



Family Support & Prevention Service an umbrella of services



Annual Report ~ State Fiscal Year 2008

CHILDREN FIRST

Oklahoma's Nurse-Family Partnership

Dear Reader,

On behalf of Children First Staff, I am pleased to present our Annual Report for SFY 2008. This summary of our activities serves as confirmation of our dedication to preventing child abuse and neglect in Oklahoma.

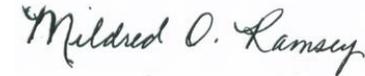
As you review the contents of this report you will see that Children First's, Oklahoma's Nurse-Family Partnership Program, clients represent the population for whom the model was developed – young, unmarried and low-income first-time mothers. A partnership with the Nurse-Family

Partnership National Service Office (NFP) continues to ensure that the program is being implemented with fidelity and performs well against NFP national averages.

I commend the nurses who provide home visitation services. They are a dedicated team of professionals committed to making a difference in the lives of Oklahoma families. By focusing on family strengths and supporting the optimization of family functioning, our nurses help families accomplish their goals while achieving positive outcomes for the program.

Thank you for your support of the Children First program and the families it serves. Together we can make a difference.

Sincerely,



Mildred Ramsey, RN, MPH
Director, Children First



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CHILDREN FIRST: AN EQUAL CHANCE FOR SUCCESS

In Oklahoma and in the United States, not all women who become pregnant are equally prepared to be pregnant, physically emotionally or financially. Not all parents have the ability to cope with the stresses of parenting or have the ability to access needed resources. Ultimately, the result is that not all babies are afforded equal chances in life, even from the time they are born.

An overwhelming, and growing, body of evidence supports the notion that babies throughout the state and nation are born without an equal opportunity to begin life. Inadequate social support, low maternal education and low income are consistently found to be associated with poor maternal and infant health.

Data from the Oklahoma PRAMS survey shows low education and/or low income are associated with the following circumstances which

contribute to poor pregnancy and health outcomes: not getting preconception counseling¹, unintended pregnancy², smoking during pregnancy³, preterm birth, low birth weight, not breastfeeding⁶, postpartum depression⁷ and placing a baby in the prone position⁸ to sleep. In addition, strong disparities also exist among African American and the American Indian mothers and babies in Oklahoma when compared with the white population⁹.

Such inequities among new Oklahoma parents do not have to persist, nor should these inequities translate into poor outcomes for their children. Risks can be reduced through proven family support intervention programs.

The Oklahoma State Department of Health, through the Family Support and Prevention Service, implements several programs to enhance the capacity of parents to care for their children. Children First, Oklahoma's Nurse-

Family Partnership, is one program being offered to first-time Oklahoma parents to ensure an equal chance for success.

This report describes the activities, clients and outcomes of Oklahoma's Children First program for State Fiscal Year 2008.



“Every child has the right to health and a life free from violence.”

“Preventing child maltreatment: a guide to taking action and generating evidence,” the World Health Organization and International Society for Prevention of Child Abuse and Neglect http://whqlibdoc.who.int/publications/2006/9241594365_eng.pdf



CHILDREN FIRST: PROGRAM DESCRIPTION

History

In 1996, the State of Oklahoma chose to implement David Olds’ Nurse-Family Partnership evidence-based model of nurse home visitation services with a goal to reduce child abuse and neglect. The chosen delivery system was Oklahoma’s county health department system. In 1997, the program was piloted in four counties, Garfield, Garvin, Muskogee and Tulsa, with 22 nurses. By October 1998, the program had expanded statewide to serve clients in all 77 counties. At its peak in 2002, funding for Children First supported 270 nurse positions with an annual enrollment of over 3,700 pregnant women. Budget cuts in SFY 2003, reduced funding to a level that supported approximately 170 nurse positions with an annual enrollment of approximately 2500 clients. During its more than 10 years’ existence, Children First has served over 30,000 families.

Enrollment Criteria

Enrollment in the Children First program is voluntary. Although nurses place great importance on retaining clients for the full intervention, clients are not obligated to participate for a certain amount of time. They must, however, meet the following eligibility criteria:

- Client must be a first-time mother;
- Client income must be at or below 185% of the Federal Poverty Level; and
- Client must be less than 29 weeks pregnant at enrollment.

Services

Children First provides nurse home visitation services to pregnant women and their families during pregnancy and up to two years after the child is born. Clients receive regular weekly or bi-weekly home visits from a registered nurse. During these visits, nurses assess clients’ health status and socioeconomic needs; assess child health and development, provide information and education on a variety of topics; provide

anticipatory guidance so clients know what to expect in the months ahead; provide support and encouragement as clients strive to reach personal goals; and connect clients with any community resource they may need to achieve a healthier life.

Mission and Vision

The mission of Children First is 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 resources, thereby promoting the well being of families through public health nurse home visitation, ultimately benefiting multiple generations.

The vision is to promote a continuum of healthy pregnancies, healthy babies, healthy families and healthy communities.

Objectives

- Increase clients' self-sufficiency
- Improve clients' parenting skills
- Improve pregnancy outcomes, such as low birthweight and prematurity
- Strengthen the parent-child bond
- Improve clients' problem-solving abilities
- Improve clients' access to community resources
- Improve child health and development
- Help clients achieve personal goals

Goals

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



Figure 1: Highest Education Completed of Children First Enrollees, SFY 2008

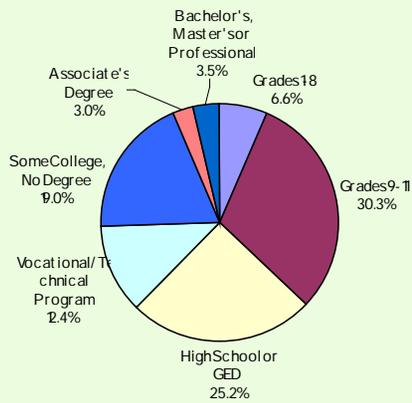


Figure 2: Age of Children First Fathers, SFY 2008

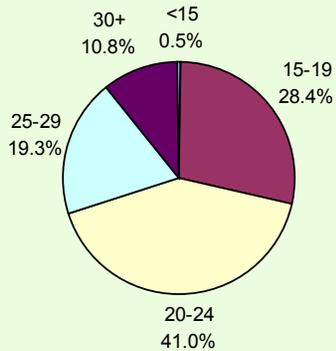
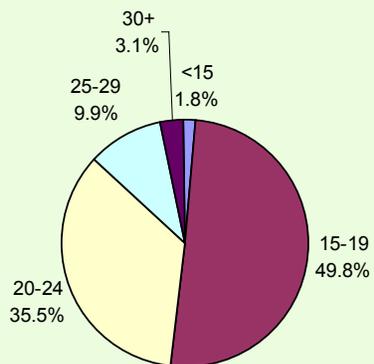


Figure 3: Age of Children First Enrollees, SFY 2008



CHILDREN FIRST: CLIENT DEMOGRAPHICS, SFY 2008

The Children First program strives to enroll young first-time mothers who have low income levels, limited health and social resources. Literature shows this demographic to be most in need of such services, as they are known to have higher rates of child maltreatment and poorer birth outcomes. Research has shown that by serving this traditionally high-risk population during the early stages of pregnancy, Nurse-Family Partnership programs can positively impact birth outcomes and reduce instances of child abuse and neglect.¹¹ Although the intervention focuses on first-time mothers, the program promotes the involvement of fathers, grandparents and other supporting persons in parenting.

Education

Overall, the majority of Children First enrollees have completed high school or beyond (Figure 1). However, for clients who are older than 18, 16% have not completed high school/GED (18% for new clients aged 19-21 and 14% for clients aged 22 and over). In addition, only 53%

of clients 19 years and older have any education beyond high school (31% of 19-21 year olds and 64% of new clients 22 years old and older).

Age

The average age of Children First enrollees was 20.2 years old. The youngest client was 12 years old and the oldest client was 42 years old. Nearly 52% of clients were teenagers (<20 years old); 35.5% were in their early twenties; and 13.0% were 25 or older (Figure 3).

The average age of Children First fathers was 22.9 years old. The youngest Children First father was 11 years old and the oldest was 60 years old. Fewer than 30% of Children First fathers were teenagers; most were in their early twenties (41.0%) or older, with nearly 30% older than 24 (Figure 2).

Race/Ethnicity

While the majority of new Children First clients self-reported being white, the non-white population is proportionally higher in the Children

First population than in the state of Oklahoma in general.

Percent	Race/Ethnicity, Children First Enrollees
55.0	White
14.0	Hispanic
12.5	African American
10.8	American Indian
5.9	Multiracial
1.5	Asian
0.2	Hawaiian/PI

Income

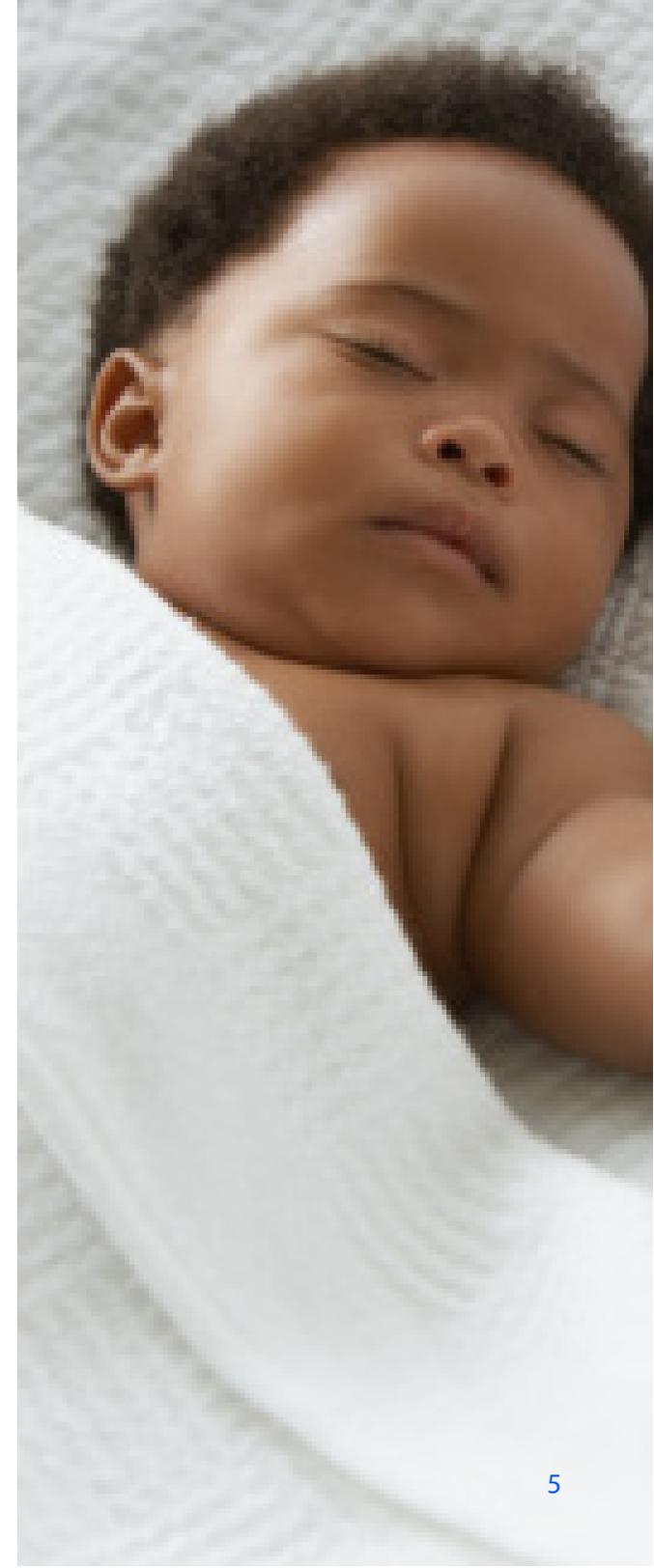
Most clients had household incomes below \$20,000 (58.3%); nearly 26% of new clients did not know their household income, the majority of whom were teenagers.

Percent	Income Category
28.0	<\$9,000
30.3	\$9,001-\$20,000
11.2	\$20,001-\$30,000
4.7	>\$30,000
25.8	Client did not know

Marital Status

Most new clients were single and had never been married.

Percent	Marital Status Category
74.1	Single
22.4	Married
2.5	Divorced
0.6	Separated
0.2	Widowed



CHILDREN FIRST: CLIENT CHARACTERISTICS/RISK FACTORS

Figure 8: Percent of C1 Enrollees Reporting Select Life Stress Events During Past Year, SFY 2008

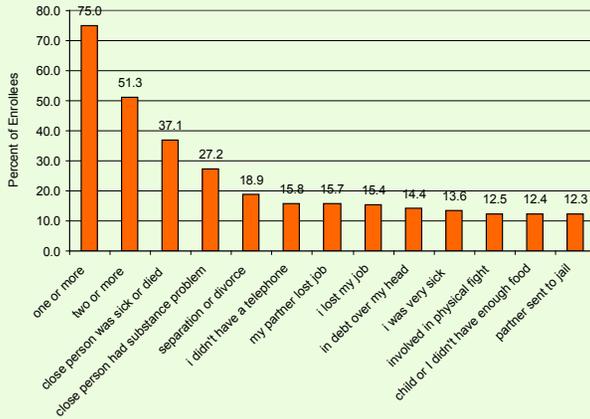


Figure 9: Percent of Clients in Each Program Stage At Risk For or Experiencing Select Risk Indicators, Children First, SFY 2008

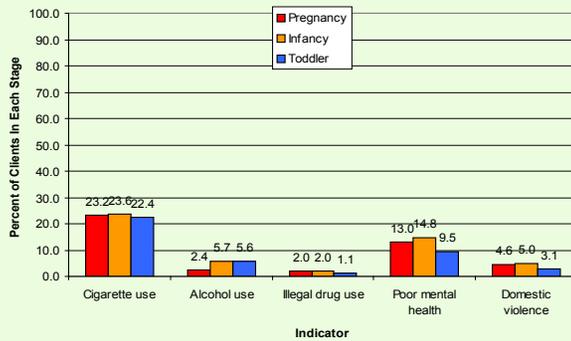
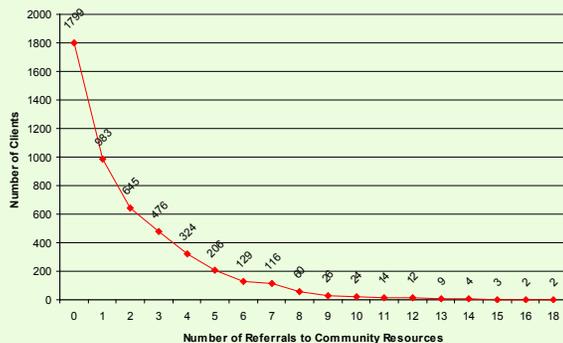


Figure 11: How many referrals to community resources did Children First clients receive during SFY 2008
9,151 referrals made to 3,035 clients



Life stressors

There is no single known cause of child maltreatment and no single description that applies to all families in which abuse and neglect occurs. Research has, however, recognized certain risk factors commonly associated with maltreatment. These risk factors include stressors such as substance abuse, marital/family issues, low-income or unemployment, single parenthood, domestic violence and lack of social support. Children within families and environments in which these factors exist have a higher probability of experiencing maltreatment.¹⁵

Assessment tools utilized during home visits yield information on the types of stressors faced by Children First families. Overall, 75% of our clients have experienced at least one life stress event in the previous year; 51% have experienced two or more. The most frequently experienced stress events were having some-

body close to them have a serious illness or die (37.1%), followed by having somebody close to them have a problem with alcohol or drug abuse (27.2%) (Figure 8).

Knowing the impact that these stressors can have on the ability to parent, the program provides training for nurses in case management and problem-solving methods such as motivational interviewing, solution-focused approaches and the stages of change. Nurses use strategies learned in these trainings to help families develop plans to reduce stressors, increase their protective factors and access needed services. The World Health Organization (WHO) recognizes good parenting, strong attachment between parents and children and positive non-physical disciplinary techniques as protective factors against child maltreatment¹⁶.

Children First utilizes Nursing Child Assessment Satellite Training (NCAST) and Keys to Caregiving to assess parent-child interactions. The Partners in parenting Education (PIPE) curricula is used to show parents the importance of secure infant attachment and teach skills they need to be better parents.

CHILDREN FIRST: ACTIVITIES SFY 2008

Program activities focus on recruiting, enrolling and retaining clients. Nurses perform marketing and outreach activities in their local communities to increase the referral base. Each team has developed unique strategies to reach potential clients during that critical time when services

are more likely accepted. Assessments and services are designed and provided in a manner to ensure that both client and program achieve optimal outcomes.

Tables 1 and 2 provide a snapshot of the program activities during SFY 2008.



121	Nurses = number of non-supervisory nurse home visitor positions (full-time employees)
4,836	Number of families served by Children First
6,510	Referrals = unique women referred to the program
2,464	Enrollees = a woman who had a demographics intake form
37.8%	Enrollment rate = percent of referred women who enrolled in the program
45,903	Completed visits = completed or supervisory home visits
1,423	Births = a family who had a birth form
445	Graduates = a family who stayed in the program through the child's 2nd birthday
2,163	Phone calls made to or on behalf of clients
5,342	Child developmental screenings performed using the Ages and Stages Questionnaire
83%	Percent of mothers with infants 1 month old who were screened for post partum depression using the Edinburgh Postnatal Depression Scale.

6,758	Total number of referrals to Children First (duplicate clients included)
3,281	Health Department Family Planning Clinic
1,419	WIC, the Supplemental Nutritional Program for Women, Infants and Children
941	Other referral Source
450	BabyLine (Tulsa)
169	Self-referrals
148	Health Department Maternity Clinic
128	Indian Health Service
69	Current or Previous Children First Client
67	Other Pregnancy Testing Clinic
36	Private Physician
29	School
10	Faith-Based Organization
9	DHS
2	HMO or Health Care Plan



CHILDREN FIRST: OUTCOMES

Preventing Child Maltreatment

Children First home visitors have the unique opportunity to be in the home with participating families on a regular basis and routinely monitor the health and safety of children born into the program. Nurses become familiar with the family and their environment, allowing nurses to recognize early signs of maltreatment. Children First nurses are mandatory reporters of suspected child abuse and neglect and consistently evaluate any occurrence that may be harmful to the child. In addition, nurses involve other family members in the program and are likely to activate concern when maltreatment is suspected.

Oklahoma Department of Human Services Matching Study

In a recent review article in the journal *Lancet*, the Nurse-Family Partnership model was identified as having the strongest evidence of preventing child maltreatment and associated outcomes.¹⁷

The Nurse-Family Partnership Model developed by Dr. David Olds is rooted in the theory that helping new mothers engage in good preventive health practices, obtain quality prenatal care, improve economic self-sufficiency and learn how to responsibly and competently care for their children reduces the risk of child maltreatment. The Children First program is proving this theory to be true in Oklahoma.

During SFY 2008, Children First (C1) program staff conducted a study in which children born to participating Children First families were matched to data from the Oklahoma Department of Human Services (OKDHS) on child maltreatment reports and confirmations. Authors examined characteristics of the reports, and compared report and confirmation outcomes to the general population of children ages birth to two years old in Oklahoma. C1 program participants are at greater risk for child maltreatment than the general population.

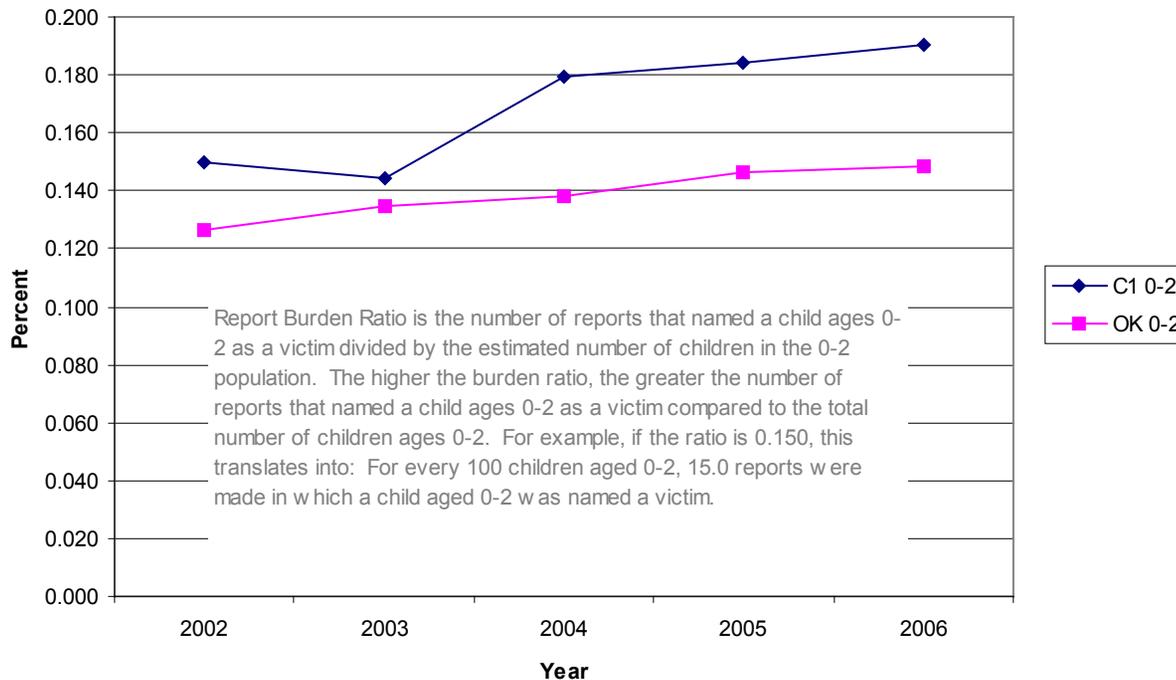
The analysis comparing C1 and non-C1 children ages 0-2 years old found that:

- From 2002-2006, the same proportion of C1 and non-C1 children ages 0-2 years old were named as a potential victim on an OKDHS report (11.79% vs. 11.89%), but more reports were made on C1 children than were made on the non-C1 population (Report Burden Ratio

= 0.170 vs. 0.139). This suggests that once C1 children were identified as being at risk for maltreatment, more people were making reports.

- Despite having the same proportion of children named in reports to OKDHS and having more reports made on those children, the C1 child population experienced, as a trend, an overall 6.04% lower child maltreatment confir-

Figure 4: Referral Burden Ratio, Children First vs. Oklahoma Children Ages 0-2 Years

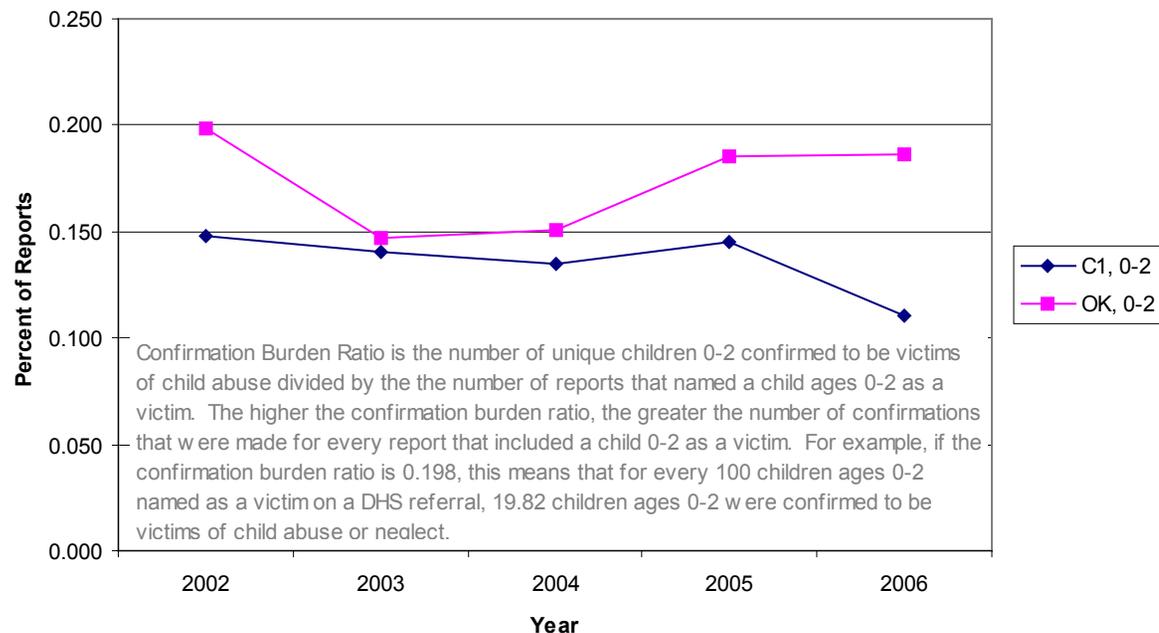




“Children are one third of our population and all of our future.”

~Select Panel for the Promotion of Child Health, 1981

Figure 5: Child Maltreatment Confirmation Burden Ratio, Children First vs. Oklahoma Children Ages 0-2 Years



mation rate per 1,000 child-years over the 5-year period (22.7 vs. 24.2, chi-square=2.7, $p=0.10$) and a consistently and significantly lower number of maltreatment confirmations for every report made to OKDHS (Confirmation Burden Ratio = 0.136 vs. 0.177).

- The C1 confirmation rate is the same as or slightly lower than the general population’s rate. This can be interpreted as a positive outcome in that C1 keeps younger, poorer, less educated first-time parents from having

worse outcomes than the general population of families. If the general population of Oklahoma 0-2 year olds had the same confirmation rate as C1 0-2 year olds between 2002-2006, 914 fewer Oklahoma children would have been confirmed maltreatment victims. We look forward to studying these outcomes in greater depth as more diverse comparison groups become available.

Note: All C1 children were included in these analyses, regardless of how long the family remained in the program after the child was born. For both C1

and non-C1 children, age was defined as birth through 35 months; for C 1 children, this means that the analysis examined an additional 11 months after C1 families were no longer eligible to participate. The non-C1 child group was comprised of all children ages 0-2 years old during the study period (2002-2006); eligibility for C1 participation is unknown. However, C1 mothers enrolled in the C1 program from 2002-2006 were more likely than non-C1 first-time mothers to be teenagers (52% vs. 28%), to have less than a high school education (42% vs. 23%), and to be single (68% vs. 46%), all of which are risk factors for child maltreatment.

The analysis of reports to OKDHS involving C1 children found that:

- Of the 19,396 children born to C1 participating mothers between 1997-2007, 27.9% were named on a report for suspected child maltreatment to OKDHS during their lifetime.
- Biological parents were named as alleged perpetrator on over 60% of reports.
- The greatest number of reports was made

Table 3: Percent of OKDHS Reports Involving C1 Children By Perpetrator, 1997-2007

Percent	Suspected Perpetrator
38.9	Biological Mother
21.7	Biological Father
11.0	Missing (No Information)
7.9	Grandparent
6.2	No Relation
4.3	Alleged Father or Step Father
1.9	Childcare Center or Home
1.8	Aunt or Uncle
1.4	Foster Parent
4.9	Other Categories <1%

Table 4: Number of OKDHS Reports Involving C1 Children By Child's Age, 1997-2007

Age	Number of Reports	Percent
Infant (Birth - 11 months)	2974	21.5
1 Year (12-23 months)	2392	17.3
2 Years (36-47 months)	2061	14.9
3 Years	1933	14.0
4 Years	1560	11.3
5 Years	1327	9.6
6 Years	922	6.7
7 Years	454	3.3
8 Years	199	1.4
9 Years	17	0.1
Wrong/Missing Birth Date	9	0.1
Total	13848	100





for the youngest children, with those reports involving children younger than 3 years old comprising 53.7% of reports.

- There were 8,737 reports for children ages 0-2 years old (i.e. birth-35 months, the age range reported by OKDHS); over 76% of reports involved an allegation of neglect; 20.5% involved abuse allegations and 3.4% involved sexual abuse allegations.

- Of the 8,737 reports made involving C1 children ages 0-2 years, 1,357 resulted in a confirmation of abuse or neglect: 78.6% of confirmed reports involved neglect allegations; 20.3% involved abuse allegations; and 1.0% involved sexual abuse allegations.

For more information on this study, please contact the Children First program.

Figure 6: Child Maltreatment Reports by Type, C1 Children Ages 0-2 Years, 2002-2006
(Note: Children can be named on multiple reports so the number of reports is greater than the number of children.)

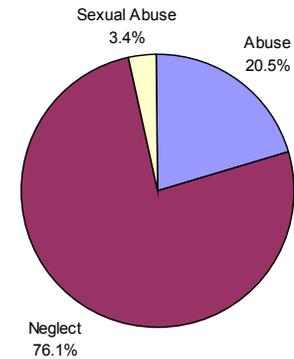


Figure 7: Confirmed Child Abuse and Neglect by Category, C1 Children Ages 0-2 Years, 2002-2006

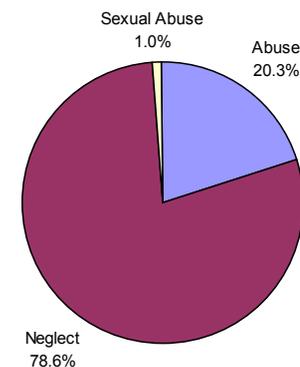


Table 5: Preterm and Low Birthweight among Children First babies in SFY 2008, compared to all Oklahoma Births in 2007

Plurality	Children First, SFY 2008				Oklahoma, 2007			
	% LBW	% VLBW	% Preterm	% Very Preterm	% LBW	% VLBW	% Preterm	% Very Preterm
Singletons	6.6	0.7	8.0	1.1	5.5	1.1	7.6	1.4
Multiples	71.8	5.1	59.0	5.1	49.2	12.7	54.2	12.1

Very low birthweight is less than 1500 grams (3 1/3 pounds).

Low birthweight is less than 2500 grams (5 1/2 pounds).

Preterm is less than 37 weeks completed gestation.

Very preterm is less than 32 completed weeks gestation.

Preterm and Low Birthweight

In SFY 2008, there were 1,418 babies born to Children First clients: 1,379 singleton births and 39 babies who were twins or triplets. Gestational age and weight at birth are measures of infant health, with birth before 37 weeks gestation considered premature, and weight less than 2500 grams considered low birth weight. Table 5 shows specific data on low birthweight and preterm birth among Children First births in 2008 as compared to all 2007 births in Oklahoma (latest year available). Multiple births (twins, triplets, etc.) were separated from singleton births in the data table below because

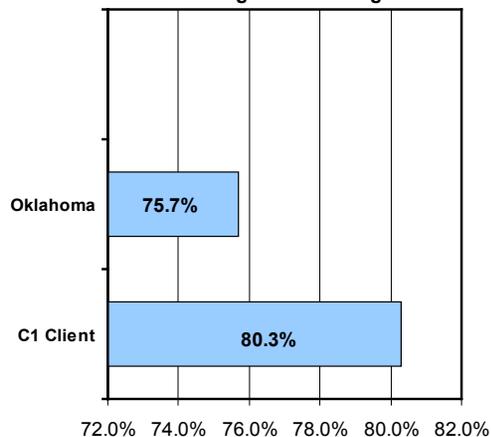
they are more likely to have low birthweight and be born preterm. Including multiple births with singleton births would skew the data.

Smoking Cessation

During SFY 2008, 18.6% of new clients and 15.9% of clients at 36 weeks gestation reported smoking in the past 48 hours. There were 113 clients who smoked at intake and had 36-week follow-up smoking data during SFY 2008. Among these clients, 48.7% quit or reduced smoking from intake to follow-up, 20.4% had no change in smoking behavior, and 30.0% increased smoking.



Figure 12: Percent of C1 clients Initiating breastfeeding



Breastfeeding Initiation and Duration

Among Children First clients who gave birth in SFY 2008 and had 4-week postpartum data, 80.3% had initiated breastfeeding. In general, 75.7% of Oklahoma women initiate breastfeeding⁶. By the 4-week postpartum visit, 57.5% were still giving their baby breast milk. (Figure 12).

Immunizations

During SFY 2008, 86.6% of children were up to date on immunizations at the last visit during which data was collected. Approximately 78.5% of Oklahoma children had been fully immunized¹⁸.

Figure 13: Reasons the Most Frequently Missed Well-Child Visits Were Missed by Children First Clients, SFY 2008

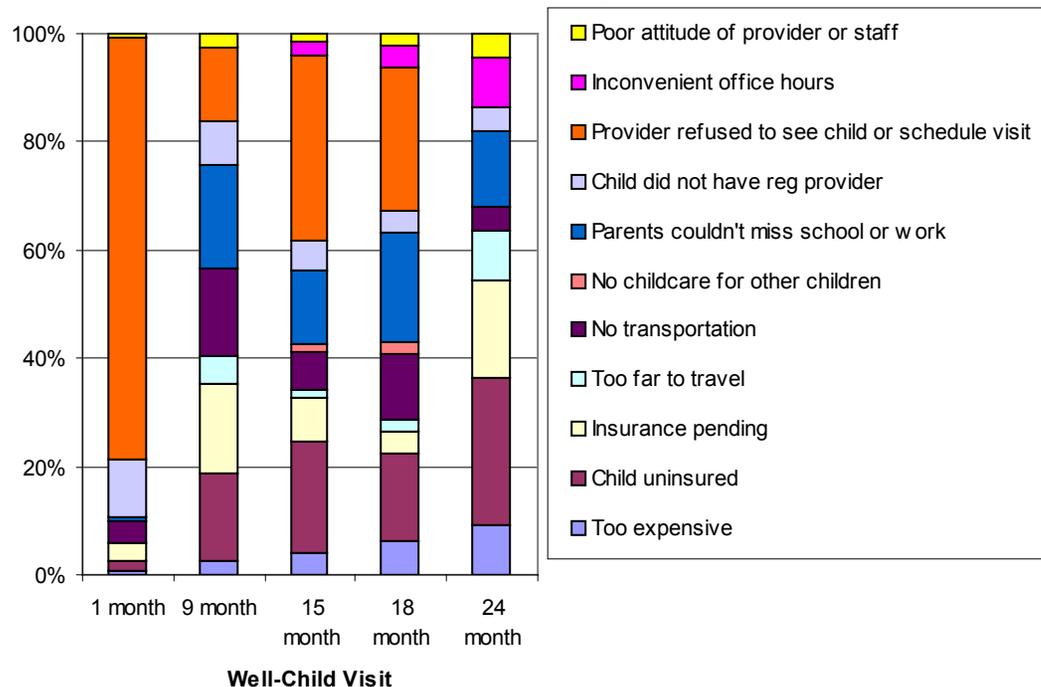
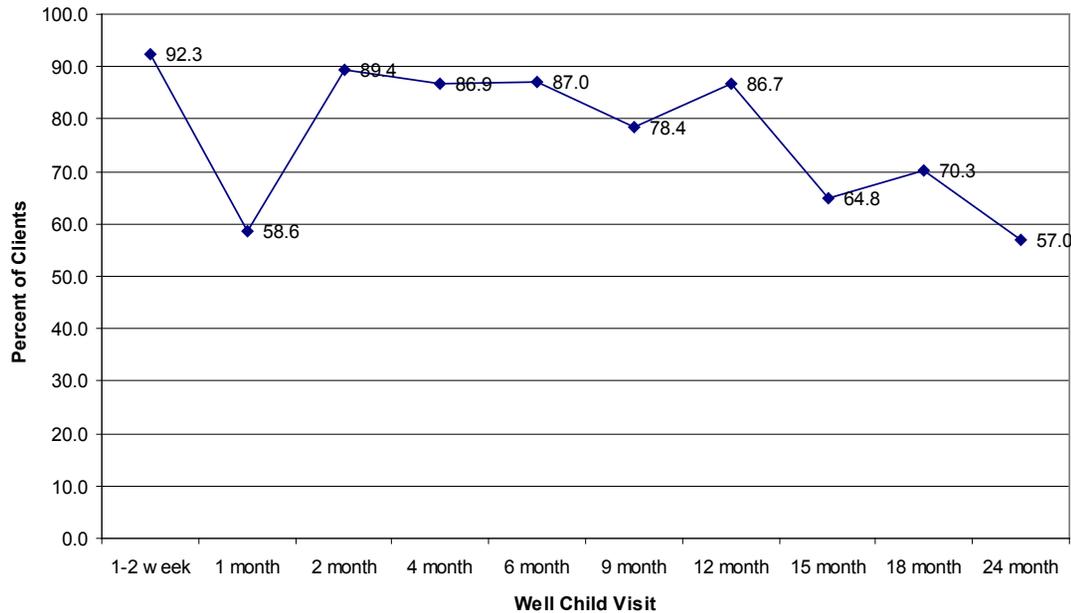


Figure 14: Percent of Completed Well Child Visits by Child Age, SFY 2008



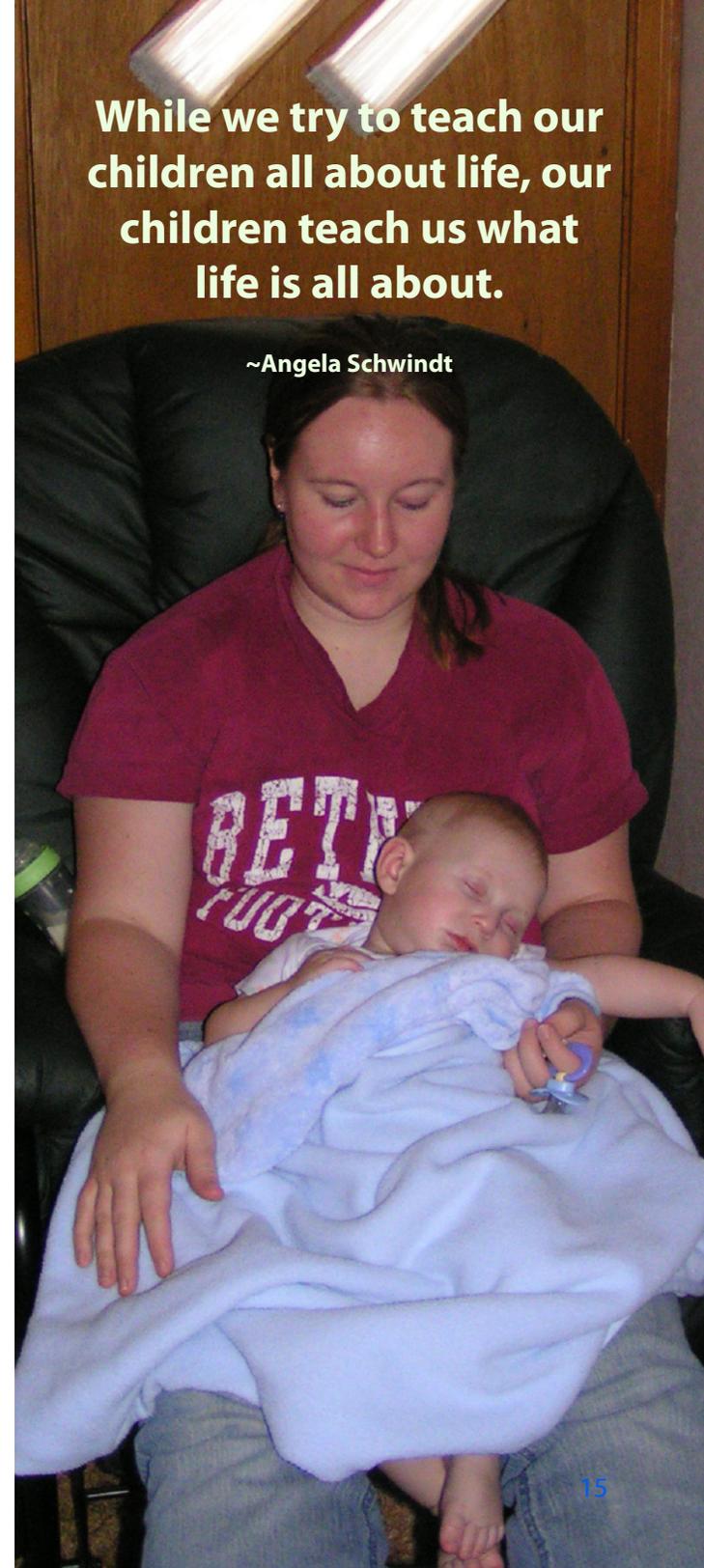
Well Child Visits

The Children First program tracks whether clients attend Well Child visits in accordance with the APA recommended schedule (<http://www.aap.org/healthtopics/compmed.cfm>). Program data shows the percent of clients who attend Well Child visits varies by the visit timeline, with clients appearing most likely to attend the 1-2 week visit, after which the percentage of clients attending visits appears to decline (Figure 14). Certain visits stand out as consistently less attended, notably the 1-month, 9-month, 15-month, 18-month and 24-month visits. Overall, 57.0% of children had attended the

recommended number of Well Child visits. Figure 13 shows the reasons for which clients report missing Well Child visits, for each of the most frequently missed visits. For the 1-month visit, the vast majority of clients report that the provider refused to schedule the child for that visit. This also appears to be a significant reason for missing the 15- and 18-month visits. In addition, as the child ages, child health insurance issues and the parent's work or school schedule increasingly become reasons for not attending Well Child visits following the recommended schedule.

While we try to teach our children all about life, our children teach us what life is all about.

~Angela Schwindt





SAVING TAXPAYERS MONEY

The Children First program uses the Nurse-Family Partnership (NFP) model of home visitation studied for three decades by Dr. David Olds. Through three randomized trials, research has shown NFP programs to cut costs to taxpayers by reducing child abuse and neglect, decreasing emergency room visits for accidents and poisonings and reducing the number of arrests of both children and mothers by age 15. Moreover, results have shown a reduction in behavioral and intellectual problems by the time the child turns 6 years old.¹²

A recent study by the RAND Corporation indicated for every dollar spent on NFP programs, \$5.70 was saved. Based on this figure, the \$35.7 million used to fund services provided to Oklahoma families translates to a savings of \$102.6 million since 2004.¹³

In 2004, the Washington State Institute of Public Policy found a net return to government of \$17,180 per family served, or a \$2.88 return for every dollar invested in the program. This amount

is likely to be greater among higher risk families and does not include the likely reduction of costs associated with subsequent pregnancies, preterm births and early childhood injuries and associated medical expenses among families participating in NFP programs.¹⁴

The Prevention Research Center for the Promotion of Human Development recently published a Pennsylvania Cost-Benefit Report showing NFP programs save \$3.59 for every dollar spent.

PARTNERS IN PREVENTION

Children First collaborates with organizations, agencies and programs at the national, state and community level.

National Recognition of NFP Model

- The Coalition for Evidence-Based Policy identifies Nurse-Family Partnership as meeting its “Top Tier” evidence of effectiveness.
- The Brookings Institution report “Supporting Young Children and Families: an Investment Strategy that Pays,” recommends policy focus-

ing on nurse home visitation services, specifically NFP. Report states NFP programs have a cost savings of \$2 billion.

- Washington State Institute for Public Policy reports on the benefits and costs of evidence-based programs like NFP that prevent children from entering and remaining in the child welfare system.
- The Partnership for America's Economic Success reports on longer-term societal impacts of early childhood programs, like Nurse-Family Partnership.
- RAND Corporation recently published "Early Childhood Interventions Proven Results, Future Promise" identifying Nurse-Family Partnership as a program with a strong evidence base.
- Blueprints for Violence Prevention, rates Nurse-Family Partnership as "Model Program."
- Office of Juvenile Justice & Delinquency Prevention (OJJDP) gives NFP programs an exemplary rating.
- A recent article by MacMillan et al. in The Lancet which reviewed interventions aimed at prevention of maltreatment before it oc-

curs found NFP to be "The programme 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."¹⁷

National Supporters of NFP Programs

- The Edna McConnell Clark Foundation
- Google
- Robert Wood Johnson Foundation
- The W.K. Kellogg Foundation
- The Picower Foundation

Additional Funding for Children First

- Children First received a Ronald McDonald House Charities Grant through the Nurse-Family Partnership National Service Office in the amount of \$ 75,000 to purchase safety items for program families. Staff researched the leading causes of child fatality in children 0-2 years and found suffocation due to roll-over incidents and vehicle crashes were leading contributors. With this in mind, 642 cribs and 654 car seats were purchased to be distributed

to participating families who were unable to purchase their own.

- Community-Based Child Abuse Prevention (CBCAP) Funds were utilized to partially fund home visitation services in Oklahoma during SFY 2008. C1 used these funds to supplement contract services with Oklahoma City County and Tulsa City County Health Departments to provide Children First services.
- Through a contract with the Oklahoma Health Care Authority, Children First is reimbursed for providing nursing assessments and care coordination services to all clients receiving Medicaid benefits. Funds are utilized to partially fund the Oklahoma City-County and Tulsa Health Department contracts.

Program Staff Collaborative Partnerships

- Oklahoma Health Care Authority works with C1 to identify Medicaid recipients who are first-time mothers and offer services to these recipients.
- Oklahoma Department of Human Services office staff provides training to all new Children

First nurses on OKDHS services available for Children First clients and issues related to paternity. Through a partnership with DHS and the Office of Child Abuse Prevention, Children First clients have access to vouchers that can be used to cover child care for their children in times of crisis.

- C1 works closely with other Health Department services such as WIC, Women's Health, Child Guidance, Screening and Special Services and Injury Prevention to provide training for nurses and identify opportunities to collaborate regarding specific client needs.

CHILDREN FIRST: REQUIRED REPORTING

Oklahoma State Statute 63-1-110-1 establishes the Children First Fund for the operation of the Children First program. Part B of the statute requires the State Department of Health to report certain family characteristics every year. The following meet the reporting requirement (Figure 15, Table 6) as described in this statute for Oklahoma's State Fiscal Year 2008 (July 1, 2007 through June 30, 2008).

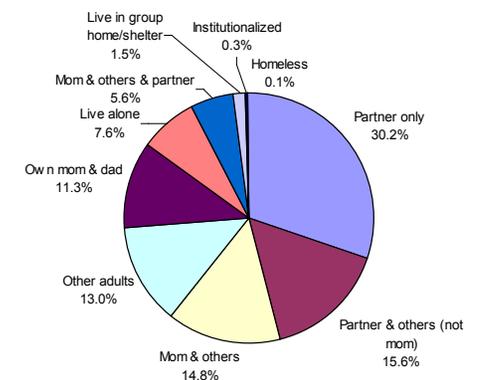
2,464	New families were accepted into the Children First program
243	Referrals to other programs for ineligible families
51.5%	Clients who were teenagers (<20 years old)
74.1%	Clients who were single, never married
11.2%	Clients living with their parents
31.4%	Clients whose household included their mother
51.0%	Clients whose household included their partner

C1 Cost and Expenditures

Salary and Fringe (Central Office)	\$485,788.35
Travel	\$13,833.13
Contractual	\$56,500.00
Supplies	\$11,914.34
Equipment	\$0.00
Other	\$33,807.33
Data Processing	\$35,937.50
Total Administrative Costs (Program Support)	\$637,780.65
Total Expenditures (Direct and Support)	\$13,739,734.40
Expenditure Per Family Served	\$2,841.14

Note: Reported costs and expenditures are based on validation estimates. This means that it includes time and effort from OSDH employees who are not paid directly from the Children First budgets but who performed Children First services. The Children First program received \$11.55 million in funding from the State of Oklahoma during SFY 2008. The program generates additional revenue from services provided to Medicaid-eligible clients.

Figure 15: Living Arrangements of Children First Enrollees, SFY 2008



Program Evaluation

The Purpose of program evaluation is to monitor the performance of the Children First program and to use data for program improvement. During home visits, nurses collect health-related data on their clients and clients' children. These data are stored in a secure database at the Oklahoma State Department of Health, and are used to prepare evaluation reports.

Unless otherwise indicated: the data utilized in preparing the Oklahoma State Fiscal Year information were collected by Oklahoma's Children First program between July 1, 2007 and June 30, 2008.



Research

Since the program's implementation, Children First data have been used, both internally and externally to show effectiveness at benefiting Oklahoma families.

In 2004, Dr. Helene Carabin and colleagues at the University of Oklahoma Health Sciences Center published a study that showed Children First to be effective at preventing very preterm and very low birth weight births and reducing infant mortality among participants, when compared to a retrospective comparison group.¹⁸

In 2006 an internal analysis was performed to review deaths among infants and children born into the Children First Program from 1997 to 2004. The analysis found the infant mortality rate for Children First participants is approximately half of the rate for other first-time births in Oklahoma (3.4 vs. 8.2 deaths for every 100,000 live births). Also noted, this infant mortality rate meets goals set by Healthy People 2010 (3.4 vs. 4.5)

Children First is currently participating with Dr. David Olds, director of the Prevention Research Center and founder of Nurse-Family Partnership, in a research project to develop intervention strategies to address client enrollment and retention. The PRC leads the effort to improve the Nurse-Family Partnership model by reducing participant attrition and addressing issues such as mental illness and intimate partner violence.



11/1

County	Completed Visits	Families Served	Referrals	Enrollees	Enrollment Rate	Births	Graduates
Adair	128	25	39	5	13	2	-
Alfalfa	3	-	4	-	-	-	-
Atoka	242	21	38	7	18	7	3
Beaver	88	8	7	3	43	1	1
Beckham	355	43	74	15	20	9	5
Blaine	351	32	33	14	42	9	7
Bryan	1,150	133	188	86	46	35	5
Caddo	305	40	71	25	35	9	1
Canadian	915	84	106	41	39	30	5
Carter	552	50	114	22	19	22	5
Cherokee	865	80	27	35	130	24	14
Choctaw	167	27	69	26	38	6	-
Cimarron	-	-	-	-	N/A	-	-
Cleveland	2,779	274	350	167	48	65	17
Coal	196	19	29	8	28	7	1
Comanche	898	99	252	41	16	37	9
Cotton	250	19	10	9	90	5	1
Craig	307	35	32	15	47	12	1
Creek	440	49	154	28	18	16	-
Custer	399	40	68	13	19	13	5
Delaware	405	43	62	16	26	9	6
Dewey	8	1	-	-	N/A	-	1
Ellis	28	4	-	-	N/A	1	1
Garfield	1,117	151	272	76	28	46	8
Garvin	349	46	98	24	24	15	1
Grady	685	64	131	29	22	28	3
Grant	23	3	5	-	-	3	-
Greer	117	14	22	7	32	4	2
Harmon	53	6	6	2	33	2	1
Harper	92	11	11	4	36	2	2
Haskell	153	11	40	7	18	4	3
Hughes	158	19	45	13	29	4	-
Jackson	506	67	111	30	27	23	8
Jefferson	96	12	11	4	36	2	2
Johnston	290	27	31	15	48	7	1
Kay	401	38	101	11	11	8	4
Kingfisher	717	60	39	19	49	18	11
Kiowa	132	20	22	6	27	5	1
Latimer	226	21	31	10	32	4	1

County	Completed Visits	Families Served	Referrals	Enrollees	Enrollment Rate	Births	Graduates
LeFlore	1,637	138	158	76	48	48	10
Lincoln	746	63	65	21	32	19	13
Logan	1,081	118	172	67	39	36	14
Love	96	9	21	5	24	3	-
Major	124	16	23	7	30	7	3
Marshall	274	32	46	16	35	10	1
Mayes	5	5	78	-	-	-	-
McClain	365	30	41	14	34	7	2
McCurtain	384	57	97	30	31	6	4
McIntosh	428	37	57	8	14	11	4
Murray	237	31	41	23	56	10	2
Muskogee	915	116	84	59	70	23	7
Noble	174	16	22	12	55	5	2
Nowata	-	-	-	-	N/A	-	-
Okfuskee	34	4	28	2	7	1	1
Oklahoma	5,026	530	460	269	58	168	61
Okmulgee	347	44	97	35	36	11	3
Osage	-	-	-	-	N/A	-	-
Ottawa	796	92	130	51	39	27	13
Pawnee	513	49	58	32	55	20	-
Payne	1,067	115	157	62	39	30	18
Pittsburg	1,088	122	117	46	39	29	20
Pontotoc	694	68	100	41	41	26	9
Pottawatomie	1,065	101	225	63	28	41	4
Pushmataha	62	8	29	8	28	1	-
Roger Mills	23	2	2	1	50	-	1
Rogers	750	83	129	44	34	29	6
Seminole	464	55	65	33	51	16	3
Sequoyah	871	99	97	42	43	27	15
Stephens	177	27	135	4	3	10	2
Texas	332	37	61	16	26	14	1
Tillman	226	21	26	10	38	8	2
Tulsa	8,928	909	803	496	62	256	80
Wagoner	6	2	8	-	-	-	-
Washington	457	47	103	17	17	14	3
Washita	26	4	6	-	-	1	-
Woods	24	3	18	1	6	1	-
Woodward	280	23	28	5	18	7	3
TOTAL	45,903	4,836	6,553	2,464	38	1,423	445

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This report is submitted in compliance with Oklahoma Statute 63-1-110.1 by:

James M. Crutcher, MD, MPH, Secretary of Health and Commissioner of Health
Edd D. Rhoades, MD, MPH, Deputy Commissioner, Family Health Services
Annette Wisk Jacobi, JD, Chief, Family Support and Prevention Service
Mildred Ramsey, RN, MPH, Director, Children First

Data and Content:

Mary Beth Cox, MSW, MPH, Program Evaluator, Children First

Design and Layout:

Sarah Ashmore, BA, Program Coordinator, Children First

Reviewers:

Connie Frederick, RN, BSN, Nurse Consultant, Children First
Amber Sheikh, MPH, Program Evaluator, Office of Child Abuse Prevention

Contact:

Oklahoma State Department of Health
Family Health Services
Family Support and Prevention Service
Children First Program
1000 NE 10th Street
Oklahoma City, OK 73117-1299
Web: <http://cf.health.ok.gov>
Phone: 405-271-7611
Fax: 405-271-1011

Email:

AnnetteJ@health.ok.gov
MildredR@health.ok.gov



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