CHILDREN FIRST

OKLAHOMA'S NURSE - FAMILY PARTNERSHIP
STATE FISCAL YEAR 2017 ANNUAL REPORT

2017

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PROGRAM OVERVIEW

3 History
Mission
Services

4 Screening Tools
Nursing Assessments
Enrollment
Visit Schedule
Program Costs

CHARACTERISTICS

5 Household Income
Age
Education
Marital Status
6 Race/Ethnicity
Employment
Household Composition
Health Concerns
Life Stressors

CLIENT STORY

7 Client Story - Louetta Germundson, RN

MATERNAL HEALTH

8 Prenatal Care
Postpartum Depression
Smoking Cessation

CHILD HEALTH

9 Gestational Age and Birth Weight
Neonatal Intensive Care Unit
Breastfeeding
10 Developmental Milestones
Immunizations and Well Child Exams

CLIENT STORY

11 Client Story - Lacresha Williams

FAMILY SAFETY

12 Intimate Partner Violence
Injury Prevention
13 Child Maltreatment

FAMILY STABILITY

14 Father Involvement
15 Pregnancy Spacing
Socioeconomic Indicators

ACTIVITIES

16 Referrals
17 2017 County Data

CONCLUSION

18 Acknowledgments

PROGRAM OVERVIEW

HISTORY

In 1996, the Oklahoma State Legislature authorized legislation to create Children First. Representatives from Tulsa Children's Consortium, the Oklahoma State Legislature and the Oklahoma State Department of Health reviewed home visiting models and chose to implement the "Olds Model," now known as Nurse-Family Partnership (NFP). Implementation began in SFY 1997 with pilot sites in Garfield, Garvin, Muskogee and Tulsa Counties. Current funding supports approximately 76 nurse and supervisor positions.

Oklahoma utilizes the NFP model to improve child health outcomes and minimize risk factors known to contribute to child maltreatment. The NFP model is based on more than three decades of research by David Olds, Ph.D. and colleagues. NFP has been recognized by the United States Department of Health and Human Services as an evidence-based model.[1] In addition, the model has been recognized by the Coalition for Evidence-Based Policy as meeting "top tier" evidence of effectiveness and by the Centers for Disease Control and Prevention (CDC) as a program that has great potential to reduce the economic burden of child maltreatment.[2,3] The model has been found to reduce the cost of long-term social services and to benefit multiple generations by striving to:

- Improve pregnancy outcomes by helping women alter their health-related behaviors, including reducing use of cigarettes, alcohol and illegal drugs;
- Improve child health and development by helping parents provide more responsible and competent care for their children; and
- Improve families' economic self-sufficiency by helping parents develop a vision for their own future, plan future pregnancies, continue their education and find work.[4]

MISSION

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.

SERVICES

Home visitation services are provided through the county health departments under the Oklahoma State Department of Health and at the independent City-County Health Departments in Oklahoma and Tulsa Counties. A first time mom, referred to as a client in this report, is enrolled prior to 29 weeks of pregnancy. Specially trained public health nurses provide assessments, education, information and linkages to community services to meet needs identified for each family. Nurse home visitors follow public health protocols and evidence-based NFP visit guidelines that focus on five domains of functioning: 1) personal health, 2) environmental health, 3) maternal life course development, 4) maternal role development and 5) networks for supportive relationships. Standardized assessment tools are utilized to assess risks for depression, substance abuse, intimate partner violence, physical abnormalities, child growth and developmental delays. Services rendered by the nurses are not intended to replace services provided by the Primary Care Provider (PCP). In fact, nurses often consult and collaborate with both the client's and child's PCP to ensure continuity of care and improved health outcomes. Children First services are provided to:

- Improve maternal health throughout pregnancy and after the child's birth;
- Improve child health and development from birth to age two;
- Enhance family functioning and family stability;
- Improve maternal life course development; and
- Decrease the risk of injury, abuse and neglect.

1. Avellar, S., Paulsell, D., Sama-Miller, E., and Del Grosso, P. (2013). Home Visiting Evidence of Effectiveness Review: Executive Summary. Office of Planning Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services, Washington, D.C.
2. Coalition for Evidence-Based Policy. Retrieved from: http://toptierevidence.org/
3. Child Maltreatment: Prevention Strategies. Centers for Disease Control and Prevention. Retrieved from: http://www.cdc.gov/ViolencePrevention/childmaltreatment/prevention.html.
4. Oklahoma Children First Program Evaluation Report. Nurse-Family Partnership, September 24, 2010.

SCREENING TOOLS

- Patient Health Questionnaire (PHQ9) (Client)
- Health Habits Questionnaire (Client)
- Intimate Partner Violence Questionnaire (Client)
- Ages and Stages Developmental Questionnaire (Child)
- Ages and Stages Social-Emotional Questionnaire (Child)
- DANCE (Dyadic Assessment of Naturalistic Caregiver-Child Experiences) (Client & Child)

NURSING ASSESSMENTS

- Brief Health Assessments of Client and Child
- Vital Signs of Client and Child
- Client Weight and Blood Pressure
- Child Weight and Height

ENROLLMENT

Women enrolling in the Children First program must meet the following criteria:

- The participant must be a first time mother;[5]
- The monthly household income must be at or below 185% of the federal poverty level; and
- The mother must be less than 29 weeks pregnant at enrollment.

Participation in Children First is voluntary. While the NFP intervention is designed to start early in the pregnancy and continue until the child's second birthday, clients are not obligated to participate for any finite length of time.

VISIT SCHEDULE

The suggested visit schedule is as follows:

- Weekly for four weeks following enrollment;
- Every other week until the baby is born;
- Every week during the six-week postpartum period;
- Every other week until the child is 21 months of age; and
- Monthly until the child turns 2 years of age.

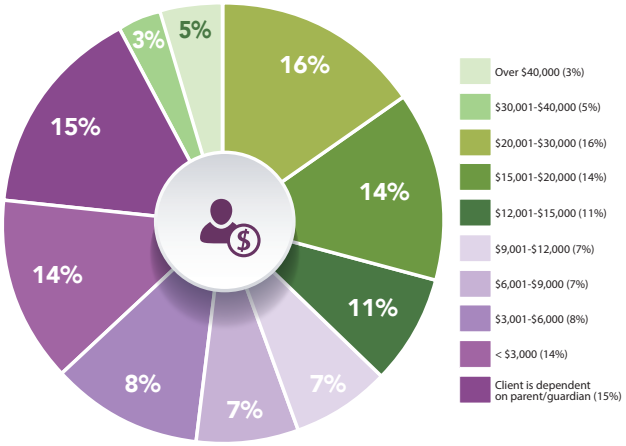
PROGRAM COSTS

During SFY 2017, a total of $8,794,665 was expended on Children First activities. Funding sources included state appropriations, county millage, and Medicaid reimbursements as well as federal funds from the Community-Based Child Abuse Prevention Grant and the Maternal, Infant and Early Childhood Home Visiting Grant. The cost per family was $3,983 (total expenditures divided by the number of families served). The data in this report does not include clients served by the Maternal, Infant and Early Childhood Home Visiting Grant.

5. A first time mother is: 1) a woman who is expecting her first live birth, has never parented and plans on parenting this child; 2) a woman who is expecting her first live birth, has never parented and is contemplating placing the child for adoption; 3) a woman who has been pregnant, but has not delivered a child due to abortion or miscarriage; 4) a woman who is expecting her first live birth, but has parented stepchildren or younger siblings; 5) a woman who has delivered a child, but her parental rights were legally terminated within the first few months of that child's life; or 6) a woman who has delivered a child, but the child died within the first few months of life.

PARTICIPANT CHARACTERISTICS

Reports show that home visitation programs have the most benefit for young mothers with low financial, social or psychological resources.[6] In addition to these characteristics, the NFP model is designed specifically to target first time pregnant women to provide the best chance of promoting positive behaviors before negative ones have taken hold.[7] Throughout the years, Children First has been successful in enrolling clients who meet these characteristics. The following demographics reflect the status of new Children First clients at enrollment during SFY 2017, unless otherwise stated.



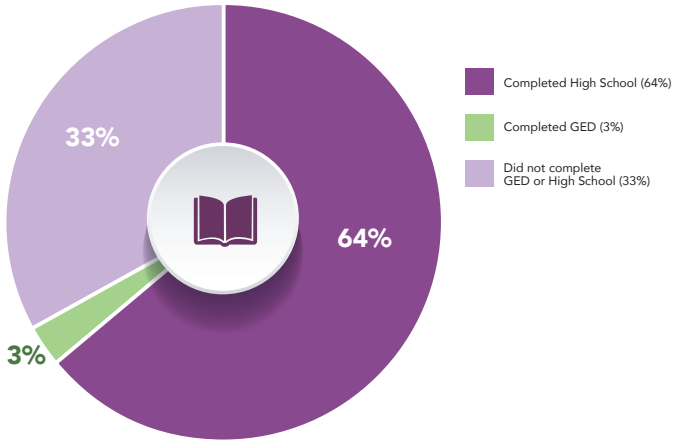
HOUSEHOLD INCOME *Figure 1*

In order to participate in Children First, the client must not have a household income greater than 185% of the federal poverty level. This dollar amount varies based on the number of people in each household. For a single woman living alone, an income of $21,978 would meet the financial criteria. For a couple expecting their first baby, this amount increases to $29,637.[8] Seventy-seven percent of new Children First enrollees in SFY 2017 had an annual household income of $20,000 or less, including fifteen percent who were dependent on a parent/guardian.

AGE OF CLIENT					
UNDER 18	18-19	20-24	25-29	30 & OLDER	RANGE: 13-44
11.2%	20.7%	40.5%	17.7%	9.8%	MED=21

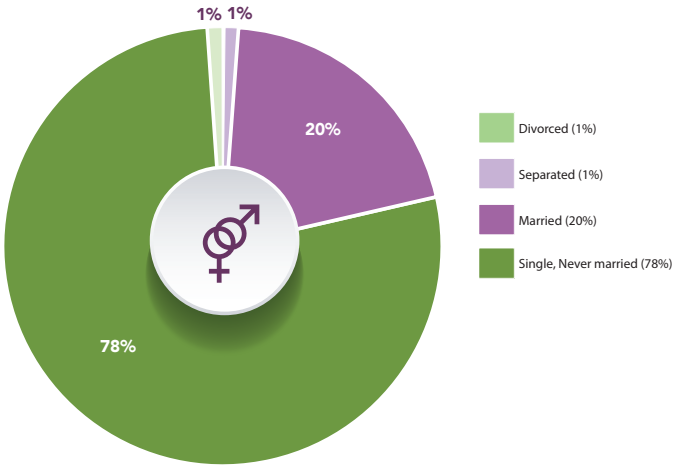
AGE *Figure 2*

The median age of new enrollees in SFY 2017 was 21 years of age and the age range was 13 to 44 years of age. At enrollment in SFY 2017, thirty-two percent of Children First clients were under the age of 20 and seventy-two percent were under the age of 25.



EDUCATION *Figure 3*

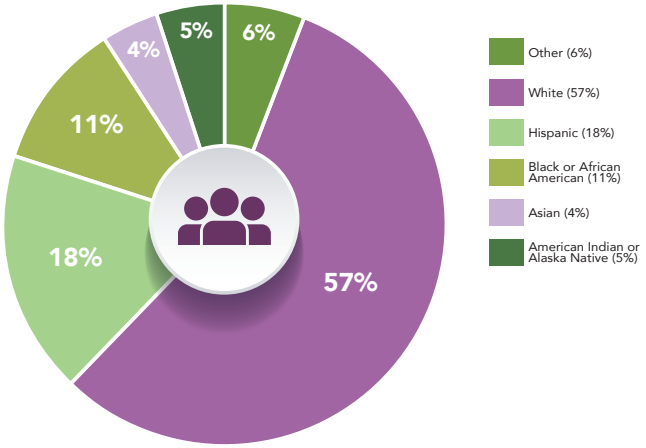
In SFY 2017, sixty-seven percent of new Children First enrollees had completed high school or a GED.



MARITAL STATUS *Figure 4*

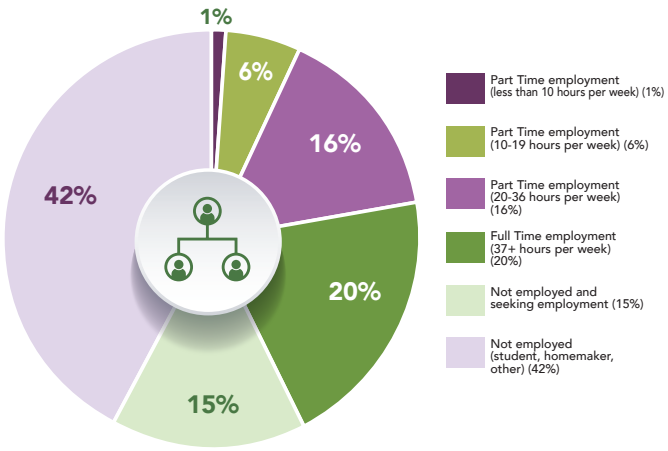
At enrollment in SFY 2017, most (seventy-eight percent) new Children First clients were single, never married.

6. Centers for Disease Control and Prevention. Task Force on Community Prevention Services. First Reports Evaluating the Effectiveness of Strategies for Preventing Violence: Early Childhood Home Visitation. MMWR. October 3, 2003.
7. Goodman, A. Grants Results Special Report: The Story of David Olds and the Nurse Home Visiting Program. Robert Wood Johnson Foundation. July 2006.
8. 2017 Poverty Guidelines. Office of the Assistant Secretary for Planning and Evaluation United States Department of Health and Human Services. Retrieved from: https://aspe.hhs.gov/poverty-guidelines



RACE/ETHNICITY *Figure 5*

The majority, (fifty-seven percent) of new Children First clients in SFY 2017 identified themselves as White. Less than forty percent identified themselves as Hispanic, Black, Asian, or American Indian.



EMPLOYMENT *Figure 6*

Over half (fifty-seven percent) of Children First enrollees in SFY 2017 were unemployed at the time of enrollment. Twenty percent were employed full-time.

HOUSEHOLD COMPOSITION	
	PERCENT
Father of the Child	49%
Other Family Members	37%
Client's Mother	22%
Husband/Partner	2%
Other Child	3%
Other Adults	15%

HOUSEHOLD COMPOSITION *Figure 7*

Almost half (forty-nine percent) of all new Children First clients lived with the father of their child in SFY 2017.

HEALTH CONCERNS	
	PERCENT
High Body Mass Index (overweight + obese)	53%
Depression	26%
Asthma	17%
Previous Miscarriage, Fetal or Neonatal Death	11%
Diabetes	3%
High Blood Pressure	4%
Chronic Infections (urinary/vaginal)	12%

HEALTH CONCERNS *Figure 8*

Pregnancy and birth outcomes are impacted by a client's pre-pregnancy health status. Nurses utilize well-developed tools and questionnaires to assess the client's health status at enrollment. As partners, the client and nurse develop a plan of care to reduce factors associated with poor birth outcomes. The number one health concern identified at enrollment was having a high body mass index. Just over half (fifty-three percent) of new Children First clients were identified as overweight or obese (pre-pregnancy weight). Only forty percent of new enrollees did not have at least one health concern at the time of enrollment in SFY 2017.

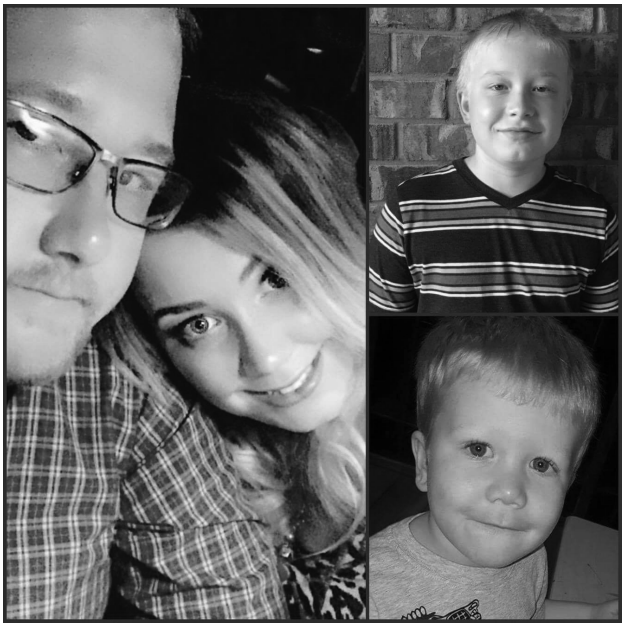
LIFE STRESSORS	
	PERCENT
Close family member became sick or died	28%
Client became separated or divorced	15%
Person close to the client had a problem with drinking or drugs	19%
Client was very sick	9%
Client was in a physical fight	7%
Client's husband/partner was sent to jail	8%
Client was in extreme debt	9%
Client lost job	15%
Client's husband/partner lost job	11%
Client was without a phone	13%
Client & child did not have enough food	9%
Client went to jail	15%

LIFE STRESSORS *Figure 9*

Assessments performed at client enrollment yield information on the types of stressors experienced by Children First clients. Questionnaires are designed to elicit information about the client's social environment, such as adequacy of housing, exposure to intimate partner violence, family stressors, incarcerations, etc. Nurses use this information to assist families in identifying areas for behavioral change and accessing needed community services.

LOUETTA GERMUNDSON, RN

MY STORY



My name is Louetta, and I was a Children First (C-1) client in 2005 through 2008. My nurse, Tracie Rochester, RN, BSN, was there for me during a vulnerable time in my life. I became pregnant with my first son, Braden, when I was a junior in high school. I married my husband just prior to the birth of our son. I was nervous and scared how becoming a mother at a young age would impact my relationship with my husband and parents. I was also nervous because I had never had to take care of a newborn. Fortunately, I had a C-1 nurse who was there to support me during my first pregnancy and help ease my transition into motherhood.

While my nurse didn't replace my doctor visits, she was there to offer guidance and support, as well as connect me to available community resources during my pregnancy. My nurse monitored me throughout our visits and was even the first to tell me that my blood pressure was elevated. My nurse counseled me on risk factors associated with high blood pressure and encouraged me to discuss my blood pressure with my doctor. Thankfully, I took her advice seriously and discussed these issues with my doctor. I was diagnosed with pregnancy-induced hypertension and pre-eclampsia later in my pregnancy. It was nice to have someone looking after me and providing the education that my doctor's office didn't seem to have time to provide adequately. I was also thankful to have a nurse to discuss my fears and concerns related to the labor and delivery process.

As if being a pregnant teen wasn't scary enough, my nurse was there once again to help me transition to motherhood. "Children do not come with instruction manuals," as I have been told by many, but my nurse helped to guide me and to instill confidence in me as a new mother. My nurse provided evidence-based information about child safety, such as car seat and crib safety guidelines, which helped me to keep my child safe. My nurse monitored my child for developmental delays, and reminded me when his immunizations were due. My nurse also provided me with positive feedback regarding my abilities to parent my child, which boosted my confidence.

When I got pregnant at age seventeen, I felt like my life as I knew it had ended. I was worried that I had disappointed my family, and feared I would never realize my dream of going to college. Not only was I a young mother, but I was also a young wife. Getting married and becoming a parent at a young age were trying at times, but my nurse offered a listening ear and helped guide me toward solutions that worked well for me and my family. Because of my nurse, I not only had support transitioning into my role as a mother, but I had guidance during times when my relationships with my husband and parents became strained due to the added responsibilities of raising a child. I feel like my nurse helped me to communicate my feelings more effectively, which in turn, preserved the relationships with my husband and parents.

Through the C-1 program I gained a mentor, someone who believed in me and provided guidance, which in turn made me believe in myself. My nurse taught me about goal setting, and helped me to prioritize and focus on my personal goals. She gave me the tools that I needed to thrive not only as a mother, but as a person. My nurse provided encouragement, which motivated me to finish high school. I was so moved by the way that she believed in me, that I would tell her that I wanted a job like hers, a job where I could make a difference in the lives of young mothers. I knew then that I wanted to pay it forward in some way; I later became a nurse.

My son and I were discharged from the program after he turned two years old. The graduation ceremony was not only symbolic of my little boy growing up, but also symbolized the beginning of another chapter in my life. This next chapter would be all about putting my skills and restored confidence to good use. Since completion of the program, I have completed both an Associate Degree of Science and an Associate Degree of Applied Science in Nursing. I graduated from Northern Oklahoma College's nursing program in 2011. I currently work in a public health setting, which serves a vulnerable population, including young and first time mothers. I am a member of Teen Engagement, Advocacy, and Mentorship (TEAM), a coalition designed to prevent teen pregnancy. I am actively pursuing my Bachelor of Science in Nursing through Northeastern State University with an anticipatory graduation date of May 2018. My husband and I have now been married for eleven years and have two precious sons, Braden (age 11 years) and Blake (age 3 years). Braden, my little C-1 graduate, is doing well. He is in Chisholm Elementary's Gifted and Talented Education (GATE) program and has made the Superintendent's Honor Roll. The C-1 program had a positive impact on my family, and I am forever grateful to my nurse who believed in me and gave me tools I needed to become a successful mother.

Sincerely,

Louetta Germundson, RN

NINETY-TWO PERCENT OF CHILDREN FIRST CLIENTS WHO GAVE BIRTH IN SFY 2017 RECEIVED 10 OR MORE PRENATAL CARE VISITS.

MATERNAL HEALTH OUTCOMES

PRENATAL CARE

Beginning prenatal care in the first trimester and attending regular prenatal visits help to ensure a healthy pregnancy and increase the probability of having a healthy baby. By allowing a healthcare provider to identify potential problems early, the majority of pregnancy and birth related health issues can be prevented.[9] Children First nurses stress the importance of early and adequate prenatal care as well as connect their clients to a PCP. During the course of the pregnancy, the Children First nurse and PCP are in contact and share pertinent health information about the client to ensure continuity of care.

POSTPARTUM DEPRESSION

Postpartum depression is not preventable, but it can be treated. Nationally, approximately thirteen percent of women display symptoms of depression after the delivery of a baby.[10] Early detection of postpartum depression is a goal of Children First. The Edinburgh Postnatal Depression Scale was used from July 1, 2016 trough September 30, 2016 to screen for depression. In order to align with the Nurse Family Partnership Model, Children First nurses began to administer the Patient Health Questionnaire (PHQ9) screening tool October 1, 2016. Screenings are performed at enrollment, at 36 weeks pregnancy, during the immediate postpartum period, at 4-6 months postpartum, at 12 months postpartum, and at any time that depression is suspected. Should the screening indicate signs of depression, according to the scoring tool, the Children First nurse will immediately connect the client to a healthcare or mental healthcare professional and follow up at the next visit.

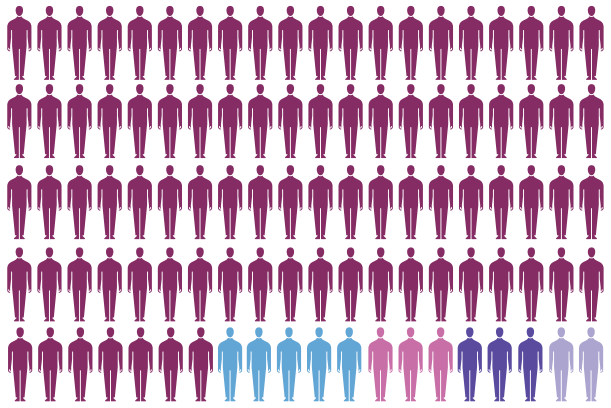
SMOKING CESSATION

Smoking is one of the most important known preventable risk factors for low birth weight and preterm delivery as well as many other adverse pregnancy and birth outcomes. Additionally, exposure to secondhand smoke is a major cause of childhood disease and illness, including asthma.[11] Children First nurses utilize motivational interviewing techniques to guide behavior change and refer smokers to the Oklahoma Tobacco Helpline as well as their PCP to help clients decrease tobacco use.

PHQ9
There were 3,057 Depression Scale screenings administered to 1,414 mothers in SFY 2017. Approximately eleven percent of clients screened between July 1, 2016 through June30, 2017, indicated signs of depression and required immediate attention by a healthcare or mental health professional.

SMOKING

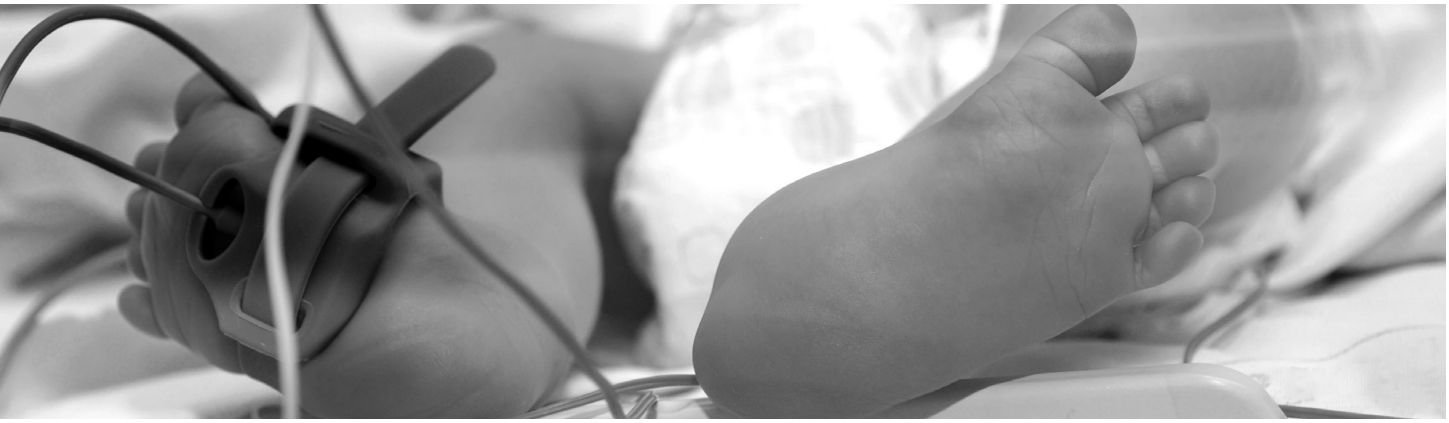
Figure 10



93% percent of Children First clients served in SFY 2017 quit, reduced, or never began smoking between intake and 36 weeks of pregnancy.

- Clients who did not smoke at intake and still do not smoke (87%)
- Clients who smoked at intake and still smoke (5%)
- Clients who reduced or quit smoking by 36 weeks of pregnancy (3%)
- Clients who decreased smoking since intake (3%)
- Clients who increased or began smoking since intake (2%)

9. Prenatal Care. Medline Plus. Retrieved from: http://www.nlm.nih.gov/medlineplus/prenatalcare.html
10. Postpartum Depression. JAMA Patient Page. Retrieved from: http://jama.jamanetwork.com/article.aspx?articleid=186751
11. Tobacco Use and Pregnancy. Centers for Disease Control and Prevention. Retrieved from: http://www.cdc.gov/reproductivehealth/tobaccousepregnancy/



CHILD HEALTH OUTCOMES

GESTATIONAL AGE AND BIRTH WEIGHT

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 CDC, preterm birth is the most frequent cause of infant death, the leading cause of long-term neurological disabilities in children, and costs the United States' healthcare system more than $26 billion each year.[12,13] Babies born weighing at least five pounds eight ounces (2,500 grams) are considered normal birth weight. Babies born weighing less than five pounds eight ounces are considered low birth weight, and very low birth weight infants are those weighing less than three pounds five ounces (< 1,500 grams). Babies born at low and very low birth weight are at increased risk for health problems and developmental delays.[13] Children First nurses perform a brief health assessment at every prenatal home visit. These assessments include a short health questionnaire, weight and blood pressure measurements to assess for signs and symptoms related to pre-eclampsia and gestational diabetes, and risk factors for preterm birth and/or delivery of a baby with low birth weight.

In SFY 2017, 11% of Children First mothers reported that their baby spent time in the NICU.

NEONATAL INTENSIVE CARE UNIT

Babies born early, with low birth weight or other birth complications, may spend time in the Neonatal Intensive Care Unit (NICU). Time spent in the NICU translates into decreased attachment and bonding between mom and baby. The physical assessments conducted by Children First nurses intended to reduce the risk of preterm labor and babies born with low birth weight, also help to prevent entry into the NICU. If the baby does need to be admitted to the NICU, the Children First nurse will tailor the curriculum to help the mother care for her baby's unique needs.

Of all Children First babies born in SFY 2017, 11% were born preterm and 2% were born very preterm. Of all Children First babies born in SFY 2017, 10% were born with low birth weight and 2% were born with very low birth weight.

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 promote breastfeeding because of the benefits for both mom and baby. Children First nurses provide facts about the benefits of breastfeeding for both mom and baby as well as dispel myths. Additionally, Children First nurses demonstrate breastfeeding holds using models, and after the baby is born, can provide assistance while the mother is breastfeeding. The nurse can connect the client with a lactation consultant if necessary.

Among Children First mothers who gave birth in SFY 2017, 90% initiated breastfeeding with their new infant.

12. Preterm Birth. Centers for Disease Control and Prevention. Retrieved from: http://www.cdc.gov/reproductivehealth/MaternalInfantHealth/PretermBirth.htm
13. Birth Weight. March of Dimes. Retrieved from: http://www.marchofdimes.org/mission/the-economic-and-societal-costs.aspx

CHILD HEALTH OUTCOMES

DEVELOPMENTAL MILESTONES

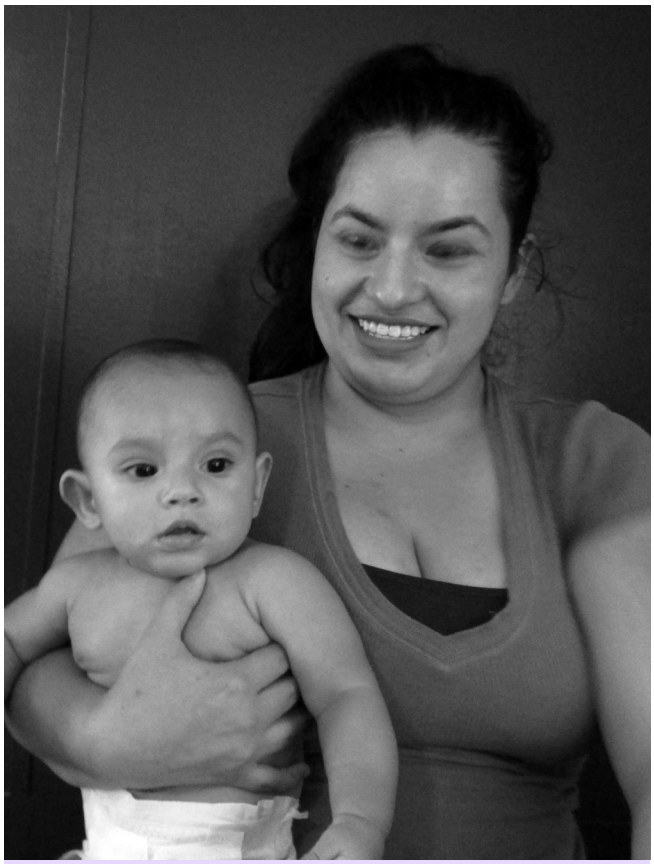
The Ages and Stages developmental assessment tool is utilized to assess cognitive, language, motor, problem solving, social and emotional milestones for children enrolled in Children First. These screenings are administered to children enrolled in the program regularly, beginning when the child is two months of age. If a delay is suspected, according to the scoring tool, the nurse will refer the client to SoonerStart (early intervention), Child Guidance, or the child's PCP.[14]

There were 3,202 Ages and Stages Questionnaires completed in SFY 2017 for Children First clients. In addition, 1,288 Ages and Stages – Social-Emotional Questionnaires were completed.

IMMUNIZATIONS AND WELL CHILD EXAMS

Children First nurses encourage and refer clients to the child's PCP to maintain an up-to-date status for child immunizations and well child examinations. Immunization records are retrieved from the state database and reviewed with the client. Clients can also use these records as proof of immunization when enrolling in daycare. The Children First nurse will review the assessments completed by the PCP during the well child visit with the client to build an understanding of their child's health.

At their last home visit in SFY 2017, 94% of Children First mothers reported that their child was up-to-date on their immunizations and 88% were up-to-date on their well child exams.



Ana Martinez
OKLAHOMA COUNTY

14. SoonerStart is an early intervention program for families of infants and toddlers (birth to 36 months) who have developmental delays. Retrieved from: https://www.ok.gov/health/County_Health_Departments/Carter_County_Health_Department/SoonerStart_Early_Intervention/

LACRESHA WILLIAMS

MY STORY

Lacresha enrolled in the Children First Program in October 2015 after she had moved back to Tulsa from Atlanta in order to assist her mother who was recovering from surgery.

From the beginning, Lacresha was very excited about having a nurse come and visit her at home. She rarely missed a visit and frequently wondered why there was no such program that she knew about like this in Atlanta. Throughout Lacresha's visits with her nurse, she demonstrated a thirst for knowledge about all things pregnancy and baby related.

Lacresha's plan was to return to Atlanta which she did when her daughter, Eliza, turned 6 months old. However, with limited support and faced with the challenges of single parenthood, Lacresha and Eliza returned to Tulsa when Eliza was 1 year old. Lacresha contacted her C1 nurse upon her return to Tulsa and home visits resumed.

Lacresha states that Children First has helped her in the following ways:

"If I have a question that maybe my doctor didn't have time for or seemed in a rush, to answer, I know that I could always count on my nurse to give me information, and if she didn't know right away, she would always go away and collect the information and come back with more details."

"Also, if I had goals for myself to help me stay my course, or stay on track, my nurse kept me accountable. She also gave really good information about the stages and ages of kids and what was to be expected as they get older–including the health and the safety aspects. My nurse brought a lot of good information on stuff that I didn't even think to look up. And the nurse is very personable, reliable and very friendly."

Lacresha was successful at getting Eliza enrolled in a research based Early Childhood Program in Tulsa. The excitement of this early learning opportunity, however, turned to dismay when a situation arose which required Lacresha to deal sensitively and tactfully with a staff member who was not addressing a concern that Lacresha had expressed. Lacresha's nurse offered a listening ear as well as coaching on how best to effectively communicate with the child care staff about her concerns. Lacresha handled this interaction with patience, professionalism and understanding and over a short period of time the issue was resolved. Eliza enjoys the rich learning environment the center provides and is thriving!

Lacresha works as a full time leasing agent for an apartment complex in Tulsa and was recently promoted to assistant manager.

Lacresha has many talents. She has started her own small business, 'Photos on a Mission', as a photographer, and has authored a book 'A Day In the Life of a Kindergartner,' to assist parents and child care staff in recording young children's accomplishments "as they happen" in the learning environment.

Lacresha is diligently working toward achieving her heart's desire which is to return to school and study sonography.

FAMILY SAFETY OUTCOMES

INTIMATE PARTNER VIOLENCE

Intimate partner violence is a serious, preventable public health problem that affects millions of Americans. Physical, sexual, or psychological harm caused by a current or former partner not only negatively affects the physical and emotional well-being of the mother, but her children as well.[15] Children First nurses assess their clients at intake, 12 weeks of pregnancy, when the child is 16 months of age, and as needed using a questionnaire which asks about physical, sexual, and emotional abuse. If any concerns arise, a safety plan is created by the client with the help of the nurse and a referral is made to local domestic violence services.

INTIMATE PARTNER VIOLENCE

Figure 11

In SFY 2017, 94% of Children First clients did not experience domestic violence in the past six months.

- Clients who were not experiencing domestic violence at intake and are still not experiencing domestic violence (81%)
- Clients who were experiencing domestic violence at intake, but are now not experiencing domestic violence (13%)
- Clients who were not experiencing domestic violence at intake, but are now experiencing domestic violence (0%)
- Clients who were experiencing domestic violence at intake and are still experiencing domestic violence (6%)

CAR SEAT SAFETY

Ninety-six percent of Children First clients reported always traveling with their child in a car seat in SFY 2017.

INJURY PREVENTION

According to the CDC, unintentional injuries such as suffocation, drowning, motor vehicle crashes, and burns are the leading causes of death and disability for children under 4 years of age.[16] Children First nurses conduct a home safety check with the family when the child is 10 and 21 months of age. These safety checks include an inspection of the crib to ensure a safe sleep environment that is free from stuffed animals, bumper pads, pillows, and other people; inspection of smoke detectors, including number, placement, and working order; as well as multiple discussions about car seats, water safety, gun safety, etc.

WATER SAFETY

Ninty-seven percent of Children First clients reported never leaving their child unattended near water in SFY 2017.

SAFE SLEEP

Forty-six percent of Children First clients with a child two months of age reported never co-sleeping with their child, and 32% reported co-sleeping with their child only some of the time in SFY 2017.

Eighty-six percent had at least one working smoke detector.

15. Intimate Partner Violence. Injury Prevention and Control: Centers for Disease Control and Prevention. Retrieved from: http://www.cdc.gov/violenceprevention/intimatepartnerviolence/index.html
16. National Action Plan. Centers for Disease Control and Prevention, Retrieved from: https://www.cdc.gov/safechild/index.html

CHILD MALTREATMENT

Of the 1,788 children who received at least one home visit from Children First in SFY 2017, 1,658 of them (93 percent) had not been named as a potential victim in an Oklahoma Department of Human Services (OKDHS) report after enrolling in Children First. Furthermore, 1,751 of them (98 percent) have not had a confirmed child maltreatment case with OKDHS since enrolling in Children First. None of the Children First children served in SFY 2017 had been named in a report to OKDHS for sexual abuse. It is noteworthy that only 7 percent of the Children First families served in SFY 2017 had been reported for potential maltreatment despite all entering in the program with risk factors.

Figure 12

CHILDREN WITH A CONFIRMED CASE OF MALTREATMENT

The data below is related to the 37 confirmed cases of maltreatment among children participating in Children First during SFY 2017. The family may or may not have been actively engaged in Children First at the time the report was made.

Gender of Victim	Percent
Male	53%
Female	47%
Type of Maltreatment in Confirmed Cases	
Abuse	94%
Neglect	6%
Type of Abuse in Confirmed Abuse Cases	
Threat of Harm	50%
Other (includes: beating/hitting, exposure to domestic violence, failure to protect, inadequate or dangerous shelter, inadequate physical care, and thrown)	50%
Type of Neglect in Confirmed Neglect Cases	
Threat of Harm	39%
Other (includes: burning/scalding, failure to obtain medical attention, failure to protect, failure to provide adequate nutrition, inadequate or dangerous shelter, inadequate physical care, lack of supervision, and thrown)	61%
Perpetrators in Confirmed Maltreatment Cases	
Mother	54%
Father	40%
Grandparent	4%
No Relation	2%

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OKLAHOMA COUNTY

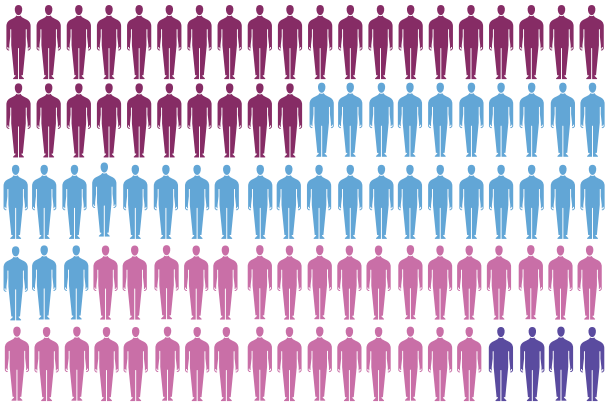
FAMILY STABILITY OUTCOMES

FATHER INVOLVEMENT

When fathers are involved in the lives of their children, the children are more likely to exhibit healthy self-esteem and do well in school.[17] Children First nurses encourage the father of the baby to participate in all home visits. If the father is unable to participate, activities are left with the mother for the father to use at a later date. The importance of the client's personal relationships is discussed, including having a supportive relationship with a person who gives mutual emotional and monetary support.

FATHER INVOLVEMENT

Figure 13



96% percent of Children First fathers spent time with their child in SFY 2017.

- Fathers who spent time with their child at intake and still spend time with their child (30%)
- Fathers who have decreased their time spent with their child since intake (33%)
- Fathers who have increased time spent with their child since intake (33%)
- Fathers who did not spend time with their child at intake and still do not spend time with their child (4%)

17. Rosenberg, J. and Wilcox, W.B. The Importance of Fathers in the Healthy Development of Children. The U.S. Department of Health and Human Services Administration on Children, Youth and Families, Children's Bureau, Office on Child Abuse and Neglect, Chapter 3 (2006).

PREGNANCY SPACING

The amount of time between pregnancies, known as the interpregnancy interval, is calculated as the number of months between the date the last pregnancy ended and the date of the last menstrual period prior to the subsequent pregnancy. According to the CDC, women with short interpregnancy intervals may be at risk for poor pregnancy outcomes.[18] The recommended time between birth and the next pregnancy is a minimum of eighteen months.[19] Children First nurses educate their clients on the importance of family planning and refer them to their local county health department or PCP to receive a form of birth control.

SOCIOECONOMIC INDICATORS

Economic security is important to the well-being of children and families. Poverty places families with children at risk of experiencing unhealthy outcomes. The stress of unemployment places a burden on parents as well as financially straining the family. Parents with less education often have lower household incomes, even if they are employed full-time.[20] Children First nurses connect their clients to local services to further their education and/or obtain a job thereby increasing their income. Financial aptitude, using credit wisely, and saving are all topics that are covered during visits, including active skills building for money management.

SPACING

Only 10% percent of Children First clients served in SFY 2017 were pregnant with their second child before their first child reached one year of age. By the time their first child reached 18 months of age, 12% of Children First mothers were pregnant with their second child.

EMPLOYMENT

Of the Children First clients served in SFY 2017 who were unemployed at intake, 20% had found work by the time their child was six months of age.

HOUSEHOLD INCOME

Of the Children First clients served in SFY 2017, 47% increased their household income by the time their child was 12 months of age.

EDUCATION

Among the Children First clients over the age of 18 served in SFY 2017 who did not have a high school diploma or GED at intake, 27% earned their high school diploma or GED by the time their child was 18 months of age.

18. Interpregnancy Interval. Centers for Disease Control and Prevention. Retrieved from: http://www.cdc.gov/pednss/what_is/pnss_health_indicators.htm
19. Zhu, BP. Effect of Interpregnancy Interval on Birth Outcomes: Findings from Three Recent U.S. Studies. International Journal of Gynecology & Obstetrics. April 2005.
20. Single-Parent Families in Poverty. Retrieved from: http://www3.uakron.edu/schulze/401/readings/singleparfam.htm

CHILDREN FIRST ACTIVITIES

REFERRALS

Each team of nurses has developed unique strategies to reach potential clients in their respective counties. Lead nurses have provided outreach to private physicians, the Indian Health Service, the Oklahoma Health Care Authority, public schools, and local community agencies. There were 3,684 referrals made to the Children First program. Of these, 1,282 met the eligibility guidelines. Among the women who were not eligible to participate, referrals were made to the Oklahoma State Department of Health Child Guidance Service and other home visitation programs such as Parents as Teachers and SafeCare.

Figure 14

ENTITIES REFERRING TO CHILDREN FIRST	
REFERRAL SOURCE	#
Women, Infants and Children (WIC)	1,964
Health Department Family Planning	1,184
Self-Referral	11
Family/Friends/Neighbor	15
Community Connector	37
Faith-Based Organization	7
Current/Past C1 Client	14
Health Department Maternity	12
parentPro	13
Indian Health Service	7
Hospital, Medical Provider, HMO or Private Physician	68
School	12
Department of Human Services	4
Pregnancy Testing Clinic	17
Other Home Visiting Program	9
Other	335
Oklahoma Health Care Authority (OHCA)	42
Supplemental Nutrition Assistance Program (SNAP)	2
Community-based Agency	13

Yalissa Granados
OKLAHOMA COUNTY

Figure 15

SERVICES	
TYPES OF REFERRALS AND SERVICES	#
Referrals	3,684
Eligible Referrals	1,282
New Enrollees	1,079
Families Served	2,208
Completed Visits	22,104
Births	374

Figure 16

2017 COUNTY DATA

County Name	Completed Visits	Referrals	Families Served	New Enrollees	Births	Average Length of Enrollment in days*
Adair	202	31	20	10	4	313
Alfalfa	48	0	4	0	0	611
Atoka	43	26	7	8	2	290
Beaver	0	1	0	0	0	-
Blaine	62	0	8	0	0	539
Caddo	53	14	10	4	0	257
Canadian	827	103	80	43	13	371
Carter	229	51	32	16	1	322
Cherokee	787	65	69	40	7	655
Choctaw	162	46	17	13	2	791
Cimarron	0	0	0	0	0	-
Cleveland	2,162	227	179	78	29	360
Coal	43	14	7	2	0	225
Comanche	469	73	58	25	10	332
Cotton	29	0	2	0	0	651
Craig	226	24	20	6	1	576
Custer	137	27	19	1	0	388
Delaware	468	62	38	17	0	471
Dewey	22	2	2	0	0	335
Ellis	49	2	5	1	0	328
Garfield	426	137	59	38	7	331
Garvin	285	50	21	8	4	324
Grady	61	22	6	1	1	386
Grant	22	5	2	0	0	134
Greer	0	1	0	0	0	-
Harmon	0	1	0	0	0	-
Harper	23	1	1	0	0	-
Haskell	49	13	5	1	0	551
Hughes	120	29	17	12	2	275
Jefferson	10	2	1	0	0	387
Johnston	67	26	9	8	1	149
Kay	86	45	12	3	0	317
Kingfisher	308	27	32	11	2	384
Kiowa	39	8	4	0	0	288
Latimer	-	-	-	-	-	-
LeFlore	777	63	56	17	5	371
Lincoln	310	55	35	15	4	352
Logan	648	91	72	47	14	249
Love	18	10	2	1	0	328
Major	-	14	-	-	-	394
Marshall	134	32	23	15	0	237
Mayes	141	39	11	9	7	236
McClain	253	27	19	7	5	286
McCurtain	410	1	39	1	2	237
McIntosh	163	50	19	7	1	286
Murray	70	24	8	4	0	349
Muskogee	331	70	33	12	6	379
Noble	22	13	3	2	1	194
Okfuskee	82	21	8	7	1	261
Oklahoma	3,239	663	328	212	92	537
Okmulgee	40	45	8	8	1	261
Osage	29	14	5	3	1	260
Ottawa	389	68	39	20	5	337
Pawnee	1	8	1	1	0	163
Payne	183	71	23	10	2	194
Pontotoc	111	48	22	16	4	204
Pottawatomie	423	129	49	25	9	407
Pushmataha	39	16	8	3	9	521
Rogers	395	72	54	11	5	340
Seminole	86	45	14	10	2	299
Sequoyah	109	33	10	4	0	327
Stephens	91	37	20	4	0	361
Texas	79	25	14	7	2	234
Tulsa	5,324	629	457	212	111	335
Wagoner	49	18	5	0	0	452
Washington	225	88	36	24	2	201
Woods	0	9	0	1	0	-
Woodward	419	19	41	18	6	229
						Avg
TOTAL	**22,104**	**3,684**	**2,208**	**1,079**	**374**	**346**

*Includes any client who received services within SFY17, regardless of when they started or ended the program.

ACKNOWLEDGMENTS

We want to thank all of the families who open their doors, their lives and their hearts to *Children First* home visitors. In addition, we acknowledge our health department co-workers and community partners who work with us to make a difference in the lives of Oklahoma families.

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