Appendix A
Evaluation Methodology

Healthy Start

Evaluation Methodology

In cooperation with OCCF, the Oregon Office of Family Health (OFH), and the Department of Human Services/Child Welfare, NPC Research collects data through the following procedures:

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

Outcome Methodology

The Healthy Start home visitor collects outcome information on Intensive Service families to use for the evaluation. The worker completes a Family Intake form when the family begins service.[1] The home visitor then completes a Family Update form every 6 months. The Family Intake and Updates cover demographic information about the family, access to basic services and resources, health and health care, family stress and strengths, parent-child interaction, and family progress.

The participating parent completes a baseline survey at intake and follow-up surveys at 6 and 12 months after the birth of the child, and annually thereafter until completion of services. The Parent Surveys gather information from the parent's perspective about what is enjoyable and what is difficult about being a parent and how their life is going.

The Healthy Start home visitor also completes two standardized measures that provide data for the evaluation. Workers conduct a Home Observation of the Environment (HOME) annually starting at the baby's first birthday. The 12- and 24-month HOME is for infants and toddlers. The preschool HOME is used for measures starting at age 3. Home visitors also complete a developmental screening called the Ages and Stages Questionnaire (ASQ) at various points in the baby's life. The ASQ is completed three times the first year, at 4, 8, and 12 months of age. Thereafter, the ASQ is completed every 6 months until the child reaches 3 years of age, and then is completed annually. The ASQ has a specific version for each time point. The table on page 60 summarizes the instruments collected.

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

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

[1] For families who receive services prenatally, the Family Intake is started at the beginning of service, with the remaining information about the child being completed upon the child's birth.

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

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

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

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

Table A 1. Measurement Tools and Data Collection Timeline

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

Appendix B

Performance Measurement

Healthy Start

Performance Measurement System

The effectiveness of Healthy Start is assessed using a performance measurement strategy. This strategy is the primary tool for accountability in both government and not-for-profit programs, having expanded over the past 40 years from mainly financial accounting to a more comprehensive tracking system of inputs, activities and outputs, and outcome results. Performance measurement and program evaluation are related but not identical processes.[2] Program evaluation typically involves the use of a comparison group that does not receive the program services. Outcomes are measured for both groups in order to prove that any effects are, in all probability, caused by the intervention.

PERFORMANCE MEASUREMENT

Shows the extent to which:

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

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

- Planned activities were conducted,
- Expected outputs were produced, and
- Anticipated results were achieved.

The 2002–03 Healthy Start Status Report assesses the successes and challenges experienced in the pursuit of Healthy Start's goals. Two sets of indicators were used:

1. Implementation and Service Indicators
2. Outcome Indicators

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

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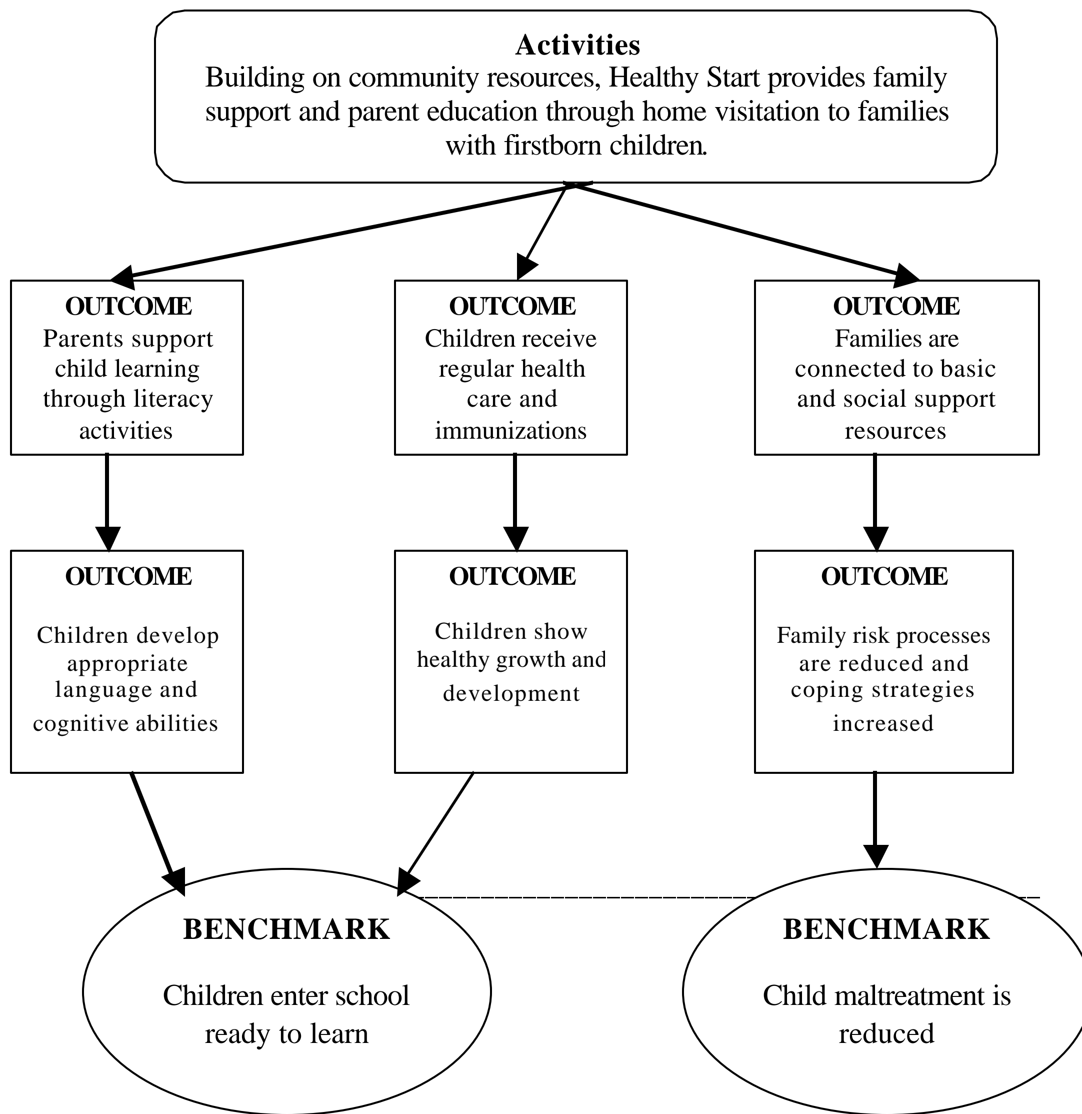
[2] Hatry, H. (1997). Where the rubber meets the road: Performance measurement for state and local public agencies. *New Directions for Evaluation*. 75, (Fall), 31-44. San Francisco, CA: Jossey-Bass.

Figure B 1. Logic Model for Healthy Start



Appendix C

Detailed Healthy Start Program Description

Healthy Start Program Description

History of Program Implementation

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

Concurrent efforts were underway in other states that led to the development of the Healthy Families America (HFA) Initiative in 1993. Like HFA, Oregon's program was based on the Hawaii Healthy Start program. Healthy Start of Oregon and HFA share a model based on the Essential Components and/or Critical Elements (see Appendix G), and work towards the same goals. The HFA model has provided the underlying structure for Healthy Start. Below we give a brief history of when counties began to implement Healthy Start programs.

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

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

Counties joining 1996–2002

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

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

Sites new in 2001–02 and 2002–03

Fourth wave. With the passage of HB 3659 during the 2001 legislative assembly, the Healthy Start program expanded to additional program sites. During that fiscal year, the Oregon CCF provided training and technical assistance to the remaining counties to facilitate their implementation as Healthy Start sites. Four new counties began serving families as Healthy Start sites: Benton, Klamath, Wallowa, and Yamhill. Two sites that had been using the Healthy Start model (Benton and

FY 02-03 Counties with State Funding

First Wave
Clackamas
Clatsop
Deschutes
Jackson
Josephine
Marion/Polk
Tillamook

Second Wave
Hood River
Lane
Linn
Union

Third Wave
Coos
Douglas
Harney
Lincoln
Umatilla
Wasco/Sherman
Washington

Fourth Wave
Benton
Klamath
Wallowa
Yamhill

Fifth Wave
Baker
Columbia
Crook
Curry
Grant
Jefferson
Lake
Morrow
Multnomah

Sixth Wave
Gilliam
Malheur
Wheeler

Yamhill Counties) received state funding for their programs for the first time in the 2001–02 fiscal year.

Fifth wave. During fiscal year 2002-03, 9 additional counties that had been working toward implementation starting serving clients as Healthy Start sites. These counties included: Baker, Columbia, Crook, Curry, Grant, Jefferson, Lake, Morrow, and Multnomah. The remaining three counties began implementation after the end of the 2002-03 fiscal year.

Program changes in 2002-03

Fiscal year 2002–03 also saw the temporary closure of the Healthy Start site in Lincoln County, as well as the decision by Marion and Polk counties, and Sherman and Wasco, to establish independent (rather than bi-county) sites. These sites, which were not implemented for the full fiscal year 2002-03, are not included in the data for this report.

Healthy Start is Research Based

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

- **Early and comprehensive assessment** of families can accurately establish the risk for poor child outcomes, including the risk for child maltreatment.[3]
- Compared to shorter-term home visitation, **regular contact during the first three years of the child's life** produces the greatest reductions in child abuse potential and the greatest benefits for children and their parents.[4]
- **Support is most effective during periods when stress is high, resources are few and parenting practices are being established.** Preventive efforts show greatest effects for children and families who are at greater social risk by virtue of their poverty and single parent status.[5]
- **Recent research shows that early interactions and experiences directly affect the way the brain develops.** Early and ongoing intervention effectively supports families in their role as the child's first teacher during the time when children's most rapid physical, cognitive and social development occurs.[6]

Healthy Start of Oregon is based on proven strategies for:

- Decreasing child maltreatment among higher-risk families
- Increasing number of children ready for school

[3] Gray, J.D., Cutler, C.A., Dean, J. G., & Kempe, C. H. (1979). Prediction and prevention of child abuse and neglect. *Journal of Social Issues*, 35, 127-139. Also see Murphy, S., Orkow, B., & Nicola, R. (1985). Prenatal prediction of child abuse and neglect: A prospective study. *Child Abuse and Neglect*, **9**, 225-235.

[4] Olds, D. (1997). The prenatal/early infancy project: Fifteen years later. in G.W. Albee & T. P. Gullotta (Eds.) *Primary Prevention Works*, pp. 41-67. Thousand Oaks, CA: Sage Publications.

[5] Olds, D.L., & Kitzman, H. (1993). Review of research on home visiting. *The Future of Children,* 3(3), 51-92.

[6] Campbell, F.A., & Ramey, C.T. (1994). Effects of early intervention on intellectual and academic achievement: A follow-up study of children from low-income families. *Child Development*, **65**, 684-698. Also see Shore, R. (1997). *Rethinking the brain: new insights into early development*. New York, NY: Families and Work Institute.

- **Training and supervision are essential.** Home visitation is most successful when visitors are "well-trained to promote positive health-related behaviors and qualities of infant care-giving, and to reduce family stress by improving the social and physical environments in which families live." [7]

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

The Healthy Start Approach: A Universal Basic Service

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

The first step in Healthy Start's service is outreach to first-birth families, to invite them to participate in services from Healthy Start. During this outreach process, first time parents learn about Healthy Start services, Healthy Start's informed consent process, and are provided with basic information such as parenting education materials or community resources information. At this point, parents are typically asked if they are interested in participating in Healthy Start screening. The initial screening is a part of Healthy Start's services, and parents must provide informed consent before completing the screening form. Families whose screening indicates that they are eligible for additional services are invited to participate in a more comprehensive assessment (see Figure below). In each county, the screening and assessment system results from the collaboration of health care and other providers of perinatal services.

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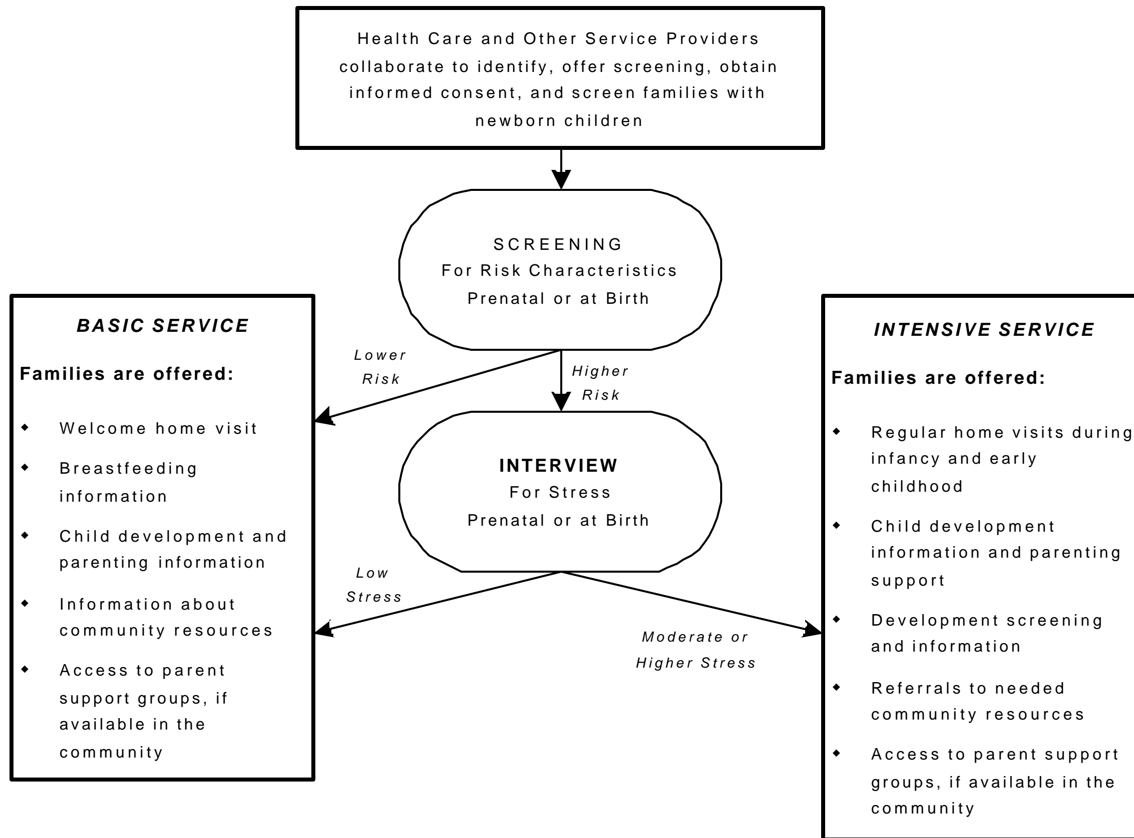
[7] Olds, D.L., Henderson, C. Kitzman, H., Eckenrode, J., Cole, R., & Tatelbaum, R. (1998). The promise of home visitation: Results of two randomized trials. *Journal of Community Psychology*, **26** (1), 5-21.

[8] Karoly, L.A., Greenwood, P.W., Everingham, S.S., Hoube, J., Kilburn, M.R., Rydell, C. P., Sanders, M. & Chiesa, J. (1998). *Investing in our children: What we know and don't know about the costs and benefits of early childhood interventions.* Santa Monica, CA: RAND.

Figure C 1. Healthy Start Family Assessment and Service Delivery System



Screening. The comprehensive family assessment process begins with voluntary screening of first-birth families for global characteristics associated with poor child and family outcomes. During the past several years, the screening process used by Healthy Start sites has changed. These changes have resulted in a general decrease in the number of families screened, although this must be balanced with the knowledge that through the informed consent procedure parents have increased choice and privacy with regards to participation. Specifically, the passage of HB 3659 required that Healthy Start obtain the express written consent of parent(s) before preliminary screening can occur. This legislation created changes in the screening processes that were in place in some counties, and has required the development and expansion of new interagency agreements and partnerships, which take substantial time and effort to create and maintain. As counties strengthen their new screening processes, we would expect that the number of families reached should rise.

The second major change was the transition from the Hawaii Risk Indicators (HRI) screen to the Oregon Children's Plan (OCP) Screen, which is designed to be a self-report instrument completed by parents. Items included on the OCP screen include slight modifications of the 15 items previously obtained through the HRI, plus additional questions. Sites began using the OCP screen in July 2002. The screening tool was evaluated and modified in 2003 and a revised tool was created. The new tool, called the New Baby Questionnaire, is being implemented in February 2004.

If screening shows the presence of risk characteristics Healthy Start provides, with the parents consent, additional assessment to determine the need for longer-term family support services.

Assessment interview. Families whose screening information indicates that they are at higher risk and who consent to further assessment are contacted by trained family assessment workers. These

workers interview the family using the *Kempe Family Stress Inventory (KFSI).*[9] Ten areas of potential stress are explored in depth, including issues relating to family lifestyle and supports, social isolation, expectations for infant behavior, and parent-child bonding. Families whose KFSI indicates that they are experiencing either moderate or high levels of family stress are offered Healthy Start Intensive Home Visiting Services, if program slots are available. Workers are also trained to explore and build on areas of family strength.

> ***HEALTHY START is voluntary***
>
> Families are free to decline assessment and/or service at any time.

Basic Service[10]

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

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

Intensive Service

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

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

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

Staffing of Basic and Intensive Service

Nurses, family support workers, or trained volunteers typically furnish the shorter-term Basic Service. Intensive Service home visitors are well-trained parent educators, social service workers and/or nurses.

Quality assurance. An established framework of Fifteen Essential Components (see Table below) provides a blueprint for Healthy Start's wellness approach. The essential components are based on research and proven strategies. While all 15 components are present in each of the 19 Healthy Start sites described in this report, communities have tailored local operations to address local needs and

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[9] Korfmacher, J. The Kempe Family Stress Inventory: A review. (1999). *Child Abuse & Neglect*, **24** (1), 129-140.

[10] As part of efforts that have occurred in Jan-Feb 2004 to refocus Healthy Start more closely to a consistently implemented model throughout the state, the term "Basic Service" has been changed to "Universal Basic Services." This new terminology will be used in future years.

build on local resources. The 15 Essential Components form a framework with sufficient flexibility to allow local communities to develop procedures that work locally, while maintaining the integrity of the program model. However, maintaining this integrity requires continued support and assistance during program implementation.

In January 2004, the Oregon Commission on Children and Families, after receiving recommendations from the Healthy Start Quality Assurance Committee and the Healthy Start Rebalance Committees, decided to pursue credentialing with Healthy Start's parent model, Healthy Families America. Healthy Families America has a well-structured, research-based, and well-established quality assurance process based on 12 Critical Elements that are similar to Healthy Start's essential components (see crosswalk of Healthy Start 15 Essential Components with the Healthy Families America Standards in Appendix G). In future years, the status report will include descriptions of efforts made toward continuous program improvement in these areas.

Table C 1. Framework of 15 Essential Components

Guiding Principles	Service	Quality Assurance
• Universal and voluntary • Early initiation of service • Family focus • Respect for diversity • Collaboration • Community investment	• Comprehensive assessment system • Basic service for lower risk families • Intensive Service for vulnerable families • Access to health care services	• Limited caseloads • Skilled staff • Comprehensive training • Ongoing supervision • Results-based accountability

Appendix D

Data Tables

FY 2002 – 03

Table 1

Reach Rate for First Birth Children by Birth Year

	FY 2001-02			FY 2002-03						
	2001 First Births from OHD Statistics	**Number of first birth children screened**	**Percent of first birth children screened**	**2002 First Births from OHD Statistics**	**Number of first birth children with detailed screening data available**	**Number of documented screening refusals**	**Number of documented refusals to share information**	**Total First Birth families contacted**	**Percent of contacted families screened[11]**	**Percent of First Birth families contacted**
Healthy Start of Benton County	NA	NA	NA	**361**	240	NA	NA	**240**	**66%**	**66%**
Healthy Start of Clackamas County	1,620	419	26%	**1,590**	490	381	88	**959**	**36%**	**60%**
Clatsop Healthy Families	153	80	52%	**184**	61	NA	NA	**61**	**33%**	**33%**
Coos County Healthy Start	232	27	12%	**258**	45	11	7	**63**	**20%**	**24%**
Deschutes Ready Set Go	630	291	46%	**608**	334	147	NA	**481**	**55%**	**79%**
Douglas County Healthy Start	438	214	49%	**401**	214	NA	NA	**214**	**53%**	**53%**
Harney County Healthy Start	30	3	10%	**25**	3	NA	NA	**3**	**12%**	**12%**
Hood River County Families First Network	120	67	56%	**112**	58	NA	NA	**58**	**52%**	**52%**
Jackson County Healthy Start	865	476	55%	**839**	348	NA	NA	**348**	**41%**	**41%**
Healthy Start of Klamath County	NA	NA	NA	**274**	96	NA	NA	**96**	**35%**	**35%**
Lane County Healthy Start	1,418	1,246	88%	**1,420**	1,149	NA	NA	**1,149**	**81%**	**81%**
Healthy Start of Linn County	493	199	40%	**518**	220	NA	46	**266**	**51%**	**51%**
Marion/Polk Healthy Start	1,922	908	47%	**1,852**	1,005	NA	NA	**1,005**	**54%**	**54%**
Tillamook Healthy Families	90	48	53%	**86**	63	NA	NA	**63**	**73%**	**73%**
Umatilla County Healthy Start^	421	47	11%	**353**	286	NA	NA	**286**	**81%**	**81%**
Union County Healthy Start	111	38	34%	**116**	70	NA	NA	**70**	**60%**	**60%**
Wasco/Sherman Families First	109	60	55%	**100**	80	NA	NA	**80**	**80%**	**80%**
Washington County New Parent Network	3,090	88	3%	**3,145**	457	43	11	**511**	**15%**	**16%**
Yamhill County Healthy Start	468	135	29%	**458**	142	NA	NA	**142**	**31%**	**31%**
Total for Sites*	**NA**	**NA**	**NA**	**12,700**	**5,361**	**582**	**152**	**5,635**	**43%**	**44%**

NOTE: First birth statistics for each year are from the Oregon Vital Statistics, Oregon Health Division (OHD). First birth families are those where a mother is bearing her first child. Number of children screened refers only to (a) children whose families who have been screened by Healthy Start and (b) whose information has been entered on the OHD Babies First/Healthy Start database. Healthy Start sites are sensitive to family privacy. Confidentiality assurances and appropriate release of information forms must be in place before screening information is entered into the Babies First/Healthy Start database. ^In FY02-03 Umatilla County screened all births. Calculations are adjusted based on first-birth screening percentage.

*** Totals for FY 01-02 are not comparable to FY 02-03 totals due to differences in which counties participated.**

[11] Percentage is based on the number of screens entered in the OHD Babies First/Healthy Start database plus the number of families screened who refused to share information with the state database.

Table 2

Percentage of First Birth Families Screened and Assessed by County

	Total Families	Benton	Clack-amas	Clat-sop	Coos	Des-chutes	Doug-las	Har-ney	Hood River	Jack-son	Kla-math	Lane	Linn	Marion Polk	Tilla-mook	Uma-tilla^	Union	Wasco/ Sherm	Wash-ington	Yam-hill
SCREENING																				
Total first birth families contacted	**5,635**	**240**	**959**	**61**	**63**	**481**	**214**	**3**	**58**	**348**	**96**	**1,149**	**266**	**1,005**	**63**	**286**	**70**	**80**	**511**	**142**
Total first birth families with detailed screening data available	5,361	240	490	61	45	334	214	3	58	348	96	1,149	220	1,005	63	286	70	80	457	142
Number screened at higher risk	2,581	97	328	19	28	142	106	1	37	207	59	493	148	467	25	48	2*	52	240	82
Percent screened at higher risk	**47%**	**40%**	**67%**	**31%**	**62%**	**43%**	**50%**	**33%**	**64%**	**60%**	**62%**	**43%**	**67%**	**47%**	**40%**	**11%**	**3%**	**65%**	**53%**	**58%**
Risk Characteristics																				
Mother is single	47%	26%	48%	69%	63%	42%	50%	100%	47%	60%	55%	43%	57%	45%	61%	54%	0%	56%	59%	51%
Inadequate income	20%	9%	29%	23%	20%	15%	22%	0%	28%	20%	18%	18%	17%	17%	64%	19%	0%	18%	36%	24%
Partner is unemployed	18%	14%	21%	40%	48%	9%	20%	0%	35%	20%	31%	13%	23%	16%	35%	27%	0%	32%	26%	17%
Late, minimal, or no prenatal care	12%	6%	15%	8%	3%	5%	5%	0%	6%	9%	12%	14%	10%	13%	59%	26%	0%	7%	18%	17%
History of substance abuse	9%	3%	10%	15%	27%	21%	10%	0%	6%	13%	11%	5%	3%	15%	38%	6%	0%	9%	8%	5%
Teen mother, 17 or younger	9%	1%	8%	12%	21%	7%	9%	0%	7%	18%	15%	7%	10%	9%	8%	15%	10%	10%	16%	11%
Families with 2 or more risk characteristics	**43%**	**29%**	**61%**	**21%**	**72%**	**33%**	**37%**	**50%**	**48%**	**57%**	**56%**	**34%**	**56%**	**41%**	**39%**	**28%**	**0%**	**54%**	**58%**	**54%**
ASSESSMENT																				
First birth higher risk families interviewed with Kempe	**1,166**	**28**	**191**	**16**	**21**	**51**	**13**	**1**	**35**	**21~**	**44**	**338**	**29**	**124**	**22**	**15**	**2**	**44**	**138~**	**33**
Percent of first birth higher risk families interviewed	45%	29%	58%	84%	75%	36%	12%	100%	95%	10%	75%	69%	20%	27%	88%	31%	100%	85%	58%	40%
Low Family Stress (0 - 20)	14%	25%	13%	6%	14%	16%	0%	0%	60%	14%	9%	7%	14%	10%	5%	0%	0%	30%	28%	3%
Moderate Family Stress (25 - 35)	45%	39%	48%	75%	14%	49%	54%	0%	29%	52%	48%	45%	52%	61%	27%	27%	0%	36%	34%	46%
High Family Stress (40 - 60)	37%	29%	37%	13%	57%	35%	46%	100%	11%	29%	41%	42%	35%	29%	68%	60%	50%	32%	36%	42%
Severe Family Stress (65 - 100)	4%	7%	2%	6%	14%	0%	0%	0%	0%	5%	2%	6%	0%	1%	0%	13%	50%	2%	1%	9%
Percent of assessed families with a moderate or higher level of stress (eligible for intensive service)	**86%**	**75%**	**87%**	**94%**	**86%**	**84%**	**100%**	**100%**	**40%**	**86%**	**91%**	**93%**	**86%**	**90%**	**95%**	**100%**	**100%**	**70%**	**72%**	**97%**

Note: Statistics are limited to screening and interviews conducted with first-birth families. Only families screened at higher risk on the OCP are interviewed. Family stress levels are measured by the Kempe Family Stress Inventory (KFSI), conducted by trained assessment workers either during the prenatal period, at birth, or within two weeks of the baby's birth. Stress is assessed in ten categories, with total scores ranging from 0 – 100. Families with scores of 25 or higher are eligible for Intensive Service.

^ In FY02-03 Umatilla County screened all births. Calculations are adjusted based on first-birth screening percentage.

* This number is an underreporting due to data issues.

~ Program reports conducting a greater number of Kempe Assessments. The number here reflects data obtained by the evaluation team.

Table 3

Number of Children Screened/Served by Service Type and County

SITE	FY 2001-02 Basic Service Only	FY 2001-02 Intensive Service Total Enrolled	FY 2001-02 Basic Service, Declined Further Service	FY 2001-02 Total Children Served (Initial & Basic)	FY 2002-03 Basic Service Only	FY 2002-03 Intensive Service Total Enrolled	FY 2002-03 Basic Service, Declined Further Service	FY 2002-03 Total Children Served (Initial & Basic)	Percent Change[12]
Healthy Start of Benton County	NA	NA	NA	NA	185 (73%)	36 (14%)	32 (13%)	253	NA
Healthy Start of Clackamas County	125 (19%)	443 (67%)	98 (15%)	666	159 (22%)	457 (63%)	106 (15%)	722	8%
Clatsop Healthy Families	78 (52%)	73 (48%)	0	151	39 (34%)	77 (66%)	0	116	-23%
Coos County Healthy Start	0	64 (100%)	0	64	15 (14%)	95 (86%)	0	110	72%
Deschutes Ready Set Go	382 (70%)	151 (28%)	12 (2%)	545	254 (59%)	157 (36%)	23 (5%)	434	-20%
Douglas County Healthy Start	88 (34%)	135 (52%)	39 (15%)	262	101 (33%)	152 (50%)	54 (18%)	307	17%
Harney County Healthy Start	0	12 (100%)	0	12	0	13 (100%)	0	13	8%
Hood River Families First Network	97 (70%)	40 (29%)	1 (1%)	138	37 (36%)	65 (63%)	1 (1%)	103	-25%
Jackson County Healthy Start	334 (51%)	297 (45%)	23 (4%)	654	183 (34%)	340 (64%)	10 (2%)	533	-18%
Healthy Start of Klamath County	NA	NA	NA	NA	39 (35%)	63 (56%)	11 (10%)	113	NA
Lane County Healthy Start	666 (46%)	539 (37%)	252 (17%)	1,457	574 (40%)	611 (43%)	245 (17%)	1,430	-2%
Healthy Start of Linn County	143 (61%)	72 (31%)	20 (9%)	235	166 (62%)	77 (29%)	24 (9%)	267	14%
Marion/Polk Healthy Start	616 (51%)	570 (47%)	24 (2%)	1,210	733 (55%)	602 (45%)	4 (1%)	1,339	11%
Tillamook Healthy Families	103 (65%)	46 (29%)	10 (6%)	159	25 (23%)	75 (69%)	8 (7%)	108	-32%
Umatilla County Healthy Start^	41 (53%)	29 (37%)	8 (10%)	78	261 (81%)	51 (16%)	10 (3%)	322	312%
Union County Healthy Start	20 (38%)	29 (55%)	4 (8%)	53	45 (46%)	52 (53%)	1 (1%)	98	85%
Wasco/Sherman Families First	61 (43%)	72 (51%)	9 (6%)	142	48 (43%)	57 (51%)	7 (6%)	112	-21%
Washington New Parent Network	3 (2%)	170 (98%)	1 (1%)	174	191 (27%)	488 (69%)	31 (4%)	710	308%
Yamhill County New Parent Network	81 (51%)	76 (48%)	2 (1%)	159	100 (47%)	106 (50%)	5 (2%)	211	33%
Total*	*	*	*	*	**3,155 43%**	**3,574 49%**	**572 8%**	**7,301**	*

NOTE: **Basic Service** is Healthy Start's shorter-term service and includes screening, information about community resources and/or a welcome-home visit. Children in families receiving Basic Service were born during July 1, 2002 – June 30, 2003. **Intensive Service** is Healthy Start's longer-term service. Children in families receiving Intensive Service during FY 2002-03 were born during the period from July 1, 1995 – June 30, 2003. Statistics include families who were screened by Healthy Start but declined further service. **Declined Further Service** describes families who refused service after screening. * **Totals for FY 01-02 are not comparable to FY 02-03 totals due to differences in county participation.**

^ In FY02-03 Umatilla County screened all births. Calculations are adjusted based on first-birth screening percentage.

[12] Percent change is calculated based on total number of first births screened each year, not percentage of first births each year.

Table 4

Percentage of Healthy Start Families with Basic Service by Risk Level and County

	Lower Risk Families with Basic Service				Higher Risk Families with Basic Service				
	Intensive Service not offered, other visit(s) provided	Intensive Service not offered, no other visits	Unable To Locate	**Total Lower Risk***	Intensive Service not offered, other visit(s) provided	Intensive Service not offered, no other visits	Unable To Locate	**Total Higher Risk***	**Total Families with Basic Service***
Healthy Start of Benton County	135	0	0	**135 (72%)**	51	0	1	**52 (28%)**	**187**
Healthy Start of Clackamas County	0	106	8	**114 (68%)**	1	16	37	**54 (32%)**	**170**
Clatsop Healthy Families	24	50	4	**78 (96%)**	1	0	2	**3 (4%)**	**81**
Coos County Healthy Start	2	0	1	**3 (60%)**	3	0	0	**3 (40%)**	**15**
Deschutes Ready, Set, Go	214	99	1	**314 (70%)**	95	32	10	**137 (30%)**	**453**
Douglas County Healthy Start	15	27	13	**55 (66%)**	2	4	19	**25 (34%)**	**101**
Harney County Healthy Start	0	0	0	**0**	0	0	0	**0**	**0**
Hood River County Families First	0	19	0	**19 (39%)**	3	25	1	**29 (61%)**	**49**
Jackson County Healthy Start	27	5	0	**32 (46%)**	30	2	0	**32 (54%)**	**183**
Healthy Start of Klamath County	19	4	0	**23 (59%)**	12	4	0	**16 (41%)**	**39**
Lane County Healthy Start	345	6	120	**471 (82%)**	100	0	6	**106 (18%)**	**578**
Healthy Start of Linn County	40	15	7	**62 (38%)**	28	31	44	**103 (62%)**	**167**
Marion/Polk Healthy Start	193	57	164	**414 (58%)**	72	62	174	**308 (42%)**	**743**
Tillamook Healthy Families	15	85	6	**106 (97%)**	1	0	2	**3 (3%)**	**109**
Umatilla County Healthy Start^	173	3	0	**176 (95%)**	12	0	0	**12 (5%)**	**386**
Union County Healthy Start	9	0	0	**9 (100%)**	0	0	0	**0**	**45**
Wasco/Sherman Families First	3	47	0	**50 (56%)**	6	33	1	**40 (44%)**	**90**
Washington New Parents Network	8	8	12	**28 (66%)**	17	10	20	**47 (34%)**	**194**
Yamhill Co New Parent Network	43	4	0	**47 (52%)**	38	1	0	**39 (48%)**	**102**
Total Families FY 2002-03	1,265	535	336	**2,136 (69%)**	472	220	317	**1,009 (31%)**	**3,692**

NOTE: Lower risk families have either a negative screen on the Oregon Children's Plan (OCP) or low stress such as scores of 0 – 20 on the Kempe Family Stress Inventory (KFSI). **Higher risk families** are those with a positive screen on the Oregon Children's Plan (OCP) and no KFSI assessment. **Basic Service** begins with screening the family for risk characteristics and often includes a "welcome home" visit by a volunteer or other Healthy Start worker *after* screening has been conducted. Other services may include a friendly telephone call and/or a mailed packet of information about community resources. **Unable to locate** refers to families who can't be located for further service after screening. ***Percentages and grand totals include those with missing service information.**
^Totals do not match Tables 1-3 due to calculations for Umatilla County being based on all births for this analyses.

Table 5

Percentage of Healthy Start Families Receiving Intensive Service During FY 2002-03 By County and Birth Year of Child

SITE	Born Before 1997	Born FY 97-98	Born FY 98-99	Born FY 99-00	Born FY 00-01	Born FY 01-02	Born FY 02-03	Total Intensive Service FY 2002-03	Average Months of Service (SD)
Healthy Start of Benton County	0%	0%	0%	0%	12%	26%	63%	**43**	10.4 (9.2)
Healthy Start of Clackamas County	1%	1%	3%	4%	15%	27%	50%	**477**	14.1 (14.0)
Clatsop Healthy Families	0%	1%	6%	13%	19%	33%	27%	**78**	20.5 (15.5)
Coos County Healthy Start	0%	0%	0%	2%	37%	29%	31%	**99**	16.1 (10.0)
Deschutes County Ready Set Go	3%	1%	4%	8%	13%	33%	38%	**183**	18.1 (16.2)
Douglas County Healthy Start	0%	0%	1%	5%	17%	40%	38%	**154**	13.4 (10.2)
Harney County Healthy Start	0%	0%	0%	13%	31%	31%	25%	**16**	20.2 (10.9)
Hood River County Families First Network	0%	1%	8%	11%	19%	28%	32%	**72**	21.9 (15.6)
Jackson County Healthy Start	1%	0%	3%	8%	16%	27%	46%	**342**	15.1 (13.8)
Healthy Start of Klamath County	0%	0%	0%	0%	2%	25%	73%	**64**	7.3 (5.8)
Lane County Healthy Start	1%	1%	1%	5%	11%	28%	53%	**624**	11.3 (12.1)
Healthy Start of Linn County	0%	0%	1%	3%	17%	40%	39%	**77**	14.0 (11.2)
Marion/Polk Healthy Start	1%	3%	2%	5%	17%	29%	45%	**617**	15.3 (14.6)
Tillamook Healthy Families	0%	0%	8%	8%	14%	28%	42%	**78**	17.1 (15.1)
Umatilla County Healthy Start	0%	0%	0%	0%	26%	24%	50%	**74**	12.3 (9.6)
Union County Healthy Start	0%	0%	0%	6%	11%	36%	47%	**53**	10.9 (9.2)
Wasco/Sherman Families First Network	0%	3%	5%	8%	11%	25%	48%	**64**	17.0 (15.6)
Washington County New Parents Network	1%	2%	1%	2%	12%	34%	48%	**491**	14.6 (12.4)
Yamhill New Parents Network	0%	0%	0%	0%	23%	41%	36%	**108**	13.9 (9.9)
Total Intensive Service Families, All Sites, FY 2002-03	**1%**	**1%**	**2%**	**5%**	**15%**	**30%**	**46%**	**3,714**	**14.4 (13.3)**

NOTE: Fiscal years begin on July 1 and extend through June 30. Statistics are for children born within those parameters. Average months of service does not include any service provided during the prenatal period. Standard deviation is in parentheses.

Table 6

Service History for Intensive Service Families during FY 2002-03 in Participating Counties

INTENSIVE SERVICE	Total	Benton	Clack-amas	Clat-sop	Coos	Des-chutes	Doug-las	Har-ney	Hood River	Jack-son	Kla-math	Lane	Linn	Marion-Polk	Tilla-mook	Uma-tilla	Union	Wasco Sherm	Wash	Yam-hill
Engaged, remained in service	50%	49%	49%	54%	36%	43%	42%	69%	67%	49%	45%	51%	56%	39%	46%	61%	45%	56%	67%	57%
Engaged, graduated	3%	0%	3%	3%	7%	3%	1%	0%	1%	5%	2%	5%	4%	1%	3%	0%	8%	0%	0%	1%
Engaged, left for other reasons	38%	47%	40%	41%	49%	49%	45%	19%	26%	36%	36%	25%	36%	51%	37%	32%	40%	36%	29%	33%
Didn't engage	10%	5%	9%	3%	8%	6%	12%	13%	6%	10%	17%	19%	4%	8%	14%	7%	8%	8%	4%	9%
Total Intensive Service	**3,714**	**43**	**477**	**78**	**99**	**183**	**154**	**16**	**72**	**342**	**64**	**624**	**77**	**617**	**78**	**74**	**53**	**64**	**491**	**108**
Other Reasons Left																				
Moved, no locate	12%	14%	6%	15%	14%	7%	11%	0%	7%	11%	32%	9%	3%	16%	7%	36%	8%	4%	14%	18%
Moved out of county	16%	24%	24%	15%	19%	17%	19%	67%	47%	12%	14%	15%	26%	11%	20%	20%	8%	17%	12%	8%
Declined, due to work/school	17%	19%	19%	31%	16%	20%	15%	0%	7%	17%	5%	9%	29%	18%	20%	0%	40%	17%	18%	10%
Declined, no longer interested	14%	10%	18%	8%	2%	13%	20%	0%	13%	23%	0%	17%	3%	14%	3%	8%	12%	4%	13%	8%
Other	41%	33%	33%	31%	49%	43%	35%	33%	26%	37%	49%	50%	39%	41%	50%	36%	32%	58%	43%	56%
Total Engaged, left for other reasons	**1,380**	**21**	**191**	**13***	**57**	**90**	**74**	**3***	**15***	**149**	**22**	**169**	**31**	**297**	**30**	**25**	**25**	**24**	**105**	**39**
MONTHS OF SERVICE																				
1 - 6 months	37%	51%	39%	20%	21%	25%	35%	14%	26%	37%	59%	53%	29%	36%	34%	41%	42%	30%	26%	32%
7-12 months	21%	18%	21%	17%	20%	21%	19%	14%	10%	19%	30%	16%	24%	23%	19%	19%	25%	24%	32%	23%
13-18 months	13%	15%	13%	15%	19%	19%	18%	14%	13%	10%	11%	10%	15%	11%	9%	13%	15%	6%	15%	12%
19-24 months	10%	5%	9%	12%	17%	9%	14%	14%	10%	8%	0%	8%	15%	9%	16%	15%	8%	14%	11%	14%
25-36 months	12%	10%	12%	20%	23%	14%	13%	36%	23%	17%	0%	8%	12%	12%	9%	13%	8%	14%	9%	19%
37-48 months	4%	0%	4%	10%	0%	7%	2%	7%	15%	6%	0%	4%	3%	5%	9%	0%	2%	4%	3%	0%
More than 48 mos	3%	0%	4%	6%	0%	6%	0%	0%	5%	2%	0%	1%	20%	6%	6%	0%	0%	8%	4%	0%
Total	**3,133**	**39**	**390**	**69**	**75**	**146**	**135**	**14**	**62**	**268**	**53**	**524**	**66**	**532**	**70**	**69**	**48**	**50**	**434**	**89**
LEVEL ONE VISITS IN LAST 6 MONTHS																				
More than 12 visits	55%	57%	52%	49%	50%	61%	50%	83%	61%	81%	25%	61%	55%	44%	72%	29%	40%	53%	67%	32%
7 - 12 visits	33%	43%	34%	37%	40%	25%	46%	-	30%	19%	67%	28%	35%	44%	22%	42%	40%	23%	26%	43%
3 - 6 visits	10%	0%	6%	11%	8%	12%	5%	17%	9%	0%-	8%	10%	10%	13%	6%	25%	10%	20%	4%	23%
Less than 3 visits	3%	0%	7%	3%	3%	1%	0%	0%	0%	0%	0%	1%	0%	0%	0%	4%	10%	3%	3%	2%
Mean visits/month	2.3	2.6	2.1	2.1	2.3	2.5	2.3	2.4	2.5	2.8	2.0	2.3	2.3	2.1	2.6	1.6	1.8	2.2	2.7	1.8
Standard deviation	1.0	0.9	1.0	1.1	0.9	1.1	0.7	0.9	0.9	0.8	1.3	0.9	0.8	0.9	1.1	0.8	0.8	1.3	1.2	0.8
Number of families	**810**	**14***	**128**	**35**	**38**	**75**	**22**	**6***	**23**	**21**	**12***	**108**	**29**	**55**	**18**	**24**	**10***	**30**	**118**	**44**

NOTE: Statistics describe families with records on the OHD Babies First/Healthy Start database who received Intensive Home Visiting during FY 2002-03. Families are considered enrolled if they accept Intensive Service. Families are defined as engaged if they receive three or more months of Intensive Service. Level 1 families are offered weekly home visits.

*** Percentages can be misleading when sample size is small.**

Table 7

Selected Characteristics of FY 2002-03 Healthy Start Families by Service Type

	Total	Benton	Clack-amas	Clat-sop	Coos	Des-chutes	Doug-las	Har-ney	Hood River	Jack-son	Kla-math	Lane	Linn	Marion Polk	Tilla-mook	Uma-tilla	Union	Wasco/ Shermar	Wash-ington	Yam-hill
Number of Lower Risk Families with Basic Service	**2,136**	**135**	**114**	**78**	**3***	**314**	**55**	**0**	**19**	**32**	**23**	**471**	**62**	**414**	**106**	**176**	**9***	**50**	**28**	**47**
Average age of mother	27.1	29.4	28.1	25.7	20.5	28.9	25.7	0	27.6	25.4	26.1	27.2	26.8	25.8	26.7	24.4	24.0	28.3	25.2	26.2
17 years or younger	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Avg education level (in years	13.7	12.4	14.8	12.1	11.0	13.9	13.0	0	14.4	12.6	13.5	14.2	12.9	13.7	12.2	13.0	14.0	13.4	12.9	13.3
Less than high school/GED	44%	48%	5%	72%	100%	9%	40%	0%	16%	92%	9%	33%	70%	18%	95%	85%	96%	8%	91%	23%
Avg family size	3.5	3.0	3.0	3.6	3.0	4.0	3.2	0	3.1	3.1	3.3	3.5	3.0	3.1	4.7	4.1	2.9	3.9	2.9	3.1
Mother is employed, full or part-time	64%	73%	69%	22%	0%	69%	77%	0%	58%	50%	46%	66%	56%	43%	70%	49%	0%	48%	50%	57%
Never married	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Median monthly income	$1,503	1,422	992	1,443	881	1,643	1,798	0	3,529	1,253	925	1,310	1,258	1,279	755	2,034	1,059	1,830	945	1,385
Oregon Health Plan/Medicaid	30%	11%	7%	53%	100%	22%	23%	0%	28%	34%	14%	18%	7%	20%	59%	57%	42%	38%	41%	14%
Number of Higher Risk Families with Intensive Service	**3,714**	**43**	**477**	**78**	**99**	**183**	**154**	**16**	**72**	**342**	**64**	**624**	**77**	**617**	**78**	**74**	**53**	**64**	**491**	**108**
Average age of mother	21.4	24.3	22.3	21.3	21.4	20.9	21.1	21.2	21.6	22.0	20.2	21.3	21.4	21.2	21.0	21.7	21.5	21.5	21.2	20.3
17 years or younger	19%	8%	16%	18%	15%	22%	18%	0%	20%	19%	28%	19%	17%	18%	16%	37%	8%	15%	25%	22%
Avg education level (in years	10.8	11.8	11.1	10.9	11.2	11.2	11.5	11.5	9.2	10.7	11.3	11.3	9.9	10.3	10.8	11.2	12.1	10.9	10.3	10.6
Less than high school/GED	59%	54%	53%	62%	50%	54%	47%	56%	76%	68%	53%	44%	70%	65%	83%	73%	51%	53%	67%	71%
Avg family size	3.1	3.5	3.0	3.0	3.0	3.1	2.9	4.0	3.0	3.0	3.0	2.9	3.3	3.3	1.7	3.0	2.9	3.4	3.4	3.0
Mother employed, full or part time	21%	17%	29%	28%	9%	22%	10%	39%	21%	28%	13%	18%	22%	16%	30%	26%	31%	22%	20%	14%
Never married	73%	69%	61%	77%	67%	80%	70%	100%	59%	77%	75%	82%	67%	74%	65%	81%	67%	75%	71%	75%
Median monthly income	$1,023	896	1,264	985	974	946	1,045	1,751	959	926	822	897	1,121	1,026	405	922	1,037	988	1,096	1,026
Oregon Health Plan/Medicaid	81%	80%	67%	85%	89%	84%	80%	80%	96%	81%	83%	86%	89%	81%	83%	85%	62%	97%	82%	81%

NOTE: Statistics describe families receiving Healthy Start Service during FY 2002-03. Lower risk families have a negative screen or a positive screen with low stress (< 25) on the Kempe Family Stress Assessment. Higher risk families are those with a positive screen on the Oregon Children's Plan (OCP) and either moderate or higher stress (25+) on the Kempe Family Stress Assessment. Family income is reported only at intake. Sample size varies for some indicators due to mis sing data. Percentages are not reported when more than 25% of the data is missing for a given indicator or when small sample size threatens confidentiality of information. *** Note percentages can be misleading when sample size is small.**

Table 8

Percentage of Children Receiving Intensive Home Visitation during FY 2002-03 with Selected Demographic Characteristics

	Total	Benton	Clack-amas	Clat-sop	Coos	Des-chutes	Doug-las	Har-ney	Hood River	Jack-son	Klamath	Lane	Linn	Marion Polk	Tilla-mook	Uma-tilla	Union	Wasco/ Sherm	Wash-ington	Yam-hill
Child age: July 1, 2002																				
Under 6 months	17%	23%	18%	12%	5%	14%	16%	6%	15%	19%	22%	23%	14%	14%	18%	26%	17%	16%	15%	18%
6 – 11 months	24%	37%	27%	14%	24%	20%	17%	6%	17%	20%	47%	26%	22%	25%	17%	20%	27%	22%	27%	15%
12 – 17 months	21%	19%	19%	21%	15%	24%	25%	13%	8%	20%	28%	20%	22%	22%	22%	19%	29%	21%	23%	15%
18 – 23 months	12%	7%	10%	14%	12%	10%	16%	25%	17%	11%	2%	11%	16%	11%	10%	10%	12%	16%	15%	28%
24 – 29 months	9%	7%	8%	4%	19%	10%	13%	31%	6%	10%	0%	6%	12%	11%	12%	11%	6%	5%	8%	11%
30 – 35 months	7%	7%	8%	9%	18%	6%	6%	6%	13%	8%	0%	6%	8%	6%	5%	15%	6%	6%	5%	14%
36 – 47 months	6%	0%	6%	19%	6%	7%	7%	13%	15%	7%	2%	7%	5%	6%	8%	0%	4%	6%	3%	0%
48 months and older	4%	0%	4%	8%	0%	9%	1%	0%	10%	4%	0%	2%	1%	5%	8%	0%	0%	8%	4%	0%
Child race/ethnicity																				
African-American	2%	3%	2%	0%	2%	1%	0%	0%	2%	1%	7%	3%	0%	1%	0%	1%	6%	0%	2%	0%
Asian/Pacific Islande	2%	3%	2%	0%	1%	0%	0%	0%	2%	1%	3%	2%	0%	2%	0%	0%	0%	0%	2%	0%
American Indian/ Alaska Native	1%	0%	2%	0%	5%	1%	1%	0%	0%	1%	7%	2%	0%	1%	3%	6%	0%	5%	1%	0%
Hispanic/Latino	34%	23%	36%	33%	10%	8%	6%	0%	72%	30%	15%	17%	52%	56%	19%	23%	0%	34%	63%	44%
White, not Hispanic	61%	73%	58%	67%	82%	90%	93%	100%	25%	66%	69%	77%	48%	40%	78%	70%	94%	61%	32%	56%
Language spoken at home																				
English	73%	80%	68%	68%	92%	98%	96%	100%	35%	74%	92%	87%	57%	61%	87%	92%	97%	72%	47%	66%
Spanish	27%	21%	31%	32%	5%	2%	4%	0%	65%	26%	8%	13%	44%	38%	13%	8%	3%	26%	51%	34%
Other	1%	0%	1%	0%	4%	0%	0%	0%	0%	0%	0%	1%	0%	1%	0%	0%	0%	2%	2%	0%
Number with Health Risks																				
Premature birth	9%	14%	10%	8%	10%	8%	15%	13%	8%	10%	3%	8%	5%	6%	9%	11%	15%	8%	7%	16%
Low birth weight	6%	12%	6%	9%	7%	7%	9%	13%	7%	5%	2%	6%	5%	4%	6%	8%	15%	6%	4%	15%
Drug-affected at birth	2%	2%	2%	3%	3%	4%	3%	13%	3%	1%	0%	1%	0%	1%	0%	7%	0%	5%	1%	1%
Medically high risk (CaCOON)	1%	0%	1%	1%	0%	0%	1%	0%	3%	1%	0%	1%	0%	1%	0%	0%	0%	5%	1%	0%
Number of Children	**3,714**	**43**	**477**	**78**	**99**	**183**	**154**	**16**	**72**	**342**	**64**	**624**	**77**	**617**	**78**	**74**	**53**	**64**	**491**	**108**

NOTE: Statistics describe children whose families received intensive home visitation during FY 2002-03. Other languages spoken at home include Russian, Chinese, Japanese, Korean, Vietnamese, and Cambodian/Laotian. Premature birth is 36 weeks or less gestation. Low birth weight is less than 5 lbs. Drug -affected is a positive toxicology screen at birth. Medically high risk includes established risk categories such as heart disease, chronic orthopedic disorders, metabolic disorders, microcephaly and other congenital defects of the central nervous system.

Table 9a

Percentage of Intensive Service Families during FY 2002-03 with Risk Characteristics at Intake

MATERNAL HISTORY	Total	Benton	Clack -amas	Clat- sop	Coos	Des- chutes	Doug- las	Har- ney	Hood River	Jack- son	Klamath	Lane	Linn	Marion Polk	Tilla- mook	Uma- tilla	Union	Wasco Sherm	Wash	Yam- hill
Physically abused or neglected as a child	34% (773)	55% (18)	31% (109)	36% (16)	39% (26)	40% (45)	42% (47)	78% (7)	14% (7)	34% (83)	46% (18)	34% (82)	33% (22)	36% (130)	38% (23)	32% (14)	29% (12)	39% (18)	28% (89)	23% (17)
Sexual abuse or incest	19% (361)	29% (8)	11% (32)	29% (10)	27% (12)	31% (29)	40% (25)	78% (7)	9% (4)	20% (42)	14% (5)	24% (49)	16% (7)	18% (54)	27% (15)	24% (8)	26% (9)	13% (5)	12% (31)	13% (9)
Foster or out-of-home care	17% (414)	30% (9)	15% (55)	24% (13)	24% (16)	24% (30)	19% (18)	50% (6)	8% (4)	16% (41)	31% (12)	12% (34)	15% (9)	17% (66)	34% (21)	16% (7)	21% (8)	15% (7)	11% (37)	25% (21)
Raised by alcoholic or drug-affected parent	35% (729)	53% (16)	28% (91)	50% (26)	42% (25)	49% (57)	52% (43)	50% (6)	14% (5)	42% (102)	57% (20)	28% (60)	28% (16)	32% (97)	37% (19)	42% (18)	39% (15)	51% (21)	24% (70)	32% (22)
Developmental disability	6% (165)	10% (3)	5% (20)	2% (1)	10% (7)	11% (16)	10% (13)	15% (2)	9% (5)	5% (13)	5% (2)	7% (26)	2% (1)	5% (20)	6% (4)	10% (5)	10% (4)	8% (4)	3% (10)	10% (9)
History of depression, other mental illness	43% (1,045)	41% (13)	45% (168)	42% (20)	57% (34)	63% (87)	64% (67)	39% (5)	18% (9)	40% (104)	51% (18)	54% (176)	33% (21)	42% (156)	25% (15)	27% (10)	31% (12)	43% (21)	28% (89)	30% (20)
History of alcohol or substance abuse	31% (776)	44% (14)	26% (96)	43% (26)	31% (22)	54% (78)	50% (54)	36% (4)	12% (6)	42% (107)	39% (15)	30% (92)	18% (11)	22% (89)	36% (21)	44% (20)	21% (8)	42% (20)	21% (72)	24% (21)
History of criminal activity	12% (296)	36% (11)	9% (34)	20% (12)	16% (11)	22% (31)	19% (18)	8% (1)	0%	17% (43)	13% (5)	7% (21)	8% (5)	11% (45)	7% (4)	28% (13)	8% (3)	15% (7)	8% (28)	5% (4)

NOTE: Statistics describe Intensive Service families with babies born during the period from July 1, 1998, through June 30, 2003.
***Note percentages can be misleading when sample size is small.**

Table 9b

Percentage of Intensive Service Families during FY 2002-03 With Risk Characteristics at Intake

PATERNAL HISTORY	Total	Benton	Clack-amas	Clat-sop	Coos	Des-chutes	Doug-las	Har-ney	Hood River	Jack-son	Klamath	Lane	Linn	Marion Polk	Tilla-mook	Uma-tilla	Union	Wasco Sherm	Wash	Yam-hill
Physically abused or neglected as a child	34% (118)	33% (2)	27% (24)	0%	57% (8)	47% (7)	53% (9)	0%	0%	35% (10)	38% (3)	28% (9)	42% (5)	39% (17)	60% (3)	50% (1)	17% (2)	50% (3)	33% (14)	14% (1)
Sexual abuse or incest	3% (8)	0%	1% (1)	0%	0%	9% (1)	0%	0%	0%	4% (1)	0%	4% (1)	11% (1)	3% (1)	14% (1)	0%	0%	0%	0%	14% (1)
Foster or out-of-home care	10% (40)	0%	10% (10)	0%	10% (1)	35% (6)	21% (5)	50% (1)	0%	3% (1)	25% (2)	10% (4)	23% (3)	6% (3)	0%	50% (1)	8% (1)	0%	5% (2)	0%
Raised by alcoholic or drug-affected parent	30% (95)	40% (2)	19% (15)	100% (1)	50% (5)	69% (11)	55% (11)	50% (1)	0%	26% (7)	50% (3)	7% (2)	31% (4)	28% (11)	57% (4)	0%	39% (5)	67% (2)	22% (8)	50% (3)
Developmental disability	5% (24)	0%	2% (2)	20% (1)	12% (2)	22% (4)	7% (2)	0%	0%	3% (1)	0%	7% (4)	0%	4% (2)	17% (2)	0%	8% (1)	9% (1)	4% (2)	0%
History of depression, other mental illness	13% (45)	0%	6% (5)	0%	0%	44% (8)	37% (7)	50% (1)	13% (2)	8% (2)	0%	9% (3)	31% (4)	14% (6)	0%	0%	17% (2)	13% (1)	10% (4)	0%
History of alcohol or substance abuse	32% (133)	20% (1)	19% (20)	57% (4)	17% (2)	79% (15)	58% (15)	100% (2)	27% (3)	39% (12)	33% (3)	24% (9)	29% (4)	21% (12)	38% (3)	50% (1)	25% (3)	80% (8)	29% (14)	33% (2)
History of criminal activity	20% (88)	40% (2)	7% (7)	60% (3)	25% (4)	48% (10)	48% (14)	33% (1)	0%	25% (7)	44% (4)	10% (4)	19% (3)	12% (7)	33% (3)	50% (1)	0%	50% (6)	20% (9)	33% (3)

NOTE: Statistics describe Intensive Service families with babies born during the period from July 1, 1998, through June 30, 2003.
***Note: Percentages can be misleading when sample size is small.**

Table 10

Children Aged 0-2 Free From Maltreatment in 2002
By Screening Results*

HEALTHY START CHILDREN, aged 0-2 yrs.	Total	Ben-ton	Clack-amas	Clat-sop	Coos	Des-chutes	Doug-las	Har-ney^	Hood River	Jack-son	Kla-math	Lane	Linn	Marion Polk	Tilla-mook	Uma-tilla	Union	Wasco Sherm	Wash	Yam-hill
Families screened at lower risk																				
Child abuse victims in 2002	35	0	2	4	0	5	3	^	1	1	0	1	2	2	2	8	1	3	0	0
Lower risk children, 0 – 2 yrs	6,394	223	301	174	30	696	207	^	79	334	53	1,454	164	928	264	747	169	102	335	129
% free from maltreatment	**99.4%**	**100.0%**	**99.3%**	**97.7%**	**100.0%**	**99.3%**	**98.6%**	^	**98.7%**	**99.7%**	**100.0%**	**99.9%**	**98.8%**	**99.8%**	**99.3%**	**98.9%**	**99.4%**	**97.0%**	**100.0%**	**100.0%**
Incidence rate per 1,000**	**5**	**0**	**7**	**23**	**0**	**7**	**14**	^	**13**	**3**	**0**	**1**	**12**	**2**	**8**	**11**	**6**	**29**	**0**	**0**
Families screened at higher risk																				
Child abuse victims in 2002	111	4	4	3	3	6	3	^	4	24	3	33	5	8	3	1	0	5	3	2
Higher risk children, 0 – 2 yrs	6,449	153	736	96	60	543	282	^	129	643	90	1,273	297	1,151	96	97	16	160	426	199
% free from maltreatment	**99.8%**	**97.4%**	**99.5%**	**96.9%**	**95.0%**	**98.9%**	**98.9%**	^	**96.9%**	**96.3%**	**96.7%**	**97.4%**	**98.3%**	**99.3%**	**96.9%**	**99.0%**	**100.0%**	**96.9%**	**99.3%**	**99.0%**
Incidence rate per 1,000**	**17**	**26**	**5**	**31**	**50**	**11**	**11**	^	**31**	**37**	**33**	**26**	**17**	**7**	**31**	**10**	**0**	**31**	**7**	**10**
Total Healthy Start Families																				
Child abuse victims in 2002	**152**	**4**	**6**	**7**	**4**	**12**	**6**	^	**5**	**25**	**3**	**34**	**7**	**10**	**6**	**9**	**1**	**8**	**3**	**2**
Total children, aged 0 – 2 yrs	12,919	377	1,040	270	92	1,240	489	^	208	990	143	2,727	464	2,088	363	847	185	263	795	330
% free from maltreatment	**98.8%**	**98.9%**	**99.4%**	**97.4%**	**95.7%**	**99.0%**	**98.8%**	^	**97.6%**	**97.5%**	**97.9%**	**98.8%**	**98.5%**	**99.5%**	**98.3%**	**98.9%**	**99.5%**	**97.0%**	**99.6%**	**99.4%**
Incidence rate per 1,000**	**12**	**11**	**6**	**26**	**43**	**10**	**12**	^	**24**	**25**	**21**	**12**	**15**	**5**	**17**	**11**	**5**	**30**	**4**	**6**
Non-Healthy Start Children aged 0 - 2 years																				
Child abuse victims in 2002	1,156	8	72	11	62	45	38	^	4	95	77	214	56	232	11	14	19	2	143	55
Number children, 0 – 2 yrs not served by Healthy Start	52,019	1,223	7,147	542	1,120	1,727	1,636	^	418	3,258	1,437	4,352	2,271	8,420	116	1,272	409	341	14,282	2,048
% free from maltreatment	**97.8%**	**99.3%**	**98.9%**	**98.0%**	**94.5%**	**97.4%**	**97.7%**	^	**99.0%**	**97.1%**	**94.6%**	**95.1%**	**97.5%**	**97.2%**	**90.5%**	**98.9%**	**95.4%**	**99.4%**	**98.9%**	**97.3%**
Incidence rate per 1,000**	**22**	**7**	**10**	**20**	**55**	**26**	**23**	^	**10**	**29**	**54**	**49**	**25**	**28**	**95**	**11**	**46**	**6**	**10**	**27**

NOTE: Healthy Start children are those born between January 1, 2001 and December 31, 2002 whose families were screened on the 15-item Oregon Children's Plan (OCP). Records were checked electronically by the Oregon State Office for Services to Children and Families (SCF) for confirmed incidents of child maltreatment. Non-Healthy Start Children are the total number of children born in each county during 2000 and 2001 according to OHD birth statistics *minus* the number of children screened/served by Healthy Start. Similarly, child abuse victims among non-Healthy Start children are the total number of child maltreatment victims aged 0 – 2 years for each county *minus* Healthy Start victims. Number of children 0-2 years not served by Healthy Start is calculated as the 2001 + 2002 births in county minus children served by Healthy Start during those two years.

*** Totals may not add up because some families are missing screening result information.**

**** Incidence rates are affected by sample size and can be misleading when sample sizes are small.**

^ Due to DHS restrictions on reporting data about small samples, these data are unavailable for this report.

Table 11

Healthy Start Children Free From Maltreatment During 2002
By Service Type

Free from maltreatment, 2002	Total	Benton	Clack-amas	Clat-sop	Coos	Des-chutes	Dou-glas	Har-ney	Hood River	Jack-son	Kla-math	Lane	Linn	Marion Polk	Tilla-mook	Uma-tilla	Union	Wasco Sherm	Wash	Yam-hill
BASIC SERVICE																				
No maltreatment	**99.4%**	**100.0%**	**99.1%**	**98.1%**	**100.0%**	**99.5%**	**99.1%**	**-**	**^**	**98.4%**	**100.0%**	**99.7%**	**99.1%**	**99.7%**	**98.5%**	**99.2%**	**100.0%**	**98.3%**	**100.0%**	**99.5%**
Incidence rate per 1,000*	5	0	9	19	0	5	9	-	^	16	0	3	9	3	15	8	0	17	0	5
Total Lower risk, Basic Service	7,953	288	319	206	23	1,025	217	0	153	621	60	1,384	343	1,532	263	743	109	173	275	219
INTENSIVE SERVICE																				
No maltreatment	**97.6%**	**90.0%**	**99.4%**	**^**	**94.2%**	**95.8%**	**98.1%**	**^**	**92.6%**	**95.7%**	**95.5%**	**96.8%**	**97.3%**	**99.4%**	**97.0%**	**95.9%**	**98.5%**	**94.4%**	**99.3%**	**99.0%**
Incidence rate per 1,000*	24	90	6	^	58	17	19	^	74	43	45	32	27	6	30	41	15	56	7	10
Total Intensive Service, engaged	3,687	44	491	63	69	167	159	8	54	328	67	806	75	522	67	74	66	71	455	101
DECLINED SERVICE																				
Declined, no maltreatment	**99.1%**	**100.0%**	**100.0%**	**^**	**-**	**100.0%**	**99.1%**	**-**	**^**	**97.6%**	**100.0%**	**99.3%**	**95.7%**	**94.1%**	**100.0%**	**100.0%**	**100.0%**	**94.7%**	**100.0%**	**100.0%**
Incidence rate per 1,000*	9	0	0	^	-	0	9	-	^	24	0	7	43	59	0	0	0	53	0	0
Total Declined	1,279	45	230	1	0	48	113	0	1	41	76	537	46	34	33	30	10	19	65	10
ALL HEALTHY START FAMILIES**																				
Child abuse victims, 2002	**152**	**4**	**6**	**7**	**4**	**12**	**6**	^	**5**	**25**	**3**	**34**	**7**	**10**	**6**	**9**	**1**	**8**	**3**	**2**
No maltreatment, 2002	**98.8%**	**98.9%**	**99.4%**	**97.4%**	**95.7%**	**99.0%**	**98.8%**	^	**97.6%**	**97.5%**	**97.9%**	**98.8%**	**98.5%**	**99.5%**	**98.3%**	**98.9%**	**99.5%**	**97.0%**	**99.6%**	**99.4%**
Incidence rate per 1,000*	**12**	**11**	**6**	**26**	**43**	**10**	**12**	^	**24**	**25**	**21**	**12**	**15**	**5**	**17**	**11**	**5**	**30**	**4**	**6**
Total children aged 0 – 2 years	12,919	377	1,040	270	92	1,240	489	8	208	990	143	2,727	464	2,088	363	847	185	263	795	330

NOTE: Records of 12,919 Healthy Start children born between January 1, 2001 and December 31, 2002 were checked by the Oregon State Office for Services to Children and Families for confirmed incidents of child maltreatment.

Lower risk families receiving Basic Service include those families who screened negative on the Oregon Children's Plan (OCP). **Higher risk families receiving Basic Service** include families with positive screens on the OCP, but no further assessment due to full caseloads; and families with a positive screen on the OCP and a score of less than 25 on the Kempe Family Stress Inventory (KFSI). **Basic Service** includes both higher and low risk families who received no additional service. **Intensive Service** includes higher risk families, all of whom have a positive screen on the OCP and a score of 25 or higher on the KFSI. **Declined Service** includes higher risk families who declined further service after screening.

* **Incidence rates are affected by sample size and can be misleading when sample sizes are small.**

** **Totals for all families may not be consistent with other row totals because some families are missing information about service type.**

^ **Due to DHS restrictions on reporting data about small samples, these data are unavailable for this report.**

Table 12

Likelihood of Child Maltreatment as a Function of Number of Risks in Children aged 0 – 2 years during 2002

Number of Risk Characteristics on 15-item Oregon Children's Plan	Parameter Estimate	Odds of Child Victimization
Any one risk vs. none (n=2019)*	B=.020	1.02
Any two risks vs. none (n=1568)	B=.895	2.45**
Any three risks vs. none (n=1294)	B=.740	2.10**
Any four risks vs. none (n=948)	B=.994	2.70**
Any five risks vs. none (n=636)	B=1.10	3.03***
Any six or more risks vs. none (n=750)	B=2.01	7.48***

NOTE: A logistic regression model was used to model the effects of the total number of risk characteristics shown by each family on the likelihood of child maltreatment for 12,919 children aged 0 – 2 years during 2002, for which there was child victimization information ($\chi^2 = 64.20$, df = 1, $p < .0001$).

Odds ratios show the likelihood of child maltreatment occurrence for families with risk characteristics in comparison to families with no risk characteristics. For example, among families screened by Oregon Healthy Start, children whose families have two or more risks at the time of birth are 2.45 times more likely to have been confirmed victims of child maltreatment than children whose families had no risks.

*Sample sizes reflect the number of families within each risk grouping (e.g., 2019 families had only one risk factor).

Table 13

Child Maltreatment Victims by Stress Level

	2000			2001			2002		
	Number/ Percent	**No Abuse**	**Victims**	**Number/ Percent**	**No Abuse**	**Victims**	**Number/ Percent**	**No Abuse**	**Victims**
Kempe Family Stress Assessment									
Assessed at low stress	633 (19%)	98.9%	11/1,000	379 (13%)	100.0%	0/1,000	667 (18%)	99.0%	10/1,000
Assessed at moderate stress	1,297 (39%)	98.9%	11/1,000	1,285 (45%)	98.8%	12/1,000	1,554 (43%)	99.0%	10/1,000
Assessed at high stress	1,219 (37%)	97.0%	29/1,000	1,116 (39%)	96.0%	40/1,000	1,247 (35%)	96.6%	34/1,000
Assessed at severe stress	123 (4%)	93.5%	65/1,000	99 (3%)	89.2%	108/1,000	129 (4%)	92.4%	78/1000
Total higher risk families interviewed	3,272	98.0%	20/1,000	2,879	97.5%	25/1,000	3,597	97.9%	27/1,000

NOTE: Statistics describe confirmed cases of child maltreatment for Healthy Start children aged 0 – 2 years where families have both screening and assessment information. First, families are screened using the 15-item Oregon Children's Plan. Families with positive screens are interviewed by trained assessment workers using the Kempe Family Stress Assessment.

Kempe Family Stress Assessments are rated on a scale of 0 – 100. Low family stress is rated as 0-20, moderate family stress as 25-35, high family stress as 40 – 60, and severe family stress as 65 or higher. Families with moderate to higher levels of stress (25 or higher) are offered Healthy Start's intensive visiting services.

Table 14

Prenatal Care for Families with Intensive Service During FY 2002-03

	Total	Benton	Clack -amas	Clat- sop	Coos	Des- chutes	Doug- las	Har- ney	Hood River	Jack -son	Kla- math	Lane	Linn	Marion Polk	Tilla- mook	Uma- tilla	Union	Wasco Sherm	Wash	Yam- hill
EARLY COMPREHENSIVE PRENATAL CARE																				
Intensive Service Families with information on prenatal care	2,689	35	441	58	65	141	83	5*	57	253	56	561	50	374	51	29	11*	61	286	72
Early, comprehensive prenatal care for initial pregnancy	74%	91%	74%	53%	88%	82%	82%	100%	81%	83%	73%	67%	82%	74%	51%	72%	73%	89%	71%	65%
Intensive Service Families with New Pregnancy	694	4*	166	36	18	47	17	3*	20	52	8*	128	13	82	13	3*	3*	22	42	17
Early prenatal care for initial pregnancy	71%	100%	69%	47%	94%	87%	82%	100%	65%	77%	75%	70%	85%	70%	62%	67%	33%	86%	55%	59%
Early prenatal care for new pregnancy	81%	100%	80%	86%	89%	85%	94%	100%	75%	81%	88%	81%	77%	77%	85%	67%	67%	77%	81%	82%
Percent change	14%	0%	16%	83%	-5%	-2%	15%	0%	15%	5%	17%	16%	-9%	1%	37%	0%	51%	-10%	47%	39%

NOTE: Statistics refer to Intensive Service families served by each site during the period from July 1, 2002 – June 30, 2003. Information on early, comprehensive prenatal care for initial pregnancy is for Intensive Service families with screening information on the OHD/Babies First database.

Percent change measures the magnitude of the change and refers to the *percentage increase or decrease* between two values. Percent change is calculated by subtracting the first value from the second value. The difference is then divided by the first value to determine what percentage of the starting point, the difference is.

***Note that percentages can be misleading when sample size is small.**

Table 15

Child Growth and Development for Children with Intensive Service During FY 2002-03

	Total	Ben- ton	Clack -amas	Clat- sop	Coos	Des- chutes	Doug- las	Har- ney	Hood River	Jack- son	Kla- math	Lane	Linn	Marion Polk	Tilla- mook	Uma- tilla	Union	Wasco Sherm	Wash	Yam- hill
NORMAL GROWTH & DEVELOPMENT																				
Percent with normal development at oldest screening age [a]	87%	69%	85%	93%	89%	88%	85%	78%	90%	87%	89%	89%	74%	88%	87%	80%	100%	87%	90%	91%
Number of children with at least one developmental screening	2,060	16	309	56	61	129	73	9*	39	184	26	297	50	349	45	30	27	45	250	65
CHILD DEVELOPMENT BY AGE																				
Normal development at 12 months	92%	80%	89%	97%	93%	94%	88%	83%	89%	87%	92%	93%	100%	95%	86%	92%	100%	93%	93%	100%
Number screened at 12 months	1,028	5*	165	35	27	70	32	6*	26	86	12	167	22	173	22	13	10	27	110	20
Normal development at 24 months	85%	25%	89%	86%	67%	90%	100%	50%	94%	85%	NA	86%	55%	88%	55%	50%	100%	91%	86%	88%
Number screened at 24 months	412	4*	65	22	6*	31	7*	2*	17	34	NA	71	11	88	11	2*	1*	11	21	8*
Normal development at 36 months	82%	NA	84%	67%	NA	80%	NA	NA	88%	100%	NA	88%	100%	83%	33%	NA	NA	83%	67%	NA
Number screened at 36 months	114	NA	19	6*	NA	15	NA	NA	8*	4*	NA	16	2*	29	3*	NA	NA	6*	6*	NA
EARLY INTERVENTION																				
Early intervention services	95%	NA	100%	100%	100%	92%	100%	100%	100%	92%	NA	89%	100%	88%	100%	100%	NA	100%	100%	100%
Number of children with developmental disabilities	120	0	22	3*	4*	14	4*	1*	3*	13	0	18	2*	17	4*	1*	0	4*	8	2*

NOTE: Statistics refer to Intensive Service families with outcome information submitted to NPC Research by each site during the period from July 1, 2002 – June 30, 2003. Children are screened for normal growth and development at 4, 8, 12, 18, 24, 30, 36 and 42 months of age using the Ages and Stages Questionnaire, originally published as the Infant/Child Monitoring Questionnaire. If development falls outside of the normal range, further assessment is conducted and if appropriate, the child is referred to early intervention services.

[a] Screening data is for the oldest age at which the child was screened. If the child is not yet 18 months old, for example, screening at 12 months is reported.

***Note that percentages can be misleading when sample size is small.**

Table 16

Health Care for Children with Intensive Service During FY 2002-03

	Total	Benton	Clack -amas	Clat-sop	Coos	Des-chutes	Doug-las	Har-ney	Hood River	Jack-son	Klamath	Lane	Linn	Marion Polk	Tilla-mook	Uma-tilla	Union	Wasco Sherm	Wash	Yam-hill
ADEQUACY OF HEALTH CARE																				
Child has primary health care provider	96% (2,090)	100% (16)	96% (308)	95% (57)	97% (64)	98% (136)	93% (97)	100% (10)	100% (39)	97% (180)	100% (29)	99% (300)	100% (50)	95% (344)	98% (49)	97% (31)	100% (27)	96% (48)	96% (242)	93% (63)
Regular, well-child checkups	90% (1,952)	88% (14)	92% (294)	92% (54)	94% (62)	96% (133)	88% (91)	60% (6*)	92% (36)	87% (160)	89% (24)	94% (285)	94% (47)	86% (313)	90% (46)	75% (24)	100% (27)	88% (44)	94% (238)	79% (54)
HEALTH AND NUTRITION STATUS																				
Good or better health	89% (1,933)	94% (15)	91% (292)	87% (52)	82% (54)	95% (129)	85% (88)	90% (9*)	95% (37)	85% (157)	83% (24)	92% (277)	100% (50)	88% (319)	78% (40)	72% (23)	100% (27)	94% (47)	94% (238)	82% (55)
Good or better nutrition	84% (1,805)	69% (11)	85% (272)	87% (52)	74% (49)	87% (118)	72% (75)	70% (7*)	92% (36)	84% (155)	90% (26)	83% (249)	90% (45)	80% (291)	75% (38)	69% (22)	100% (27)	92% (46)	93% (236)	75% (50)
PASSIVE SMOKE EXPOSURE																				
No passive smoke exposure	58%	42%	66%	61%	57%	40%	46%	21%	80%	55%	51%	59%	70%	60%	51%	44%	47%	27%	68%	55%
Sample sizes for "passive smoke exposure" question	3,013	36	412	67	88	164	144	14	61	292	47	430	70	469	69	57	47	55	395	96
IMMUNIZATIONS																				
Immunizations up-to-date	91%	88%	91%	86%	82%	92%	88%	50%	97%	94%	85%	94%	92%	91%	96%	88%	100%	90%	94%	87%
Some immunizations, but not up-to-date	7%	13%	8%	9%	15%	6%	10%	50%	3%	5%	15%	5%	8%	8%	4%	6%		10%	6%	13%
Number of children	2,156	16	320	59	66	139	104	10*	38	185	27	301	50	360	51	32	27	48	255	68
Fully immunized at age 2	92%	75%	91%	89%	92%	98%	90%	100%	96%	94%	NA	96%	87%	91%	95%	100%	100%	94%	100%	64%
Children with immunization information at age 2	612	4*	97	28	13	44	30	2*	22	46	0	89	15	128	21	3*	2*	18	36	14

NOTE: Statistics refer to Intensive Service families with outcome information submitted to NPC Research by each site during the period from July 1, 2002 – June 30, 2003. Health outcomes are tracked by home visitors and reported at 6-month intervals on a *Family Update*. Outcome information is taken from the most recent report for each child.
***Note that percentages can be misleading when sample size is small.**

Table 17

Nurturing and Supportive Environments for Children with Intensive Service during FY 2002-03

FAMILY EFFECTIVENESS AS CHILD'S FIRST TEACHER	Total	Benton	Clack-amas	Clat-sop	Coos	Des-chutes	Doug-las	Har-ney	Hood River	Jack-son	Kla-math	Lane	Linn	Marion Polk	Tilla-mook	Uma-tilla	Union	Wasco Sherm	Wash	Yam-hill
Home Observation for Measurement of the Environment (HOME)[13]																				
Good or higher on HOME at 12 months	73%	57%	72%	74%	61%	82%	62%	33%	84%	80%	92%	76%	65%	82%	74%	67%	89%	88%	45%	69%
Number with HOME scores at 12 months	1,045	7*	158	42	28	74	66	9*	25	81	13*	154	23	196	31	6*	9*	25	82	16
Good or higher on HOME at 24 months	79%	33%	69%	77%	57%	88%	73%	67%	94%	73%	NA	75%	93%	89%	67%	33%	100%	91%	69%	75%
Number with HOME scores at 24 months	437	3*	61	17	7*	32	26	3*	22	33	0	69	14*	99	15*	3*	1*	11*	13	8*
Change in HOME scores[14]																				
Mean HOME at 12 months	38.8	-	38.6	36.9	35.7	40.2	36.6	36.0	39.2	39.3	NA	38.9	40.1	39.4	38.3	NA	40.0	40.9	37.2	34.0
Mean HOME at 24 months	39.7	-	38.7	37.4	34.7	42.7	38.0	36.7	41.7	39.7	NA	39.3	41.8	40.3	38.0	NA	41.0	41.9	40.6	41.0
Number with HOME scores at both times	321	0	48	14*	3*	21	21	3*	19	23	0	52	9*	78	14	0	1*	9*	5*	1*
HOME Sub-scales																				
Parent responsivity and affection																				
Good or higher at 12 months	76%	86%	72%	83%	62%	84%	65%	44%	89%	66%	77%	77%	65%	83%	71%	78%	90%	84%	72%	82%
Good or higher at 24 months	82%	33%	74%	78%	57%	91%	81%	67%	96%	70%	NA	882%	93%	87%	73%	33%	100%	92%	100%	75%
Availability of toys/learning materials																				
Good or higher at 12 months	69%	73%	70%	67%	66%	84%	57%	22%	30%	85%	92%	67%	52%	73%	77%	75%	80%	84%	47%	77%
Good or higher at 24 months	79%	0%	71%	76%	57%	85%	85%	100%	68%	94%	NA	86%	71%	80%	73%	33%	100%	83%	56%	88%
Parent involvement in child learning																				
Good or higher at 12 months	73%	14%	75%	74%	60%	83%	65%	22%	73%	87%	85%	71%	57%	75%	87%	44%%	80%	88%	59%	75%
Good or higher at 24 months	78%	33%	68%	79%	57%	82%	69%	33%	95%	77%	NA	79%	86%	86%	73%	33%	100%	91%	56%	75%

NOTE: Family Effectiveness as Child's First Teacher is measured by the Home Observation for Measurement of the Environment (HOME). The HOME combines a semi-structured parent interview with direct observation of the home environment and is conducted when the child is 12 months of age and again at 24 months. Percentages for "good or higher" refer to families whose total scores on the HOME are well above average, falling at the 75th percentile or higher for the normative population. Sub-scales on the HOME include: **Responsivity,** (items such as parent's voice conveys positive feelings toward child and parent spontaneously praises child at least twice during visit), **Learning Materials** (items such as presence of muscle activity toys or equipment, complex eye-hand coordination toys, and toys for literature and music), and **Involvement** (items such as parent consistently encourages developmental advances and provides toys that challenge child to develop new skills). ***Note that percentages can be misleading when sample size is small.**

[13] Percentages represent different groups of people at 12 and 24 months. All families who had a completed HOME at either time point are included.
[14] Change scores represent only those people with a completed HOME at both 12 and 24 months.

Table 18

Family Literacy Activities for Children with Intensive Service during FY 2002-03

FAMILY LITERACY ACTIVITIES	Total	Ben-ton	Clack-amas	Clat-sop	Coos	Des-chutes	Doug-las	Har-ney	Hood River	Jack-son	Kla-math	Lane	Linn	Marion Polk	Tilla-mook	Uma-tilla	Union	Wasco Sherm	Wash	Yam-hill
<u>**Individual Activities**</u>																				
Reads to child at least 3 times per week																				
At 12 months of age	81%	86%	92%	59%	80%	81%	86%	78%	100%	75%	100%	82%	67%	78%	71%	33%	100%	90%	86%	82%
At 24 months of age	89%	^	92%	64%	^	100%	77%	^	100%	96%	^	89%	100%	91%	78%	^	^	90%	100%	^
Percent Change	10%	NA	0%	8%	NA	23%	-10%	NA	0%	28%	NA	8%	49%	17%	10%	NA	NA	0%	16%	NA
Child has at least 3 books																				
At 12 months of age	97%	86%	98%	100%	97%	100%	97%	89%	95%	100%	100%	98%	100%	94%	100%	100%	100%	90%	100%	100%
At 24 months of age	99%	^	100%	100%	^	100%	100%	^	100%	100%	^	98%	100%	97%	100%	^	^	100%	100%	^
Percent Change	2%	NA	2%	0%	NA	0%	3%	NA	5%	0%	NA	0%	0%	3%	0%	NA	NA	11%	0%	NA
Home has at least 10 books																				
At 12 months of age	55%	57%	71%	46%	60%	62%	59%	33%	58%	58%	46%	66%	33%	40%	50%	11%	100%	50%	43%	47%
At 24 months of age	67%	^	74%	55%	^	81%	68%	^	84%	58%	^	73%	78%	56%	50%	^	^	100%	71%	^
Percent Change	22%	NA	4%	20%	NA	31%	15%	NA	45%	0%	NA	11%	136%	40%	0%	NA	NA	100%	65%	NA
Number w/Family Literacy scores at 12 and 24 months	339	^	49	22	^	21	22	^	19	24	^	56	9*	77	14	^	^	10	7*	^
Sample size for counties with 12 month data only (insufficient 24 month data for comparison)	NA	7	NA	NA	30	NA	NA	9	NA	NA	13	NA	NA	NA	NA	8	10	NA	NA	17

NOTE: Family literacy activities are measured by three items on the HOME: Ten or more books are present in the home, Child has at least 3 books of own, and Parent reads to child at least 3 times per week. Percent change measures the magnitude of the change and refers to the *percentage increase or decrease* between two values. Percent change is calculated by subtracting the first value from the second value. The difference is then divided by the first value to determine what percentage of the starting point, the difference is.

*** Note that percentages can be misleading when sample size is small.**

^ Sample size at 24 months was not adequate to do comparisons. Counties without 24-month comparisons are not included in the state total.

Table 19

Parenting Skills for Intensive Service Families Receiving 6 and 12 Months of Service

	Total	Ben-ton	Clack-amas	Clat-sop	Coos	Des-chutes	Doug-las	Har-ney	Hood River	Jack-son	Kla-math	Lane	Linn	Marion Polk	Tilla-mook	Uma-tilla	Union	Wasco/ Sherm	Wash	Yam-hill
PARENTING SKILLS																				
Improved at 6 months	82%	80%	87%	78%	89%	83%	78%	33%	88%	78%	100%	87%	77%	81%	65%	75%	68%	83%	77%	83%
Improved at 12 months	83%	75%	84%	66%	94%	77%	95%	63%	84%	75%	73%	85%	92%	84%	71%	85%	100%	82%	82%	93%
INDIVIDUAL SKILLS																				
Knowledge of child development																				
Improved at 6 months	74%	60%	76%	73%	77%	77%	73%	0%	88%	66%	86%	80%	82%	78%	57%	67%	59%	50%	70%	78%
Improved at 12 months	74%	50%	78%	59%	72%	67%	87%	38%	75%	71%	64%	77%	72%	79%	54%	69%	80%	59%	76%	79%
Confidence in knowing what is right for child																				
Improved at 6 months	68%	60%	71%	68%	67%	70%	60%	67%	71%	59%	86%	74%	73%	67%	54%	67%	59%	50%	66%	72%
Improved at 12 months	69%	50%	74%	64%	87%	60%	84%	63%	68%	61%	73%	63%	72%	70%	46%	33%	80%	59%	75%	72%
Ability to help child learn																				
Improved at 6 months	61%	60%	63%	57%	65%	61%	56%	0%	88%	54%	71%	67%	64%	58%	46%	58%	50%	56%	62%	67%
Improved at 12 months	63%	75%	67%	57%	69%	61%	73%	75%	65%	59%	64%	61%	84%	61%	43%	39%	80%	48%	69%	69%
Ability to cope with stress in life																				
Improved at 6 months	46%	60%	49%	43%	49%	47%	48%	33%	58%	47%	29%	47%	33%	42%	30%	42%	23%	33%	50%	44%
Improved at 12 months	48%	75%	48%	44%	43%	47%	65%	38%	63%	45%	18%	50%	63%	46%	39%	31%	50%	36%	47%	57%
Families with information at 6 months	**1318**	**5**	**244**	**37**	**46**	**83**	**45**	**3**	**24**	**116**	**14**	**214**	**22**	**191**	**37**	**12**	**22**	**18**	**152**	**36**
Families with information at 12 months	**1045**	**4**	**185**	**43**	**31**	**64**	**37**	**8**	**24**	**75**	**11**	**158**	**25**	**162**	**28**	**13**	**10**	**27**	**111**	**29**

NOTE: Ratings for *Parenting Skills* are reported on the *Parenting Ladder*. Parents self-report on each item at the time of the child's birth, at 6 months and again at 12 months. Also, at 6 and 12 months, parents "retrospectively" report where they were on each item when their child was born. Four items are included in Parenting Skills: knowledge of child development; confidence in knowing what is right for child; ability to help child learn; and ability to cope with stress. Each item is rated from 0 = "low" to 6 = "high. Percentages refer to parents who rated themselves higher in comparison to their retrospective rating of where they were when their child was born.

***Note that percentages can be misleading when sample size is small.**

Table 20

Parent-Child Interactions
For Families Receiving Intensive Service during FY 2002-03

PARENT CHILD INTERACTION SCALE	Total	Ben-ton	Clack-amas	Clat-sop	Coos	Des-chutes	Doug-las	Har-ney	Hood River	Jack-son	Kla-math	Lane	Linn	Marion Polk	Tilla-mook	Uma-tilla	Union	Wasco Sherm	Wash	Yam-hill
At Intake																				
Mean	4.07	3.64	4.13	4.18	3.94	4.09	4.03	4.06	4.09	3.98	3.91	4.13	3.98	4.10	3.95	3.95	4.37	4.29	4.18	3.56
Standard Deviation	0.77	1.09	0.75	0.85	0.78	0.82	0.93	0.51	0.74	0.60	0.56	0.78	0.59	0.79	0.72	0.88	0.74	0.83	0.73	0.64
Number at intake	2,888	35	402	70	78	153	148	13	58	267	42	439	68	445	68	53	40	53	364	92
Positive most of the time or higher	61%	49%	64%	71%	53%	63%	60%	46%	62%	54%	55%	62%	52%	63%	52%	59%	80%	72%	68%	25%
At 6 months																				
Mean	4.32	4.22	4.35	4.39	4.31	4.24	4.39	4.25	4.45	4.20	4.27	4.44	4.49	4.32	4.12	3.60	4.63	4.43	4.33	4.01
Standard Deviation	0.67	0.75	0.61	0.82	0.67	0.69	0.72	0.27	0.54	0.60	0.61	0.61	0.41	0.70	0.62	0.99	0.75	0.91	0.64	0.70
Number at 6 months	1,787	9*	299	51	48	110	82	5*	24	159	22	262	37	290	47	16	24	42	198	62
Positive most of the time or higher	74%	67%	77%	77%	67%	76%	77%	80%	79%	70%	82%	81%	95%	72%	60%	38%	88%	83%	72%	60%
At 12 months																				
Mean	4.30	3.55	4.31	4.53	4.28	4.21	4.31	3.96	4.45	4.12	4.20	4.37	4.62	4.32	4.30	3.77	4.58	4.57	4.25	3.99
Standard Deviation	0.67	0.26	0.67	0.60	0.58	0.66	0.80	0.48	0.45	0.62	0.51	0.70	0.40	0.63	0.52	1.05	0.48	0.61	0.68	0.76
Number at 12 months	1,311	5*	207	49	41	87	66	7*	25	100	15	191	27	236	37	16	10*	31	128	33
Positive most of the time or higher	72%	0%	73%	80%	76%	68%	73%	57%	84%	67%	73%	78%	93%	72%	62%	44%	90%	84%	66%	64%

NOTE: Ratings for the 8-item *Parent-Child Interaction Scale* are reported on a *Family Update* at 6 month intervals. Home visitors rate the most recent observations they have made of the interactions between the mother (or primary caregiver) and the child. Items include expression of warmth of love, sensitivity to child's needs, accurate interpretation of child's cues, appropriate responses to child behaviors, synchronous interactions, plays with child, encouragement of developmental advances, and lack of disapproval, anger, or hostility. Ratings are 1=not at this time, 2=seldom, 3=sometimes, 4=most of the time and 5=almost always.

***Note that percentages can be misleading when sample size is small.**

Table 21

Utilization of Health Care Resources for Families with Intensive Service during FY 2002-03

	Total	Ben-ton	Clack-amas	Clat-sop	Coos	Des-chutes	Doug-las	Har-ney	Hood River	Jack-son	Kla-math	Lane	Linn	Marion Polk	Tilla-mook	Uma-tilla	Union	Wasco Sherm	Wash	Yam-hill
PARENT'S HEALTH INSURANCE STATUS																				
Private insurance	15%	19%	28%	9%	10%	11%	15%	7%	3%	13%	16%	12%	7%	15%	13%	11%	34%	2%	12%	10%
Medicaid/OHP	80%	78%	67%	84%	89%	84%	80%	79%	96%	80%	82%	85%	89%	80%	83%	85%	62%	97%	92%	81%
CHAMPUS or other public insurance	1%	0%	1%	1%	0%	1%	2%	14%	0%	1%	0%	1%	0%	1%	0%	0%	0%	0%	1%	0%
No insurance	5%	3%	4%	5%	1%	5%	3%	0%	1%	8%	2%	2%	4%	5%	4%	4%	4%	2%	6%	9%
Number of families with insurance information	**3,346**	**37**	**469**	**77**	**97**	**177**	**151**	**14**	**69**	**318**	**55**	**462**	**72**	**554**	**77**	**72**	**53**	**62**	**424**	**106**
UTILIZATION OF HEALTH CARE																				
Parent(s) linked to primary health care provider	61% (1,622)	50% (13)	65% (233)	59% (37)	64% (55)	75% (113)	64% (81)	77% (10*)	88% (38)	65% (158)	53% (20)	68% (252)	41% (24)	59% (260)	85% (49)	62% (28)	55% (24)	51% (25)	44% (152)	56% (50)
Family uses emergency services for routine care																				
Frequently	2%	6%	1%	7%	2%	1%	7%	0%	0%	1%	4%	1%	0%	2%	0%	16%	4%	4%	2%	4%
Once or twice	21%	50%	24%	15%	30%	14%	23%	100%	21%	14%	32%	23%	12%	17%	25%	31%	22%	25%	22%	29%
No utilization for routine care	76%	44%	75%	78%	68%	85%	70%	0%	80%	85%	64%	76%	88%	81%	76%	53%	74%	71%	77%	66%
Number of families with emergency services for routine care information	**2,152**	**16**	**320**	**60**	**66**	**139**	**104**	**10***	**39**	**185**	**28**	**301**	**50**	**361**	**49**	**32**	**27**	**48**	**249**	**68**

NOTE: Statistics refer to Intensive Service families with outcome information submitted to NPC Research by each site during the period from July 1, 2002 – June 30, 2003. Health outcomes are tracked by home visitors and reported at 6-month intervals on a *Family Update*. Outcome information is taken from the most recent report for each family. Utilization of health care information is available only for families who received 6 months or more of Intensive Service during FY 2002-03.

***Note that percentages can be misleading when sample size is small.**

Table 22

Adequacy of Essential Resources for Intensive Service Families Receiving 6 Months of Service

	Total	Ben-ton	Clack-amas	Clat-sop	Coos	Des-chutes	Doug-las	Har-ney	Hood River	Jack-son	Kla-math	Lane	Linn	Marion Polk	Tilla-mook	Uma-tilla	Union	Wasco/ Sherm	Wash-ington	Yam-hill
WIC																				
Needed at intake	74	1	15	1	1	2	1	0	0	8	0	19	1	4	0	1	5	1	10	4
Needed at 6 months	13	0	4	0	0	0	0	0	0	1	0	6	0	0	0	0	0	0	1	1
Percentage change*	-82%	-100%	-73%	-100%	-100%	-100%	-100%	0%	0%	-88%	0%	-68%	-100%	-100%	-100%	-100%	-100%	-100%	-90%	-75%
MEDICAID/OHP																				
Needed at intake	117	0	24	5	2	6	5	0	2	9	3	9	0	14	0	3	0	0	28	7
Needed at 6 months	35	0	7	1	0	1	1	0	1	2	0	2	0	5	0	0	0	0	12	3
Percentage change*	-70%	0%	-71%	-80%	-100%	-83%	-80%	0%	-50%	-78%	-100%	-78%	0%	-64%	0%	-100%	0%	0%	-57%	-57%
EDUCATION ASSISTANCE																				
Needed at intake	555	2	92	19	10	34	35	1	12	53	6	57	20	104	9	6	4	14	62	15
Needed at 6 months	341	1	53	15	4	21	20	0	10	35	1	24	15	65	7	3	3	7	48	9
Percentage change*	-39%	-50%	-42%	-21%	-60%	-38%	-43%	-100%	-16%	-34%	-83%	-59%	-25%	-38%	-22%	-50%	-75%	-50%	-23%	-40%
DRUG/ALCOHOL COUNSELING																				
Needed at intake	130	1	16	3	1	22	10	2	3	17	4	8	0	15	3	0	1	5	16	3
Needed at 6 months	56	0	9	3	1	16	4	1	0	10	1	2	0	3	0	0	0	3	1	5
Percentage change*	-57%	-100%	-44%	0%	0%	-27%	-60%	-50%	-100%	-41%	-75%	-75%	-100%	-80%	-100%	-100%	-100%	-40%	-94%	-33%
MENTAL HEALTH COUNSELING																				
Needed at intake	284	3	62	6	8	26	16	0	3	35	6	30	5	41	3	2	2	4	23	9
Needed at 6 months	140	0	40	3	3	17	5	0	0	17	1	13	2	21	1	1	1	2	7	6
Percentage change*	**-51%**	**-100%**	**-35%**	**-50%**	**-63%**	**-35%**	**-69%**	**0%**	**-100%**	**-51%**	**-83%**	**-57%**	**-60%**	**-49%**	**-67%**	**-50%**	**-50%**	**-50%**	**-70%**	**-33%**

NOTE: Parents rate the extent to which family needs are met for various resources using a 5-point scale ranging from 1=never, 2=seldom, 3=sometimes, 4=usually, and 5=always.

***Note that percentages can be misleading when sample size is small.**

* In these analyses, negative percent change indicates a reduction in need.

Table 23

Reduction in Risk Processes For Intensive Service Families

	Total	Benton	Clack-amas	Clat-sop	Coos	Des-chutes	Dou-glas	Har-ney	Hood River	Jack-son	Klamath	Lane	Linn	Marion Polk	Tilla-mook	Uma-tilla	Union	Wasco/ Sherm	Wash-ington	Yam-hill
SUBSTANCE ABUSE																				
Experienced at intake	30%	1%	14%	3%	1%	12%	10%	1%	1%	12%	1%	8%	1%	14%	3%	1%	1%	5%	11%	3%
Experienced at 12 months	24%	1%	15%	2%	1%	16%	9%	1%	0%	11%	1%	13%	1%	15%	2%	1%	0%	4%	6%	3%
Total families with information	585	2*	106	26	15	44	35	4*	5*	57	7*	51	12	101	19	5*	6*	23	55	12
Percent change*	-20%	0%	+7%	-33%	0%	+33%	-10%	0%	-100%	-8%	0%	+63%	0%	+7%	-33%	0%	100%	-20%	-45%	0%
DOMESTIC VIOLENCE																				
Experienced at intake	6%	3%	9%	4%	1%	13%	9%	1%	3%	11%	0%	4%	0%	17%	3%	0%	1%	4%	17%	0%
Experienced at 12 months	6%	3%	10%	4%	0%	15%	7%	0%	0%	15%	2%	7%	0%	21%	0%	3%	0%	3%	7%	3%
Total families with information	977	5*	168	41	24	66	49	4	20	81	11	124	24	157	32	11	6	28	101	25
Percent change*	0%	0%	+11%	0%	-100%	+15%	-22%	-100%	-100%	+36%	+200%	+75%	0%	+24%	-100%	+300%	-100%	-25%	-59%	+300%
CRIMINAL ACTIVITY																				
Experienced at intake	3%	0%	13%	3%	3%	16%	16%	0%	3%	3%	9%	3%	0%	16%	0%	3%	0%	0%	6%	6%
Experienced at 12 months	3%	3%	10%	7%	0%	17%	17%	0%	0%	3%	0%	13%	0%	20%	0%	10%	0%	0%	0%	0%
Total families with information	1,188	5*	197	48	30	78	66	5*	24	85	13	180	24	214	34	14	8*	30	104	29
Percent change*	0%	+300%	-23%	+130%	-100%	+6%	+6%	0%	-100%	0%	-100%	+333%	0%	+25%	0%	+233%	0%	0%	-100%	-100%
RISK REDUCTION																				
One or more risks at intake	31%	1%	13%	3%	1%	11%	7%	1%	1%	10%	2%	10%	1%	12%	4%	1%	1%	7%	12%	4%
One or more risks at 12 months	21%	1%	10%	3%	2%	15%	9%	0%	0%	11%	0%	11%	2%	15%	3%	1%	0%	4%	9%	4%
Percent change*	-32%	0%	-23%	0%	+50%	+36%	+29%	-100%	-100%	+10%	-100%	+10%	+50%	+20%	+25%	0%	-100%	-43%	-25%	0%
Total families with information	549	3*	103	24	13	40	29	3*	7*	51	8*	48	15	85	21	5*	6*	23	54	11

NOTE: Ratings for *Family Risk Processes* are reported on a *Family Update* at 6-month intervals. Home visitors report if the risk processes is an issue for any of the family members at the current time. Reported data is from the latest Family Update received by NPC Research for each Intensive Service family. Percent change is the percentage of increase or decrease from the first level to the second. It is calculated by dividing the difference between the two levels by the first level. ***Note that percentages can be misleading when sample size is small. Total families with information includes only those families who responded yes or no to the risk items.**
* In these analyses, negative percent change indicates a reduction in risk.

Table 24

Level of Satisfaction for Parents Receiving Healthy Start Intensive Home Visiting and Family Support Services

PARENT SATISFACTION	Total	Bentor	Clack-amas	Clat-sop	Coos	Des-chutes	Doug-las	Har-ney	Hood River	Jack-son	Klamath	Lane	Linn	Marion Polk	Tilla-mook	Uma-tilla	Union	Wasco Sherm	Wash-ington	Yam-hill
Has Healthy Start helped you:																				
Meet the needs of your child																				
Helped a lot	87%	100%	88%	90%	90%	88%	83%	67%	89%	88%	94%	88%	84%	88%	86%	87%	83%	86%	86%	83%
Helped a little	12%		11%	10%	11%	12%	17%	33%	11%	11%	6%	11%	16%	11%	11%	13%	13%	14%	14%	15%
Total families	1,710	12*	285	48	57	112	71	9*	36	138	16	254	38	271	44	23	23	35	190	48
Understand your child's behavior and feelings																				
Helped a lot	89%	85%	89%	92%	88%	92%	87%	89%	94%	88%	88%	92%	92%	90%	88%	83%	84%	80%	89%	89%
Helped a little	10%	15%	11%	9%	12%	8%	13%	11%	3%	11%	13%	7%	8%	9%	12%	17%	16%	20%	11%	11%
Total families	1,714	13*	286	47	58	110	71	9*	35	138	16	254	39	272	43	24	25	35	193	46
Find positive ways to teach or discipline your child																				
Helped a lot	83%	50%	82%	92%	83%	87%	86%	56%	94%	84%	75%	85%	85%	84%	79%	71%	83%	80%	83%	80%
Helped a little	15%	50%	16%	9%	16%	12%	13%	44%	3%	14%	25%	14%	15%	15%	19%	25%	17%	20%	16%	18%
Total families	1,676	12*	275	47	58	108	71	9*	35	133	16	246	39	268	43	24	23	35	190	44
Meet your needs for community services like education, child care																				
Helped a lot	78%	58%	78%	94%	78%	81%	70%	56%	94%	74%	62%	77%	87%	78%	68%	82%	86%	77%	79%	68%
Helped a little	19%	42%	17%	7%	22%	14%	27%	44%	6%	24%	31%	22%	10%	18%	30%	18%	14%	21%	17%	30%
Total families	1,591	12*	255	46	51	104	60	9*	34	129	13*	236	39	255	40	22	21	34	187	44
Get help with any serious problem																				
Helped a lot	78%	69%	76%	92%	78%	87%	75%	78%	82%	79%	67%	77%	71%	79%	75%	90%	90%	78%	77%	74%
Helped a little	17%	23%	18%	8%	16%	9%	19%	22%	15%	18%	22%	16%	24%	18%	25%	11%	5%	16%	17%	20%
Total families	1,421	13*	202	39	49	99	59	9*	27	120	9*	209	34	229	40	19	19	32	178	35
How are you treated:																				
Always listened to by home visitor	91%	83%	93%	84%	94%	94%	91%	71%	84%	91%	89%	94%	93%	88%	91%	100%	100%	88%	87%	87%
Always can decide wha help visitor provides	72%	56%	69%	75%	78%	83%	68%	43%	60%	76%	31%	78%	63%	75%	73%	60%	55%	71%	67%	67%
Always received easy tc understand information	83%	75%	83%	86%	83%	87%	84%	67%	84%	82%	93%	88%	70%	81%	77%	93%	93%	82%	82%	83%
Always, in a crisis, visitoı helps find a solution	79%	70%	79%	83%	83%	86%	84%	67%	80%	85%	89%	79%	65%	78%	85%	73%	83%	89%	73%	78%
Total families with information	1,415	9*	219	46	43	94	56	8*	29	118	11*	217	32	237	37	61	56	28	161	41

NOTE: Parents report experience on Parent Survey II, when the target child is 6, 12, 24 and 36 months old. Ratings are taken from last completed Parent Survey II. "How much, if at all, has Healthy Start helped you" items are rated as 1=Don't know, 2=Didn't help, 3=Helped a little, and 4=Helped a lot. How are you treated items are rated as 1=Don't know, 2=Not often, 3=Sometimes, 4=Usually, and 5=Always. Percentages refer only to ratings 5=Always. ***Note that percentages can be misleading when sample size is small**

Appendix E
Fifteen Essential Components of Healthy Start Programs

Healthy Start Framework
Essential Components

Universal and voluntary

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

Family focus

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

Diversity is respected

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

Collaboration

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

Community Investment

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

Comprehensive assessment system

Healthy Start uses a standardized risk assessment process as adopted by the Oregon State Commission on Children and Families to identify families that would benefit most from intensive services.

Early initiation of service

Service is initiated during the prenatal period or at birth.

Basic services

For families assessed with few, if any risk characteristics, short-term services are offered during the perinatal period that, depending on needs, may include a welcome-home visit, information on child development, positive parenting strategies, breast-feeding assistance, and community resources and supports. Programs are strongly encouraged to maximize the use of trained volunteers and other community resources to provide these services.

Intensive services

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

Health care services

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

Limited caseloads

Intensive service caseloads are limited or weighted for intensity of service to assure that home visitors have an adequate amount of time to spend with each family to meet varying needs, plan for future activities, and accurately document services. Healthy Start uses an established weighted caseload system to ascertain caseloads. This system provides for a review of community and client characteristics in determining caseload size. Limited caseload means, for most communities a caseload of 26-30 points at any one time, or a maximum of 15 families at Level 1, or 25 families per home visitor.

Staff characteristics

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

Supervision

Program staff will receive ongoing, effective supervision. The purpose of supervision is to optimize the growth of families and children and accomplish program goals. Effective

supervision provides regular feedback, evaluation, guidance, training and support to all Healthy Start staff. The program will demonstrate a plan for effective and ongoing supervision that promotes accountability, quality assurance, skill and professional development, and retention of staff and families. Programs will have written procedures outlining the mechanism for providing supervision for all staff classifications.

Training

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

Results-based accountability

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

Appendix F
OCP Screen

AGENCY/CLINIC/PROVIDER NAME
ADDRESS
TELEPHONE NUMBER

Parents are the key to a child's success. The Oregon Children's Plan includes a variety of services that provide information about parenting, bonding with your baby, healthy infant growth and development and childcare resources in your community. By completing this form, you may be connected with services in your community that you are eligible for and are of interest to you. The goal of the Oregon Children's Plan is to make sure you and your baby are getting the services you want and need. We're here to help parents raise healthy, happy babies.

The Oregon Children's Plan is voluntary! *If you are interested in learning more about Oregon Children's Plan services,* please take a few minutes to answer the questions. They may seem personal, but your answers are private and will help make sure you get the support you need and want.

Your Name ____ *first* *middle initial* *last*	**Gender:** ❑ Female ❑ Male
Address	**Your birth Date:**
City	Phone where we can contact you:
State ZIP	
If your baby has been born:	**Gender:** ❑ Female ❑ Male
Baby's Name: ____ *first* *middle initial* *last*	**Birth Date:**

CONSENT*: *(Please initial one and sign below.)

__ Yes, I consent for our family to participate in screening services through the Children's Plan. I understand that this consent is voluntary and I am free to accept or refuse services offered to me, as I choose. I understand that, whether or not I consent to participate in screening, I can continue to receive or apply for any services for which I am eligible.

___No, I do not wish to participate.

Parent(s) Signature *Date*

AUTHORIZATION:
No information about you or your family will be disclosed to others except with your written permission or as otherwise authorized by law. Attached is an authorization form for you to fill out if you wish to be contacted by someone for services.

Please answer the following questions about you and your pregnancy.

Question	Response	
1. What is your primary language?	**Written:** ______ **Spoken:** ______	
2. Is this your first child?	❑ Yes	❑ No
3. How far along were you when you first saw a health care provider (doctor, nurse practitioner, midwife) for prenatal care?		❑ 2 months ❑ 3 months ❑ 4 months ❑ 5 or more months
4. Do you have health insurance?		❑ Private health insurance ❑ Oregon Health Plan ❑ No health insurance
5. What is your housing situation?		❑ Good enough ❑ Not sure about next month ❑ Homeless
6. Have you graduated from high school or received a GED?	❑ Yes	❑ No
7. Are you married?	❑ Yes	❑ No
8. How would you describe your financial situation?		❑ Have enough money ❑ Getting by ❑ Not enough money
9. Are you employed?	❑ Full-time ❑ Part-time	❑ Seasonal ❑ Not employed
10. Is your spouse/partner employed?	❑ Full-time ❑ Part-time	❑ Seasonal ❑ Not employed ❑ Not applicable
11. How would you describe your current stress level?		❑ Low stress ❑ Medium stress ❑ High stress
12. How would you describe the relationships in your household?		❑ Relationships are positive ❑ We have a few problems, but generally work them out ❑ We have a lot of problems
13. Do you or any other member of the household use tobacco?	❑ Yes	❑ No

14. In the last year, have you ever drunk or used drugs more than you meant to?	❑ Yes	❑ No
15. Have you felt you wanted or needed to cut down on your drinking or drug use in the last year?	❑ Yes	❑ No
16. Do you have any ongoing physical health problems?	❑ Yes	❑ No
17. Do you have any physical health problems that developed during the pregnancy?	❑ Yes	❑ No
18. Do you have a developmental disability?	❑ Yes	❑ No
19. Have you ever had problems with depression?	❑ Problems now with depression ❑ Problems in the past with depression ❑ No problems	
20. Do you have a history of receiving mental health counseling or psychiatric care?	❑ Yes	❑ No
21. Have you or your partner ever been involved with the corrections system or spent time in jail?	❑ Yes	❑ No
22. Parents face many problems and last minute emergencies when raising young children. Who can you count on to be dependable when you need help?	*(Check all that apply):* ❑ Partner/spouse ❑ Friend ❑ Parent(s)/other family member ❑ No one at this time	
23. When is the best time to contact you about services that may be useful to you and your family?	❑ Morning ❑ Afternoon ❑ Evening	

If your baby has been born:

24. Do you have a health care provider for your baby? **Name of baby's health care provider___________________________**	❑ Yes	❑ No
25. Just after birth, did your baby stay in the hospital for more than 3 days?	❑ Yes	❑ No

SCREENING INFORMATION

S16 Screen/Assessment Result

☐ Positive screen, positive assessment 1
☐ Positive screen, negative assessment 2
☐ Positive screen, no assessment 3
☐ Negative screen 4
☐ Other (specify) 5 ____________

S17 Initial Action

☐ Accepted intensive visiting services 1
☐ Declined services 2
☐ Intensive visiting services not provided, other visit(s) / short term home visiting 3
☐ Intensive visiting services not provided, no other visit(s) / information only4
☐ Unable to locate 5
☐ Strategies designed to recruit or engage families 6

P1 Time of Screening/Assessment

☐ During prenatal period 1
☐ Birth or within 2 weeks 2
☐ At age 6 months 3
☐ At age 12 months 4
☐ Other (specify) 5 ____________

Appendix G

Crosswalk of Healthy Start Essential Components and Healthy Families America Critical Elements

Healthy Start Framework	Healthy Families America Critical Elements
Early Initiation of Service	**Standard 1.**
	1. Initiate services prenatally or at birth.
Service is initiated during the prenatal period or at birth.	**1-1. Program ensures it identifies participants in the target population for services either while mother is pregnant (prenatally) and/or at the birth of baby.**
	1-1.A.The program has a description of the target population that includes key demographic information such as number of resident live births per year, number of women of child-bearing age, number of single parents, age of the target population, and race/ethnicity/linguistic/cultural characteristics of population and places where the population is found (e.g., local hospitals, prenatal clinics, high schools, etc.).
	1-1.B.The program's system of formal organizational agreements with community entities (e.g. prenatal clinics, hospitals, etc.) identifies the participants in the target population to determine their need for service.
	1-1.C. The program's system of formal and/or informal services in coordination with other entities ensures potential participants are identified and referred to the program in a timely manner (i.e., giving the program the necessary time to locate the participant and complete an assessment within two weeks of the birth of the baby).
	1-1.D.Screenings/Assessments to determine eligibility for services occur either prenatally or within the first two weeks after the birth of the baby.
	1-2.The program defines, measures, and monitors the acceptance rate of participants into the program in a consistent manner and on a regular basis.
	1-2.A.The program defines, measures and monitors the acceptance rate of participants into the program.
	1-2.B.program analyzes at least annually (i.e., both formally, through data collection, and informally through discussions with staff and others involved in assessment process) who refused the program among those determined to be eligible for services and the reasons why.
	1-2.C.The program addresses how it might increase its acceptance rate based on its analysis of programmatic, demographic, social and other factors related to choosing not to participate in program after being found eligible.
	1-3.The program ensures that, for those who accept home visitor services, the first home visit occurs prenatally or within the first three months after the birth of the baby.

Healthy Start Framework	Healthy Families America Critical Elements
Comprehensive Assessment System	**Standard 2.**
Healthy Start uses a standardized risk assessment process as adopted by the Oregon Commission on Children and Families to identify families that would benefit most from intensive services.	***2. Use a standardized (I.e., in a consistent way for all families) assessment tool to systematically identify families who are most in need of services. This tool should assess the presence of various factors associated with increased risk for child maltreatment or other poor childhood outcomes (i.e., social isolation, substance abuse, parental history of abuse in childhood).***

	2-1. The program uses a tool(s) e.g., screening tools, assessment tools, etc.) to identify the participants within the target population who are most in need of intensive home visitor services.
	2-1.A. The program uses a tool(s) (e.g., screening tools, assessment tools, etc.) to identify the participants within the target population who are most in need of intensive home visitor services.
	2-1.B.The tool(s) assesses for the presence of factors including increased risk for child maltreatment or other poor childhood outcomes (e.g., social isolation, substance abuse, parental history of abuse in childhood, etc.).
	2-1.C.The screening and/or assessment tools(s) are used uniformly with the target population.
	2-2.The program ensures that staff and volunteers who use the screening and/or assessment tool(s) have been trained in its use prior to allowing them to administer it.
	2-2.A. The program has guidelines for training workers who will use the tool to ensure that the worker has adequate understanding and knowledge of how to use the tool appropriately. These guidelines require that the training include the theoretical background (i.e., its purpose, what it measures, etc.) on the tool(s) and hands-on practice in using the tool(s).
	2-2.B. The trainer is qualified, through educational background and completion of training in the use of the tool(s) to train others.
	2-2.C. Staff and volunteers who use the tool(s) have been trained in its/their use prior to administering it/them.
	2-3.The program uses criteria to identify participants in need of service and documents this in its files.
	2-3.A. Criteria indicate the constellation of factors necessary for an individual to demonstrate need for service.
	2-3.B. The program assures that the criteria are clearly and uniformly summarized in writing and documented in individual participant files.
	2-3.C. Criteria are applied uniformly.

Voluntary	**Standard 3.**
Healthy Start strives to offer all new parents with a first-born child a range of services from basic to intensive. Participation is voluntary with positive, continuing outreach efforts to insure that families who would benefit most from the services have an opportunity to become involved.	***3. Offer services voluntarily and use positive, persistent outreach efforts to build family trust.***
	3-1. Services are offered to families on a voluntary basis.
	3-2. The staff uses positive outreach methods to build family trust, engage new families, and maintain family involvement in program.
	3-2.A. The program has guidelines that specify a variety of positive outreach methods.
	3-2.B. The staff uses the guidelines in order to build family trust, engage them in services and maintain family involvement.

	3-3. The program offers outreach under specified circumstances for a minimum of three months for each participant before discontinuing services.
	3-3.A. The program guidelines specify the circumstances under which a participant is placed in outreach status.
	3-3.B. The program guidelines specify that outreach is continued for participants for three months and that outreach is only concluded prior to three months when participants have been engaged, re-engaged in services, refused services or have moved from the area.
	3-3.C. The program places participants in outreach appropriately and continues outreach for three months, only concluding outreach prior to three months when the participants have (re)engaged in services, refused services or moved from the area.
	3-4. The program defines, measures and monitors its retention rate of participants in the program in a consistent manner and on a regular basis.
	3-4.A. The program defines, measures and monitors its retention rate. The definition of its retention rates includes all participants who received outreach and home visitation from the program.
	3-4.B. The program analyzes at least annually (i.e., both formally through data collection and informally, through discussions with staff and others involved in program services) which individuals dropped out of the program, at what point in services, and reasons why.
	3-4.C. The program addresses how it might increase its retention rate based on its analysis of programmatic, demographic, social and other factors related to dropping out of the program after receiving services.

Intensive Services	**Standard 4.**
For families assessed with multiple risk characteristics, long-term services are offered intensively (initially once a week) with well-defined criteria for increasing or decreasing intensity of service over a five-year period. Depending upon needs, services such as information on child development, breastfeeding assistance, positive parenting strategies, community resources and supports, are provided by trained family support workers and/or collaborative partners with utilization of other available community resources.	***4. Offer services intensely (I.e., at least once a week) with well-defined criteria for increasing or decreasing intensity of service and over the long term (i.e., three to five years)***
	4-1.The program has a well-thought-out system for managing the intensity of home visitor services. (Includes levels of service, appropriate number of home visits, analyzes and addresses increasing home visitation completion rate minimum of 75%, criteria for increasing/decreasing intensity of service, progress regularly reviewed)
	4-1.A. The levels of service (i.e., weekly visits, bi-weekly visits, monthly visits, etc.) offered by the program are clearly defined.
	4-1.B. Participants at the various levels of service (i.e., weekly visits, bi-weekly visits, monthly visits, etc.) offered by the program receive the appropriate number of home visits, based upon the level of service to which they are assigned.
	4-1.C. The program analyzes and addresses how it might increase its home visitation completion rate. (Please note: This standard applies regardless of whether the 75% threshold identified above in standard 4-1.B. is being met.)
	4-1.D. The criteria for increasing/decreasing the intensity of the service are clearly defined and linked to the levels of service offered by the program.
	4-1.E. Each participant's progress is regularly reviewed by the family, home visitor, and supervisor. (Please note: All parties do not have to be present at the same time to conduct this review).

	4-1.F.The progress of the participant is the basis for the decision to move the participant from one level of service to another.
	4-2. The program offers home visitation services intensively after the birth of the baby.
	4-2.A. states that participants receiving intensive home visitation services are offered weekly home visits for a minimum of six months after the birth of the baby.
	4-2.B. Program ensures that participants remain on the most intensive home visitation level (at least weekly) for a minimum of six months after the birth of the baby
	4-3. The program offers home visitation services to participants for a minimum of three years after the birth of the baby.
	4-3.A. The program policy states that it will offer home visitation services to participants for a minimum of three years after the birth of the baby.
	4-3.B. The program ensures that it offers home visitation services to participants for a minimum of three years after the birth of the baby (for those participants who wish to continue participating).

Diversity is Respected	**Standard 5.**
Services are programmatically competent such that the staff understands, acknowledges, and respects differences among participants. Services and materials used reflect the cultural, linguistic, geographic, and ethnic/racial diversity of the population served. Programs will recognize cultural and special needs and make every reasonable effort to address those needs.	***5. Services should be culturally competent such that staff understands, acknowledges, and respects cultural differences among families; staff and materials used should reflect the cultural, linguistic, geographic, racial and ethnic diversity of the population served.***
	5-1. The program has a description of the cultural, racial/ethnic, and linguistic characteristics of all groups within the current service population.
	5-2. The program demonstrates culturally competent practices in all aspects of its service delivery.
	5-2.A. The program has staff, volunteers, and/or agreements with other, appropriate community entities to provide culturally competent services to all group(s) within the service and target populations.
	5-2.B. The program's materials are reflective of the diversity of the service and target populations.
	5-2.C. Ethnic, cultural, and linguistic factors are taken into account in assigning workers to participants and in overseeing home visitor-participant interactions. (Note: It is not necessary that worker and participant possess the same cultural, racial/ethnic, and/or linguistic characteristics.)
	5-3. The program provides staff training on culturally competent practices based on the unique characteristics of population(s) being served (I.e., age related factors, language, culture, etc.) by the program.
	5-4. The program regularly evaluates the extent to which all aspects of its service delivery system (I.e., family assessment, service planning, home visitation, supervision, etc.) are culturally competent.
	5-4.A. There is an annual review of cultural competency that addresses the following components: materials, training and service delivery system.
	5-4.B. The annual review of culturally competent practices includes participant input regarding culturally appropriate services.
	5-4.C. The annual review of culturally competency practices includes staff input regarding culturally appropriate services.

	5-4.D. The review is reported at least annually to the appropriate supervisory or advisory/governance group.
	5-4.E. The appropriate supervisory or advisory/governance group takes action on the recommendations contained within the report
Family Focus	**Standard 6.**
The family is the driving force in determining the constellation of supports needed, and in working in partnership with the program to support their child's development. Services are based on supporting positive parent-child interaction and child development, utilizing a holistic approach that recognizes the needs of the child and the parents.	***6. Services should focus on supporting the parent(s) as well as supporting parent-child interaction and child development.***
	6-1. Issues identified by the participant in the initial assessment are addressed during the course of home visiting.
	6-1.A. The supervisor and home visitor review the issues identified by the participant in the initial assessment.
	6-1.B. The home visitor and participant review issues identified in the initial assessment.
	6-2. Delivery of services to participants is guided by the Individual Family Support Plan (IFSP) and the process of developing the plan uses participant support practices.
	6-2.A. The home visitor and participant collaborate to identify participant strengths and competencies.
	6-2.B. The home visitor and participant collaborate to assess participant needs and the services which are desired to help address these needs.
	6-2.C. The home visitor and participant collaborate to set participant goals for the home visitation service.
	6-2.D. The home visitor and participant collaborate to establish a plan with specific strategies/objectives to achieve identified goals.
	6-2.E. The home visitor, and supervisor review IFSP progress at regular intervals (i.e., bi-weekly, monthly, quarterly).
	6-2.F. The home visitor, participant and supervisor collaborate to update each participant's IFSP at regular intervals. (All parties do not have to be present at the same time to conduct this review).
	6-2.G. The IFSP serves as the guide for delivering services.
	6-3. Before or on the first home visit, the participant is informed about their rights, including confidentiality, both verbally and in writing.
	6-4. The program promotes positive parenting skills, parent-child interaction and knowledge of child development with participants.
	6-4.A. The program has comprehensive guidelines regarding promotion of positive parenting skills, parent-child interaction and knowledge of child development with participants.
	6-4.B. Home visitor shares information with participants on appropriate activities designed to promote positive parenting skills.
	6-4.C. Home visitor shares information with participants on appropriate activities designed to promote positive parent-child interaction.
	6-4.D. Home visitor shares information on appropriate infant and child development with participants.
	6-4.E. Home visitor shares information with participants on appropriate health and safety related issues.
	6-5. The program monitors the development of participating infants and children with a standardized developmental screen.

	6-5.A. The program has guidelines for administration of a standardized developmental screen/tool that specify how the tool is to be used with all children participating in the program, unless developmentally inappropriate.
	6-5.B. The program ensures that a standardized developmental screen/tool is used to monitor child development at specified intervals, unless developmentally inappropriate.
	6-6. Those who administer developmental screenings have been trained in the use of the tool before administering it.
	6-7. The program tracks target children who are suspected of having a developmental delay and follows through with appropriate interventions (e.g., referrals, follow-up, etc) as needed.
	6-7.A. The program has guidelines that address how it tracks and follows through with appropriate actions for child participants suspected of having a developmental delay.
	6-7.B. The program tracks target children suspected of having a developmental delay.
	6-7.C. The program follows through with appropriate actions (i.e., referrals, in-depth evaluations, or examinations, treatment or other services) for target children suspected of having a developmental delay.

Health Care Services	Standard 7.
The program promotes the health and well-being of the child and all family members by coaching families on prevention of health problems and ways to appropriately access needed health services, and by advocating for their needs within the health care system. At a minimum, all families receiving intensive services are linked to a primary health care provider so that the child can receive timely immunizations and well child care. Routine health and developmental screening is done to identify problems and refer for further assessment and early treatment, if needed.	***7. At a minimum, all families should be linked to a medical provider to assure optimal health and development (e.g., timely immunizations, well-child care, etc.) Depending on the family's needs, they may also be linked to additional services such as financial, food, and housing assistance programs, school readiness programs, child care, job training programs, family support centers, substance abuse treatment programs, and domestic violence shelters.***
	7-1. Participating family members (as defined by the program) have a medical/health care provider to assure optimal health and development.
	7-1.A. The program has guidelines for documenting medical/health care provider(s) for all participating family members.
	7-1.B. Home visitors provide information, referrals and linkages to available health care resources for all participating family members.
	7-1.C. Target children have a medical/health care provider.
	7-2. The program ensures that immunizations are up to date for target children.
	7-2.A. The program identifies an immunization schedule to be met and has guidelines to document immunizations for all target children.
	7-2.B. Immunizations for target children are up to date. (Please note: the percentage should not include children whose family beliefs preclude immunizations. Evidence of this must be documented in the participant file.)
	7-3. Participants are linked to additional services on an as-needed basis taking into account one or more of the following: information gathered in the assessment process, through the development of the IFSP, through home visits, from other service providers, etc.
	7-3.A. The program connects participants to appropriate referral sources and services in the community based upon the information gathered.

	7-3.B. The program follows up with the referral source, service provider, and/or participant to determine if the participant received needed services.
Limited Caseloads	**Standard 8.**
Intensive service caseloads are limited or weighted for intensity of service to assure that home visitors have an adequate amount of time to spend with each family to meet varying needs, plan for future activities, and accurately document services. Healthy Start uses an established weighted caseload system to ascertain caseloads. This system provides for a review of community and client characteristics in determining caseload size. Limited caseload means, for most communities, no more than 15 families on the most intensive level per home visitor..	**8. Services should be provided by staff with limited caseloads to assure that home visitors have an adequate amount of time to spend with each family to meet their unique and varying needs and to plan for future activities (I.e., for many communities, no more than fifteen (15) families per home visitor on the most intense service level. And for some communities, the number may need to be significantly lower, e.g., less than ten (10)).**
	8-1. Services are provided by staff with limited caseloads to assure that home visitors have an adequate amount of time to spend with each participant to meet their needs and plan for future activities.
	8-1.A. The program's policy regarding established caseload size is no more than fifteen (15) participants at the most intensive level (at least weekly visits) per full time home visitor.
	8-1.B. The program's policy regarding maximum caseload size is no more than twenty-five (25) at any combination of service levels per full-time home visitor.
	8-1.C. Home visitors are within the caseload ranges, as stated in standard 8-1.A and 8-1.B.
	8-2. The program's caseload system ensures that home visitors have an adequate amount of time to spend with each participant.
	8-2.A. The program has guidelines for managing its caseloads.
	8-2.B. The program uses the guidelines identified above in 8-2.A. to manage its caseload sizes.

Staff Characteristics	**Standard 9.**
Program Staff are selected because of their education, work and life experiences, ability to effectively communicate and establish trusting relationships, ability to demonstrate interpersonal and helping skills, ability to work with diverse communities, ability to identify and provide access to other services, and appropriate technical skills. Staffs have a framework, based on education and/or experience, for handling the variety of experiences they may encounter when working with at-risk families.	***9. Service providers should be selected because of their personal characteristics (I.e., non-judgmental, compassionate, ability to establish a trusting relationship, etc.), their willingness to work in or their experience working with culturally diverse communities, and their skills to do the job.***
	9-1. Service providers and program management staff are selected because of a combination of personal characteristics, experiential, and educational qualifications.
	9-1.A.Screening and selection of program managers includes consideration of characteristics including, but not limited to: • A solid understanding of and experience in managing staff; • Administrative experience in human service or related program(s), including experience in quality assurance/improvement and program development; • A bachelor's degree in human services administration or related field required (Master's degree preferred).
	9-1.B. Program managers have: • A solid understanding and experience in managing staff; • Administrative experience in human service or related program(s), including experience in quality assurance/improvement and program development; and • A bachelor's degree in human services or related field required (Master's degree preferred).

	9-1.C. Screening and selection of supervisors includes consideration of characteristics, including but not limited to: • A solid understanding of and experience in supervising and motivating staff, as well as providing support to staff in stressful work environments; • Knowledge of infant and child development and parent-child attachment; • Experience with participant services that embrace the concepts of family-centered and strength-based service provision; • Knowledge of maternal-infant health and dynamics of child abuse and neglect; • Experience in providing services to culturally diverse communities/participants; • Experience in home visitation with a strong background in prevention services to the 0-3 age population; and, • Bachelor's degree in human services or related field required (Master's degree preferred).
	9-1.D. Supervisors have: • A solid understanding and experience in supervising and motivating staff as well as providing support in stressful work environments; • Knowledge of infant and child development and parent child attachment; • Experience with participant services that embrace the concepts of family-centered and strength-based service provision; • Knowledge of maternal-infant health and concepts of child abuse and neglect; • Experience in providing services to culturally diverse communities/participants; • Experience in home visitation with a strong background in prevention services to the 0-3 age population; and, • Bachelor's degree in human services or related field required (Master's degree preferred).
	9-1.E. Screening and selection of direct service staff include consideration of personal characteristics, including but not limited to: • Are experienced in working with or providing services to children and participants; • An ability to establish trusting relationships; • Acceptance of individual differences; • Experience and willingness to work with the culturally diverse populations that are present among the program's target population; • Knowledge of infant and child development; and • Are experienced in working with or providing services to children and participants.

	9-1.F. Direct service providers: • Are experienced in working with or providing services to children and participants; • Have demonstrated ability to establish trusting relationships; • Demonstrate acceptance of individual differences; • Have experience with and willingness to work with the culturally diverse populations that are present among the program's target population; • Are knowledgeable about infant and child development; and, • Meet the educational requirements, as established by the program.
	9-1.G. The same expectations/requirements apply to both direct service staff and volunteers and interns performing the same function.
	9-2. The program actively recruits, employs, and promotes qualified personnel and administers its personnel practices without discrimination based upon age, sex, race, ethnicity, nationality, handicap, or religion of the individual under consideration.
	9-2.A. The program is in compliance with the Equal Opportunity Act in the United States.
	9-2.B. The program has a written equal opportunity policy that clearly states its practices in recruitment, employment, transfer and promotion of employees.
	9-2.C. The program disseminates its equal opportunity policy and uses recruitment materials that specify the non-discriminatory nature of the program's employment practices
	9-3. The program's recruitment and selection procedures assure that its human resource needs are met.
	9-3.A. The program's recruitment and selection practices are in compliance with applicable law or regulation and include: • Notification of its personnel of available positions before or concurrent with recruitment elsewhere; • Personal interviews with applicants before selection; and, • Documentation that three references from unrelated persons have been obtained.
	9-3.B. The agency conducts appropriate, legally permissible and mandated inquiries into the background of prospective employees and volunteers who will have responsibilities where clients are children.
	9-3.C. The rate of personnel turnover is measured and evaluated regularly and action is taken to correct identified problems.

Training	Standard 10.
Local commissions and program staff implementing existing and new Healthy Start efforts will receive research information, technical assistance and training from the State to build local capacity and knowledge. Intensive core training, specific to roles, assures that program staffs understand the essential components of family assessment and home visitation, as adopted by the Oregon State Commission on Children and Families. All program staff and volunteers receive basic training through their local collaboration including information on working with diverse populations, substance abuse, reporting child abuse, domestic violence, drug-exposed infants, and services in their community.	***10 a. Service providers should have a framework, based on education or experience, for handling the variety of experiences they may encounter when working with at-risk families. All service providers should receive basic training in areas such as cultural competency, substance abuse, reporting child abuse, domestic violence, drug-exposed infants, and services in their community.***
	10 b. Service providers should receive intensive training specific to their role to understand the essential components of family assessment and home visitation (i.e., identifying at-risk families, completing a standardized risk assessment, offering services and making referrals, promoting use of preventive health care, securing medical homes, emphasizing the importance of immunizations, utilizing creative outreach efforts, establishing and maintaining trust with families, building upon family strengths, developing an individual family support plan, observing parent-child interactions, determining the safety of the home, teaching parent-child interaction, managing crisis situations, etc.).
	NOTE: In order to streamline the responses to critical elements 10 and 11 (which address worker skills and training), we have combined the two critical elements and measure them as one section.
	10-1. The program has a system for assuring that the following trainings are made available for all staff (assessment workers, home visitors, and supervisors): Orientation, Intensive role specific training, additional training within six months and 12 months of hire, on-going training.
	10-1.A. The program has a training plan that assures access to required trainings in a timely manner for all staff (home visitors, assessment workers and supervisors).
	10-1.B.The program has a system to monitor staff training
	10-2. Staff (assessment workers, home visitors, and supervisors), receive orientation (separate from intensive role specific training) prior to direct work with children and families to familiarize them with the functions of the program.
	10-2.A. Assessment workers and home visitors are oriented to their roles as they relate to the program's goals, services, policies and operating procedures, and philosophy of home visiting/family support prior to direct work with children and families.
	10-2.B. Supervisors are oriented to their role as it relates to the program's goals, services, policies and operating procedures, and philosophy of home visiting/family support prior to supervision of staff.
	10-2.C. Staff (assessment workers, home visitors and supervisors) are oriented to the program's relationship with other community resources prior to direct work with children and families.
	10-2.D.Staff (assessment workers, home visitors and supervisors) are oriented to child abuse and neglect indicators and reporting requirements prior to direct work with children and families.
	10-2.E. Staff (assessment workers, home visitors and supervisors) are oriented to issues of confidentiality.
	10-2.F. Staff (assessment workers, home visitors and supervisors) are oriented to issues related to boundaries.
	10-3. Staff (assessment workers, home visitors and supervisory) receive intensive training within six months of date of hire specific to their role within the home visitation program to help them understand the essential components of their role within the program.
	10-3.A. conducting assessments have received intensive role specific training within six months of date of hire to understand the essential components of family assessment.

	10-3.B. Home visitors have received intensive role specific training within six months of date of hire to understand the essential components of home visitation.
	10-3.C. Supervisory staff have received intensive role specific training within six months of date of hire to understand the essential components of their role within the home visitation program, as well as the role of family assessment and home visitation.
	10-4. Staff (assessment workers, home visitors and supervisory) demonstrate knowledge on a variety of topics necessary for effectively working with families and children within six months of hire.
	10-4.A. Staff (assessment workers, home visitors and supervisors) demonstrated knowledge of infant care within six months of the date of hire.
	10-4.B. Staff (assessment workers, home visitors and supervisors) demonstrated knowledge of child health and safety within six months of the date of hire.
	10-4.C. Staff (assessment workers, home visitors and supervisors) demonstrated knowledge of maternal and family health within six months of the date of hire.
	10-4.D. Staff (assessment workers, home visitors and supervisors) demonstrated knowledge of infant and child development within six months of the date of hire.
	10-4.E. Staff (assessment workers, home visitors and supervisors) demonstrated knowledge of the role of culture in parenting within six months of the date of hire.
	10-4.F. Staff (assessment workers, home visitors and supervisors) demonstrated knowledge of supporting the parent-child relationship within six months of the date of hire.
	10-5. Staff (assessment workers, home visitors and supervisors) demonstrate knowledge on a variety of topics necessary for effectively working with families and children within 12 months of hire.
	10-5.A. Staff (assessment workers, home visitors and supervisors) demonstrated knowledge of child abuse and neglect within 12 months of the date of hire.
	10-5.B. Staff (assessment workers, home visitors and supervisors) demonstrated knowledge of family violence within 12 months of the date of hire.
	10-5.C. Staff (assessment workers, home visitors and supervisors) demonstrated knowledge of substance abuse within twelve months of the date of hire.
	10-5.D.Staff (assessment workers, home visitors and supervisors) demonstrated knowledge of staff related Issues within 12 months of the date of hire.
	10-5.E. Staff (assessment workers, home visitors and supervisors) demonstrated knowledge of family issues within 12 months of the date of hire.
	10-5.F. Staff (assessment workers, home visitors and supervisors) demonstrated knowledge of mental health within 12 months of the date of hire.
	10-6. The program ensures that all program staff receive ongoing training which takes into account the worker's knowledge and skill base.

Supervision	Standard 11.
Program staff will receive ongoing, effective supervision. The purpose of supervision is to optimize the growth of families and children and accomplish program goals. Effective supervision provides regular feedback, evaluation, guidance, training and support to all Healthy Start staff. The program will demonstrate a plan for effective and ongoing supervision that promotes accountability, quality assurance, skill and professional development, and retention of staff and families. Programs will have written procedures outlining the mechanism for providing supervision for all staff classifications.	***11. Service providers should receive ongoing, effective supervision so that they are able to develop realistic and effective plans to empower families to meet their objectives; to understand why a family may not be making progress and how to work with the family more effectively; and to express their concerns and frustrations so that they can see that they are making a difference and in order to avoid stress-related burnout.***
	11-1. The program ensures that direct service staff receive regular, and ongoing supervision.
	11-1.A. The program's policy states that weekly individual supervision is provided to all direct service staff (i.e., assessment and home visitation staff).
	11-1.B. The program ensures that weekly individual supervision is received by all direct service staff. (Please note: supervisory sessions should not be split into more than two regularly scheduled sessions).
	11-1.C. The ratio of supervisors to direct service staff is sufficient to allow regular, ongoing, and effective supervision to occur.
	11-2. Direct service staff (I.e., assessment and home visitation staff) are provided with skill development and professional support and held accountable for the quality of their work.
	11-2.A.The program has supervisory procedures to assure that direct service staff (i.e., assessment and home visitation staff) are provided with the necessary skill development to continuously improve the quality of their performance.
	11-2.B. The program has supervisory procedures to assure that direct service staff (i.e., assessment and home visitation staff) are provided with the necessary professional support to continuously improve the quality of their performance.
	11-2.C. The program's supervisory procedures assure that direct service staff (i.e., assessment and home visitation staff) are held accountable for the quality of their work.
	11-3. The program's policies and procedures manual is used to guide newer service providers in the delivery of services.
	11-3.A. The program has a policies and procedures manual.
	11-3.B. The program uses policies and procedures manual as a guide in the provision of services.
	11-4. Volunteers and student interns who are performing the same/similar functions as direct service staff are receiving the same type and amount of supervision.
	11-5. Supervisors receive regular, on-going supervision which holds them accountable for the quality of their work and provides them with skill development and professional support.
	11-5.A. The program has procedures to assure that supervisors receive regular and on-going supervision which holds them accountable for the quality of their work and provides them with skill development and professional support.
	11-5.B. Program ensures that supervisors receive regular, on-going supervision.
	11-6. Program managers are held accountable for the quality of their work and are provided with skill development and professional support.

Collaboration	Governance and Administration
Healthy Start is based on a collaboration of local Commissions on Children and Families, Health Departments and community providers of services that builds on existing perinatal programs and develops an integrated home visiting system. Confidentiality barriers are addressed through information sharing and/or interagency collaboration.	***The program is governed and administered in accordance with principles of effective management and of ethical practice.***
	GA-1. The program has a written statement of purpose that guides the administration of its services
	GA-1.A.The program has a written statement of purpose that reflects the goals and criteria contained in the critical elements and addresses the needs of children, families, and the community.
	GA-1.B. The statement is reviewed formally by the program's advisory/governing group at least every four (4) years.
	GA-2. The program has broadly-based, advisory/governing group (e.g., a voluntary Board, governing body, an advisory committee, etc.) which serves in a advisory and/or governing capacity in the planning, implementation, and assessment of program services.
	GA-2.A. The program's advisory/governing group is an effectively organized, active body carrying out the functions specified in GA-2.
	GA-2.B. The advisory/governing group has a wide range of needed skills and abilities and provides a heterogeneous mix in terms of skills, strengths, community knowledge, professions, age, race, sex, nationality or ethnicity.
Results-Based Accountability	GA-2.C. The advisory/governing group is aware of community issues that affect program participants, program planning, implementation, and assessment, either through direct representation by community members/program participants or another effective alternative.
The State Commission on Children and Families will contract with an independent evaluator to provide ongoing data collection and evaluation of Healthy Start services. Local Healthy Start programs will work with the contracted evaluator to assure that the provision of program services, implementation, and performance outcomes for children and families are adequately researched and evaluated.	**GA-3. The program has a mechanism in place for families (i.e., past or present participants) to provide formalized input into the program.**
	GA-4. The manager (or other program representative) and the *advisory/governing group* work as an effective team with information, coordination, staffing, and assistance provided by the manager to plan and develop program *policy*.
	GA-5. The program monitors and evaluates quality of services.
	GA-5.A. The program routinely reviews the progress towards its program goals and objectives.
	GA-5.B. The program reviews participant grievances.
	GA-5.C. The program regularly conducts an analysis of participant satisfaction with services.
	GA-5.D. The program has a formal mechanism for reviewing the quality of all aspects of the program (assessment, home visitation and supervision).
	GA-5.E. The program has a follow-up mechanism to address areas for improvement identified during quality assurance review.
	GA-6. The program has a policy and procedure for reviewing and recommending approval or denial of research proposals, whether internal or external, that involve past or present participants.
	GA-7. The program assures participant privacy and voluntary choice with regard to research conducted by or in cooperation with the program.

	GA-8. Program reports suspected cases of child abuse and neglect.
	GA-8.A. Program has clear criteria through which to identify suspected cases of child abuse and neglect.
	GA-8.B. Program's reporting procedure regarding reporting of suspected cases of child abuse and neglect specifies immediate notification of the program supervisor and/or program manager and are in compliance with all applicable laws and regulations. Other appropriate staff/supervisors within the program are notified as needed.
	GA-8.C. Program follows its procedure regarding reporting of suspected cases of child abuse and neglect.
	GA-9. Program has an internal reporting procedure for reporting participant (especially child) deaths that occur while the participant is in the program.
	GA-9.A. Program has a procedure that specifies immediate notification of the program supervisor and/or program manager in cases of participant deaths. Other appropriate staff/supervisors within the program are notified as needed.
	GA-9.B. Procedure ensures that staff receive crisis/grief counseling, as needed.
	GA-10. The program has a written budget and monitors expenditures to manage financial resources and support program activities for the program.
	GA-11. The budget is reviewed and approved by a group (other than program manager) prior to the beginning of the fiscal year.
	GA-12. The program seeks diversification and balance in its sources of funding.
	GA-13. The program (or program's sponsoring agency) makes available to the community an annual report or fiscal, statistical, and service data regarding the program.
	GA-14. The program (or the program's sponsoring agency) is audited annually by an independent certified public accountant approved by the governing body.