits that were completed for each family and worker.

Using data for the second half of FY 2005-06 (January 2006-June 2006), the statewide average showed that FSWs were delivering 76% of expected home visits, exceeding the HFA criteria of successful delivery of 75% of expected visits (see Table 11). This number is an average for the home visitor across all the families on his/her caseload, and thus does not represent whether each individual family received the appropriate level of services.

However, in August 2006, HFA provided clarification regarding this standard, and the form was revised to track the new criteria, which states that for each FSW, 75% of the families on his/her caseload are to receive at least 75% of the expected number of visits. This figure was unavailable for January 2006-March 2006, but was available for the April-June quarter. This somewhat stricter standard shows that some improvements may be needed to ensure that home visitors are successful in delivering home visits for each family. Statewide, 68% of families received

² Hispanic/Latino vs. Caucasian (X^2 (1) =23.74, p<.000); Spanish-speaking vs. English-speaking (X^2 (1) =27.37, p<.000); mothers with greater than a high school education vs. mothers with less education (X^2 (1) =3.67, p=.06).

75% of their expected visits. However, there was considerable variation by county on this indicator as well, with 11 of the 27 counties providing data meeting the HFA standard (41%), while 7 of the remaining counties failed to provide even half (50%) of the required visits.

WHO DROPS OUT OF INTENSIVE SERVICES?

HFA standards call for programs to annually analyze "who drops out of the program and why." To begin to answer this question, data were collected about the reasons families ex-

ited the program (as reported by Family Support Workers, see Table 23). We also compared families who left the program prior to completion to those families who remained in Intensive Services in terms of demographic characteristics (see Tables 21 & 22).

"Healthy Start is a HUGE help to new moms. It's hard to try and figure out what to do for a new child. Healthy Start makes it so much easier."

- Healthy Start Parent

further analysis. Results indicated the following:

- 73% of enrolled families were still in the program after 3 months of service.
- 58% of enrolled families were still in the program after 6 months of service.
- 41% of enrolled families remained in the program after 12 months of service.

Clearly, retaining families for the duration of the program is an area in need of improve-

> ment. While HFA does not designate a certain retention rate that programs must meet, research clearly shows that the benefits for families increase with longer duration of home visiting services (Gomby, Culross, & Behrman, 1999).

Next, we analyzed whether there were differences in the 12-month retention rates for the following groups of families: Hispanic/Latino vs. Caucasian; married vs. single; teen vs. non-teen mothers; mothers with greater than a high school education vs. mothers with less education; and employed vs. unemployed mothers.

Results indicated that at 12 months after program enrollment, Hispanic/Latino families (as well as families in which Spanish is the primary language spoken at home) were significantly more likely³ to have stayed in the program (51% retained) compared to white/Caucasian families (37%) or to families of other racial/ethnic backgrounds (4%). Twelve-month retention rates did not differ significantly for any of the remaining groups of families.

A total of 1,441 Intensive Service families exited the program during FY 2005-06 (43% of total Intensive Service families served this fiscal year). The mean age of children at the time of exit was 12.5 months, indicating that most families left the program around the time of the child's first birthday.

Results suggested that the most frequent reason for leaving Intensive Services was that parents were no longer interested in receiving services (36%), families moved (26%), or families were unable to be contacted by their worker (15%). Twelve percent (12%) of children reached the program's age limit (typically, 3 years of age).

To examine longer-term retention in the Healthy Start program, the cohort of families who were enrolled during FY 2004-05 (and thus, who could potentially have remained in the program for up to 1 year) was selected for

³ Hispanic/Latino vs. Caucasian ($X^2(2)=26.9$, p<.001).



Summary & Conclusions

HEALTHY START OUTCOMES

The outcome evaluation clearly shows that children and families benefit from Healthy Start services. Families who have engaged in Intensive Service home visiting show positive outcomes in a variety of key domains, including parent-child interactions, health and health care (including immunizations), parenting skills, and healthy child development. Healthy Start appears to be effective in supporting the development of positive home environments for children and supporting parents to engage in important early-literacy activities such as reading frequently to their children.

Data from national studies of higher-risk families indicate that the results for families participating in Healthy Start are better than would be expected, especially in terms of child health, immunizations, and early literacy activities.

SCREENING AND ASSESSMENT SYSTEM

Healthy Start builds on family strengths, implementing a legislative philosophy designed to create wellness for all Oregon children and families. Information from participating counties shows family interest in and need for Healthy Start service is substantial. It is important for Healthy Start to continue to provide *a continuum of service*, ranging from non-stigmatizing screening and referral to long-term support services beginning prenatally and continuing through the early childhood years.

Programs vary considerably in their ability to identify and screen first-birth families. Less than 10% of families declined initial contact with the Healthy Start program. While this finding seems to indicate that Healthy Start is perceived as voluntary, it also suggests that programs may need to continue to examine their techniques for approaching and engaging families initially, so that families in need

do not "slip through the cracks." Balancing consistent, comprehensive outreach within the context of a voluntary program will continue to be a challenge.

Further, while the program as a whole offered services to 56% of eligible families, county rates ranged from 11% to 100%. Healthy Start State staff members have focused technical assistance to help local programs establish linkages with key partners (such as hospital systems and physicians) to ensure successful screening processes. Currently, however, the statewide screening rate does not meet HFA standards.

Additionally, counties vary considerably in the rates with which families screened at higher risk are reached in order to complete the second phase of the eligibility process (the Kempe Assessment). Program sites frequently note the lack of resources for assessing all potentially eligible families as a challenge. However, in the future with the new one-step eligibility process that was developed during the restructure process, this will not remain an issue.

ENGAGEMENT AND RETENTION

Healthy Start continues to do a good job engaging and serving families who are at higher risk for negative child outcomes. About half of the families were enrolled for at least a year, and most families were successfully screened in the critical early weeks of the child's development.

Higher-risk families have stressful lives that put parents and children at risk for poor outcomes. Multiple risk factors create an "environment of risk" that substantially reduces the chances for children's healthy development and school success. Healthy Start clearly does a good job engaging highest-risk families in the initial period of their participation; however, longer-term retention rates for higher-risk families could be increased to maximize the positive impacts that are possible through this program.

QUALITY ASSURANCE AND TECHNICAL ASSISTANCE PROCESS

FY 2005-06 brought expansion of Healthy Start's quality assurance effort, including increased training and technical assistance for direct service staff, program supervisors and managers. The quality assurance effort included program preparation of Site Self-Assessments as part of the Healthy Families

America (HFA) credentialing process, and site visits by HFA peer reviewers to 13 randomly selected sites, demonstrating that program administration, staff supervision, and direct interactions with families are

aligned with HFA's research-based 12 critical elements for effective home visiting practice. Credentialing will help to ensure consistency and quality in the services delivered across the state in terms of key program elements: outreach, screening and assessment, frequency and intensity of home visits, staff training and supervision, and program administration and evaluation.

Reviews of the home visiting research have consistently found that high-quality, intensive home visiting services delivered to those most in need are the most likely to show positive effects (Gomby, et al., 1999; Raikes, Green, Atwater, & Constantine, in press). The credentialing effort systematically improves the quality of implementation of Healthy Start services across the program sites.

CONCLUSIONS

Results show a number of areas in which Oregon's Healthy Start program has had considerable success. Outcomes for families participating in Intensive Services are generally quite positive across a variety of domains that have been shown in the research literature to be important predictors of child maltreatment, school readiness, and longer-term outcomes such as school success, criminality, and teenaged pregnancy (Shonkoff & Phillips, 2000). These results suggest that the core elements of Healthy Start's home visiting programs are working to support families to be successful.

A review of Table A (the summary of progress towards HFA standards) shows that of

" Healthy Start has helped me and my

family with understanding American

ways, but also respects my own

culture and my country's ways."

- Healthy Start Parent

the 23 HFA standards statewide tifying 75% of the target

that are monitored by the evaluation⁴, the Healthy Start program meets or exceeds the performance standard for each area except one: iden-(screening)

population. This goal is ambitious, especially given the reduced program budgets during 2005-06. A few other areas suggest some need for improvement, in particular connecting families with needed resources and retaining those high-risk families most in need of services. Again, the current statewide service reductions make it difficult for Healthy Start staff to refer families, as often the resources are not available in the community. These results suggest that challenges remain in terms of continuing to build effective systems for identifying, contacting, and screening families, and for retaining participating families in services.

This year's evaluation shows that programs vary considerably in terms of service delivery and implementation. Continued effort to bring all programs up to HFA and Oregon standards of performance is needed. will require continued commitment to improvement by the local and state Healthy Start teams, and ongoing training and technical assistance. Programs need to develop effective systems that bring together a range

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⁴ Additional HFA standards are monitored by the program but are not part of data submitted to the evaluation.



of community partners in a shared effort to support families with Healthy Start and other community services. Among some counties, establishing an infrastructure to identify and engage families is especially challenging, as reflected by relatively low rates of offering services to families.



The credentialing process has assisted programs in working to address many of these challenges. The state's investment in credentialing brings greater consistency and quality of services and is likely to be worth the effort. Research on home visiting programs shows these services *can* work; however, the quality and intensity of services must be held at high levels. The credentialing process, which is based on extensive reviews of the home visiting research literature to identify best practices, clearly defines quality indica-

tors that must be achieved *statewide* in order for a credential to be awarded. Efforts to obtain the HFA credential should continue to be supported.

Further, home visiting services that are delivered in conjunction with other community supports such as specialized services for serious issues (e.g., substance abuse, domestic violence, mental illness), high quality daycare or preschool, early intervention, health care providers, and other resources are generally acknowledged to create the best outcomes for children. Healthy Start needs to improve its ability to successfully connect families with needed resources. This outcome requires community-wide work in building collaborations to provide these services to families. Healthy Start needs to partner with other agencies and providers, and to continue to diversify and leverage funding. This effort will require widespread backing for an effective system of supports for children and families, within which Healthy Start can play an important, but not isolated, role.

The Healthy Start program overall provides important resources to families at the birth of their first child. It continues to demonstrate positive outcomes for families at risk, by supporting the development of positive home environments, early literacy activities, health care, and positive parent-child interactions, all of which are critical to prevention of child abuse.

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Table A. Progress Towards Selected HFA Critical Elements — FY 2005-06

HFA Element	Source of Data ¹	Statewide Results	HFA Standard
HFA Element for which the evaluation provides data	Origin of the data	Statewide result for the corresponding HFA element, and the table where this information can be found for individual counties	HFA standard for the element
1-1.A. Description of target population	First birth data from Oregon Department of Human Services Web site (http://oregon.gov/DHS/ph/chs/data/ytd/fstbirth.html) downloaded October 2006 for most current 2005 calendar year.	 18,604 eligible births, including first births in the 31 counties funded to serve first births; all births in the 3 counties funded to serve all births, and mixed first and all-births for Jefferson County. 	The program has a description of the target population and identified organizations within the community in which the target population can be found, which, while sufficient for its needs could be more comprehensive (are comprehensive and up to date).
	County demographic data from the Oregon Depart- ment of Human Services Web site.	• http://oregon.gov/DHS/ph/chs/data/birth/race/2004/	(Same as above)
1-1.B. Identification of target population	The number of families offered service is the sum of screened families plus additional contacts and screening refusals documented annually by programs.	Table 1 & 2 • 10,336 families offered services (56% of eligible)	The system of organizational agreements enables the program to identify at least 75% of the participants in the target population for screening or assessment.
	Clients with a New Baby Questionnaire submitted to NPC Research with a screening date between July 1, 2005, and June 30, 2006, plus the program counts of the number of families who are screened but decline to participate in the evaluation are counted in the screening rate.	Table 1: • 7,510 (40% of eligible) families screened	

¹ Item numbers reflect the most recent form revisions (July 1, 2004).



HFA Element	Source of Data ¹	Statewide Results	HFA Standard
HFA Element for which the evaluation provides data	Origin of the data	Statewide result for the corresponding HFA element, and the table where this information can be found for individual counties	HFA standard for the element
1-1.D. Screenings/ Assessment to determine eligibility for services occur prenatally or within first two weeks of birth of the baby	Screen date is taken from the New Baby Questionnaire (Item 1) or from the Family Manager datasystem. Date of birth is taken from the New Baby Questionnaire (Item 2), or in cases in which birth date is missing, the Family Manager system, or the Family Intake form (Item 11). Time to screen is calculated as the number of days between birth date and screening date. Prenatal screens are counted as zero days.	 Table 3: 1,785 (25%) screened prenatally 4,485 (62%) screened within 2 weeks of birth 877 (12%) screened after two weeks. Overall: 87% screened at or before 2 weeks of age. Median time to screen = 1 days 	80% of eligibility screenings or assessments occur either prenatally or within the first two weeks after the baby's birth.
1-2.A. Acceptance rate of participants	Healthy Start Intensive Service "Accepted" by parent, from Kempe Scoring Sheet (Item B).	 Table 9, 18 & 19: 90% of eligible families accepted service at the time of assessment 	The program defines, measures and monitors its acceptance rate and evidence indicates acceptance rates are measured in a consistent manner and at least yearly.
1-2.B. Analysis of who refused the program and why (of those eligible)	Healthy Start Intensive Service "Declined" by parent, from Kempe Scoring Sheet (Item B). Demographic data are obtained from the New Baby Questionnaire [mother's age (#6a), ethnicity (#7), language spoken at home (#10), marital status (#12), education level (#14), and employment status (#15)].	 Percentage within each ethnic group who declined [vs. those who accepted]: Hispanic families were significantly more likely to accept services (96%) compared to White/Caucasian families (87%) Mothers with less than a high school education were somewhat more likely to accept services (92%), compared to those with more education (89%). There were no significant differences in acceptance rates for par- 	The program annually analyzes who refused the program and why. This analysis relies on demographic and informal sources to identify those who refused (ideally, the analysis also addresses programmatic, demographic, social and other factors).

HFA Element	Source of Data ¹	Statewide Results	HFA Standard
HFA Element for which the evaluation provides data	Origin of the data	Statewide result for the corresponding HFA element, and the table where this information can be found for individual counties	HFA standard for the element
1-2.B. (cont.) Analysis of who refused the program and why (of those eligible)		ents in any of the following sub- groups: married vs. single; teen vs. non-teen, employed vs. un- employed	
1-3. First home visit occurs prenatally or within 3 months of the birth of the baby	Date of first home visit is on the Family Intake Form (item 2), or if missing, is taken from the Exit Form. Baby's birth date comes from the New Baby Questionnaire (item 2) or the Family Intake form (item 11). Time to first visit is calculated as the number of days between first home visit date and baby's birth date.	Table 11: • 91% (965 families) received first visit prenatally or within 3 months of the birth of the baby	80% of first home visits occur within the first three months after the birth of the baby.
3-4.A. Participant retention rate	Retention rates calculated for all families served in IS during 04-05. Service is defined in this analysis as anyone having a first home visit. Date of first home visit is on the Family Intake Form (item 2), or if missing, is taken from the Exit form. Date of last home visit is on the Exit Form. Reasons for leaving are taken from the Exit Form. Intensive Service clients without an Exit Form are coded as "still in service."	 Table 20: 73% remained in after 3 months of service 58% remained in after 6 months of service 41% remained in after 12 months of service. 	The program defines, measures, and monitors its retention rate, and evidence indicates retention rates are measured in a consistent manner and at least yearly (more than once a year).



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HFA Element for which the evaluation provides data	Origin of the data	Statewide result for the corresponding HFA element, and the table where this information can be found for individual counties	HFA standard for the element
3-4.B. Analysis of which families drop out of the program and why	Reasons for leaving are taken from the Exit Form. Demographic Characteristics of exited families are taken from the New Baby Questionnaire (Items 6b, 7, 10, 12, and 14).	 Table 23: 1,441 families exited the program during FY 2005-06. Reasons for exiting the program included: 36% parent no longer interested 26% family moved 15% family was unable to be contacted by the program 12% of children "aged out" of the program Tables 21 & 22: Within each subgroup, the percentage of those who exited: Hispanic/Latino families were significantly less likely to have dropped out of service at 12 months post-enrollment (49%) compared to Caucasian families (63%) or to families of other racial/ethnic backgrounds (66%) Spanish speaking families were significantly less likely than English speaking families to have dropped out of the programs at 12 months post-enrollment. 12-month retention rates did not differ for any of the following subgroups: There were no significant differences in acceptance rates for parents in any of the following subgroups: married vs. single; teen vs. non-teen, employed vs. unemployed 	The program annually analyzes who drops out of the program and why. Analysis relies on demographic and informal sources to identify those who dropped out (ideally analysis also addresses programmatic, demographic, social and other factors).

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HFA Element for which the evaluation provides data	Origin of the data	Statewide result for the corresponding HFA element, and the table where this information can be found for individual counties	HFA standard for the element
4-2B. Families receive appropriate number of home visits for their assigned level of service	Home visit tracking forms completed by FSWs and submitted to NPC monthly or quarterly.	Table 11: 76% of families received the expected number of home visits given their service level	75% of families receive at least 75% of the appropriate number of home visits based on service level (e.g., family on Level 1 receives at least 3 visits per month).
5-1. Description of current service population	Demographic data are from the New Baby Questionnaire (# 6b (age), 7 (ethnicity), & 10 (language spoken at home). Additional data describing the current service population is presented in Tables 5-8 (screened families) and 12-15 (Intensive Service families).	Table 5: All Screened Families: African American (2%) Hispanic/Latino (20%) Asian (4%) American Indian (1%) Caucasian (67%) Hawaiian (<1%) Multiracial (4%) Other (1%) Table 6: English spoken at home (78%) Spanish spoken at home (18%) Other language spoken at home (4%) Teen Mothers (9%) Single Mothers (52%) Less than high school education (26%)	Program has a description of the current service population that addresses cultural characteristics, racial/ethnic characteristics, and linguistic characteristics.
5-1. Description of current service population		Intensive Service Families Table 12: • African American (2%) • Hispanic/Latino (38%) • Asian (4%) • American Indian (1%)	



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HFA Element for which the evaluation provides data	Origin of the data	Statewide result for the corresponding HFA element, and the table where this information can be found for individual counties	HFA standard for the element
5-4.B. Culturally competent practices/services, including participant input	Most recent responses on Parent Survey II (#9), items: My home visitor (1) respects my family's race, culture, and/or religious beliefs; (2) provides materials for my child that positively reflect our cultural background	 Caucasian (50%) Hawaiian (<1%) Multiracial (4%) Table 13: English spoken at home (63%) Spanish spoken at home (34%) Other language spoken at home (3%) Teen Mothers (17%) Single Mothers (72%) Mothers with less than a high school education (45%) TABLE 34 44% of parents "strongly agreed" with the cultural competency items 31% "agreed" with the cultural competency items 	The program reviews its practices for cultural competency and includes direct input form the participants on (at least) 3 of the following: culturally sensitive practice, materials, communication, and staff-participant interaction. Review could be more comprehensive.
6-2A-C. The home visitor and participant collaborate to identify participant strengths, competencies, needs, services to help address those needs, and goals for home visitation	Most recent responses on Parent Survey II, #9. Ratings of staff strength orientation are assessed by parent responses to: My home visitor (1) Lets me decide what goals I want to work toward, (2) Sees strengths in myself I didn't know I had, (3) helps me use my own skills and resources to solve problems, and (4) helps me learn new skills. Answers are averaged to	 Table 36: 54% strongly agreed that staff show a strengths orientation 38% "agreed" that staff show a strengths orientation 	The home visitor and participant collaborate to identify participant strengths and competencies, assess participants' needs, and set goals for home visitation.

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HFA Element for which the evaluation provides data	Origin of the data	Statewide result for the corresponding HFA element, and the table where this information can be found for individual counties	HFA standard for the element
	create a "strengths orientation" subscale.		
6-4. Program promotes positive parenting skills, parent-child interaction, and knowledge of child development	Most recent responses on Parent Survey II # 5a & 5c. Most recent response on Parent Survey II #4. Cumulative HOME score at 12 and 24 months (#1 to 4#5).	 Table 32: 86% of parents reported improved parenting skills after 6 months in the program 70% of parents reported improved ability to help their child after 6 months in the program Table 33: 89% of families had positive parent-child interactions at their most recent Parent Survey administration 79% of families had a "good" or higher score on the HOME at 12 months 	Standards related to worker provision of information. Data suggest positive outcomes in the parenting domain.
6-5.B. Use of standardized developmental screen/tool to monitor child development	Most recent response on Family Update (#36b). Note: This information is based on the Family Support Worker's most recent administration of the ASQ.	 Table 32: 88% of children were within the "normal" range of development 73% of all age-eligible children received at least one ASQ assessment 	The program uses a standard- ized developmental tool at specified intervals to monitor child development for target children in the program unless developmentally inap- propriate.
6-7.B. & 6-7.C. Documentation of children suspected of having a developmental delay, program follows through with appropriate referrals/services	Most recent responses on Family Update (#33, 35).	84 children had an identified developmental delay; 86% of these children were reported as receiving early intervention services	Consistent evidence that the program routinely tracks target children suspected of having a developmental delay.



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7-1.C. Participating children have a medical provider	Most recent response on Family Update (Primary caregiver = #28, well-child check-ups = #21, emergency room for routine care = #23).	 Table 24 98% of children have health care provider 94% received well-child checkups Table 25 7% frequently use emergency room for routine care, 	80% of target children have a medical/health care provider.
7-2.B. Immunizations for participating children are up to date	Most recent response on Family Update (Up to date immunizations = #20a). FSWs primarily use parent immunization cards or the ALERT system for immunization information. Calculations for up to date immunizations by age 2 are based on responses to #20a for all target children 2 years or older (as calculated by date of birth and date of Family Update).	 Table 26: 92% of children had up to date immunizations; 7% had some immunizations, but not up to date 94% reported to be fully immunized by age 2 	80% of target children have up-to-date immunizations.
7-3.A. Program connects participants to appropriate referral sources and services	Family Support Workers ratings on the 6-month Family Update #11 (Version 4).	Table 30: Percent who needed and were connected with service at 6 months: Dental Insurance (84%) Education Assistance (92%) TANF (95%) Housing Assistance (87%) Job Training (92%)	Isolated instances found when participants needing referral were not connected to appropriate services in the community.
GA-3. Program has mechanism in place for families to provide formalized input into program	The family provides ratings of satisfaction with staff on the Parent Survey II (Ver- sion 3: #9a-n; Version 4 will only assess Empow- erment Approach and Cul-	Table 34: Strength-based Practice (Empowerment Approach) • 54% strongly agree • 38% agree	The program has mechanisms for participants to provide input to the program and at least includes participant satisfaction surveys.

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GA-3. Program has mechanism in place for families to provide formalized input into program	tural Competency, #9 a-h). Parent survey ratings of how helpful Healthy Start home visitors are in a variety of areas. On the Parent Survey II, families can write comments about the program including: (1) What do you think is the best thing about Healthy Start? (2) How could Healthy Start be better? (3) Is there anything else you want to tell us?	 8% not sure Table 35: Parents rated Healthy Start as helpful in: Providing parenting information (99%) Obtaining basic resources (94%) Help with emotional issues (91%) Encouraging positive social networks (93%) Parent open-ended feedback will be compiled, with identifying information removed, and electronically sent to programs 	
GA-5.A. Program routinely reviews progress towards its program goals and objectives	Annual status report (this document).	NA Not needed for the local programs but may be good for the state to have	The program conducts an analysis of program goals and objectives at least annually.