Building Results: From Wellness Goals to Positive Outcomes for Oregon's Children, Youth, and Families

Clara C. Pratt and Aphra Katzev

Oregon will develop the best future for its people if we share a common vision, develop strategies to achieve this vision, and track our progress toward this vision. The Oregon Commission on Children and Families and Oregon's 36 county commissions have identified five critical goals to improve the well-being of children, youth, and families (Figure 1). These goals will help focus government, non-governmental, business, and other community efforts.

Oregon's goals for children, youth, families, and communities are:

- Nurturing Families
- Healthy, Thriving Children
- Positive Youth Development
- Academic Success and Progress for Children and Youth
- Caring Communities and Systems

Oregon will reach these goals by making steady, deliberate steps— through hundreds of small and large community programs, collaborations, and other efforts. Indicators of progress—from statewide benchmarks to individual program performance indicators—are essential to guide each step toward our goals. Carefully planned, built on a solid empirical base, and consistently evaluated, these multiple community efforts will create a more positive environment for all children, youth, and families.

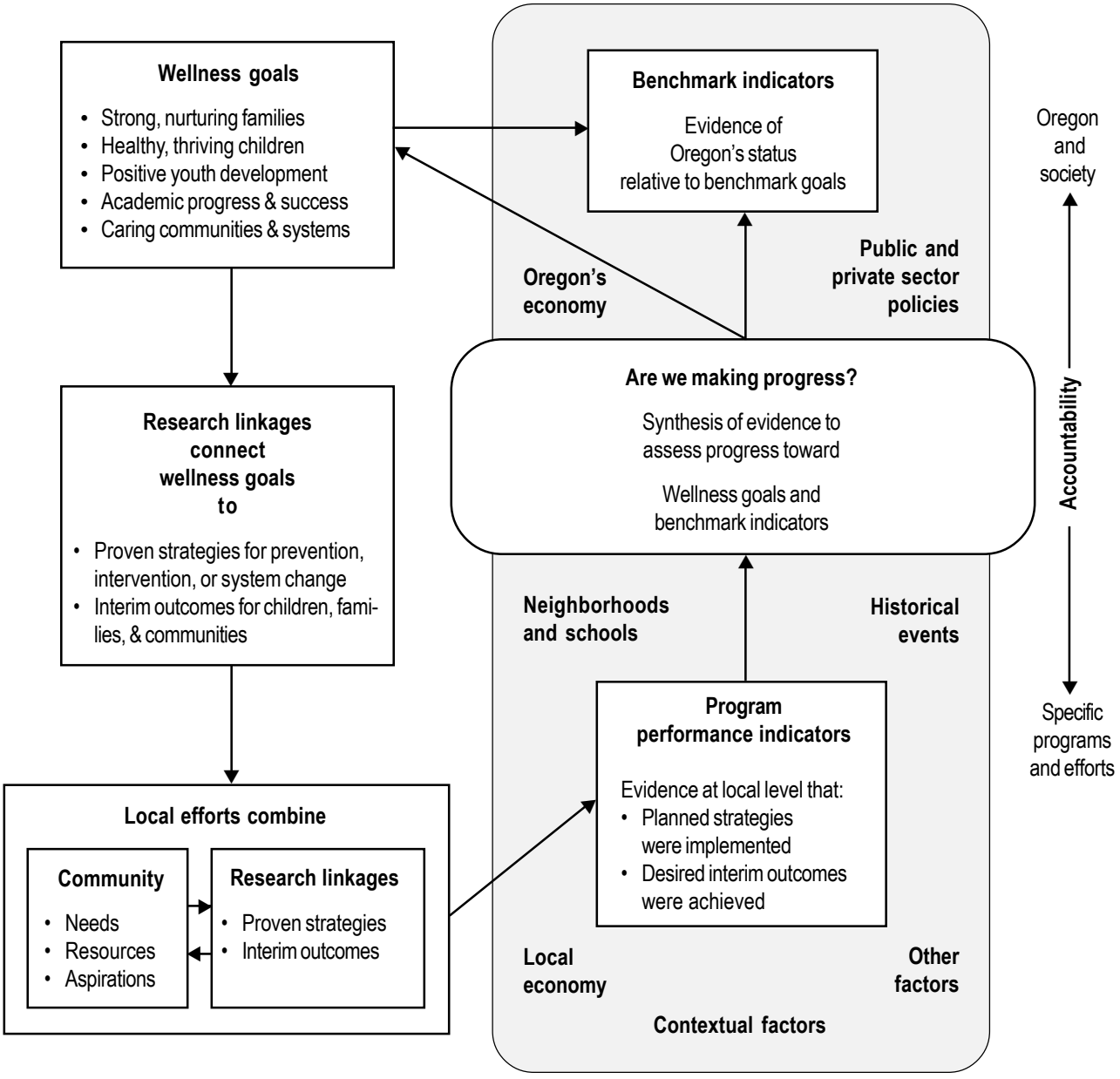
The model described in this paper illustrates the relationships among Oregon's wellness goals for children, youth, families, and communities. It describes:

- Research on interim outcomes and proven strategies to achieve these outcomes.
- Community needs, aspirations, and resources.
- Contextual factors that influence outcomes.
- Indicators of progress and accountability—benchmark indicators and program performance indicators.

Research linkages: Connecting goals to strategies and outcomes

Research can inform our efforts to improve the well-being of Oregon's children, youth, families, and communities. Specifically, research can help to:

Figure 1. Wellness for Oregon's Children, Youth, and Families



- Establish realistic short-term or interim outcomes that can be connected reliably to long-term goals.
- Identify prevention, intervention, and other strategies that are proven to be effective in reaching desired outcomes and goals.
- Define risk and other characteristics of persons who might benefit from support, thus helping communities to target prevention and intervention strategies.

In short, research can guide the development and evaluation of specific prevention and intervention efforts by revealing proven strategies and realistic, interim outcomes that will lead to long-term goals.

Research can reveal proven strategies and identify realistic, interim outcomes that will lead to long-term goals.

Research has limitations, however. Because human development and behavior are so complicated, research is just beginning to unravel the many factors that lead to positive, or negative, outcomes for children, youth, families, and communities. Sometimes studies provide conflicting findings. Other times, the individuals who were included in a study aren't really like those in another community. Perhaps the questions asked aren't exactly what we need to know. Most importantly, we learn more through new research every day.

Because of these limitations, research can inform, but not fully dictate, prevention and intervention efforts. Only research findings that met two criteria were included in this current guide. Specifically, the research had to, repeatedly and reliably, do the following.

- Demonstrate a strong connection between the desired goal and measurable, interim outcomes for children, youth, families, and communities.
- Clarify policies, programs, and other strategies that are proven to lead to the desired goals and interim outcomes.

This research provides critical information about achieving wellness goals through proven strategies and realistic interim outcomes.

Community needs, aspirations, and resources

To create locally appropriate strategies and outcomes, research must mesh with the needs, aspirations, and resources of individual communities. Communities can build on reliable research findings to:

- Guide the local assessment of needs and resources.
- Establish measurable interim outcomes for local prevention and intervention efforts.
- Focus prevention and intervention efforts on strategic activities with the greatest potential payoff.

In addition to building on empirically proven strategies and measurable interim outcomes, effective community planning also must do the following (Bogenschneider, 1996):

- Address important local needs, aspirations, and resources
- Involve the target audience in planning, design, implementation, and evaluation.
- Respond to cultural, ethnic, and gender diversity.
- Create a comprehensive, responsive, and ongoing support system for children, youth, and families.

Such effective community planning will result in successful local strategies that improve the well-being of children, youth, families, and communities.

Contextual factors

In this era of accountability, it is important to acknowledge the social, political, economic, and physical environments that can strongly influence the success of any program. For example, a very powerful and potentially effective youth employment program may fail to achieve its intended outcomes in times of high unemployment. Terrible weather can reduce participation in a planned series of classes. These and other major contextual factors that influence prevention and intervention efforts and outcomes must be acknowledged when planning, conducting, and evaluating program efforts.

Indicators of progress

When empirically sound and locally appropriate prevention and intervention efforts are underway, it is critical to monitor and evaluate these efforts. Two types of data or information can be used to assess progress toward Oregon's goals. These are:

- Oregon Benchmarks: aggregate social indicators such as statewide or county-wide rates of family poverty and juvenile crime.
- Program Performance Indicators: data or information on individual program efforts and outcomes.

Each type of indicator is discussed briefly below.

Oregon Benchmarks. Originally adopted in the early 1990's, Oregon Benchmarks rely on aggregated state (and in some cases regional, county, or local) data to provide a picture of Oregon's status relative to its various goals. For example, under the goal of "Nurturing Families, Thriving Children," Oregon identified several benchmark indicators, including statewide rates of child abuse, teenage pregnancy and parenthood, domestic violence, family poverty, and readiness to learn at entrance to kindergarten (Oregon Progress Board, 1994).

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It is important to remember that benchmarks are indicators of our status relative to our goals. Benchmarks are not the goals themselves. Thus, the focus of OCCF and local CCF efforts is not solely on reaching these benchmarks, but rather on achieving the broader goals of healthy children, positive youth development, academic achievement for all children and youth, and nurturing families and communities.

For some of these goals, clear or powerful benchmarks have not been identified. For others, the benchmarks capture a minimum desired standard, not an ideal goal. For example, the lack of child maltreatment is one indicator of child well-being but it does not fully capture the goal of nurturing families. To more fully as-

sess progress toward Oregon's goals, benchmarks must be combined with performance indicators and other evidence of progress toward well-being for children, youth, and families.

Performance Indicators. Performance indicators tie long-term goals to specific program strategies and interim outcomes for children, youth, families, and communities.

There are three categories of program performance indicators—input, output, and outcome. All are important. Each provides vital and unique information about a program or other effort. The three categories of performance indicators are:

- **Input indicators.** What was invested in the effort? What resources (staff, skills, money, materials, and others) were allocated and used in the effort?
- **Output indicators.** What was done? What activities—educational workshops, newsletters, support groups, individual counseling, public awareness campaigns, or media events were undertaken? How long and how frequent were the activities? How many people participated? Was the intended participant group or audience reached?
- **Outcome indicators.** What resulted from the effort? What knowledge, skills, attitudes, or behaviors did participants demonstrate as a result of the intervention? Did risk factors for poor outcomes (such as teen pregnancy or alcohol abuse) decrease? Did protective factors (such as positive relationships or social support) increase? Did participants in the intervention demonstrate the desired behavior during and after the intervention period? Did teens avoid pregnancy, stay off drugs and alcohol, make academic progress? Did parents demonstrate positive parenting skills and create enriching home learning environments?

Most programs track input and output indicators. These provide essential information for understanding the nature and scope of prevention and intervention efforts. Outcomes or results of efforts are less often stated or tracked, but they are the critical third element if goals are to be effectively pursued and reached. As programs move to more fully assess outcomes, it is important to continue to track inputs and outputs as well. Results or outcomes make little sense without an understanding of the resources (inputs) and activities (outputs) that lead to these outcomes.

There are three categories of program performance indicators—input (what was invested?), output (what was done?), and outcome (what resulted?).

Ideally, performance outcomes are stated in the same terms as benchmarks. For example, if a community program addresses the state's benchmark of reduced juvenile crime, it is important for that program to track juvenile crime among participants. Stating performance outcomes in the same terms as benchmarks makes it easier to assess an individual program's contribution to achievement of the state's benchmarks and goals.

It is often not possible to directly use already collected benchmark data to assess the success of an individual program. Aggregate benchmark data cannot be used to assess outcomes of individual programs if:

- The program serves only part of the population included in the benchmark data. A very successful program that reduces delinquency among 100 at-risk teens is not likely to result in improvement in state or county-wide benchmarks on juvenile crime.
- Confidentiality or other data access problems limit identifying program participants in the aggregated benchmark data. A child abuse prevention program may serve 500 families in a large county. But confidentiality policies may limit identifying these families in the county or state records on confirmed child abuse and neglect cases.
- Benchmark data were collected or reported for periods of time that are not appropriate to evaluating a program. Readiness for school at age 5 is an Oregon benchmark. A parent education program may work with parents of infants and toddlers to increase the numbers of these children who are ready for kindergarten. The staff cannot, however, wait for these children to enter kindergarten in three to five years to determine the program's effectiveness.

When a program cannot rely directly on benchmark data to assess its outcomes, outcomes can still be related to benchmarks.

- Outcomes can be stated in the same behavioral terms as benchmarks such as alcohol use or sexual activity. Available records or program participants' self reports on this behavior can then be used to assess the effectiveness of the program.
- Programs can track outcomes in terms of other behaviors that are reliably related to a benchmark. For example, the parent education program that seeks to improve the readiness for kindergarten of toddlers can track parent behavior (such as creating a stimulating home learning environment) and toddler's abilities (such as pre-literacy skills). These parental behaviors and toddlers' abilities are strongly related to readiness for school at age 5 (Caldwell & Bradley, 1994).

Programs aimed at improving the high school graduation rate or reducing juvenile crime could assess such interim outcomes as:

- Commitment to school
- Attendance
- Behavioral referral and
- Grades.

These interim outcomes are strongly related both to eventual graduation and to juvenile crime prevention.

When interim outcomes are strongly and empirically related to longer-term goals, the achievement of these outcomes is evidence of progress toward those goals.

Are we making progress?

Taken together, program performance indicators, statewide and local benchmark data, and other community indicators can reveal our progress toward our long-term statewide goals. As we move toward positive youth development for all youth, we should see evidence of:

- Increased community opportunities for youth.
- More effective family support and supervision.
- Increased social skills and academic progress.

These interim outcomes will occur before we see statewide reductions in teen pregnancy or juvenile crime. Tracking these interim outcomes will inform us of where we are relative to state goals and benchmarks. Knowing this will allow for mid-course corrections and targeting resources into the most effective strategies.

References

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Assessing Success for Oregon's Healthy Start

Here's how family wellness outcomes have been linked to goals and benchmarks to measure the success of the Healthy Start Program in Oregon.

Healthy Start offers support to all families with newly born children, targeting first-birth families as they make the transition into parenthood. Almost 80 percent of first-birth families in the 12 participating counties were reached by Healthy Start during fiscal year 1995–96. Just 7 percent of them declined Healthy Start service.

All families reached by Healthy Start are screened for characteristics that may put them at risk for poor child or family outcomes, including child maltreatment.

Families with few, if any, risk characteristics are offered basic, short-term support services. Families with higher levels of stress and at risk for poor outcomes are eligible for longer-term intensive support. About two-thirds of the families received short-term basic service. One-third were eligible for longer-term service, but not all were served because intensive support services were full. About 25 percent of Healthy Start families in FY 95–96 received intensive service.

Healthy Start has made progress toward the following Oregon benchmarks.

Children will be ready for school at kindergarten age.

- More than 90 percent of babies from higher risk families are developing normally.
- 100 percent of the children whose development is outside the normal range have been referred for intervention services.
- 78 percent of Healthy Start's higher risk families consistently engage in positive parent-child interactions.
- 59 percent are creating well above average learning environments for their young children.

Families are linked to health care providers.

- Almost all of Healthy Start's children from higher risk families have a primary health care provider and 89 percent are receiving regular well-child checkups.
- 89 percent of the parents also have a primary health care provider and 85 percent never use costly emergency room services for routine health care.

Children are immunized.

- 90 percent of Healthy Start's babies from higher risk families are up-to-date with immunizations in comparison to 71 percent of Oregon's two-year-olds who are adequately immunized.
- More than 90 percent of Healthy Start's children from higher risk families will be immunized at age 2.

Risk of child maltreatment is reduced.

After 12 months of Healthy Start intensive support, higher risk families experience reductions in several risk factors, including chaotic lifestyles, untreated substance abuse or mental health problems, and the use of harsh punishment.

Quality of family life is improved.

After receiving 12 months of intensive service:

- 60 percent of higher risk families report that need for housing, food, and other basic resources are almost always met.
- 62 percent of higher risk families demonstrate consistently positive family functioning, including providing nurturing care for their children.