Healthy Start of Oregon 2006-2007 Status Report

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Informing policy, improving programs

ACKNOWLEDGMENTS

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Staff members and volunteers spend long hours collecting information and "doing the paperwork." We are particularly grateful for their dedication and commitment to the evaluation process. Further, this report would not have been possible without the interest and involvement of Healthy Start's families. The families deserve special recognition for their willingness to cooperate and answer a multitude of questions. The input of staff, volunteers, and families at all of the Healthy Start sites is extremely valuable and deeply appreciated.

Special thanks to the 31 Healthy Start programs operating in the 34 following counties that were included in this year's status report:

Benton County
Clackamas County
Clatsop County
Columbia County
Coos County
Crook County
Curry County
Deschutes County
Douglas County
Gilliam County
Grant County
Harney County
Hood River County
Jackson County
Jefferson County
Josephine County
Klamath County
Lane County
Lincoln County
Linn County
Malheur County
Marion County
Morrow County
Multnomah County
Polk County
Sherman County
Tillamook County
Umatilla County
Union County
Wallowa County
Wasco County
Washington County
Wheeler County
Yamhill County

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

This year, we received more than 1,300 comments from parents about the Healthy Start program. Here are just a few examples of what parents told us is the ***"best thing about Healthy Start***:"

[Because of Healthy Start] now me and my son are safe, and I get a chance at a better life.

How knowledgeable [the home visitor] is, and how willing to help. If she doesn't know something she makes sure to find out for me. It has opened my eyes about a lot of things I never knew.

There are so many benefits to having this program, it is hard to choose just one! It would have to be the interaction with someone who really cares and helps me.

They visit me and I don't feel so alone. They bring me information about children and other things that is so helpful.

They do a really good job. They bring bilingual books and information, and they are very respectful and open to other cultures.

Being able to talk about problems and concerns with someone I can trust.

The workers! They care about your child just as much as you do and they want you to learn as much as you can about the development of your child.

I love having the worker come give me information about how to love and teach my son what he needs to learn, and what I need to know about how to help him develop, and what to expect as the months go by. It makes me feel confident to have someone like [worker] telling me these things.

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EXECUTIVE SUMMARY

Healthy Start is Oregon's largest child abuse prevention program. In FY 2006-07, despite a 20% cut in general fund allocations during the 2005-07 biennium, Healthy Start screened more families than in any prior year (9,788 families, representing 50% of eligible births). Oregon's Healthy Start program is unique in the nation, providing universal screening and referral services to first-time parents, and research-based home visiting services to families at higher risk of maltreatment and other negative outcomes. Healthy Start became an accredited Healthy Families America (HFA) program in June 2007, and provided evidence-based home visiting services to 2,857 children through 31 programs operating in 34 Oregon counties in FY 2006-07.

Receipt of HFA accreditation was the culmination of over two years of intensive work to develop and implement over 180 research-based quality standards across all of Oregon's Healthy Start programs. The HFA credential requires that local programs, as well as the central Healthy Start office, demonstrate the use of a comprehensive set of research-based program practices. HFA requires that all programs document evidence of adherence to evidence-based home visiting procedures, rigorous training and supervision supports, and effective program management and administration processes. Oregon was only the 6th state-level multi-site system to be accredited by HFA, although hundreds of individual programs have been credentialed.

Implementation and outcome data for the Healthy Start program are tracked through an ongoing evaluation conducted by an external evaluator, NPC Research. Although the evaluation does not collect information that speaks to all of the HFA standards, results this year found that at a statewide level, Oregon's Healthy Start program statewide met or exceeded HFA standards in almost every area in which evaluation data were available. Further, Healthy Start appears to be effectively engaging families with numerous risk factors in both screening and home visiting services. Outcome and implementation results from FY 2006-07 are summarized below, and more detailed information is provided in the full report (also available at: www.oregon.gov/OCCF and www.npcresearch.com). Child maltreatment results will be reported in a separate document scheduled for release in Spring 2008.

Outcomes for Children and Families

REDUCING RISK FACTORS FOR CHILD MALTREATMENT

Research shows that helping parents to improve their parenting skills and reduce their parenting-related stress is critical to reducing the likelihood of child maltreatment. Healthy Start's results in these areas compare favorably to other research with higher-risk families:

- Healthy Start workers report that after one year of service, 82% of Healthy

Start's higher-risk families consistently engaged in developmentally supportive interactions with their children.

- 81% of higher-risk families reported that they have improved their parenting skills.
- 39% of higher-risk parents reported a decrease in parenting-related stress from the time of the child's birth to the 6-month birthday, a time when parents generally experience highly elevated levels of parenting-related stress.

PROMOTING SCHOOL READINESS

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

- After 12 months of Intensive Service, 81% of Healthy Start's higher-risk families were creating learning environments for their young children that were rated as "good" or higher by their home visitor, as indicated by The Home Observation for Measurement of the Environment Inventory (Caldwell & Bradley, 1994). This percentage is higher than results found in other, comparable populations.
- By age 1, 86% of Healthy Start Intensive Service parents reported reading to their children three times per week or more. Nationally, only about 64% of higher-risk families read to their young children three or more times per week (Nord, Lennon, Liu, & Chandler, 1999).

PROMOTING HEALTHY DEVELOPMENT

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

- 98% of Healthy Start's children receiving Intensive Services had a primary health care provider, which greatly exceeds the Healthy Families America standard of 80%. Further, 76% of caregivers had a primary health provider.
- 87% of Intensive Service mothers received early prenatal care for their second pregnancies, compared to 80% for their first pregnancies.
- 94% of children were receiving regular well-child check-ups, compared to only 84% of young children nationally (Child Trends, 2004).
- 89% of Healthy Start children had health insurance, compared to 85% of low-income children nationally.
- 93% of Healthy Start's 2-year-olds were fully immunized, compared to only 78% of all Oregon 2-year-olds (Oregon ALERT Immunization Registry, 2006), and greatly exceeding the HFA standard of 80%. Nationally, only about 76% of children from low-income households were fully immunized by age 3 (Child Trends, 2004).
- More than three-fourths (79%) of Healthy Start Intensive Service children received regular developmental screening during FY 2006-07. Most (90%) of these children showed normal growth and development on their overall assessments, and 78% of Healthy Start Intensive Service children with identified developmental delays were linked to early intervention services.

SUPPORTING FAMILY SELF-SUFFICIENCY

Healthy Start's higher-risk families often need a variety of supports to help them meet their basic needs, and frequently set

goals related to improving their self-sufficiency. After 6 months of Intensive Services, many Healthy Start families had been connected to services they needed. Of those families indicating each of the following needs:

- 87% were connected to housing assistance,
- 94% were connected to education assistance,
- 94% were connected to job training and employment services,
- 97% were connected to Temporary Assistance for Needy Families, and
- 78% were connected to dental insurance.

Further, although a relatively small number of families needed services related to domestic violence or mental health, almost all families indicating a need in these areas were connected with services (100% and 94%, respectively).

Finally, about one-fifth (20%) of parents reported their family income situation had improved over the past 6 months, and 31% of families reported that at least one of the primary caregivers gained employment during the prior year.

Program Implementation & Service Delivery

Healthy Start continues to increase the effectiveness of its system for contacting and offering services to first-time parents, reaching more families in FY 2006-07 than in any prior year:

- A total of 13,457 families representing 69% of eligible births were identified and offered Healthy Start services during FY 2006-07 and 50% (9,788 families) agreed to participate in screening and the program's evaluation. This represents almost 2,000 more families screened in FY 2006-07 than in FY 2005-06.
- Only 7% of families declined to hear about Healthy Start at the initial point of contact. An additional 13% accepted the initial Healthy Start information, but declined to participate in screening, and 8% could not be reached after signing a preliminary release form. Of those screened, only 219, or 2%, declined to participate in the evaluation.
- Most screening (88%) took place prenatally or during the first 2 weeks after the baby's birth, exceeding the HFA standard of 80%. Early screening and engagement of families in services is critical to program success.

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

- Of those families screened, 56% screened at higher risk.
- Families screened by Healthy Start have more demographic risk factors, compared to Oregon's general population. For example:
  - 51% of those screened were single mothers, compared to 32% in the general population (KIDS COUNT, 2004)
  - 9% of those screened were teen mothers, compared to 3% in the general population (KIDS COUNT, 2004)
  - 26% of mothers screened had less than a high school education, compared to 20% in the general population (KIDS COUNT, 2004)

As a part of statewide efforts to streamline the screening and eligibility process, Healthy Start implemented a one-step eligi-

bility process during FY 2006-07. In prior years, eligibility was determined in a two-step process: (1) Risk screening using the New Baby Questionnaire, followed by (2) an in-depth Kempe Family Stress Interview/Assessment for those scoring at higher risk. Because the Kempe process involves an intensive and in-depth interview, many families who were identified as potentially eligible for Healthy Start Intensive Services never completed the second stage of the eligibility process, due to lack of program resources, inability to locate families, families refusing to participate in the Kempe, and other reasons.

This year, Healthy Start was able to offer Intensive Services to a much larger number of eligible families – 3, 388 families (compared to 1,175 in FY 2005-06). One unexpected consequence of this streamlined process was a significant increase in the number of families who declined home visiting (44% vs. only 11% last year). Importantly, however, families were significantly more likely to accept services if they had a larger number of risk factors. In particular, families were more likely to accept services if they: (1) were teen parents; (2) had less than a high school education; (3) were single parents; (4) were at risk for depression; (5) were struggling financially; (6) were having problems with family relationships; or (7) had substance abuse issues. This suggests that although more families declined to participate in Intensive Services, families who did decline may have been less in need of support. In fact, 49% of those declining services did so because they felt they did not need the service.

Families enrolled in Intensive Services are characterized by a number of risk factors:

- Families receiving Intensive Services are significantly more likely to be single-parent households, teen parents, unemployed, and have financial difficulties than families who were screened but did not participate in the home-visiting component.
- 68% of Healthy Start Intensive Service mothers and fathers grew up in homes with at least one parent who had problems with substance abuse, mental health, and/or criminal involvement.
- 82% reported a lack of nurturing parents in their own childhoods, with personal histories ranging from the mild use of corporal punishment to more serious abuse and neglect.

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

- A total of 1,273 new Intensive Service families were able to be enrolled; however, 974 (20% of eligible families) could not be offered Intensive Services because program caseloads were full.

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

- Close to 100% of Healthy Start Intensive Service parents reported Healthy Start "helped a lot" by providing parenting information. Parents also reported that their home visitor "helped a lot"

with obtaining basic resources (87%), dealing with emotional issues (87%), and encouraging the development of positive relationships with family or friends (95%). Parents reported that the services provided by the program are culturally competent (over 76%) and help them to build on their family's strengths (over 85%).

Conclusions and Looking Ahead

Outcomes for Oregon's Healthy Start program are consistently positive across a variety of domains known to be important to supporting children's healthy development and reducing the risk for child maltreatment. Further, the program is showing considerable success at the state level in meeting the standards set by Healthy Families America, as reflected by receipt of HFA accreditation in June 2007.

In addition to credentialing efforts, FY 2006-07 brought other significant program improvements and quality assurance efforts to the Healthy Start program. These efforts emphasized performance-based monitoring, changes to the screening and eligibility process, and development of community partnerships to improve screening processes. The success of these efforts is reflected in this year's process and outcome data, especially in the area of screening eligible first birth families. OCCF staff and NPC Research continue to monitor program quality using both the HFA standards and the Oregon Healthy Start Service Delivery Performance Standards. Continued technical support and assistance to the local program sites will help ensure consistency in implementing these standards so that all of Oregon's children can have a "healthy start." However, additional funds will be needed in order to reach a larger proportion of eligible families with intensive home visiting services.

HEALTHY START OF OREGON STATUS REPORT 2006-2007

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

Healthy Start Goals

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

The ultimate goals of Healthy Start are to:

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

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

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

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

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

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

Oregon Receives Healthy Families America Accreditation

In June 2007, Oregon's Healthy Start program was officially recognized as an accredited multi-site state system by Healthy Families America. Receipt of accreditation was the culmination of over two years of intensive work to develop and implement over 180 research-based quality standards across all of Oregon's Healthy Start programs and the state oversight office. To achieve accreditation through HFA, all programs must submit extensive documentation showing that they are in alignment with credentialing guidelines. Next, a random sample of 13 sites received 2- to 3-day site visits from HFA national reviewers. Additionally, the program's central office at the Oregon Commission on Children and Families (OCCF) also received a site visit and a detailed review of their training, technical assistance, evaluation, quality assurance, and administrative systems.

HFA accreditation requires that both local programs, as well as the state's Healthy Start office, demonstrate the use of a comprehensive set of research-based program practices, including evidence-based home visiting procedures, rigorous training and supervision supports, and effective program management and administration processes.

Oregon was the sixth state-level multi-site system to be accredited by HFA. There are over 400 individually accredited programs nationally.

A recent New York study of more than 1,100 parents who were randomly assigned to either the HFA program or a control group found the HFA model to be effective in improving parenting and child outcomes (Mitchell-Herzfeld et al., 2005). HFA is now officially considered to be an evidence-based promising practice (Rand, www.promisingpractices.net).

Healthy Start Program Context FY 2006-07

Budget reductions to the Healthy Start program in the 2005 Legislative Session resulted in a 20% reduction in Healthy Start funds and subsequent reduction and redirection of Healthy Start General Fund dollars. Thus, programs in FY 2006-07 were operating under a significantly reduced budget at the same time that higher standards for service delivery and program quality were being implemented during the accreditation process. While the 2007 legislative session has since nearly restored Healthy Start to previous funding levels, *during the period that this report covers (July 1, 2006-June 30, 2007), budget cuts were significant*.

Further, during this period there were other reductions in statewide services, including reduction in health insurance coverage for poor families, elimination of subsidized alcohol and drug abuse treatment slots, increased unemployment, and a general reduction in a variety of other supportive services for poor families. Child abuse rates statewide and nationally were on the rise, due in large part to the increased prevalence of methamphetamine production and use (DHS, 2006). Moreover, these challenges were occurring at

a time when programs were working intensively to meet best practice standards for quality program implementation, as well as doing the extensive documentation of program services required for HFA accreditation. Finally, during the 2005 legislative session, Healthy Start was asked to focus its efforts on the highest-risk families and to work more closely with families involved with child welfare and TANF/self-sufficiency (and therefore, families with more needs). Thus, the context for Healthy Start in FY 2006-07 can best be described as "doing more with less."

A statewide restructuring of the program occurred during 2005-06, resulting in a number of significant changes, including a move away from providing "minimum grants" to counties, support for the formation of regional programs (two were formed during 2006-07), an increase in required local match (to 25%), and an emphasis on performance-based funding. To guide this process, in addition to the HFA standards being used in the credentialing process, a set of 13 state-level Performance Indicators were developed and became incorporated into the state's ongoing quality assurance and technical assistance process (for more detailed information about the development of the Performance Indicators, see the Healthy Start 2005-06 Status Report).

"Thank you [Healthy Start], for everything. Now that me and my son are safe, I get a chance at a better life."

– Healthy Start Parent

A second major change in the Healthy Start program was to streamline the eligibility process, moving from a two-step screening and assessment process to use of a single-step eligibility screening. It was hoped that the single-step screening would result in more efficiencies in the system, and consequently, allow more resources to be spent on providing services to those most in need.

To ensure that the one-step process was a valid and reliable method for identifying families at higher risk, NPC Research used data from Healthy Start's in-depth assessment tool, the Kempe Family Stress Inventory, and from the program's well-validated risk screen, the New Baby Questionnaire (NBQ). NPC Research determined that potentially eligible families could be identified with 86% accuracy based solely on the NBQ. The new screening system specified that families with any two or more positive risk factors on the NBQ, or who indicated either a substance abuse or depression concern, were extremely likely to be found eligible on the Kempe assessment. Thus, as of July 1, 2006, programs began to use a one-step process for determining eligibility.

Outcomes for Children and Families, FY 2006-07

Over the past 12 years, a set of outcome indicators has been developed to measure Healthy Start's annual progress toward two key Oregon Benchmarks: (1) **reduced incidence of child maltreatment** and (2) **improved school readiness**. The analysis of child maltreatment data is scheduled to be released in Spring 2008. This document summarizes the remaining outcomes, organized in two major domains: (1) Risk factors for child maltreatment; and (2) School Readiness. County-level information is presented in Tables 1 through 35. Data related to Oregon Performance Standards is summarized in Tables 36 and 37.

Risk Factors for Child Maltreatment

In order to reduce rates of child maltreatment, the Healthy Start program targets several risk factors that have been found to be associated with higher incidence of child abuse and neglect (Cicchetti & Toth, 2000), including poor parenting skills and parent

stress. These results are summarized below (again, actual impacts on child maltreatment rates will be reported in a separate report in April 2007).

Positive Parenting

Positive, supportive interactions increase children's well being and are related to reductions in child maltreatment (Shonkoff & Phillips, 2000). HFA Standards require that the program have a comprehensive approach to promoting parenting skills and positive parent-child interactions (see Tables 32 & 33). Information from Healthy Start's Intensive Service families in FY 2006-07 found that after 6 months of Healthy Start services:

- 81% of higher-risk families reported **improved parenting skills**.
- 74% of higher-risk families reported **improved ability to help their child**.
- 82% of higher-risk families were rated by their Healthy Start workers as consistently **engaging in positive, supportive interactions with their children**.
- More than a third (39%) of higher-risk Intensive Service parents reported a **decrease in parenting-related stress** from the time of the child's birth to the 6-month birthday.

SCHOOL READINESS OUTCOMES

Three primary outcomes related to school readiness are tracked: (1) children's health, (2) children's growth and development, and (3) the ability of parents to provide developmentally supportive environments for their children. These results are presented below.

Health Outcomes

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

- 98% of children living in higher-risk Intensive Service families **had a primary health care provider,** which greatly exceeds the Healthy Families America standard of 80%. In addition, 76% of the parents had a primary health care provider (see Table 24).
- 94% of children living in higher-risk Intensive Service families **received well-child check-ups** (see Table 24). National data report that only 84% of children under age 6 nationally received a well-child visit during the past year (Child Trends, 2004). For poor children this rate is even lower (81%).
- Healthy Start workers reported that 93% of these children were **fully immunized** by age 2 (see Table 26). Healthy Start workers report this information primarily using parents' immunization cards and by accessing Oregon's ALERT data system. In contrast, only 78% of all Oregon 2-year-olds were fully immunized in 2006, according to the Oregon ALERT Immunization Registry (2006). Nationally, about 81% of children were found to be fully immunized by age 3, although rates for poor children are lower (76%; Child Trends, 2004). Healthy Start children exceed the HFA Standard of 80% fully immunized by age 2, as well as exceeding comparable national and local immunization rates.
- Only 7% of Intensive Service families reported regular use of emergency room services for routine health care (see Table 25).
- 89% of Healthy Start Intensive Service children had **health insurance**, compared to 85% of low-income children nationally (Table 25). Further, of the 197 children lacking health insurance at the time of screening, 94% had been connected with health insurance while enrolled in Healthy Start. In the general population in Oregon, which includes families at

considerably lower risk than Healthy Start families, 93% of children ages 0 to 5 have health insurance.

- Intensive Service mothers were more likely to receive **early prenatal care for subsequent pregnancies** (87% compared to 80% for their first pregnancies, see Table 27).

Healthy Growth and Development

HFA standards require regular developmental screening using a standardized tool and appropriate documentation and referral for children with identified delays. Healthy Start programs use the Ages and Stages Questionnaire (ASQ), administered at specific age-based intervals, to monitor children's development (see Table 28). The rate of screening of eligible children increased for the third year in a row, from 56% of eligible children in FY 2004-05 to 73% in 2005-06, to 79% in FY 2006-07 (1,717 children screened). Recent case file reviews conducted during the credentialing process suggested that even more eligible children may have had a developmental screening, but that some of these screens are not being reported to the evaluators in a timely fashion.

67% of Healthy Start Intensive Service parents reported reading to their children at least daily, higher than the national average.

Of those children whose ASQ results were reported this year, a large majority (90%) of these children showed patterns of normal growth and development.

Further, those children with identified developmental delays were appropriately linked to early intervention. About three-fourths (78%) of the Healthy Start Intensive Service children with a diagnosed developmental delay were currently receiving early intervention at the time of the most recent Family Update.

In addition to the ASQ, programs use the Ages and Stages Social-Emotional Scale (ASQ-SE) to screen children for developmental delays. Families are eligible for the ASQ-SE when the babies reach 6 months of age (see Table 29). Of the 2,184 eligible families, 1,550 or 71% reported ASQ-SE results to the evaluation team, a sizeable increase over last year, when only 48% of eligible children were screened with the ASQ-SE. Most screened children (96%, 1,483 children) had normal ASQ-SE scores. Of the 35 children with delays indicated (not necessarily diagnosed), Healthy Start workers responded appropriately, connecting 14 (40% of those with delays indicated) to early intervention; referring 5 children to mental health services (14%), and providing information and developmental support to remaining children (12 children, 34%).

Early Literacy and Learning

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

First, after 12 months of Intensive Service, 81% of Healthy Start's higher-risk families are **creating learning environments** for their young children that their home visitor rated as "good" or higher, as indicated by the scoring criteria for The Home Observation for Measurement of the Environment Inventory (Bradley & Caldwell, 1984) (see Table 33). This result compares favorably with findings from other, comparable populations (e.g., Caldwell & Bradley, 1994).

Second, by age 1, 86% of higher-risk Intensive Service families report **reading to their children** at least three times per week (see Table 33). This is a key indicator of a positive early literacy environment. Nationally,

only about two-thirds (64%) of higher-risk families read to their young children three or more times per week (Nord, Lennon, Liu, & Chandler, 1999).

CONNECTING FAMILIES WITH RESOURCES

One of the key HFA critical elements requires programs to document evidence that they are successfully connecting families to appropriate resources and referral sources. On the Family Intake and Update forms, Family Support Workers report families' need for a variety of services, and whether these needs are met. The most frequently reported needs are listed below, along with the percent of families who were successfully connected to the appropriate service by 6 months (see Table 30).

- Housing Assistance (203 families in need, 87% connected)
- Medicaid/OHP (154 families in need, 96% connected)
- Education Assistance (130 families in need, 94% connected)
- Job Training & Employment Services (115 families in need, 94% connected)
- Mental Health Services (96 families in need, 94% connected)
- Temporary Aid for Needy Families (TANF, 93 families in need, 97% connected)
- Dental Insurance (54 families in need, 78% connected)
- Domestic Violence Services (30 families in need, 100% connected)
- Drug and/or Alcohol Abuse Treatment (16 families needed, 84% connected)

Healthy Start also appears to be supporting parents in reaching self-sufficiency. About one-fifth (20%) of parents reported that their family income situation had improved over the previous 6 months (see Table 31), and one-third (31%) reported at least one caregiver obtained a new job. While these figures suggest that Healthy Start is doing a good job linking these families with needed services, the small number of families with needs in these areas suggests that greater efforts to identify family needs, especially in the areas of drug/alcohol abuse, mental health, and domestic violence, may be needed.

DO PROGRAM OUTCOMES DIFFER FOR PARENTS WITH DIFFERENT CHARACTERISTICS?

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

Differences were examined for the following outcomes:

- *Parenting*: (1) Reported improvement in parenting skills and (2) reductions in parenting stress;
- *Support for School Readiness*: (1) HOME (Home Observation for Measurement of the Environment) scores and (2) frequency of parent reading to the child;
- *Child Health*: (1) Whether the child is connected to a primary health care provider; (2) receipt of regular well-child check-ups; and (3) whether the child is fully immunized.

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

- Hispanic vs. White/Caucasian parents[1]
- Teenaged (17 and younger) vs. non-teenaged parents

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

- Unmarried vs. married parents
- Parents at risk for depression vs. parents not at risk for depression (at screening)

Results showed the following.

Outcomes for Hispanic Parents

There was a slight trend for Hispanic parents to have somewhat less positive outcomes, although these differences were generally small and not consistent over time. Further, in terms of parenting stress, Hispanic families were actually more likely to show a reduction between birth and 6 months, compared to White/Caucasian families. Specifically[2]:

Parenting

- Hispanic parents were significantly less likely to report that their parenting skills had improved after 12 months in the program (80% reported improvement vs. 84% of White/Caucasian parents), although there was no significant difference after 6 months in the program (81% vs. 82%).
- Hispanic parents were more likely to report a reduction in parenting stress after six months in the Healthy Start program (42% reporting a reduction vs. 35% of White/Caucasian parents).

Supporting School Readiness

- Hispanic parents had somewhat less positive scores on the HOME at the child's 12 month birthday, indicating that they may be providing a less developmentally enriching environment for their children (77% scoring in the 'good or better' range vs. 86% of White/Caucasian families).
- Hispanic parents were also less likely to be reading to their child three times per week or more at the 12 month assessments (82% vs. 92% of White/Caucasian parents).

Child Health

- Hispanic children were somewhat less likely to be connected to a primary health care provider (97% vs. 99%) but were no more or less likely to receive regular well-baby visits or to be fully immunized at age 2. This may reflect a greater use of community medical clinics for health care (rather than the same health care provider), coupled with higher rates of mobility for these families.

Teenaged Parents

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

Parenting

- Teenaged parents were less likely to report that their parenting skills had improved after 6 months in the program (75% vs. 82% of non-teenaged parents), although this difference was only marginally significant (p=.056) after 12 months in the program.
- Teenaged parents were *more* likely to report a reduction in parenting stress after six months in the Healthy Start program (47% vs. 38% of non-teenaged parents).

Supporting School Readiness

- Teenaged parents were less likely to be reading to their child three times per week or more at the child's 24 month birthday (80% of parents), compared to non-teenaged parents (87%).
- There were no significant differences between teen and non-teen parents in their HOME scores.

Child Health

- There were no significant differences in health outcomes for children of teen vs. non-teen parents.

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

Marital Status

There were no significant differences on any of the outcomes for married vs. unmarried parents.

Risk for Depression:

Intensive Service parents who scored at risk for depression on the screening (NBQ) had generally similar outcomes as non-depressed parents with one exception:

Parenting

- Parents who scored at higher risk for depression on the screening (NBQ) were more likely to report an improvement in parenting skills after 6 months in the Healthy Start program (86%) vs. parents who were not at risk for depression (77%); however, this difference was not significant after 12 months in the program.

Child Health

No significant differences on any health outcomes.

Summary of Outcome Analyses for Parents with Different Characteristics

Results of these analyses did not suggest any strong patterns of difference in outcomes for parents with different characteristics. However, a few things are worth noting in terms of areas for possible program improvement. First, both Hispanic and teen parents were less likely to be reading frequently to their children. Given the importance of reading as a precursor to children's language and literacy development, Healthy Start workers may want to emphasize the importance of this activity, especially among these groups of parents.

Second, Healthy Start may need to re-double its efforts to improve the parenting skills of teenaged and Hispanic parents, especially during the first 6 months of service. Although both these groups were also more likely to report reductions in parenting stress (which indicates that the supportive component of the program is working well for these parents) their own self-assessments indicated that they did not feel they improved in their parenting as much as other parents.

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

PARENT SATISFACTION

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

Results indicate that parents almost universally report they have benefited from the services they receive from Healthy Start (see Table 35). Almost all of the Intensive Service parents (99% of the 1,703 parents respond-

ing) reported that Healthy Start helped them obtain and understand parenting information. Also, parents reported that their home visitor helped with obtaining basic resources (87%), dealing with emotional issues (87%), gaining education and job assistance (78%) and encouraging the development of positive relationships with family or friends (95%).

As shown in Table 34, almost all parents responding indicated that Healthy Start workers respected their family's cultural and/or religious beliefs (88%), and provided materials that positively reflected their cultural background (76%). Further, over 85% of all parents reported that their workers used a strengths-based approach to providing services, by helping them to see strengths they didn't know they had (85%); helping parents use their own skills and resources (88%), working as a partner with them (93%), helping them to see that they are good parents (98%), and encouraging them to think about their personal goals (96%).

Despite budget cuts, Healthy Start successfully screened a higher percentage of eligible families in FY 2006-07 than any year since 2001-02, with 50% of eligible births screened (9,788 families).

More than 1,300 parents surveyed added handwritten comments describing the benefits of Healthy Start for their families. Parents noted the "invaluable" emotional support and information provided by home visitors. Parents repeatedly commented about the value of having "someone to talk to" as well as expressing appreciation for the instructional materials, resources, activities, and information provided by Healthy Start. A number of parents credited Healthy Start with helping them to reduce their social isolation, and gain a better understanding of themselves and their children. Suggestions for improvements were almost entirely focused on parents' desires to see services broadened and expanded to serve subsequent births, to serve current children for a longer period of time, and to serve more families in need. Comments from both English and Spanish-speaking parents were unilateral in their support and appreciation for the Healthy Start program.

Program Implementation & Service Delivery Results

A consistent finding in the research literature is that effective home visiting programs should start early in the life of the child and provide comprehensive and intensive services to at-risk families. Programs that are not well implemented, or which do not successfully engage families are less likely to show positive outcomes (Sweet & Appelbaum, 2004). In Oregon's Healthy Start program, implementation and service delivery achievements are monitored using the statewide Performance Indicators, as well as the HFA standards for effective home visiting programs. Below, we present data on key performance indicators and HFA standards for Oregon's Healthy Start program.

Effective Screening to Identify Higher-Risk Families

Healthy Start's screening and assessment system strives to reach all first-time parents with screening and referral services, as an effective and non-stigmatizing way to identify families and children at greatest risk for negative outcomes. **This year, despite an almost 20% overall budget cut to program services since 2005, Healthy Start screened more first birth families (9,788 families, or 50% of eligible births) than during either FY 2005-06 (40% of eligible births) or FY 2004-05 (41%).** See Table 1 for details. Further, as shown in Table 2, Healthy Start programs successfully identified and contacted more families than any previous program

year: 13,457 families, a total of 69% of eligible first births. At the program level, more than half of the programs (18, or 58% of programs) met the statewide Performance Indicator standard by screening 50% or more of eligible first births, with screening rates ranging from 100% to 10%.

The number of parents accepting Healthy Start screening services was consistent with prior years (Table 2). Only 7% of all families offered services declined Healthy Start at the initial point of contact (i.e., were not interested in receiving any information about Healthy Start). An additional 13% accepted preliminary Healthy Start information but declined to participate in screening. Eight percent (8%) could not be located after signing a release form. Seventy-three percent of those families offered Healthy Start services were successfully screened (9,788 families, see Table 2). A few families (219, 2% of those screened, see Table 1) were screened but declined to participate in the evaluation and thus information about the characteristics and status of these families is not included in this report.

Because program capacity was limited, Healthy Start was unable to provide Intensive Services to almost 1,000 eligible families statewide.

Almost all screening (88%) took place prenatally or within 2 weeks of the child's birth (see Table 3), greatly exceeding the HFA performance standards. At the program level, 20 out of the 31 programs (65%) met the HFA standard of 80% of screenings occurring during this time frame. The median number of days from the baby's birth to when families were screened by Healthy Start was one (1) day (counting prenatal screens as zero days); county medians ranged from 0-40 days (although the county with a median of 40 days screened only four families, one of which occurred several months after the birth).

During FY 2006-07, families were considered to be at higher risk (and potentially eligible for services) if they screened positive on any two risk factors on the New Baby Questionnaire, or positive for either the maternal depression or substance use indicators. As shown in Table 4, out of 9,172 families with risk factor screening data, 56% (5,109 families) were eligible for Intensive Services home visiting.

Analyses of the number of risk factors shows that, as expected, very few families are meeting eligibility based *solely* on the presence of maternal depression or substance use; as expected, these risk factors tend to appear in conjunction with other risk factors. Of those families screened, 56% screened as eligible, but only 2% were eligible based on the presence of these single risk factors only (see Table 4). Families were most likely to have either 2 (19% of all screened families) or 3 (16%) risk factors, although a sizeable number had four or more risk factors (1,711 or 19% of those screened). Data from the Healthy Start evaluation in prior years shows a clear relationship between the number of risk factors a family has and their risk for child maltreatment, with families with four or more risk factors being more than six times as likely as families with no risk factors to have a founded maltreatment report (Green, Brekhus, Mackin, Tarte, Snoddy, & Warren, 2007).

Acceptance Rates for Intensive Services

After identifying families as eligible for Intensive Services, Healthy Start workers or other program volunteers must decide whether the family can be offered Intensive Services. The decision to offer services can be based on a number of factors, including the availability of other appropriate services, current Healthy Start caseloads, and individual program guidelines for identifying families who may have particularly high needs. One of the issues highlighted in this year's data is

a striking increase in the number of families who were *offered* Intensive Services – 2,706 families in FY 2006-07, compared to only 1,175 families in FY 2005-06 (see Table 9). This difference is very likely due to the change in eligibility process, as in FY 2005-06, like the years prior, as many as 50% of potentially eligible families (families who had a higher risk screen) did not participate in the second phase of eligibility, the Kempe assessment. Some families refused the Kempe, some could not be located in order to conduct the assessment, and some families were not contacted for assessment because programs were triaging families based on their screening scores, and only attempting to assess families who they felt would be more likely to qualify for services.

As a result of the simpler, single-step screening process, far more families were able to be offered services; however (see Table 9) far more families also declined to participate in Intensive Services than has been the case in prior years (44% declined in FY 2006-07, compared to 10% in FY 2005-06).

Given this increase in the percentage of families who declined Intensive Services, we conducted further analyses to explore which families were more or less likely to accept Intensive Services. Results suggest that families are "self-selecting" out of Healthy Start based on their risk status – specifically, families with fewer risks were less likely to accept Intensive Services ($B=-.336,\ p<.01$). This is an extremely important finding, as it suggests that Intensive Services are, in fact, going to higher-risk families who are most in need. Clearly, Healthy Start is **not** providing Intensive Services to lower-risk "easier" families (a process sometimes referred to as "creaming"); indeed, it appears that just the opposite is occurring.

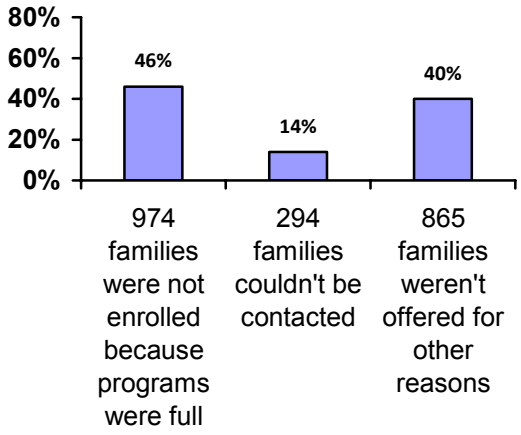
We found that mothers were ***more likely*** to accept Intensive Services if they were (1) teen parents; (2) had less than a high school education; (3) were single parents; (4) were at risk for depression; (5) were struggling financially; (6) were having problems with family relationships; (7) had substance abuse issues; or (8) were Hispanic/Latina. For example, among mothers who had less than a high school education, 62% accepted Intensive Services; among families with more educated mothers, only 51% accepted services (see Tables 18 & 19).

Counties ranged from a high of 100% acceptance in several small counties to a low of 37%, with 13 programs having an acceptance rate of 75% or higher. Statewide, 909 families (76% of those declining) declined because they felt that services were not needed; 13% declined for "other" reasons; and 11% declined because the parent stated that they were "too busy."

Intensive Service Capacity

Of the 9,172 families with risk factor screening data during FY 2006-07, 56% (5,109 families) screened at higher risk, and thus were potentially eligible for Intensive Services. However, programs were able to enroll only 1,273 new Intensive Service families (see Table 10 and Figure 1) or 25% of those eligible, indicating that the unmet need for Intensive Services is potentially quite large. Of those eligible for Intensive Services, programs indicated that 2,133 families (44% of those eligible) were not offered services; the majority of these families (974, or 46% of those not offered services) were not offered services because program caseloads were full. It appears that the need for Healthy Start home visiting services greatly exceeds the capacity of programs to enroll families in the Intensive Service component. Current program size would need to be nearly doubled in order to serve the almost 1,000 families who were not offered services because of limited program capacity.

Figure 1. Intensive Service Not Offered



WHO ARE HEALTHY START FAMILIES?

Screening and Referral

Healthy Start's goal is to provide screening, referrals, and parenting information to all first time parents. Utilizing the New Baby Questionnaire (NBQ) to screen for risk factors, Healthy Start identifies those families with significant risk factors who may be eligible for more intensive home visiting services ("Intensive Services"). Lower-risk families (defined, in FY 2006-07 as families with fewer than two risk factors and who do not score positive for depression or substance use) receive screening, information, and basic referral services only.

Intensive Services

In FY 2006-07, 2,857 families received Intensive Services and participated in the evaluation (see Table 10), a slight decrease in the number of Intensive Service families compared to 2005-06 (3,332 families). This reduction likely reflects the budget reductions, which in many programs resulted in a loss of home visitation staff. Further, it appears that the reduction in the number of families served is due primarily to a loss of continuing families, rather than to a reduction in new enrollments. Healthy Start enrolled 1,273 new Intensive Service families, a slight increase from 2005-06 (1,231 families). However, there were fewer families who continued services from the prior year (1,584 vs. 2,101 in 2005-06). This may also reflect the loss of home visitation staff due to program cut-backs, as families who have been working with a particular home visitor may be reluctant to stay in the program if their home visitor leaves.

HFA standards require programs to maintain a description of the current service tion that addresses cultural, racial/ethnic, and linguistic characteristics. As shown in Figure 2, as well as Tables 5 through 8 (all families who were screened) and Tables 12 through 15 (Intensive Service families only), families who participated in Healthy Start's Intensive Service component were significantly[1] more likely than the total group of screened families to be Spanish-speaking (33% vs. 15%), Hispanic/Latino (37% vs. 17%), teen parents (16% vs. 9%), single parents (73% vs. 51%), have less than a high school education (44% vs. 23%), have both parents unemployed

[1] Hispanic/Latino vs. Caucasian ($X^2(2)=22.3$, $p<.001$); Spanish vs. English speaking ($X^2(2)=529.0$, $p<.001$); teen vs. non-teen ($X^2(2)=189.7$, $p<.001$); married vs. single, $X^2(2)=579.6$, $p<.001$); less than high school vs. greater than high school, $X^2(2)=625.8$, $p<.001$); unemployed vs. employed ($X^2(2)=108.6$, $p<.001$); financial concerns vs. no financial concerns ($X^2(2)=927.4$, $p<.001$); depression vs. not depressed $X^2(2)=279.3$, $p<.001$); serious marital problems vs. no serious marital problems $X^2(3)=155.6$, $p<.001$); no health insurance vs. has health insurance (mothers) ($X^2(2)=1091.1$, $p<.001$); late prenatal care vs. early prenatal care ($X^2(2)=166$, $p<.001$); substance abuse vs. no substance abuse ($X^2(2)=61.6$, $p<.001$).

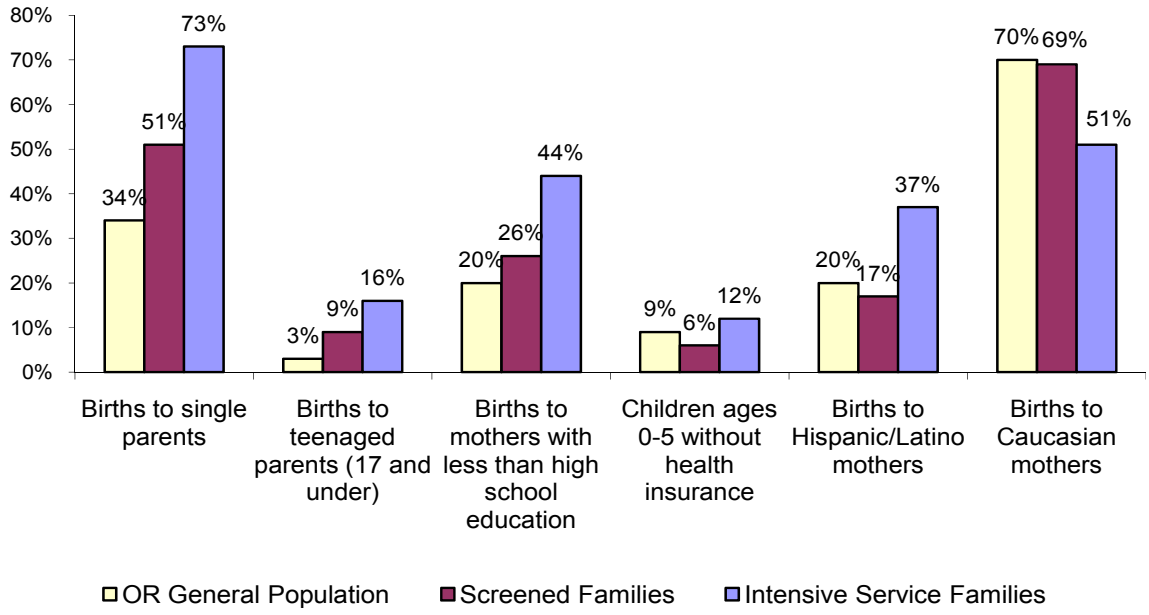
(13% vs. 8%), have financial difficulties (77% vs. 47%), have dealt with depression (40% vs. 19%), have serious marital problems (25% vs. 10%), lack health insurance (mothers) (12% vs. 5%); lack health insurance (infants) (12% vs. 6%); to have indicated a problem with substance abuse in the family (5% vs. 3%) and have had late prenatal care (31% vs. 21%).

Moreoever, as shown in Figure 2, Healthy Start families were at considerably higher risk than the general Oregon population. For example, while only 32% of all Oregon births were to single mothers, 51% of all screened/referred parents were single mothers, and 73% of Intensive Service mothers were single.

Intensive Service families were 51% Caucasian, 37% Hispanic/Latino, 3% Asian/Pacific Islander, 1% African American, 1% American Indian, and 5% multiracial. About one-third (33%) indicated Spanish as the primary language spoken at home, while an additional 3% indicated that a language other than English or Spanish was the primary language. A significant number of Intensive Service mothers (16%) were under 18 years of age, 73% were single mothers, and 44% had less than a high school education.

About 13% of Intensive Service mothers reported that neither she (nor her partner, if applicable) were employed, and 40% indicated a risk for maternal depression (see Table 15). About one-third (31%) of Intensive Service mothers indicated they had late or no prenatal care with their first pregnancy. Twelve percent of mothers (12%) indicated that they had no health insurance (see Table 14) and 65% reported being on the Oregon Health Plan (see Table 14). Among infants, 12% were not covered by health insurance.

Figure 2. Healthy Start Family Risk & Demographic Characteristics[1]

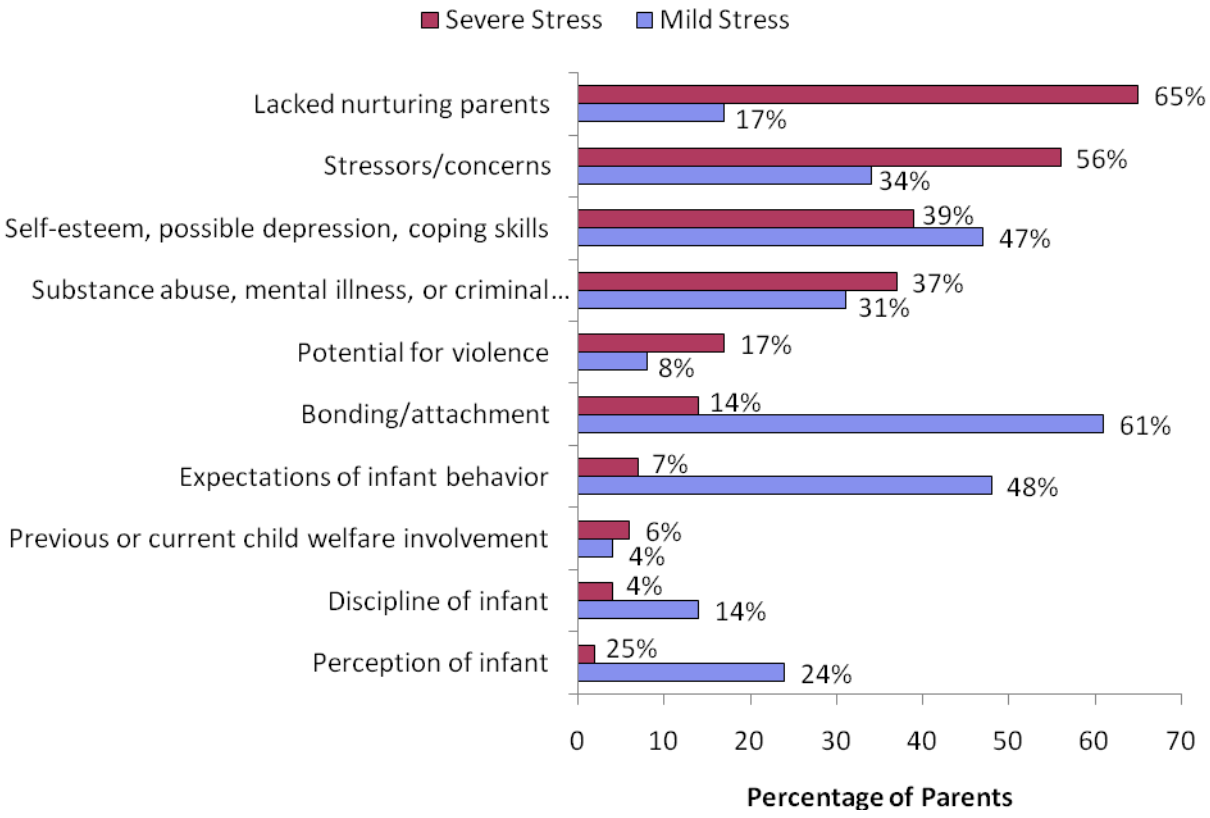


[1]Oregon general population rates are based on all births. Information is based on final 2006 vital statistics downloaded from: http://www.dhs.state.or.us/dhs/ph/chs/data/birth/birthdata.shtml

Kempe assessments, while no longer a part of the eligibility process, are conducted with families within the first month of Intensive Services in order to identify family issues and plan appropriate services (see Table 16, and Figure 3). By doing the Kempe, Family Support Workers "ask the hard questions" that are needed to identify family needs in such areas as substance abuse, domestic violence, and mental health and can form the basis for referrals for these services. Kempe assessments completed in 2006-07 document that a large proportion of the parents in Healthy Start lacked nurturing parents themselves (82%), with concerns ranging from relatively mild use of corporal punishment to more serious abuse and neglect. More than two-thirds (68%) of Healthy Start children have at least one parent who has at least a mild concern with substance abuse, mental illness or criminal involvement in their family. Ten percent (10%) of parents reported having current or previous history with the child welfare system. Almost all parents reported feeling isolated, having few available social supports, poor coping skills, and/or low self-esteem (86-90%).

Furthermore, at program enrollment, Healthy Start children often had at least one parent with risks specifically associated with poor parenting skills. For example, 55% had poor understanding of developmental milestones, 75% had concerns about bonding/attachment, and 18% reported plans for using severe discipline techniques (see Table 17). These results illustrate that Intensive Service families are at very high risk for negative family outcomes including child maltreatment (Shonkoff & Phillips, 2000).

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



ENGAGING FAMILIES IN INTENSIVE SERVICES

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

> **"Healthy Start is great, especially for mothers that come from not so healthy families, and want to make a difference in their own child's life.**
>
> ***– Healthy Start Parent***

- While 56% of 2,706 families who were offered Intensive Services agreed to participate, higher risk families were actually more likely to accept Intensive Services than lower risk families.
- About three-fourths (73%) of those families who accepted Intensive Services received a first home visit and were successfully enrolled in the program (1,150 families).
- Of those who did not receive a first home visit, about one-third (31%, 133 families) declined further services; the remainder moved (5%), were unable to be located (28%) or were unable to be served for other reasons (36%).
- 92% of Intensive Service families received their first home visit within 3 months of the baby's birth, which surpasses the HFA standard.

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

There was a strong and significant difference[1] in terms of racial/ethnic background: Hispanic/Latino families were more likely to accept Intensive Services (66%), compared to Caucasian families (52%). Similarly, Spanish-speaking mothers were more likely (67%) than English-speaking mothers (53%) to accept services. Further, reflecting the pattern described previously wherein higher risk families appear to be accepting services at higher rates, results also showed that teen mothers were more likely to accept Intensive Services than non-teen mothers (61% vs. 55%) and mothers with less than a high school education were more likely to accept services (62% vs. 52%). No other differences in acceptance rates by these demographic factors were significant[2].

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

[1] Hispanic/Latino vs. Caucasian (X^2 (1) =35.42, p<.001); Spanish-speaking vs. English-speaking (X^2 (1) =33.66, p<.001).

[2] Teen vs. non-teen mother (X^2 (1) =5.48, p<.05); High school diploma vs. no HS diploma (X^2 (1) =24.65, p<.001).

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

During FY 2006-07, the statewide average showed that 69% of families were receiving at least 75% of the expected number of home visits for their level of service, not quite meeting the HFA criteria of 75% of families (see Table 11). However, there was considerable variation by program on this indicator as well, with 20 of the 31 programs (65%) providing data meeting the HFA standard, while 3 programs provided fewer than 50% of the required visits. Thus, far more individual programs met the standard for home visit completion this year (65%) than was the case during 2005-06 (40%).

WHO DROPS OUT OF INTENSIVE SERVICES?

As shown in Table 23, a total of 1,095 Intensive Service families exited the program during FY 2006-07 (38% of total Intensive Service families served this fiscal year). The mean age of children at the time of exit was 10 months, about 2 months lower than the average age during 2005-06. This may indicate that more families are exiting the program earlier than in prior years.

As shown in Table 23, data indicate that the most frequent reason for leaving Intensive Services was that parents were no longer interested in receiving services (39%), families moved (22%), or families were unable to be contacted by their worker (13%). Six percent (6%) of children reached the program's age limit (typically, 3 years of age). Family support workers indicated that 22% of exiting families were making "excellent" progress at the time of exit, and 43% were making "good" progress.

HFA standards call for programs to annually analyze "who drops out of the program and why." To begin to answer this question, we examined retention rates for families enrolled during two fiscal years: (1) 2004-05; and (2) 2005-06. For the 2004-05 cohort, we calculated retention rates for families at 3, 6, 12, 18, and 24 months after enrollment (see Table 20-A). For the 2005-06, we calculated retention rates for families 3, 6, and 12 months after enrollment (see Table 20-B).

Results indicated the following for the 2004-05 cohort[3]:

- 81% of enrolled families were still in the program after 3 months of service
- 66% of enrolled families were still in the program after 6 months of service.
- 46% of enrolled families remained in the program after 12 months of service; 33% after 18 months, and 26% after 24 months.

For the 2005-06 cohort, retention rates were quite similar:

- 78% of enrolled families were still in the program after 3 months of service
- 65% of enrolled families were still in the program after 6 months of service.
- 43% of enrolled families remained in the program after 12 months of service.

Clearly, retaining families for the duration of the program remains a challenge for Healthy Start programs, although almost half of the programs (15, or 48%) did reach or exceed the state Performance Standard of 50% reten-

[3] It should be noted that the retention rates for the 2004-05 cohort reported here are *higher* than the retention rates for this same cohort reported in last year's status report. This is likely due to work that was done during 2005-06 by the evaluation team and local programs to ensure that families were not missing the Family Intake and Exit forms that are required for these analyses.

tion at 12 months. While HFA does not designate a certain retention rate that programs must meet, research clearly shows that the benefits for families increase with longer duration of home visiting services (Gomby, Culross, & Behrman, 1999).

"I only wish the program would go longer, and help me with my next baby."

– Healthy Start Parent

We then conducted analyses to explore whether (for the 2005-06 cohort) families who left the program before receiving at least 12 months of service were different from those families who remained in Intensive Services in terms of the following characteristics (see Tables 21 & 22): Race/ethnicity (Hispanic/Latino vs. Caucasian); marital status (married vs. single); teen parent status; education level (mothers with greater than a high school education vs. mothers with less education); and employment status.

As shown in Table 21, results indicated that at 12 months after program enrollment, Hispanic/Latino families (as well as families in which Spanish is the primary language spoken at home) were significantly more likely[4] to have stayed in the program (51% retained) compared to white/Caucasian families (42%) or families of other racial/ethnic groups (30%). Families headed by married parents also were significantly more likely to remain in the program after one year (55%) compared to families headed by single mothers (41%). Finally, families of teen mothers were less likely to be retained (35%) compared to families headed by non-teen mothers (46%)[5] (see Table 22). There were no significant differences in retention rates for families in terms of mothers' employment or education level.

[4] Hispanic/Latino vs. Caucasian vs. Other ($X^2(2)=20.9$, $p<.001$); Spanish-speaking vs. English speaking ($X^2(1)=16.8$, $p<.001$).

[5] Married vs. unmarried ($X^2(1)=13.45$, $p<.001$); teen vs. non-teen mothers ($X^2(1)=6.43$, $p<.01$).

Summary & Conclusions

HEALTHY START OUTCOMES

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

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

One area that may continue to need improvement is in the identification of domestic violence, mental health, and substance abuse issues. While those families who had an identified need in these areas were consistently linked with resources, the number of families statewide who were identified as being in need was quite low. This may indicate that workers could benefit from additional training in how to screen and assess families to accurately identify the need for these services. Given the relatively large number of families who self-identify as being at risk for depression, more consistent screening for clinical depression and affiliated mental health problems should be considered.

Finally, it should be noted that while the number of children receiving developmental

screenings has increased dramatically (with 79%, or 1,717 children, receiving a developmental screening this year), somewhat fewer children with identified developmental delays are being linked to early intervention services (78%). Building strong relationships with the early intervention system is critically important to ensure children receive needed assessment and services.

SCREENING AND ASSESSMENT SYSTEM

Healthy Start builds on family strengths, implementing a legislative philosophy designed to create wellness for all Oregon children and families. Information from participating counties shows family interest in and need for Healthy Start service is substantial, as indicated by the high rates of family participation in screening and referral services. Further, although the rate of refusals for Intensive Service home visitation was somewhat high this year, it is clear that those families most in need of Healthy Start are agreeing to participate in services. This suggests the ongoing importance of continuing to provide *a continuum of service*, ranging from non-stigmatizing screening and referral to long-term support services beginning prenatally and continuing through the early childhood years.

Healthy Start represents a unique statewide screening system to identify families in need very early in their child's life. The program was highly successful in screening families during FY 2006-07, although there was still considerable variation at the county level. Focused efforts to improve community partnerships with hospital, health clinics, private doctors' offices and other points of entry into the Healthy Start program, especially for those counties whose screening systems most need improvement will be an important area for quality improvement efforts during the upcoming year.

It will also be important to continue to monitor the one-step eligibility process to ensure that the system is working properly to identify and engage families who are in need of services. Programs in which a significant percentage of families declined to participate in Intensive Services may need to examine their processes for offering and engaging families during the early points of contact.

Capacity for Intensive Services has also been an issue for programs this year, with some programs having to turn away as many as 56% of eligible families because caseloads were full. Statewide almost 1,000 families were not able to be offered Intensive Services because programs were at capacity when the mothers gave birth.

ENGAGEMENT AND RETENTION

Healthy Start continues to do a good job engaging and serving families who are at higher risk for negative child outcomes. Intensive Service families are clearly at much higher demographic risk compared to either the general Oregon population or to families who receive only screening and referral services. Almost 20% of Intensive Service families had four or more risk factors measured by the NBQ, indicating substantially increased risk for child maltreatment.

Another feature of successful home visiting programs is the ability to deliver regular, frequent, home visits to families. This year, Healthy Start implemented a new process for tracking the successful delivery of the expected number of home visits to families on a monthly basis. This year, the state came very

close to meeting the HFA standard for home visit completion (75% of families receiving at least 75% of expected home visits); statewide 69% of families received the appropriate number of visits. Two-thirds (65%) of the individual programs met the HFA standard for successful completion of home visits.

Retaining families in Healthy Start services for the duration of the program continues to be a challenge for programs. For families enrolled during 2004-05 and during 2005-06, retention rates were similar: About 81% of Intensive Service families were still participating 3 months following enrollment, but by 6 months this figure dropped to 65-66%, and by one year, fewer than half of families were still engaged. Retention rates were somewhat higher for Hispanic families, but somewhat lower for families headed by single or teen mothers. Additional training or program development focused on engaging families once children are transitioning out of infancy may be needed. However, it should also be noted that as retention rates for families improve, without additional funding for capacity expansion the programs' ability to enroll new families will be reduced. Thus, retention of families for the full three years of services, which is one of the keys to longer term positive outcomes, may have the unintended consequence of restricting the number of new families that can be served.

CONCLUSIONS

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

A review of Table A (a summary of progress towards HFA standards) shows that of the HFA standards that are monitored by the evaluation[6], the statewide Healthy Start program meets or exceeds the performance standard in the following areas:

- The program maintains a detailed description of target population and current service population
- Eligibility screens are conducted within 2 weeks of child's birth
- The program defines and monitors acceptance and retention rates
- First home visits are delivered within 90 days of the child's birth
- The program analyzes and monitors who drops out of services and why
- The program provides culturally competent services
- The program has a regular processs to solicit parent feedback regarding services
- The program uses standardized developmental tool to monitor child development
- Children with suspected developmental delay are tracked and/or referred for support
- More than 80% of children have a medical home
- More than 80% of children have up to date immunizations
- The majority of families receive needed referrals
- The program conducts an annual evaluation of outcomes.

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

There were only two areas in which standards were not met: identifying (screening) 75% of the target population, and ensuring that 75% families receive 75% of expected home visits. The screening goal is quite ambitious, and the increase in screening rates this year was impressive considering the reduced program budgets during FY 2006-07. Home visit completion rates came very close to meeting HFA standards; as programs continue to implement the new process for monitoring home visit completion, this area is likely to continue to improve.

Programs need to develop effective systems that bring together a range of community partners in a shared effort to support families with Healthy Start and other community services. Among some counties, establishing an infrastructure to identify and engage families is especially challenging, as reflected by relatively low rates of offering services to families. These programs need targeted technical assistance to address these infrastructure problems, as well as support from state-level partners for increasing the success of Healthy Start's screening system.

Receipt of HFA accreditation was a major program milestone, and reflects the dedication and hard work of Healthy Start program managers and staff as well as state Healthy Start staff. The credentialing process has assisted programs in working to address many challenges in program implementation, documentation, and partnership development. The state's investment in credentialing has paid off in greater consistency and quality of services. Research on home visiting programs shows these services *can* work; however, the quality and intensity of services must be held at high levels. Oregon's Healthy Start program has documented that it is providing high quality, research-based services to families.

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

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

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Table A. Progress Toward Selected HFA Critical Elements — FY 2006-07

HFA Element for which the evaluation provides data	Origin of the data	Statewide result for the corresponding HFA element, and the table where this information can be found for individual counties	HFA standard for the element
1-1.A. Description of target population	First birth data from Oregon Department of Human Services Web site (http://www.dhs.state.or.us/dhs/ph/chs/data/) downloaded November 2007 for the July 2006 – June 2007 fiscal year.	**Table 1:** • 19,443 eligible births in 34 Healthy Start counties funded during 06-07.	The program has a description of the target population and identified organizations within the community in which the target population can be found, which, while sufficient for its needs could be more comprehensive (are comprehensive and up to date).
	County demographic data from the Oregon Department of Human Services Web site.	• http://www.dhs.state.or.us/dhs/ph/chs/data/	(Same as above).
1-1.B. Identification of target population	The number of families offered service is the sum of screened families plus additional contacts and screening refusals documented annually by programs.	**Table 1 & 2** • 13,457 families offered services (69% of eligible)	The system of organizational agreements enables the program to identify at least 75% of the participants in the target population for screening or assessment.
	Clients with a New Baby Questionnaire submitted to NPC Research with a screening date between July 1, 2006, and June 30, 2007, plus the program counts of the number of families who are screened but decline to participate in the evaluation are counted in the screening rate.	**Table 1:** • 9,788 (50% of eligible) families screened	

HFA Element for which the evaluation provides data	Origin of the data	Statewide result for the corresponding HFA element, and the table where this information can be found for individual counties	HFA standard for the element
1-1.D. Screenings/ Assessment to determine eligibility for services occur prenatally or within first two weeks of birth of the baby	Screen date is taken from the New Baby Questionnaire (Item 1) or from the Family Manager data system. Date of birth is taken from the New Baby Questionnaire (Item 2), or in cases in which birth date is missing, the Family Manager system, or the Family Intake form. Time to screen is calculated as the number of days between birth date and screening date. Prenatal screens are counted as zero days.	**Table 3:** • 2,686 (28%) screened prenatally • 5,741 (60%) screened within 2 weeks of birth • 1,141 (12%) screened after two weeks. • Overall: 88% screened at or before 2 weeks of age. • Median time to screen = 1 day	80% of eligibility screenings or assessments occur either prenatally or within the first two weeks after the baby's birth.
1-2.A. Acceptance rate of participants	Healthy Start Intensive Service "Accepted" by parent, from NBQ (Item D).	**Tables 9, 18 & 19:** • 56% of eligible families accepted service at the time of assessment	The program defines, measures, and monitors its acceptance rate and evidence indicates acceptance rates are measured in a consistent manner and at least yearly.
1-2.B. Analysis of who refused the program and why (of those eligible)	Healthy Start Intensive Service "Declined" by parent, from NBQ (Item D). Demographic data are obtained from the New Baby Questionnaire [age (#7a), ethnicity (#8), language spoken (#10), marital status (#13), education level (#15), and employment status (#16 & 17)].	**Tables 18 & 19** • Percentage within each ethnic group who declined (vs. those who accepted): • Hispanic families were significantly more likely to accept services (66%) compared to White/Caucasian families (52%) • Teenaged mothers were somewhat more likely to accept services (61%) compared to non-teen mothers (55%) • Mothers with less than a high school education were more likely to accept services (62%), compared to those with more education (52%).	The program annually analyzes who refused the program and why. This analysis relies on demographic and informal sources to identify those who refused (ideally, the analysis also addresses programmatic, demographic, social and other factors).

HFA Element for which the evaluation provides data	Origin of the data	Statewide result for the corresponding HFA element, and the table where this information can be found for individual counties	HFA standard for the element
1-3. First home visit occurs prenatally or within 3 months of the birth of the baby	Date of first home visit is on the Family Intake Form (item 1), or if missing, is taken from the Exit Form. Baby's birth date comes from the New Baby Questionnaire (item 2) or the Family Intake form. Time to first visit is calculated as the number of days between first home visit date and baby's birth date.	**Table 11:** • 92% (1,068 families) received first visit prenatally or within 3 months of the birth of the baby	80% of first home visits occur within the first three months after the birth of the baby.
3-4.A. Participant retention rate	Retention rates calculated for all families served in IS during 04-05 and 05-06. Service is defined in this analysis as anyone having a first home visit. Date of first home visit is on the Family Intake Form (item 1), or if missing, is taken from the Exit form. Date of last home visit is on the Exit Form. Reasons for leaving are taken from the Exit Form. Intensive Service clients without an Exit Form are coded as "still in service."	**Table 20 A (04-05):** • 81% remained in after 3 months of service • 66% remained in after 6 months of service • 46% remained in after 12 months of service. • 33% remained in after 18 months of service. • 26% remained in after 24 months of service **Table 20 B (05-06):** • 78% remained in after 3 months of service • 65% remained in after 6 months of service • 43% remained in after 12 months of service.	The program defines, measures, and monitors its retention rate, and evidence indicates retention rates are measured in a consistent manner and at least yearly (more than once a year).

HFA Element for which the evaluation provides data	Origin of the data	Statewide result for the corresponding HFA element, and the table where this information can be found for individual counties	HFA standard for the element
3-4.B. Analysis of which families drop out of the program and why	Reasons for leaving are taken from the Exit Form. Demographic Characteristics of exited families are taken from the New Baby Questionnaire (Items 7b, 8, 10, 13, and 16).	**Table 23:** 1,095 families exited the program during FY 2006-07. Reasons for exiting the program included: • 39% parent no longer interested • 22% family moved • 13% family was unable to be contacted by the program • 6% of children "aged out" of the program **Tables 21 & 22:** Within each subgroup, the percentage of those who exited: • Hispanic/Latino families were less likely to have dropped out of service at 12 months post-enrollment (49%) compared to Caucasian families (58%) or to families of other racial/ethnic backgrounds (70%) • Spanish speaking families were significantly less likely than English speaking families to have dropped out of the programs at 12 months post-enrollment. • Teen mothers were significantly less likely than non-teen mothers to have dropped out of the programs at 12 months post-enrollment. • Single mothers were significantly less likely than married mothers to have dropped out of the programs at 12 months post-enrollment. 12-month retention rates did not differ for any of the following subgroups: There were no significant	The program annually analyzes who drops out of the program and why. Analysis relies on demographic and informal sources to identify those who dropped out (ideally analysis also addresses programmatic, demographic, social and other factors).

HFA Element for which the evaluation provides data	Origin of the data	Statewide result for the corresponding HFA element, and the table where this information can be found for individual counties	HFA standard for the element
		differences in acceptance rates for parents who were employed vs. un-employed	
4-2B. Families receive appropriate number of home visits for their assigned level of service	Home visit tracking forms completed by FSWs and submitted to NPC monthly or quarterly.	**Table 11:** 69% of families received the expected number of home visits given their service level	75% of families receive at least 75% of the appropriate number of home visits based on service level (e.g., family on Level 1 receives at least 3 visits per month).
5-1. Description of current service population	Demographic data are from the New Baby Questionnaire (# 7b (age), 8 (ethnicity), & 10 (language spoken at home). **Additional data** describing the current service population is presented in Tables 5-8 (screened families) and 12-15 (Intensive Service families).	**<u>All Screened Families:</u>** **Table 5:** • African American (3%) • Hispanic/Latino (17%) • Asian (4%) • American Indian (1%) • Caucasian (69%) • Multiracial (4%) • Other (1%) **Table 6:** • English spoken at home (80%) • Spanish spoken at home (15%) • Other language spoken at home (4%) • Teen Mothers (9%) • Single Mothers (51%) • Less than high school education (22%) **<u>Intensive Service Families</u>** **Table 12:** • African American (1%) • Hispanic/Latino (37%) • Asian (3%) • American Indian (1%)	Program has a description of the current service population that addresses cultural characteristics, racial/ethnic characteristics, and linguistic characteristics.

HFA Element for which the evaluation provides data	Origin of the data	Statewide result for the corresponding HFA element, and the table where this information can be found for individual counties	HFA standard for the element
5-1. Description of current service population		• Caucasian (51%) • Multiracial (5%) **Table 13:** • English spoken at home (64%) • Spanish spoken at home (33%) • Other language spoken at home (3% • Teen Mothers (16%) • Single Mothers (73%) • Mothers with less than a high school education (44%)	
5-4.B. Culturally competent practices/services, including participant input	Most recent responses on Parent Survey II (#7), items: My home visitor (1) respects my family's race, culture, and/or religious beliefs; (2) provides materials for my child that positively reflect our cultural background	**Table 34** • 57% of parents agreed that their home visitor encouraged them to learn about their culture • 88% of parents agrleed that their home visitor respected their cultural and religious beliefs • 76% of parents agreed that their home visitor had materials that positively reflected their cultural background	The program reviews its practices for cultural competency and includes direct input form the participants on (at least) 3 of the following: culturally sensitive practice, materials, communication, and staff-participant interaction. Review could be more comprehensive.
6-2A-C. The home visitor and participant collaborate to identify participant strengths, competencies, needs, services to help address those needs, and goals for home visitation	Most recent responses on Parent Survey IIB, #7. Ratings of staff strength orientation are assessed by parent responses.	**Table 35:** • 85% of parents agreed that their home visitor helped them to see strengths in themselves they didn't know they had • 88% of parents agreed that their home visitor helped them to use their own skills and resources to solve problems	The home visitor and participant collaborate to identify participant strengths and competencies, assess participants' needs, and set goals for home visitation.

HFA Element for which the evaluation provides data	Origin of the data	Statewide result for the corresponding HFA element, and the table where this information can be found for individual counties	HFA standard for the element
6-4. Program promotes positive parenting skills, parent-child interaction, and knowledge of child development	Most recent responses on Parent Survey IIA # 5 & 6. Most recent response on Parent Survey II #4. Cumulative HOME score at 12 months.	**Table 32:** • 81% of parents reported improved parenting skills after 6 months in the program • 74% of parents reported improved ability to help their child after 6 months in the program **Table 33:** • 82% of families had positive parent-child interactions at their most recent Parent Survey administration • 81% of families had a "good" or higher score on the HOME at 12 months	Standards related to worker provision of information. Data suggest positive outcomes in the parenting domain.
6-5.B. Use of standardized developmental screen/tool to monitor child development	Most recent response on Family Update (#37b). Note: This information is based on the Family Support Worker's most recent administration of the ASQ.	**Table 28:** • 90% of children were within the "normal" range of development • 79% of all age-eligible children received at least one ASQ assessment	The program uses a standardized developmental tool at specified intervals to monitor child development for target children in the program unless developmentally inappropriate.
6-7.B. & 6-7.C. Documentation of children suspected of having a developmental delay, program follows through with appropriate referrals/ services	Most recent responses on Family Update (#34, 36).	**Table 28:** • 57 children had an identified developmental delay; 78% of these children were reported as receiving early intervention services	Consistent evidence that the program routinely tracks target children suspected of having a developmental delay.

HFA Element for which the evaluation provides data	Origin of the data	Statewide result for the corresponding HFA element, and the table where this information can be found for individual counties	HFA standard for the element
7-1.C. Participating children have a medical provider	Most recent response on Family Update (Primary caregiver = #29, well-child check-ups = #21, emergency room for routine care = #24).	**Table 24** • 98% of children have health care provider • 94% received well-child check-ups **Table 25** • 7% frequently use emergency room for routine care	80% of target children have a medical/health care provider.
7-2.B. Immunizations for participating children are up to date	Most recent response on Family Update (Up to date immunizations = #20a). FSWs primarily use parent immunization cards or the ALERT system for immunization information. Calculations for up to date immunizations by age 2 are based on responses to #20a for all target children 2 years or older (as calculated by date of birth and date of Family Update).	**Table 26:** • 92% of children had up to date immunizations; 7% had some immunizations, but not up to date • 93% reported to be fully immunized by age 2	80% of target children have up-to-date immunizations.
7-3.A. Program connects participants to appropriate referral sources and services	Family Support Workers ratings on the 6-month Family Update #11.	**Table 30:** Percent who needed and were connected with service at 6 months: • Dental Insurance (78%) • Domestic Violence (100%) • Education Assistance (94%) • Housing Assistance (87%) • Job Training (94%) • Mental Health (94%) • Medicaid/OHP (96%) • TANF (97%)	Isolated instances found when participants needing referral were not connected to appropriate services in the community.

HFA Element for which the evaluation provides data	Origin of the data	Statewide result for the corresponding HFA element, and the table where this information can be found for individual counties	HFA standard for the element
GA-3. Program has mechanism in place for families to provide formalized input into program	The family provides ratings of satisfaction with staff on the Parent Survey II B (#7) Parent survey ratings of how helpful Healthy Start home visitors are in a variety of areas. On the Parent Survey II, families can write comments about the program including: (1) What do you think is the best thing about Healthy Start? (2) How could Healthy Start be better? (3) Is there anything else you want to tell us?	**Table 34:** • 93% of parents agreed that their home visitor worked with them to meet their needs • 98% of parents agreed that their home visitor helped them to see they were a good parent • 96% of parents agreed that their home visitor encouraged them to think of their own personal goals or dreams **Table 35:** Parents rated Healthy Start as helpful in: • Providing parenting information (99%) • Obtaining basic resources (87%) • Help with emotional issues (87%) • Encouraging social support (95%) • Help with education/job assistance (78%) Parent open-ended feedback will be compiled, with identifying information removed, and electronically sent to programs	The program has mechanisms for participants to provide input to the program and at least includes participant satisfaction surveys.
GA-5.A. Program routinely reviews progress towards its program goals and objectives	Annual status report (this document).	• NA Not needed for the local programs but may be good for the state to have	The program conducts an analysis of program goals and objectives at least annually.