

# Children First

Oklahoma's Nurse-Family Partnership

## Annual Report

State Fiscal Year 2012

Family Support and Prevention Service

Oklahoma State Department of Health



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**“I loved this program and would encourage any new mother to try it.”**

**Elisabeth Stovall – Children First Client 2012**

## Introduction

In Oklahoma and in the United States, not all of the women who become pregnant are prepared for the pregnancy, and many are not prepared financially or emotionally to parent. The literature shows poverty and lack of education are associated with factors that contribute to poor pregnancy and health outcomes.<sup>1</sup> Other researchers suggest that poverty, low education and low achievement are risk factors for child maltreatment as well.<sup>2</sup> Risks associated with poor pregnancy and health outcomes and child maltreatment can be reduced through proven family support and intervention programs.

The State of Oklahoma implements several evidence-based home visiting programs to reduce risk factors, improve pregnancy and child health outcomes, and increase the capacity of parents to care for their children (Appendix 1). Children First (C1), Oklahoma's Nurse-Family Partnership, is one program being offered to women expecting their first child to ensure an increased chance for a healthy pregnancy, healthy baby, and successful parenting.

Information in the Children First Annual Report for SFY 2012 is presented to meet the reporting requirements as specified in Oklahoma State Statute, 63-1-110-1 Creation of Children First Fund, and to help answer the following questions.

1. What is Children First?
2. Is Children First serving clients for whom the model was developed?
3. What and how are services being provided?
4. What outcomes have been achieved in the Children First population?
5. What is the cost expended per family served?

Data for this report were obtained from the Oklahoma State Department of Health Public Health Client Information System (PHOCIS) and the Oklahoma State Department of Health Oklahoma Statistics on Health Available for Everyone (OK2SHARE) database.

## Program Overview

Children First is a community-based voluntary nurse home visiting program which offers public health services to families expecting to deliver and/or parent their first child. The program was authorized by the State Legislature in 1996 and has been implemented by the Oklahoma State Department of Health (OSDH) through its local health departments, as well as by the city-county health departments of Tulsa and Oklahoma City.

Implementation of Children First began in 1997 as a pilot with 19 nurses in four counties: Garfield, Garvin, Muskogee and Tulsa. The first expansion of the pilot added 125 positions (supervisors and staff nurses) and by October, 1998, services were available statewide. In SFY 1999, a second expansion was authorized with funding to support approximately 270 public health nurse positions. Decreased funding in 2003 led to a reduction in total positions (170). Current funding supports approximately 140 nurse and supervisor positions (Appendix 2).

Early in the process, representatives from Tulsa Children's Consortium, the Oklahoma State Legislature, and Oklahoma State Department of Health reviewed models available at the time and chose to implement the "Olds Model," now known as Nurse-Family Partnership (NFP). The model has been developed and tested through randomized clinical research trials since 1977 with the bulk of the research done through trials in Elmira, New York; Memphis, Tennessee; and Denver, Colorado. All three trials targeted first time, low income mothers and have shown consistent program effects, such as:



- improved prenatal health;
- fewer childhood injuries;
- fewer subsequent pregnancies;
- increased maternal employment; and
- improved school readiness.<sup>3</sup>

The Prevention and Research Center (PRC) at the University of Colorado continues to study the long-term outcomes for mothers and children who participated in the original trials. With funding from the National Institute of Mental Health (NIMH), PRC is now completing a 27-year follow-up of young adults whose mothers participated in the study during their pregnancies and the first two years of their

children's lives. With funding from the National Institute on Drug Abuse, they are beginning a 17-year follow-up of the children and families in the Memphis trial, looking at the children's school performance, cognitive skills, mental health, and disruptive behavior, and the life-course trajectories of the mothers. A 9-year follow-up of the children and mothers enrolled in the Denver trial is also underway.<sup>4</sup> The NFP model is currently being implemented in 42 states.

A study by the RAND Corporation in 2005 indicated for every dollar spent on NFP programs, \$5.70 was saved.<sup>5</sup> A 2012 cost-benefit update by Washington State Institute for Public Policy estimated long-term benefits of almost \$23,000 per participant in Nurse-Family Partnership.<sup>6</sup>

In addition, the NFP model has been recognized by:

- The Coalition for Evidence-Based Policy as meeting “Top Tier” evidence of effectiveness;<sup>7</sup>
- MacMillan et al., in *The Lancet*, as the program with the best evidence for preventing child physical abuse and neglect when administered to high-risk families prenatally and in the first 2 years of a child’s life;<sup>8</sup> and
- The Centers for Disease Control and Prevention as a program that has great potential to reduce the economic burden of child maltreatment.<sup>9</sup>

The OSDH established Children First to promote the health and safety of children and families by addressing issues related to family violence and child maltreatment. By utilizing public health nurses, the OSDH could also achieve agency goals related to improving birth and child health outcomes. Specific program goals are listed in the Children First logic model (Appendix 3).

Overall, Children First seeks to:

- improve maternal health throughout pregnancy and after the child’s birth;
- improve child health and development from birth through age two;
- enhance family functioning and family stability;
- improve maternal life course development;
- promote family safety; and
- reduce the risk of injury, abuse and neglect.

### Children First Mission

*To empower first-time eligible families to care for themselves and their babies by providing information and education, assessing health, safety and development, and providing linkages to community services, thereby promoting the well-being of families through public health nurse home visitation, ultimately benefiting multiple generations.*

### Children First Vision

*To promote a continuum of healthy pregnancies, healthy babies, healthy families and ultimately healthy communities.*

### Program Goals

- *Achieve positive pregnancy outcomes*
- *Achieve positive child health and development*
- *Improve families’ economic self-sufficiency*

## Domains of Functioning

### Personal Health

Client's Health

Nutrition

Smoking

Substance Use

Mental Health

### Environmental Health

Environmental Issues

Safety

Adequate Housing

### Maternal Life Course Development

School

Work

Family Planning

### Maternal Role

Maternal Role Models

Child Health

Child Development

Social and Emotional

### Family and Friends

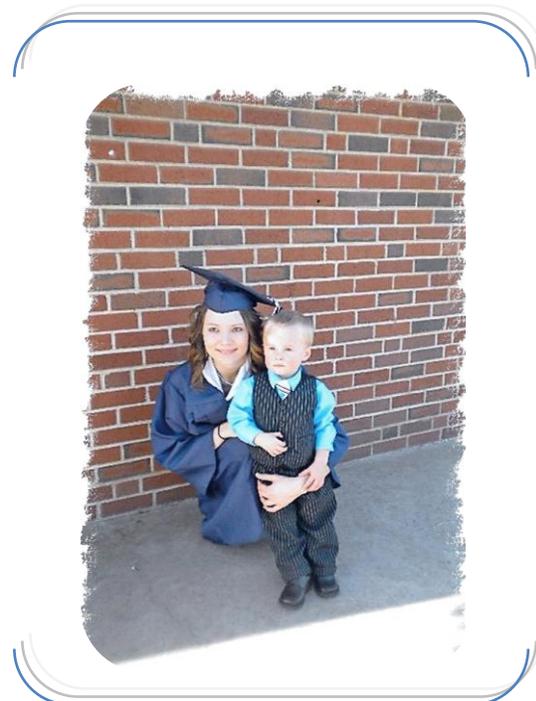
Support Network

Family Stability

Domestic Violence

To accomplish these goals, trained public health nurses provide assessments, education, information and linkages to community services to meet needs identified for each family. Nurses work with both the client's and child's primary care provider (PCP) to improve maternal and child health outcomes. Services rendered by the nurses are not intended to replace PCP services. Poor pregnancy outcomes and child health problems will be reduced to the extent that nurses are successful in working collaboratively with health care providers to increase use of prenatal care services; reduce smoking, alcohol and drug use; increase attendance at well-child visits; and ensure adequate infant growth, weight gain and development.

Nurse home visitors follow tested home visit guidelines and protocols that focus on five domains of functioning: personal health, environmental health, maternal life course development, maternal role development, and family and friend support. Nurses use these guidelines and materials to help their clients build on their own strengths, increase social support, set and attain personal goals, change unhealthy behaviors, and provide sensitive and responsive caregiving to their children.



## Client Characteristics

When models move from research to “real-world” implementation, the number one challenge is to implement the program with fidelity. Years of research have shown that the NFP model is best suited for a woman who had no previous live births; a woman who is enrolled during the early weeks of her pregnancy; a woman who has limited resources; and a woman who feels she has little or no control over her life situation.

### Enrollment Criteria

By targeting first-time mothers, Children First takes advantage of the developmental period in a woman’s life when she transitions to motherhood. This period represents a window of opportunity for behavior change – a time when a woman seeks help and is more open to support. During SFY 2012, 98.8% of the women enrolled had no previous live births. The remaining 1.2% represent women who may have had a previous live birth, but the child died within the first six months of life, was placed for adoption, or removed by DHS.

Enrolling clients early in the pregnancy allows time for the nurse and client to build a strong therapeutic relationship. Through this relationship, the nurse provides information on health issues that impact birth outcomes and child health. At the same time, the nurse is supporting the client in making decisions about career opportunities, continuing education, and family planning options.

Enrollment objectives established by NFP are to enroll 60% of participants by 16 weeks of pregnancy and the remaining 40% by the 28<sup>th</sup> week. In SFY 2012, 96.5% of new Children First clients were enrolled by the 28<sup>th</sup> week; 50.6% by week 16, 45.9% enrolled between 16 and 28 weeks; and 3.5% after the 29<sup>th</sup> week (Table 1). Enrollment after the 29<sup>th</sup> week is due to extenuating circumstances such as a change in estimated date of delivery. The percent of women enrolled prior to the 29<sup>th</sup> week has remained constant for Children First throughout the years.

### Enrollment Criteria

*Women participating in Children First must:*

- *Be expecting their first child;*
- *Have a household income at or below 185% of the Federal Poverty Level; and*
- *Be less than 29 weeks pregnant at the time of enrollment.*



**Table 1: Enrollment Standard**

Gestation	OK	NFP
By 16 weeks	50.6%	60%
By 28 weeks	45.9%	40%
29 weeks +	3.5%	0%

Figure 1: Annual Income at Intake

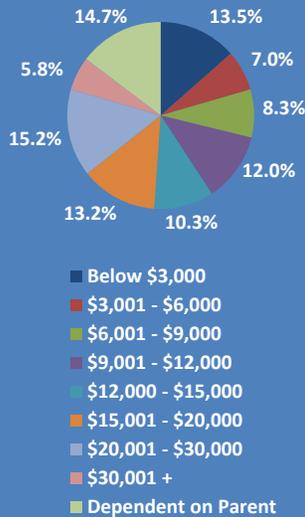


Figure 2: Supplemental Services at Intake

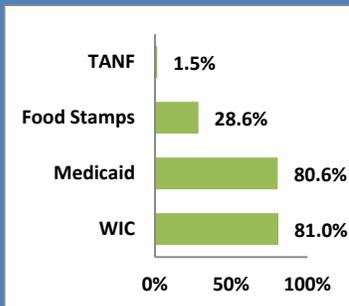
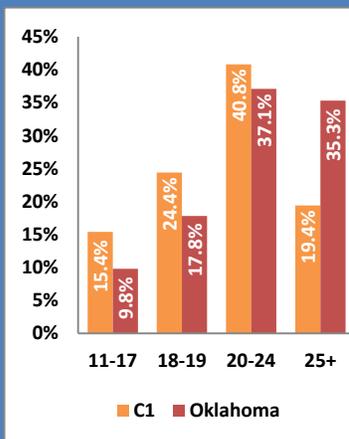


Figure 3: Age at Intake



In addition to the required enrollment criteria, Children First seeks to enroll participants who are teens, unmarried and those with other identified life stressors or maternal health characteristics that impact family well-being.

## Income

Women of all socioeconomic backgrounds were enrolled in the first NFP research trial. However, investigators found that higher-income mothers were less likely to benefit from the program.<sup>10</sup> During the early phases of implementation, Children First enrolled participants who were identified as having “low resources.” In 2002, the OSDH revised the definition of “low resources,” and the income threshold was set at 185% of the Federal Poverty Level (FPL). This income guideline aligns with enrollment guidelines for the Supplemental Program for Women, Infant and Children (WIC) and Medicaid programs. First-time mothers currently receiving WIC or Medicaid meet income qualifications for Children First.

For SFY 2012, over 50% of the new enrollees had an annual income at or below \$15,000 at intake and of those, 20.5% reported an annual income at or below \$6,000 (Figure 1).

## Supplemental Services

At intake, more than 80% of new participants were currently enrolled in Medicaid and/or receiving WIC services. Only about one quarter of new enrollees were receiving food stamps at intake and few were receiving Temporary Assistance for Needy Families (TANF) (Figure 2). Employment wages were identified as the major source of income for new participants.

## Age

Children First consistently enrolls young mothers. In SFY 2012, the average age of new Children First enrollees was 21.3 years at intake. The youngest client was 11 years old and the oldest was 42 years of age. Approximately two-fifths of the new Children First enrollees were teenagers (<20 years old); two-

fifths were in their early twenties; and one-fifth were 25 years or older (Figure 3). Clients enrolled in Children First are also younger first time mothers when compared to the general Oklahoma population, in which only 9.8% of all first births occur among women aged 11-17.<sup>11</sup>

## Education

At intake, more than half of new Children First clients have completed high school (Figure 4). However, of those clients who have had the opportunity to complete high school (those age 18 or over), only 16.2% have not completed high school/GED. In addition, only 59.8% of clients 19 years and older have any education beyond high school.

## Race/Ethnicity

While the majority of new clients self-report as white, the non-white population is proportionately higher in the Children First population than in the state of Oklahoma in general.<sup>12</sup> For SFY 2012, 16.6% of new Children First clients self-identified as Black, 16.1% as American Indian and 3.9% as “other.” Those who identified themselves as being Hispanic represent 16.1% of the Children First population (Figure 5). When compared to the maternal race of first births in Oklahoma, a greater percent of first births occurred among Hispanics in the Children First population (10.7% vs. 16.1% respectively).<sup>13</sup>

## Marital Status

Marital status of clients is assessed at program intake and every six months after childbirth. Marriage is an important indicator of family stability. The marital status of clients at enrollment shows 74.6% were single (Figure 6). The percent of clients single at intake is similar to the 73.8% in SFY 2011. Of all first births in Oklahoma, 50.1% of mothers reported being unmarried at childbirth.<sup>14</sup>

## Maternal Health

The client’s health status has a major impact on pregnancy and birth outcomes. Nurses assess the

Figure 4: High School Completion at Intake

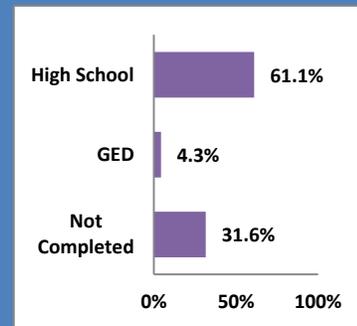
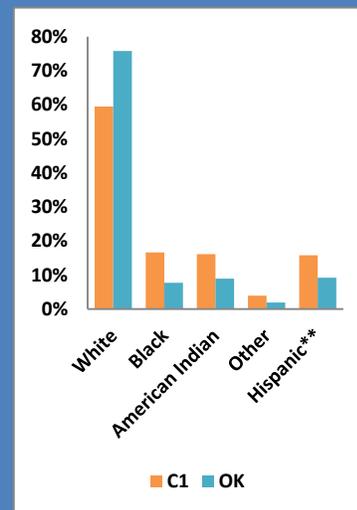


Figure 5: Race/Ethnicity\*



\*More than one possible response  
 \*\*Hispanic is a separate category to designate ethnicity.

Figure 6: Marital Status at Intake

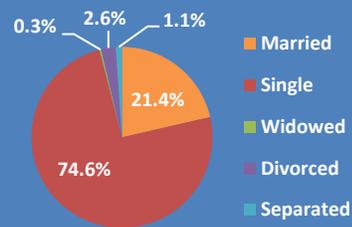


Figure 7: Maternal Health at Intake

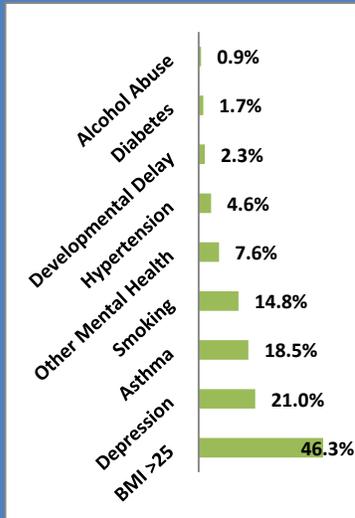
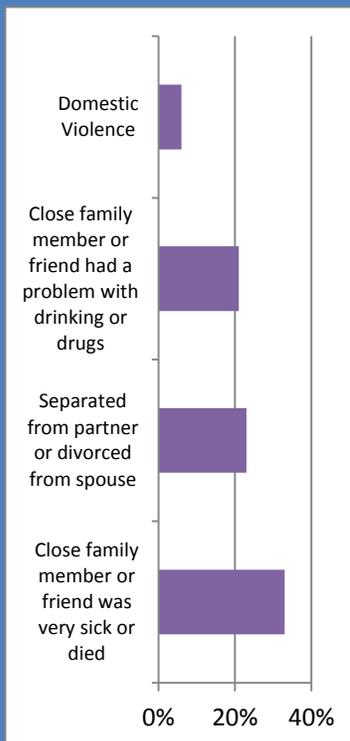


Figure 8: Life Stressors at Intake



client's health status at intake and work with each client to develop a plan of care to reduce factors associated with poor birth outcomes. Health issues identified were alcohol abuse, diabetes, developmental delay, high blood pressure, smoking, asthma, high Body Mass Index (BMI), depression, and other issues related to client mental health. At intake 14.8% of new Children First enrollees smoked, 18.5% had a history of asthma, 21.0% had a history of depression, and 46.3% were considered overweight with a BMI over 25 (Figure 7).

### Life Stressors

Families living in environments in which certain risk factors exist have a higher probability of experiencing poor health outcomes and maltreatment. Increased levels of maternal stress have been associated with low birth weight, preterm delivery, and increases in smoking and alcohol use.<sup>15</sup> Assessments performed at client enrollment yield information on the types of stressors experienced by Children First clients. Nurses use this information to assist families in changing behaviors, increasing protective factors, and accessing needed community services.

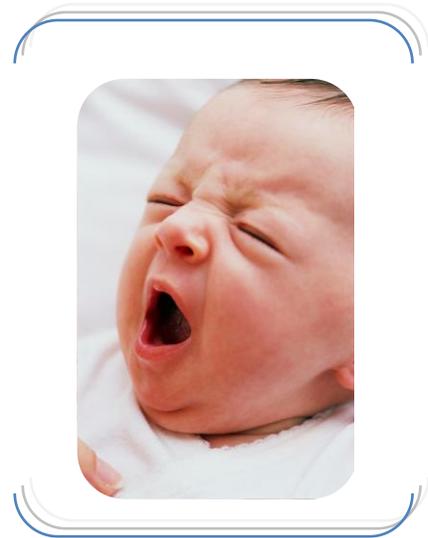
Using 2009 Pregnancy Risk Assessment Monitoring System (PRAMS) data, an OSDH study found that moving, arguing, inability to pay bills, having a family member hospitalized, and having a relative or close friend die were stressors experienced by Oklahoma PRAMS participants. PRAMS is a collaborative project between the Centers for Disease Control and Prevention (CDC) and the OSDH to provide state-specific, population-based data on maternal attitudes and experiences before, during, and shortly after pregnancy. While the PRAMS study did not detect an association between stress and low birth weight or preterm delivery, it found that stress appeared to have an indirect effect on Oklahoma mothers' high-risk behaviors due to its influence on smoking and drinking during pregnancy.<sup>16</sup>

During the spring and summer of 2012, The National Crittenton Foundation completed a pilot project utilizing the Adverse Childhood Experiences (ACES

Study) questionnaire. The questionnaire was administered to 253 adolescent mothers in 31 states and the District of Columbia to accurately reflect the obstacles they face and identify services required to provide family support. Responses revealed that 63% had been exposed to alcoholism or drug use in the home, 56% had experienced psychological abuse (by parents), 51% had experienced depression or mental illness in the home and 50% reported emotional neglect.<sup>17</sup>

During the year prior to enrollment, approximately 55% of Children First clients had experienced events similar to those experienced by the PRAMS group and Crittenton participants. The most common stressors reported at intake were the death or serious illness of a close friend or relative, separation from a partner or husband, and having a close friend or relative with an alcohol or drug abuse problem (Figure 8).

Another stressor that impacts maternal health and life course development is domestic violence. Quantifying the prevalence of domestic violence in the Children First population is difficult. The questionnaire is administered in the home environment where privacy can be difficult. The information is based on self-report and obtained, in some cases, before a trusting nurse/client relationship has developed. The percentage of clients disclosing domestic violence/intimate partner violence at intake is 6.5%, and is thought to be underreported. In child abuse reports made by Children First nurses during SFY 2012, domestic violence is noted as a factor in 29.8% of the reports.



Based on the information obtained through screening, assessment and discussion, it is reasonable to conclude that Children First participants and their children are exposed to life stressors, violence and trauma. Children First provides services to clients with characteristics that place them at risk for poor maternal and child health outcomes and child maltreatment. In the Children First population, during SFY 2012:

- 51.1% reported an annual income less than \$15,000;
- 74.6% were single at program intake;
- 39.8% were under 20 years of age at program intake;
- 55% reported having at least one major life stressor during the previous year;
- 21.0% reported a history of depression;
- 46.3% were overweight prior to their pregnancy (BMI over 25);
- 14.8% identified themselves as smokers; and
- 29.8% of child abuse reports listed domestic violence as a factor.

Table 2: Source of Referrals

2,487	Family Planning OSDH
2,005	WIC
146	Self-Referral
78	Babyline (Tulsa)
67	Faith-based Agency
36	Current/Past Client
27	OSDH Maternity
26	Pregnancy Testing Non-OSDH
19	Indian Health Services
18	Private Physician
18	HMO
14	School
3	DHS
518	Other
325	Source Not Reported
5,787	Total*

\*May include more than one referral per client.

Table 3: Program Activities

98	Nurse Home Visitors
3,547	Families Served
3,790	Eligible Referrals*
1,896	New Enrollees
938	Births
432	Graduates

\*Unduplicated Count

Table 4: Families Served

	2012	2011	2010
Families	3,547	3,616	4,073
Nurses	98	98	109

## Program Activities

Program activities focus on recruiting, enrolling, and retaining clients. Outreach and marketing are performed at the local level to increase the referral base and inform potential clients about the benefits of participating in home visitation programs.

### Enrollment

During SFY 2012, 4,051 women were referred to Children First from multiple sources. Approximately 94% of those referred were eligible for enrollment. The majority of the referrals came from an OSDH family planning clinic or WIC. Other referral sources included Babyline (Tulsa), faith-based organizations, and self-referrals (Table 2). The number of eligible referrals for SFY 2012 (3,790) is similar in number to eligible referrals received in SFY 2011 (3,868).

During the last quarter of SFY 2012, the program developed a Quick Response (QR) Code that is placed on each brochure. This code allows clients to access an on-line referral form utilizing their smart phone. Data from this self-referral process will be available in SFY 2013. For enrollment data on specific counties, please see Appendix 4.

Of the 3,790 women eligible to enroll in Children First, 1,896 (50.0%) enrolled in the program (Table 3). Three primary reasons for not enrolling were: (1) the nurse could not locate the woman or the woman did not return phone calls or keep the initial appointment; (2) women felt the program was not necessary for them and (3) the referred women were no longer pregnant. Regardless of the year of implementation, reasons why women do not enroll are basically the same.

Women who did not meet Children First enrollment criteria or who chose not to enroll but could be contacted were referred to other services and programs to meet their needs. Nurses most frequently made referrals to the Start Right Home Visiting Program and WIC.

## Families Served

Home visitation services were provided to 3,547 families during SFY 2012. The number of families served is similar to the number of families served in SFY 2011, 3,616 (Table 4).

## Home Visits and Assessments

Children First home visits are structured so that there is ample time for the mother to share her accomplishments, to address any immediate crises, and to solve associated problems since the last visit. During the visits, the nurse assesses the health status of mom and baby and provides anticipatory guidance, health education, and linkages to needed services. Nurses provide feedback to clients to highlight their strengths and achievements. The Children First nurse works with each client to develop short-term goals to be completed by the next visit and long-term goals for maternal health improvement and life course development. Although the visit schedule can be adapted to meet the needs of the family, typically the visits are scheduled as follows:

- Weekly for the first four weeks after enrollment;
- Every other week until the baby's birth;
- Weekly during the six-week postpartum period;
- Every other week until the child turns 21 months of age; and
- Monthly until the child turns 24 months of age.

During SFY 2012, Children First nurses scheduled over 42,000 visits of which 33,460 were completed, 3,751 attempted and 4,958 were canceled by clients. Overall, nurses completed 79% of all scheduled visits.

Visit content correlates with the five NFP model domains (personal health, environmental health, maternal life course development, maternal role, and family and friends) outlined by the NFP model. Specific content is determined by the client's needs, program goals and prudent nurse practice. There is an expectation that specific anticipatory guidance topics are covered prior to, or during, the appropriate developmental period. For instance, topics related to adequate weight gain, use of harmful substances, domestic violence, sudden infant death syndrome (SIDS) and shaken baby syndrome (SBS) are covered during the pregnancy. During infancy SIDS and SBS are revisited, and topics related to infant care, growth and development, and home safety are emphasized.

Client assessments are performed throughout the intervention for depression, signs of preeclampsia, postpartum depression, domestic violence and risk factors related to substance abuse. Children receive brief health assessments to evaluate adequate growth and development and to assess for symptoms related to failure to thrive. Developmental screenings are provided to determine achievement of developmental milestones. When abnormal growth or developmental delays are observed, referrals are made to the PCP, Sooner Start (Early Intervention) and/or Child Guidance Services (Appendix 1).



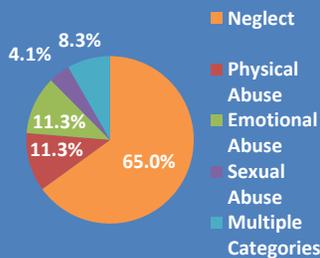
**Table 5: Assessments and Screenings**

Nursing Assessments	42,182
DV Screens	2,196
Depression Screens Intake	1,334
Depression Screens Postpartum	1,051

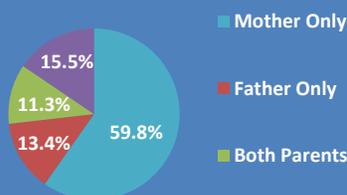
**Table 6: Referrals/Linkages to Services**

Financial Assistance	1173
Nutritional Services	1416
Crisis Intervention	111
Health Care Services	4922
Injury Prevention	661
Substance Use/Mental Health	1172
Developmental Services	244
Educational Programs	926
Charitable Services	456
Other	1894

**Figure 9: Child Abuse Reports**



**Figure 10: Alleged Perpetrator**



During SFY 2012, Children First nurses performed 42,182 nursing assessments, 2,196 domestic violence screens, 1,334 depression screens at intake and 1,051 postpartum depression screens (Table 5). More than 5,000 Ages and Stages developmental screens were administered.

After screening and assessment, developing a plan of care and making appropriate referrals are necessary steps in the care coordination process. During SFY 2012, Children First made more than 13,000 referrals to address needs identified through assessment and screening. The majority of referrals were made for financial assistance (food stamps being the referral most often made), nutritional services (WIC being the referral most often made), health care services (PCP for the child being the referral most often made), and substance abuse/mental health services (mental health treatment for the mother being the referral most often made) (Table 6).

### Child Abuse and Neglect Reports

Like all Oklahomans, Children First nurses are required to report suspected child abuse and neglect. For the 3,547 families served in SFY 2012, Children First made 97 reports for suspected abuse and neglect. Neglect, physical abuse, and emotional abuse were the most commonly reported types of abuse, the majority of cases involving neglect (Figure 9). Of the reports made by Children First nurses, the majority listed the mother only as the alleged perpetrator (Figure 10). Domestic violence was noted in 29.8% of the reports and substance abuse was noted as a factor in 17.5% of reports.

In Oklahoma for 2011, the Department of Human Services (DHS) reported 83.3% of their confirmed cases to be the result of neglect, 12.0% for physical abuse and 4.7% for sexual abuse. In addition, DHS reported that 45.9% of confirmed cases listed the mother of the baby as the alleged perpetrator and 31.3% involved only the father of the baby.<sup>18</sup>

## Outcomes

A primary goal of Children First is to improve the health and well-being of the mother and her child. By providing interventions and referrals early in the pregnancy and early in the child's life, Children First makes a difference in their lives.

Children First serves a distinct population of first-time mothers with incomes at or below 185% FPL. Demographics, behaviors and lifestyles for Children First clients place them at higher risk for having poor outcomes when compared to women that comprise state or national averages. State and national averages reference data collected for an entire population and for a time 2-3 years prior to current program data. Although Healthy People (HP) 2020 provides science-based, 10-year national objectives for improving the health of all Americans, it provides excellent benchmarks for Children First outcomes.<sup>19</sup>

### Maternal Health

**Early and Adequate Prenatal Care** – Beginning prenatal care in the first trimester and attending regular prenatal visits help to ensure a healthy pregnancy and increase chances of having a healthy baby. One HP 2020 objective is to increase the proportion of pregnant women who receive early and adequate prenatal care to 77.9%. In Children First, 76.1% of clients enrolled in 2012 received prenatal care in the first trimester and of those, 89% attended ten or more prenatal visits (Table 7).

**Indicators for Depression** – Despite the joy of giving birth to their first child, some women may experience mild sadness, tearfulness, anxiety, irritability, or mood swings known as the “baby blues.” Other women may develop more severe symptoms related to depression. Nationally, approximately 13% of women who deliver have

Table 7: Healthy People 2020 Objectives

Objective	HP 2020	C1
MICH-10.1- Increase percent who have received prenatal care in first trimester	77.9%	76.1%
MICH-11.3- Increase percent who abstain from smoking during pregnancy	98.6%	88.9%
MICH-18- Decrease percent who return to smoking after the birth	Percent not specified	81.3%
MICH-16.6- Increase percent who use contraceptives to plan pregnancy	Percent not specified	98.0%
MICH-8.1- Reduce proportion of low birth weight births	7.8%	7.7%
MICH-8.2- Reduce proportion of babies born very low birth weight	1.4%	1.4%
MICH-9.2 & 9.3- Reduce proportion of babies born preterm	9.5%	9.0%
MICH-9.4- Reduce proportion of babies born very preterm	1.8%	1.9%
MICH-21.1- Increase percent of woman who initiate breastfeeding	81.9%	86.1%
MICH-20- Increase proportion of babies placed on their back to sleep	75.9%	87.4%

symptoms related to postpartum depression.<sup>20</sup> Maternal and Child Health Services at the OSDH conducted a study looking at PRAMS data for 2009.<sup>21</sup> When reviewing the survey question, “In the months after your delivery did you ever feel sad or hopeless almost every day for at least 2 weeks in a row that you stopped doing some usual activities?” the OSDH found one in four new mothers reported symptoms of maternal depression.

Since postpartum depression is not preventable, early detection and referral is a program goal. Children First administers the Edinburgh Postnatal Depression Screen at intake, during the immediate postpartum period and at 12 months postpartum. Approximately 93% of clients who delivered a baby in SFY 2012 received a postpartum depression screen. The percentage of clients with scores indicating a risk for depression was 8.6% at intake and 5.0% at four weeks postpartum (Figure 11). Nurses provided referrals and follow-up to ensure that clients received evaluation and treatment.

**Smoking Cessation** – A HP 2020 objective is to increase from 89.6% to 98.6% the percent of females delivering a live birth who have abstained from smoking cigarettes during pregnancy. In addition, HP 2020 has set a developmental (percent not specified) objective to reduce postpartum relapse of smoking among women who quit during pregnancy. At intake 85.3% of Children First clients reported **not** smoking, 10.3% reported smoking every day and 4.5% reported smoking on “some days.” Nurses utilized motivational interviewing techniques and referred smokers to the Oklahoma Tobacco Helpline and their PCP to help clients decrease tobacco use. At 36 weeks pregnant, a greater percentage reported **not** smoking; only 7.5% reported smoking every day, and only 3.6% reported smoking on “some days.” At 12 months postpartum the percentage of clients

Figure 11: Depression Screening

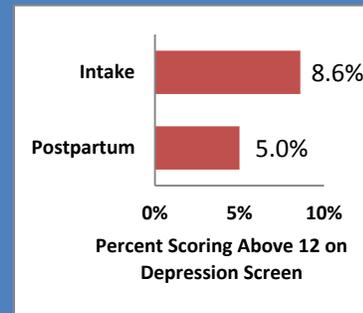


Table 8: C1 Smoking Cessation

C1	Not Smoking	Smoking
Intake	85.3%	14.7%
36 weeks Pregnant	88.9%	11.1%
12 months Postpartum	81.3%	18.7%

Table 9: Oklahoma Smoking Status

Source	Smoking
Last 3 months of pregnancy (PRAMS)	18.5%
2-6 months after delivery (PRAMS)	26.1%
Birth Certificate (OK2SHARE)	15.2%

smoking (18.7%) increased when compared to intake (14.7%) and 36 weeks pregnant (11.1%) (Table 8).

PRAMS data from 2009 showed that 18.5% of Oklahoma mothers smoked during the last 3 months of pregnancy and 26.1% smoked during the 2-6 months after delivery (Table 9).<sup>22</sup>

## Infant and Toddler Health

**Gestational Age at Birth** – Gestational age is the number of weeks between the date when the last normal menses began and the date of birth. Full term is defined as a pregnancy lasting 40-41 weeks. Preterm birth is the birth of an infant prior to 37 weeks gestation and very preterm defines those born prior to 32 weeks gestation. According to the Centers for Disease Control and Prevention, preterm birth is the most frequent cause of infant death, the leading cause of long-term neurological disabilities in children, and costs the U.S. health care system more than \$26 billion each year.<sup>23</sup> A HP 2020 objective is to reduce total preterm births to 11.4% and to reduce very preterm births to 1.8%. In a recent report by the March of Dimes, preterm births represented 13.2% of Oklahoma births and 11.7% of births nationally in 2011.<sup>24</sup> During SFY 2012, 10.9% of Children First babies were born preterm (1.9% very preterm).

**Birth Weight** – Babies born weighing at least 5 pounds 8 ounces (2,500 grams) are considered normal birth weight. Babies born weighing less than 5 pounds 8 ounces (2,499 grams) are considered low birth weight and very low birth weight infants are those weighing less than 3 pounds 5 ounces (1,500 grams). The CDC and others have recognized low birth weight as the single most important factor affecting infant death during the first 28 days of life. If babies born at low birth weight, less than 2500

Figure 12: Gestational Age

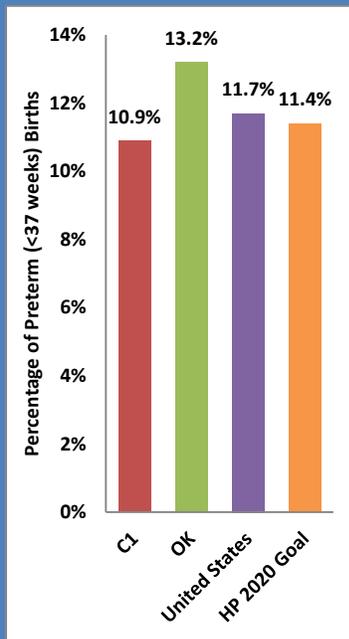
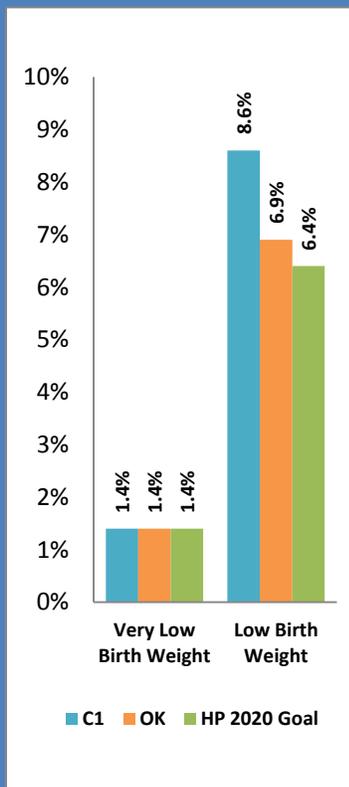


Figure 13: Birth Weight



grams, survive the first four weeks, they are at increased risks for health problems and developmental delays.<sup>25</sup> An HP 2020 objective is to reduce the percent of babies born low birth weight to 7.8 % and very low birth weight 1.4%. During SFY 2012, 10.0% of Children First babies were born at low birth weight (1.4% very low birth weight) compared to 8.3% of Oklahoma babies born at low birth weight (1.4% very low birth weight) (Figure 13).<sup>26</sup>

**Neonatal Intensive Care Unit (NICU)** – Babies born early, with low birth weight or other birth complications may spend time in the NICU. Time spent in the NICU translates into decreased attachment and bonding between mom and baby and incurs NICU costs. A partnership between the March of Dimes and the National Perinatal Information Center/Quality Analytic Services (NPIC/QAS) was formed to describe infant admissions to special care nurseries among NPIC/QAS member hospitals from July 1, 2009, to June 30, 2010. A report developed by this group showed among 183,030 newborns delivered during the study period, 14.4% were admitted to a special care nursery (neonatal intermediate care unit or neonatal intensive care unit) with an average stay of 13.2 days.<sup>27</sup> In Children First, of all of the SFY 2012 births, 7.7% spent time in the NICU. The average number of days spent was 12.5 days.



**Breastfeeding** – Babies who are breastfed are typically healthier and have reduced risks for Sudden Infant Death Syndrome. The American Academy of Pediatrics and the American College of Obstetricians and Gynecologists promotes breastfeeding because of the benefits for both mom and baby. HP 2020 set an objective to increase the proportion of infants who were ever breastfed from a 2007 baseline of 74.0% to 81.9%. The OSDH in its most recent PRAMS report using 2009-2010 data found that 71.6% of Oklahoma PRAMS participants initiated breastfeeding.<sup>28</sup> During SFY 2012, 86.1% of Children First clients initiated breastfeeding and about 32% of clients completing the Infant Health Care form at 6 months continued to breastfeed.

**Immunizations and Well Child Exams** – Children First nurses encourage and refer clients to their child's primary care provider to maintain an up-to-date status for child immunizations and well child examinations. The most recent OSDH Immunization Update reported that 77.3% of Oklahoma's 19-35 month old children were up-to-date on immunizations.<sup>29</sup> Data for SFY 2012 show the immunization status for 94% of children



participating in Children First to be current. More than 80% of children were up-to-date on their well child examinations.

***Developmental Milestones*** – The Ages and Stages screening system is utilized to assess developmental and social and emotional milestones for children enrolled in Children First. During SFY 2012, more than 4,500 screenings were performed using the Ages and Stages developmental screen and more than 1,300 screens were performed using the Ages and Stages-Social and Emotional Screen. Of those children screened using either method, 203 were referred for further evaluation.

## Safety

Family demographics and environmental factors place Children First infants and toddlers at higher risk for unintentional injury. According to the CDC, unintentional injuries (suffocation, motor vehicle, drowning and fire/burns) are the leading cause of death and disability for children under 4 years of age.<sup>30</sup> Children First nurses provide educational materials, home safety assessments and referrals to prevent injury and death related to these issues.

Although the number of infant deaths related to SIDS has declined, it still remains a significant cause of death in infants under the age of one. To reduce the risk of SIDS and other sudden unexpected infant deaths, the American Academy of Pediatrics recommends placing all infants on their “back to sleep for every sleep.”<sup>31</sup> HP 2020 set an objective to increase the proportion of infants who are put to sleep on their backs from a baseline of 69.0% to 75.9%. When assessed at 2 months, 87.4% of Children First mothers reported placing their baby on their back to sleep.

Another HP 2020 objective is to increase vehicle restraint system use in children 0-12 months from 86% to 95% and in children 1-3 years from 72% to 79%. Questionnaires administered showed that 98.8% of Children First clients reported using a car seat all of the time when the child was two months old, 98.1% when the child was 10 months old, and 97.2% when the child was 21 months old.

Children less than five years of age are 1.2 times more likely to die in a fire when compared to the general public.<sup>32</sup> For this reason, Children First families receive education on installation and maintenance of smoke alarms and preparing fire safety plans. According to a report for the National Fire Protection Association, more than two-thirds of home fire deaths from 2006-2010 resulted from fires in homes with no smoke alarms or with smoke alarms that were not functioning. When the Home Safety Checklist is administered at 2 months postpartum, 87% of Children First clients reported having a working smoke alarm. At 10 months, 93% reported having a working smoke alarm and 62% reported having a safety/evacuation plan.

### **Family Stability**

Safe and stable families are goals for all Family Support and Prevention programs. Stability in Children First is often measured by father involvement, pregnancy spacing, and workforce participation.

**Father Involvement** – When fathers are involved in the lives of their children, they are more likely to exhibit healthy self-esteem and do well in school.<sup>33</sup> Children First clients are asked to respond to a series of questions about their interaction with the father of the baby. At intake, 52.7% of the fathers reside in the home. In addition, 77% of Children First clients have daily contact with the father of their child at intake, and at six months, 66% continue to have daily contact. During the intervention, fathers are often present for the visit. The percentage of clients who report daily contact with the father of their child has remained consistent throughout program implementation.



**Pregnancy Spacing** – The amount of time between pregnancies, interpregnancy interval, is calculated as the number of months between the date the last pregnancy ended and the date of the last menstrual period. According to CDC, women with short interpregnancy intervals may be at risk for poor pregnancy and birth outcomes.<sup>34</sup> Research has shown improved life course development and health for women who increase the length of time between pregnancies. The recommended time between birth and the next pregnancy is a

minimum eighteen months.<sup>35</sup> At six months postpartum, 84% of Children First clients reported using birth control and 3.8% of clients were pregnant with a second child and at 18 months postpartum, 19.7% of Children First clients were pregnant with a second child. Of all Oklahoma mothers with a subsequent live birth, 21.1% had less than 18 months between births.<sup>36</sup>

**Education** – In SFY 2012, 102 of the 212 who entered the program without a high school diploma or GED (and were not enrolled in high school at the time) completed their GED by the time they graduated from Children First.

**Workforce Participation** – At program intake, 50.1% of Children First clients were employed. At 6 months postpartum, the percent of Children First clients who were employed increased to 82.7%, and fell slightly to 75.6% at 12 months postpartum. The percent employed remained constant at 18 months postpartum.

## Client Heart's Desire

*"When our 24 months are up with our nurse Barbara, I am going to be sad, but we are so glad we had this time with her to help us along the way. She helped us through the pregnancy and gave us parenting tips for our child. I had not graduated from high school and wanted to get my GED. I had so much going on at test time and couldn't seem to find the time to get it done. I always underestimated myself and I just knew I was going to fail. I honestly think I would have kept blowing off the test, if Barbara had not been there to encourage me. Turns out I did so much better than I did last time, my scores practically doubled. I am so glad now that I got it (GED) because I moved from being a regular cashier to getting a job in the pharmacy. I am learning a lot of new things that I really think are going to jumpstart my education in life. I think every woman that has the opportunity to have a nurse like Barbara and participate in Children First should definitely take advantage of that." – Jessica P. Vickers, Children First Client 2012*



## Required Reporting

### Demographics

In SFY 2012, the age of new Children First clients ranged from 11-42 years of age. At the time of program enrollment, 39.8% of clients were 19 years old or younger, 40.8% were between the ages of 20-24 and 19.4% were 25 years or older (Figure 14). The average age of new Children First clients in SFY 2012 was 21.3 years of age.

Nearly three-fourths (74.6%) of clients were single at the time of enrollment in SFY 2012. Twenty-one percent were married, 2.6% were divorced, 1.1% were separated and 0.3% were widowed (Figure 15).

Household composition for new enrollees showed 92.6% had a household that included a parent, significant other/partner, other child or other relative. Just over 5% of new enrollees reported living alone or with their infant/child only, and 2.3% reported living in a group home or shelter. Table 10 describes the household composition of new enrollees who reported living with others.

### Referrals

Information on prospective clients is reviewed to determine enrollment eligibility. In those cases when the ineligible woman can be contacted, she is referred to a program to meet her need. During SFY 2012, 106 women who were not eligible to enroll in Children First were referred to other programs.

### Families Served

During SFY 2012, Children First provided services to 3,547 families. The average cost per family participating in SFY 2012 was \$3,464. An average of 98 non-supervisory nurse home visitors were available monthly to provide visits. There were 15 nurse home visitors who terminated employment in Children First. There were 22 new nurses hired.

Although the recommended length of the program is from early pregnancy until the child turns two years

Figure 14: Age at Intake

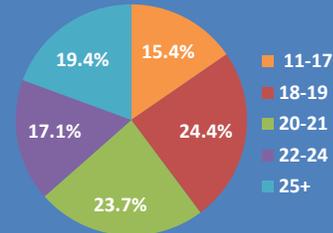


Figure 15: Marital Status at Intake

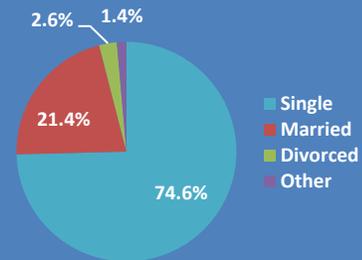


Table 10: Household Composition\*

Client's Mother	33.7%
Father of Child (FoC)	52.7%
Current Husband or Partner (not FoC)	3.8%
Other Family Members	37.7%
Other Children	1.7%
Other Adults	16.9%

\*Of all new enrollees who indicated living with others; more than one response possible

of age, participation in Children First is voluntary. Clients dictate the visit schedule, visit frequency and ultimately the length of participation. The University of Oklahoma College of Public Health analyzed data for clients who could have completed the program by June 30, 2012 (clients enrolled in SFY 2009). According to their review, 2227 clients enrolled in SFY 2009. Of those, only 18% completed the program. Client attrition occurred most often in the pregnancy phase. Participants more likely to complete the program were Hispanic clients (25%) followed by White (18%) and Other (17%). Older clients were more likely to complete the program than younger clients. Additionally, the percentage of participants who completed the program was slightly higher for clients who were in their 2<sup>nd</sup> or 3<sup>rd</sup> trimester at intake. Black participants enrolled in SFY 2009 were least likely to complete the program.<sup>37</sup>

### Accounting of Administrative Expenditures

The Children First program is funded primarily through state-appropriated dollars. In addition to state funding, the OSDH receives reimbursement for nursing assessments provided for clients who receive Federal Medicaid benefits. Funds from the Community-Based Child Abuse Prevention grant and Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Grant were also used to support the provision of direct services.

During SFY 2012, Children First operated on a budget of \$12,286,198.39. Of the total \$12.2 million, \$657,028.84 (5.3%) was used to fund Central Office activities including staff to conduct training for new nurses, technical assistance, professional development for program nurses, program evaluation, indirect (IDC) and other administrative costs.

Figure 16: Total Program Expenditures

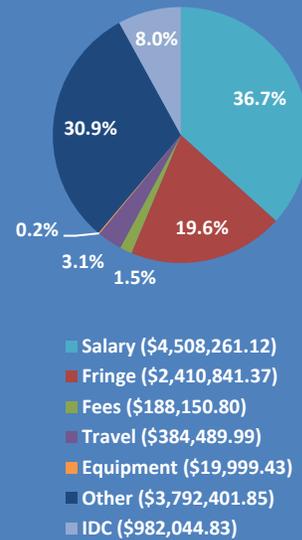
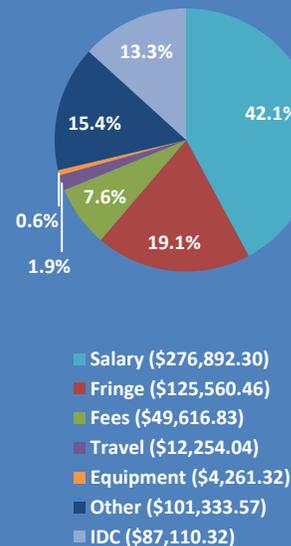


Figure 17: Central Office (Administration) Expenditures



## Appendix 1 – Oklahoma Continuum of Home Visitation Programs

	<b>Children First</b>	<b>Start Right</b>	<b>Oklahoma Parents as Teachers</b>	<b>SafeCare</b>	<b>Comprehensive Home-Based Services (CHBS)</b>
<b>Agency</b>	Oklahoma State Department of Health	Oklahoma State Department of Health	Oklahoma State Department of Education	Oklahoma Department of Human Services/ University of Oklahoma, Center on Child Abuse and Neglect	Oklahoma Department of Human Services
<b>Model</b>	Nurse-Family Partnership (NFP)	Healthy Families America (HFA)	Parents as Teachers (PAT)	SafeCare	SafeCare and other services depending on child safety needs.
<b>Staff</b>	Registered Nurses with additional training	Paraprofessional with additional training	Bachelors or Associates prepared professionals with additional training	Bachelors prepared professionals with additional training	Bachelors prepared professionals with additional training
<b>Client Enrollment Criteria</b>	Participants must: -Be expecting their first child; -Have a household income at or below 185% FPL; and -Be less than 29 weeks pregnant at the time of enrollment.	The program enrolls: -expectant women after the 29 <sup>th</sup> week of the first pregnancy, or at any time during pregnancy for subsequent births, or -families with a child age 1 or younger.	The program enrolls: -families with a child from birth up to 36 months of age.	The program enrolls: -families with at least one child age 5 years or younger; and -have risk factors such as substance abuse, domestic violence, or mental health issues.	The program provides services for families involved in the child welfare system.
<b>Length of Program</b>	Services can continue until child turns two years of age.	Services can continue until the child is six years of age.	Services can continue until the child is six years of age.	Services can continue for six to nine months.	Services can continue for six months.
<b>Visit Frequency</b>	Visits are scheduled: -weekly for the first four weeks then -every other week until the birth of the child; then -weekly for the six-week postpartum period; then -every other week until the child turns 21 months; then -monthly until the child turns two years of age.	Visits are scheduled weekly, then less frequently as determined by family's need.	Visits are scheduled monthly.	Visits are scheduled weekly.	Frequency and duration depends on level of need but typically are weekly visits.
<b>Locations</b>	77 Counties	Fifteen programs in 38 counties	43 programs throughout the state	Tulsa and Oklahoma City	77 Counties

*These early childhood home visitation programs are coordinated, monitored, evaluated and supported through the following interagency committees:*

**Interagency Child Abuse Prevention Task Force:** The State Interagency Child Abuse Prevention Task Force (ITF) was established as part of the Child Abuse Prevention Act and is responsible for the review and evaluation of all prevention program proposals submitted to the Office of Child Abuse Prevention for funding through the Child Abuse Prevention Fund, reporting to the Oklahoma Commission on Children and Youth and making recommendations to the Commissioner of Health. The ITF also assists the Office of Child Abuse Prevention in the development of the State Plan for the Prevention of Child Abuse and Neglect.

**Home Visitation Leadership Advisory Coalition:** In 2003, the Family Support and Prevention Service in collaboration with Debbie Richardson of the OSU Cooperative Extension Office saw the need and potential benefit of bringing home visitation programs together. From that vision the Home Visitation Leadership Coalition (HVLAC) was born. Participants share the common goal of working together and striving to strengthen state and local collaboration. The primary focus is based on early family support and education programs that are preventive in nature and particularly utilize home visitation approaches.

## Additional Collaborating Programs

## Description

Child Abuse Training Coordination Program (CATC)

The CATC Program provides free trainings to professionals throughout the state to assist Oklahoma counties in developing and maintaining multidisciplinary child abuse and neglect teams and provide discipline-specific multidisciplinary child abuse and neglect and domestic violence training for professionals with responsibilities for children. CATC assists professional organizations/associations to develop and implement ongoing training programs and encourages professionals to participate in on-going training.

[http://www.ok.gov/health/Child\\_and\\_Family\\_Health/Family\\_Support\\_and\\_Prevention\\_Service/Child\\_Abuse\\_Training\\_and\\_Coordination\\_Program/](http://www.ok.gov/health/Child_and_Family_Health/Family_Support_and_Prevention_Service/Child_Abuse_Training_and_Coordination_Program/)

Child Guidance

Child Guidance works with parents and children to prevent problems and to help strengthen families. To achieve this mission, the Child Guidance Service provides behavioral health,

child development, parent education, and speech-language pathology services to children and families.

[http://www.ok.gov/health/Child and Family Health/Child Guidance Service/Child Guidance Program/](http://www.ok.gov/health/Child_and_Family_Health/Child_Guidance_Service/Child_Guidance_Program/)

#### Early Head Start

This comprehensive child development program serves children from birth to age five, pregnant women, and their families. The program strives to assure that children with disabilities are located and enrolled. A full range of services are provided in the areas of education, early child development, medical, dental, mental health, nutrition and parent involvement.

[http://www.ok.gov/abletech/Financing Activities/OK Funding for AT/public/headstart.html](http://www.ok.gov/abletech/Financing_Activities/OK_Funding_for_AT/public/headstart.html)

#### Smart Start

Smart Start is Oklahoma's statewide early childhood initiative and serves as the state's Early Childhood Advisory Council. Smart Start Oklahoma seeks to provide better opportunities to the children and families in our state. The mission is to lead Oklahoma in coordinating an early childhood system focused on strengthening families and school readiness for all children.

<http://www.smartstartok.org/about-us>

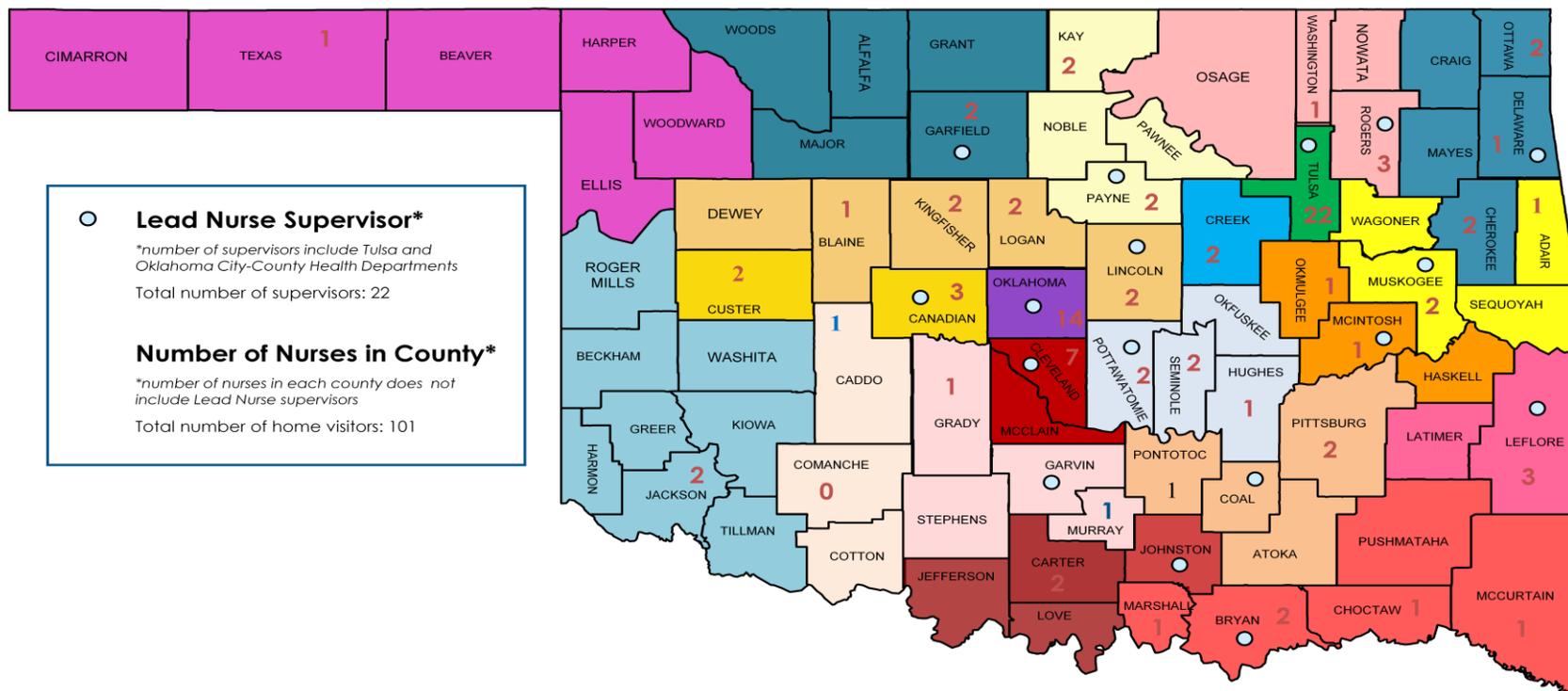
#### SoonerStart

Oklahoma's early intervention program is designed to meet the needs of infants and toddlers with disabilities and developmental delays.

[http://www.ok.gov/health/County Health Departments/Carter County Health Department/SoonerStart Early Intervention/index.html](http://www.ok.gov/health/County_Health_Departments/Carter_County_Health_Department/SoonerStart_Early_Intervention/index.html)

## Appendix 2 – Staffing Pattern Map for SFY 2012

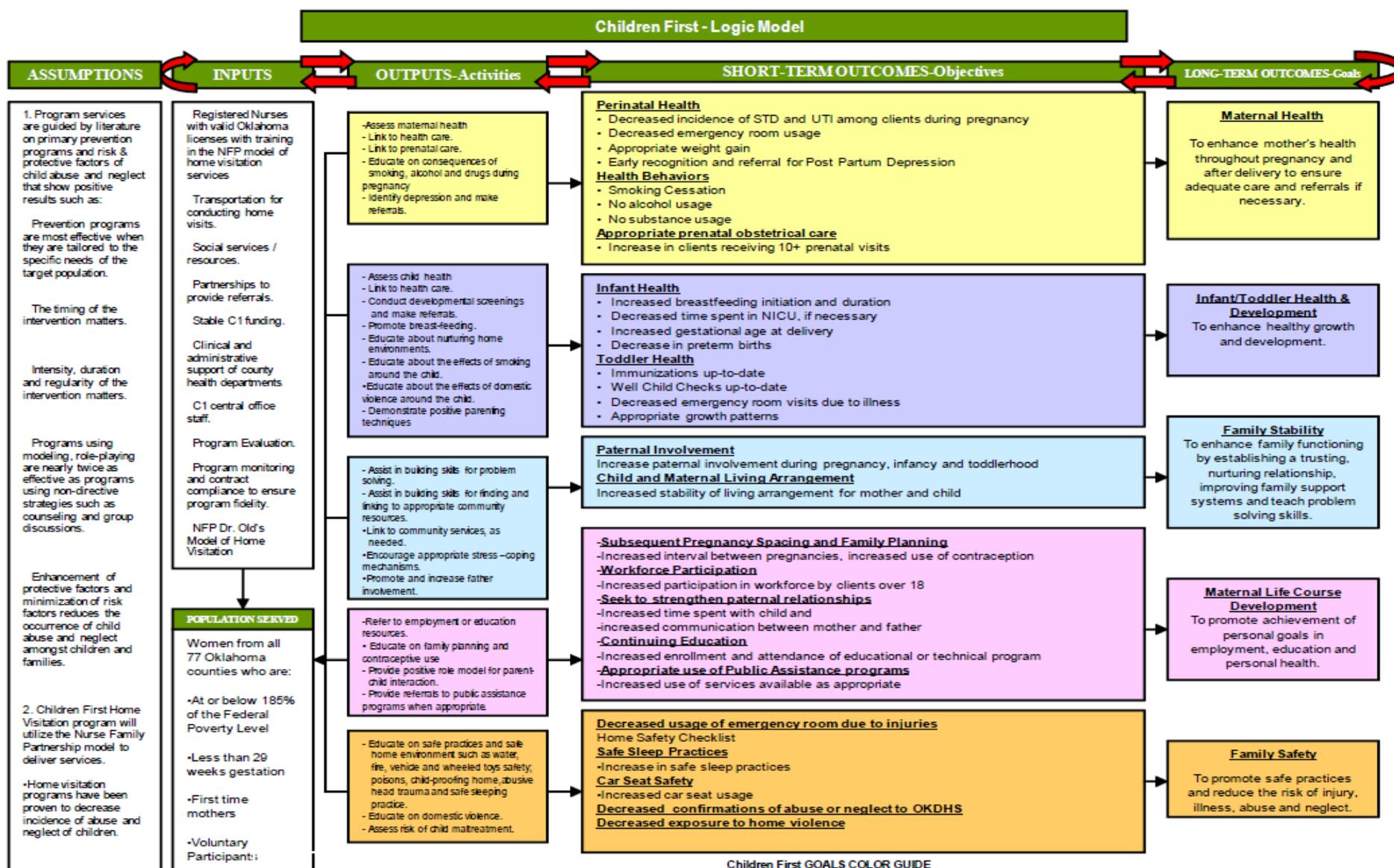
### Children First Program Staffing



The county district areas are as follows:

- Blaine, Dewey, Kingfisher, Lincoln, Logan (7)
- Creek (2)
- Nowata, Osage, Rogers, Washington (4)
- Cleveland, McClain (7)
- Coal, Pittsburg, Pontotoc, Atoka (3)
- Kay, Noble, Pawnee, Payne (3) (1 MIECHV)
- Muskogee, Sequoyah, Adair (2) (1 MIECHV)
- LeFlore, Latimer (3)
- Garvin, Grady, Murray, Stephens (2)
- Canadian, Custer (5)
- Bryan, Choctaw, Marshall, McCurtain, Pushmataha (5)
- Carter, Jefferson, Johnston, Love (2)
- Haskell, McIntosh, Okmulgee (2)
- Caddo, Comanche, Cotton (1)
- Beckham, Greer, Harmon, Kiowa, Jackson, Roger Mills, Tillman, Washita (2)
- Alfalfa, Garfield, Grant, Major, Woods (2)
- Hughes, Okfuskee, Pottawatomie, Seminole (5)
- Beaver, Cimarron, Ellis, Harper, Texas, Woodward (1)
- Cherokee, Craig, Delaware, Mayes, Ottawa (5)
- Oklahoma (10) (4 MIECHV)
- Tulsa (18) (4 MIECHV)

## Appendix 3 – Children First Logic Model



Rev: Nov 09

Yellow: Maternal health
  Purple: Child Health & Development
  Blue: Family Stability
  Pink: Maternal Life Course Development
  Gold: Family Safety

## Appendix 4 – County Data

County Name	Completed Visits	Referrals	Families Served	New Enrollees	Births	Graduates
ADAIR	131	20	25	23	3	0
ALFALFA	12	1	0	0	0	0
ATOKA	237	37	18	10	8	4
BEAVER	0	0	0	0	0	0
BECKHAM	1	33	0	1	0	0
BLAINE	373	30	31	14	11	3
BRYAN	699	104	101	67	12	6
CADDO	222	34	30	13	6	4
CANADIAN	732	77	78	48	18	16
CARTER	706	81	81	46	18	6
CHEROKEE	805	17	67	29	20	12
CHOCTAW	311	54	30	15	7	3
CIMARRON	0	0	0	0	0	0
CLEVELAND	2363	394	185	108	68	24
COAL	132	12	13	5	2	5
COMANCHE	347	89	41	30	12	1
COTTON	13	10	5	2	1	0
CRAIG	107	20	14	4	3	1
CREEK	707	47	69	45	20	6
CUSTER	428	69	49	34	10	3
DELAWARE	430	17	40	16	9	14
DEWEY	0	0	0	0	0	0
ELLIS	0	0	0	0	0	0
GARFIELD	1102	165	129	89	38	16
GARVIN	302	23	33	19	14	1
GRADY	326	38	29	16	11	5
GRANT	2	4	2	1	0	0
GREER	50	24	10	8	2	0
HARMON	54	9	5	6	3	0
HARPER	20	3	5	2	0	0
HASKELL	37	24	5	4	1	0
HUGHES	47	23	5	4	2	0
JACKSON	450	84	60	31	14	4
JEFFERSON	105	18	7	3	3	1
JOHNSTON	226	25	28	9	8	2
KAY	346	73	30	16	13	6
KINGFISHER	467	46	46	26	10	4
KIOWA	55	16	5	3	3	0
LATIMER	186	23	17	10	4	3
LE FLORE	924	150	77	39	27	11
LINCOLN	616	64	59	30	14	13
LOGAN	722	115	86	50	22	11

County Name	Completed Visits	Referrals	Families Served	New Enrollees	Births	Graduates
LOVE	47	16	8	2	2	0
MAJOR	49	4	7	1	2	1
MARSHALL	221	38	27	11	8	1
MAYES	63	27	8	6	2	0
MCCLAIN	260	59	30	8	5	7
MCCURTAIN	340	57	47	35	6	3
MCINTOSH	226	64	21	15	7	3
MURRAY	106	7	14	3	3	4
MUSKOGEE	506	46	67	45	7	11
NOBLE	69	9	4	0	2	0
NOWATA	0	0	0	4	0	0
OKFUSKEE	15	11	4	3	1	0
OKLAHOMA	3980	164	445	217	138	56
OKMULGEE	125	65	11	5	3	2
OSAGE	6	6	0	1	0	1
OSDH	0	0	0	0	0	0
OTTAWA	663	32	76	30	18	10
PAWNEE	0	1	0	0	0	0
PAYNE	675	153	89	45	15	8
PITTSBURG	499	32	65	46	19	0
PONTOTOC	54	43	13	12	1	0
POTTAWATOMIE	753	158	91	44	25	14
PUSHMATAHA	130	23	18	9	1	0
ROGER MILLS	0	0	0	0	0	0
ROGERS	802	67	73	42	23	8
SEMINOLE	254	67	35	17	5	4
SEQUOYAH	222	12	27	24	9	1
STEPHENS	140	45	36	11	2	1
TEXAS	20	39	16	0	0	0
TILLMAN	40	22	10	5	2	1
TULSA	7810	338	701	336	195	108
WAGONER	32	8	12	3	1	0
WASHINGTON	414	55	55	23	14	3
WASHITA	0	0	0	0	0	0
WOODS	71	9	10	5	4	0
WOODWARD	75	40	12	12	1	0
<b>Total</b>	<b>33460</b>	<b>3790</b>	<b>3547</b>	<b>1896</b>	<b>938</b>	<b>432</b>

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- <sup>4</sup> Prevention Research Center for Family and Child Health.  
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