



THE Probe

Quarterly Newsletter of the Oregon Public Health Association

Fall 2004

OPHA 60th Anniversary

Founders demonstrate commitment to health

BY SUSANNA LAI

The Oregon Public Health Association has been a force behind numerous efforts in disease prevention and health promotion for over half a century. Affiliated with the American Public Health Association, the oldest and largest organization for public health professionals in the world, OPHA was founded in 1944, in the anxious period when worldwide conflict was teetering to a climax.

It all began at a public health conference and exhibit held under the auspices of various health services and nonprofit organizations in Portland during the month of May, when the end of war was at last coming dimly into view. Attendees included a team of APHA executives and directors. The enthusiasm generated from this conference prompted a number of prominent lay and professional public health workers to form an organization where they could speak a common language – to act and promote public health for the common good and welfare of the people in the state.

The founding members decided to call the organization Oregon Association of Public Health Workers. The present name was adopted in 1968. The founders included Dr. Frederick D. Stricker, state health officer; Dr. Samuel B. Osgood, Josephine County health officer; Harold M. Erickson, assistant state health officer; and Mrs. Saidie Orr Dunbar, executive secretary of the Oregon Tuberculosis Association.

The association has served as a venue to solve problems and integrate programs and activities. One of the main interests of the original organization remains true today – seeking to actively participative as an interested party in health-related legislation that affects Oregonians.

In the last 60 years, OPHA has been involved in a wide range of medical, political and social issues. Numerous resolutions have been presented to the governor, to the senate president and house speaker in the state Legislative Assembly, and to members of the Committee on Medicine, Pharmacy and

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Agenda targets policy leaders

OPHA has helped to galvanize the public health community with a common purpose and a commitment to united effort.

Most notable events in the association's history

- 1954 Promulgated the necessity of sanitary dairy products in disease prevention.
- 1966 Recommended reorganization of the Public Health Service and passage of a bill before Congress to render control to governors over health problems and planning in the states.
- 1967 Lobbied for legislation to require fluoridation of drinking water statewide to curtail cavities and improve dental health.
- 1969 Acknowledged the obesity issue, advocated environmental health and workplace safety, and correlated nutrition with children's mental development.
- 1972 Approved a series of resolutions ranging from administrative plans, like placing the Oregon Department of Environmental Quality in the Health Affairs Division under the Department of Human Resources, to direct action, like requiring immunization for specific diseases before a child enters school.
- 1999 Sponsored the breastfeeding "Welcome Tea."

OPHA Mission

- *Protect and promote the health of all Oregon residents*
- *Educate and support public health workers*
- *Advocate for just and equitable health policies*

Section addresses adolescent issues

Do you work with youth? Do you have tips to share on working with adolescents? Do you have ideas to combat adolescent risky behavior? If yes, then join the newest section of OPHA, the Adolescent Risky Behavior Section, and share your ideas while working on several projects with section members!

Activities planned for the year are focused on advocacy for adolescents and helping teens and parents improve communication with each other. Break-out sessions will be held for the OPHA conference and a booth or breakout session will be planned for the Girls Initiative Network conference.

In January, the section plans to distribute a Legislative Handbook to state legislators at the beginning of the legislative session. The Adolescent Risky Behavior Legislative Handbook contains pertinent facts about Oregon adolescents and recommends legislative actions to help prevent or intervene early in negative behavior. Topics range from alcohol use and abuse through obesity to

tobacco use. We plan to have teens deliver the handbooks with section members and other OPHA volunteers.

Other planned activities focus on addressing adult/teen communication. We are pursuing grants to study how to improve communication between parents and teens. We also hope to develop trainings to improve clinic staff communication with difficult teen clients. In addition, we would also like to prepare "cheat sheets" with tips for parents on how to communicate with their teens.

The members of the Adolescent Risky Behavior (ARB) Section of OPHA invite you to join in their discussions and activities. If this topic interests you, please fill out the OPHA membership form on the back page, check the ARB Section box, and send in the form. If you are not already a member of another section, it doesn't cost you anything more than your normal OPHA dues. If you are a member of another section, the cost is an additional \$10. If you have questions, please contact Katie Riley at katieriley@comcast.net

You can help us spread the word

Please consider distributing *The Probe* to colleagues and friends interested in Oregon public health. With office technology, the best way to achieve a magazine format is by double-sided copying, with two automated staples on the left side.

THE *Probe*

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News published in The Probe aims to provide information. Views expressed in this newsletter do not necessarily represent the views of OPHA members or its board of directors.

Give us your news!

We invite you to send stories, news and graphics. Submission dates:

ISSUE	STORY DEADLINE
Winter	Dec 21
Spring	Mar 21
Summer	Jun 21
Fall	Sep 21

for publication on the 10th of January, April, July, and December

Contact Terry at terryh@pdx.edu
or

Oregon Public Health Association,
818 SW 3rd Ave, #1201, Ptd 97204

Oregon Public Health Association

60th Anniversary Celebration
Friday, November 19th, 2004

Please join us for appetizers, cocktails (wine, beer, punch)
awards, socializing, and a silent auction!

OPHA Business Meeting: 3:30 -4 p.m.

Celebration: 4 - 7 p.m.

(silent auction from 5 - 6:30 p.m.)

Akiko Berkman's home—18080 Sarah Hill Lane, Lake Oswego

\$20 (make check payable to OPHA)

R.S.V.P. by November 10, 2004 to Akiko Berkman at 503-639-1414
or e-mail your reservation to: amberkman@msn.com

The Health of Multnomah County 2004

Now available

Includes data on Maternal and Infant Health, Children's Health, Adolescent Health, Adult Health, Health of Older Adults, Communicable Disease, Unintentional Injury and Violence, and Leading Causes of Death

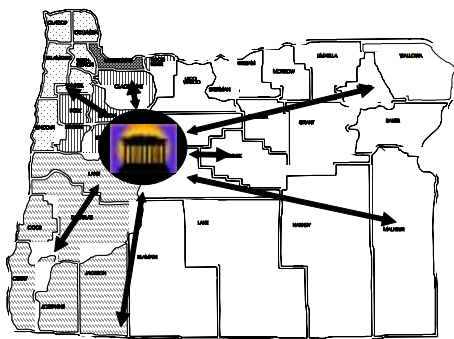
Find the report on the Multnomah County Health Department website
<http://www.co.multnomah.or.us/health/>

Hard copy is available on request: (503) 988-3674 x28185

Achievement frozen in present organization

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Dentistry. Also, each year like clockwork, during early fall and around annual board meetings, members contributed stories on health topics of regional and national importance to appear in local print media.



Inertia challenges enthusiasm

To boost enthusiasm within the organization, annual awards have been regularly announced and presented to prominent health officials in recognition of their work and contributions. Today, however, something more appears to be required.

OPHA needs to develop and maintain a strong coalition with state government at all levels

Despite OPHA's many accomplishments, interest and enrollment has declined in recent years.

Rumors of precarious sustainability are challenging the association's existence. Even the OPHA website appears frozen in time, with the exception of the quarterly distribution of *The Probe*.

Mary Lou Hennrich, executive director of Community Health Partnership, former CEO of CareOregon, one-time board member and lifetime member of OPHA, expresses concern with the recent stagnation in activities, and how this might affect the association's viability as a state affiliate with APHA. Hennrich advises and calls for organizational restructuring.

In the last decade, leadership roles within OPHA have shifted from the

original and traditional public health professionals – such as clinicians, middle managers, and government officials – to today's community activists and outreach or health promoters. According to Hennrich, while today's leaders represent a critical aspect of the organization, a "different sense of diversity," as she puts it, needs to be integrated into the mix. She recommends the inclusion of diverse public health professions and perspectives.

Hennrich also urges professionals in the medical sector to become actively involved, particularly those working in clinical/medical and academic research fields. Such members could re-energize a sustainable infrastructure by using the association to draw federal, state, and private funding.

A beautiful list of Internet resources related to public health is available on the website of the UC Berkeley Center for Family and Community Health (dated Sept. 14, 2004)

http://socrates.berkeley.edu/~jmm716/Internet_Resources.html

covering the following topics

Aging	Health statistics
Alcohol and drugs	HIV/AIDS
Biostatistics	Infectious disease
Cancer	Lung disease
Cardiovascular health	Minority health
Children, youth and family	Nutrition
Data sources	Occupational health
Diabetes	Oral health
Employment & internship opportunities	Physical activity
Environmental health	Public health
Epidemiology	Public health agencies/organizations
Global health	Research funding, implementation, and publishing
Health news	Tobacco control
Health policy	UC Berkeley
Health promotion & disease prevention	Women's health
Health sciences	

Time to polish the diamond

Most importantly, according to Hennrich, OPHA needs to develop and maintain a strong coalition with state government at all levels: in departmental affairs, at the cabinet level in the governor's office, and in legislation and policy development.

As OPHA officially celebrates its diamond anniversary in November, this is a good time to reflect on the extraordinary contributions and progressive health reforms of the past, and measure how far we have come since the organization's inception. And still, how far yet to go. With perseverance and the combined vision of past and current members, OPHA remains a valuable tool for public health professionals to network and address issues with a positive impact on the health of all Oregonians.

Consider this anniversary year a key moment to get more involved. Oregon, and the nation, needs leadership for health more than ever as we face a new era crippled by the shadow of war.

NW Public Health Leadership Institute offers collaborative leadership opportunity

Increase collaborative leadership skills in this yearlong onsite and distance learning opportunity, guided by practice-based faculty. The curriculum comprises five content modules:

- Challenges to public health
- Leadership skills assessment and development
- Crisis leadership
- Collaborative leadership and community building
- Developing leadership in staff, volunteers, and others

Qualifications. Participating scholars must have at least 5 years of professional experience in a field related to public health, at least 1 year in present position; must be in a leadership position or have demonstrated leadership interest and ability. There is no minimum educational standard.

Application deadline. Dec. 17, 2004

Tuition to be determined.

Contact. Applications and more information available online: <http://nwphp.org/nwphli/>

Northwest Public Health Leadership Institute, School of Public Health and Community Medicine, University of Washington, Box 3548409, Seattle WA 98195-4809. Fax: (206) 616-9415; Phone: (206) 616-2986; Email: nwphli@u.washington.edu

Wellstone Fellowship for Social Justice

Families USA, a national nonprofit, nonpartisan organization dedicated to the achievement of high-quality, affordable health care for all Americans, is accepting applications for the Wellstone Fellowship for Social Justice.

The fellowship is a yearlong, full-time, salaried position in health care advocacy work at Families USA in Washington, DC. Fellows will learn about Medicare, Medicaid, efforts to achieve universal coverage, and other national health-policy issues. Specifically, the fellow will be engaged in outreach to communities of color, developing techniques of grassroots organizing and mobilization.

The fellowship provides a unique opportunity to honor the memory of the late Senator Paul D. Wellstone.

Term begins. August 2005

Qualifications. All academic disciplines are welcome, preferably with a college degree as of August 2005.

Contact. More information and application available online: http://www.familiesusa.org/site/PageServer?pagename=Wellstone_Fellowship

Or contact Melissa Rosenblatt, Director, Internship and Fellowship Program, Families USA. PHONE: 202-628-3030; EMAIL: wellstonefellowship@familiesusa.org

Ford Diversity Fellows

Ford Foundation Diversity Fellowships are designed to increase the diversity of the nation's college and university faculties. Approx. 60 predoctoral, 35 dissertation, and 20 postdoctoral fellowships are available, sponsored by the Ford Foundation and administered by the National Research Council of the National Academies.

Eligibility. U.S. citizen or national; planning a career in teaching and research at the college or university level.

Awards. Predoctoral \$17,000 and institutional allowance \$5,000, for 3 years. Dissertation \$21,000 for 1 year. Postdoctoral \$40,000 for 1 year, plus employing institution \$1,500 to be matched by employing institution. All awardees have expenses paid to attend one Conference of Ford Fellows.

Application deadlines. PREDOCTORAL, Nov. 17, 2004; DISSERTATION, Dec. 1, 2004; POSTDOCTORAL, Dec. 15, 2004.

Contact. More information and applications available online: <http://national-academies.org/fellowships>

FELLOWSHIPS OFFICE, GR 346A, 500 Fifth Street, NW, Washington DC 20001. Phone: (202) 334-2872; Fax: (202) 334-3419; E-mail: infofell@nas.edu

Train at CDC

The Centers for Disease Control and Prevention (CDC) invites applications for the Public Health Prevention Service (PHPS), a 3-year national training and service program for masters-level health professionals. The ninth class of 25 participants is scheduled to begin in September 2005.

The PHPS program focuses on public health program management and provides prevention specialists with experience in program planning, implementation, and evaluation through specialized hands-on training and mentorship at CDC and state and local health agencies. Formal instruction is provided in program management, epidemiology, surveillance, emergency response, and project evaluation.

Eligibility. Professionals with a strong interest in a career in public health, a master's degree related to public health, and U.S. citizenship; at least 1 year of public health work experience may include an internship or a thesis project in a community setting.

Starting salary. Approx. \$41,000 with annual increases and benefits.

Application deadline. Jan. 15, 2005

Contact. More information and application available online: <http://www.cdc.gov/epo/dapht/phps.htm>

Public Health Prevention Service, Division of Applied Public Health Training, Epidemiology Program Office, Centers for Disease Control and Prevention, 1600 Clifton Road, NE, MS E-92, Atlanta GA 30333; Phone: Everett Exposé 404.498.6164; e-mail: phpsepo@cdc.gov

Stem-cell advances merit expanded funding

BY LESLEY RUSH

Advanced treatments and cures for cancer, diabetes, Parkinson's disease, and birth defects are on the way. Slowly.

Stem cells, both embryonic (cultivated from fertility treatment residuals) and adult (from a source like bone marrow), are the hope of future medical treatments. In time, doctors may be able to regenerate healthy tissues from a patient's own bone marrow to treat heart-attack victims and liver-disease sufferers, thus avoiding the risk of transplant rejection.

Stem cells are also the source of hot debate during this election year. Medical aspirations will take greater support and time to transpire, but with raised awareness and understanding of the U.S. position, these hopeful developments could be realized more quickly.

Private funds need public boost

In 2001, the president authorized federal funding for the 60 stem cells already cultivated for research. Yet fewer than 20 proved useful in the lab. The funding policy restricts the use or creation of further stem cell lines.

President Bush called the decision a compromise. The allocation of \$25 million dollars for embryonic research, however, was inadequate. Research centers must seek out additional funding from private sources, or look for research opportunities in other countries, where access to and support for stem cells is more readily available.

John Kerry promises to lift the ban established by the president and provide federal funding for all types of stem-cell research, and make access to new cell lines. Scientists would be allowed to make the ethical decisions in research with embryonic stem cells. Kerry insists that the restrictions in place now have made it difficult for U.S. scientists to hold a competitive edge, and have slowed the progress toward advanced treatment for some of the most devastating diseases.

Research touches sensitive issues in many countries

Outside the USA, other countries are also establishing regulations and allowances in stem-cell research. Moral considerations guide many of their decisions as well, and countries with greater religious influences have more restrictions in the lab.

In the European Union, each country is responsible for outlining its own policies for stem-cell research. The Czech Republic is drafting regulations that limit

The moral implications of stem-cell research invariably complicate the activities of research programs

research to residual embryos from fertility treatment; and has already used adult stem cells to treat patients following heart attack. France maintains a similar position, allowing research on fertilized embryos, but bans cloning.

The UK is by far the most liberal, allowing cloning in order to obtain stem cells. A South Korean team pioneered the cloning of stem cells for research. China is the sole country that implants stem cells in patients with amyotrophic lateral sclerosis (ALS), in order to slow and prevent further muscular degeneration.

OHSU pursues applications

Currently, all of the government funded embryonic cells are housed at the University of Wisconsin-Madison. Only one research center in the country has access to these versatile cells. Other universities across the country are participating in stem-cell research programs, but most, like the Oregon Stem Cell Center at Oregon Health and Science University, are not receiving full funding from the government.

The center at OHSU was founded in January 2004, with a three-year grant of \$4.5 million from Oregon Opportunity, an intergovernmental collaboration that draws in federal funding. Research at OHSU focuses on adult stem cells, aiming for applications in pancreas and liver diseases.

The Stem Cell Center's director, Dr. Markus Grompe, believes that funding for stem-cell research has increased over the last four years as a result of a growing presence in scientific and public spheres. He proposes that a change in White House power will lead to greater federal funding for stem-cell research, but also suggests that citizens who are compelled should independently donate to the research.

Other centers for stem-cell research in the country include the University of California system, Columbia, Duke, Harvard, Michigan, Stanford, and Washington University in St. Louis.

Moral divide threatens life

The moral implications of stem-cell research invariably complicate the activities of research programs. In the USA, moral divisiveness fundamentally limits research and progress toward advanced treatments using stem cells that could add years of life to people throughout the world.

Current U.S. policy was established as a tool to garner support from pro-life enthusiasts. Labeling stem-cell research a moral issue forces individuals to rank the stages of life, and the result presently appears to favor the stage of cell life over a breathing human being.

The challenge here is to avoid moral divisions, and reach a consensus on the worthy long-term aims of stem-cell research: increased efficacy of health care treatments, improved lifestyles for both the ill and the healthy, and a positive collaboration with the international healthcare community. Current advances in stem-cell research throughout the world are promising. With patience and wider support, many of these hopes will become actualized.

Apotheosis of the policy paradigm

BY TERRY HAMMOND

Visiting Michael Heumann in his office in the annex across the street from the Oregon state office building in Portland brings one into contact with a maze of acronyms, moving from familiar ones like DEQ, EPA, BLS and CDC, to progressively more complex concoctions like NIOSH, SHINE, ATSDR, CSTE, PARC, EPHT network, and particularly interesting – bear with me – ROSH codes. Like most of us wrapped in our cocoons at work, Heumann (pronounced “human”) – manager of the Environmental and Occupational Epidemiology program, under the Office of Disease Prevention and Epidemiology in the Oregon Dept of Human Services – appears largely unaware of his alphabet armor.

A small part of the language derives from local state initiatives, like the interagency Pesticide Analytical and Response Center, which has made pesticide poisoning a sentinel event in Oregon. Another small part derives from interstate cooperative endeavors, like the Council of State and Territorial Epidemiologists, which helps to prioritize health indicators in line with available data, and supports the interface of public health research and practice.

Mostly, though, state officials learn their ABCs from the feds. Heumann’s EOE program is 95 percent funded by grants from the federal government and private foundations. Most other public health programs in the state show the same dependence. Heumann estimates only 10 percent of Oregon’s public health infrastructure is supported by the state’s general fund. The Oregon State Public Health Laboratory, along with an ever-growing share of government services, subsists on fees. Even PARC, a home-grown achievement, has been drawn into the orbit of funding from the Department of Agriculture and the Environmental Protection Agency.

Fiscal parent drains resolve

In the lap of fiscal federalism, Oregon had to beg Uncle Sam for the Oregon Health Plan. Parentally subsidized, the state general fund covers only about 25 percent of OHP costs. Likewise, most attention in public health dances to the tune of what Sam approves.

Most of the ideas Oregonians take pride in really originate elsewhere. Much good work is accomplished, but the shifting of funds and ideas from far away attenuates accountability.



In fact, with the feds working on a credit card, it almost appears like no one really has to pay for efforts to clean up pollution from private companies depositing chromium and lead in the drinking water around Corvallis, uranium in the Fremont Forest, lead oxide in Lake Oswego, aluminum in Troutdale and The Dalles, asbestos in Klamath Falls, a soup of chemicals in the Portland harbor, and so on and so on. Heumann and others are helping communities with these sites, tracking hazards, exposures, and health outcomes through Oregon’s Superfund Health Investigation and Education program, funded by the Agency for Toxic Substances and Disease Registry, under the Centers for Disease Control and Prevention, in the U.S. Department of Health and Human Services.

Corporations may be fined or taken to court to help pay (or wriggle away) for damage and clean up, but one wonders, if Oregon had to pay directly, perhaps local leaders and citizens would begin to

seriously discuss personal civil and criminal liability for individual executives responsible for corporate conduct that results in “manslaughter” – as is presently underway in Canada and the UK.

Stop the killing - Now!

Similarly, if Nuremberg criminal penalties were applied to U.S. officials, perhaps we would see a more sincere effort to clean up Hanford, instead of producing yet more nuclear waste; and outside the country, perhaps we would see more concern for the uranium ammunition

strewn over Afghanistan and Iraq, which is causing nationwide birth defects, disease, and death. In addition to this grave health hazard we have exported, oddly, no one in the USA seems very concerned about the one million children in Iraq at risk of death “in the event of a crisis,” as reported in *The Probe* (Spring 2003) before the war, drawn from a report publicized by a team of physicians who visited the country. Clearly, it is not our prosperity and way of life these people resent. Killing babies is one sure way to induce hatred and terrific resistance, just as the world rose up in revulsion at the crimes of the Nazis.

Pay to save Oregon

Lack of accountability is painting a more dramatic picture in distant lands, but the problem is also evident here. Incrementally, our homeland security is being destroyed. Heumann reports there are at least 1100 priority hazardous waste

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Epidemiology applies insurance claims data

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sites in Oregon, with only a dozen or so under investigation. With the same negligence, about 400 cases of pesticide poisoning are reported each year, but since 2003 only occupational cases are investigated, funded by the National Institute for Occupational Safety and Health (also under CDC).

So long as Oregon refuses to tax itself to meet these hazards and find ways

to prevent them from proliferating, morbidity and mortality will mount, and the pressures on the healthcare system will increase. Paying is the likeliest way to get us to think about accountability, and the sustainability of our environment, our economy, and our lives.

On a larger scale, if we really had to pay for it, we would likely reconsider the present profligate commitment to an allegedly invincible military machine, now

cruising the seas of China and India, and outer space, and our national leaders would find the wherewithal to work harder for friendship and peace. By this reasoning, it appears public health will only succeed once the public rises to the challenge to take charge, and stops charging the account to others. This simple market logic ought to appeal to all sides of the political spectrum.

Solving the mystery of data translation

The diatribe above, opposing fiscal federalism is not the theme elaborated by Heumann in our cordial meeting, and should not be attributed to him. Rather, he more plainly recounted his success at bridging the gap between research and practice, and showed in a story the characteristics of science in a policy paradigm. The clear victory of reason inspires a vision of what public health researchers might do, if given a mandate by the people to perform in their behalf.

Data is very often scarce, unstandardized, or unreliable, which the ambitious effort toward indicators and minimum datasets in the 1990s has worked hard to remedy, with notable progress. In the last few years, discouragement set in, once it became generally recognized that information by itself is simply not enough to make anything change. Systematic reviews, like those provided by the Evidence-based Practice Center at OHSU, for example, condense data, but no one follows through to translate the letters into words into language into speakers to get the message to the field. Physicians in the UK have long complained about the mute quality of Cochrane Collaboration reviews. Pure science, like pure mathematics, is pointless if it never touches the ground.

Larger insurers in the USA are gradually learning to mine their claims data for clues on health improvement

(see James Robinson, May 19, *Health Affairs Web Exclusives*); but applying that knowledge requires a sense of enterprise most insurers lack, particularly now that managed care has been so thoroughly discredited. In other areas, too, like product liability, insurers have historically shown a strange inertia in regard to using data to change client behavior in ways that could ultimately save them money. This is where the enterprise of Heumann as an epidemiologist paid off – for everyone.

ROSH codes come to life

The Liberty Northwest tower, one of Oregon's primary insurers for Workers' Compensation, is just visible from Heumann's office. Five years ago, with a grant directing him to address dermatitis, Heumann went to Liberty and made an arrangement to look at their claims data. In 1996, WC claims coders began using the Redesigned Occupational Safety and Health Survey coding system to identify "nature, part, event, and sources of injury." ROSH allowed Heumann to detect patterns that pointed to a particular company with an unusual number of claims for dermatitis. He wrote a report and gave it to Liberty to distribute. Job done.

But really, the job was not done. He found that Liberty needed further prompting. Carefully, he asked the insurer if he could make contact with the problem firm in the field. Once he

saw the nature of the problem, involving poison oak, he found another firm that produced a protective lotion, acquired free samples, and gained permission to test the product on one team of workers. It worked. The workers in the field were the first to benefit. Then the owner of the firm saw the benefit of fewer sick days and better productivity, and purchased the lotion for all workers nationwide. The product manufacturer made a profit off the initial free sample. Finally, Liberty Northwest saw the result in the elimination of a whole block of claims.

In consequence, Heumann's role as a friend of insurers with access to claims data became assured. With other researchers, he is now working with Kaiser Northwest, looking for patterns in various chronic diseases.

The lesson here for public health suggests more than the typical combination of quantitative and qualitative data, favored by forward-thinking academicians. Neither one in itself, nor both together, is a paradigm. Just tools. Heumann's example shows various stages of communication and persuasion are necessary all through the process, bound together by a constant initiative until the job demonstrates results. Dynamic human connections and a final appeal to interests on all sides define the policy paradigm. The example emphasizes the innovative role of epidemiology and health research in real life, beyond the penumbra of the computer screen.

Oregon team responds to Healthy Start questions

BY BETH GREEN PHD, JULIETTE MACKIN PHD, AND JEROD TARTE MA

The Oregon Commission on Children and Families, and NPC Research, the independent evaluator for Oregon's Healthy Start evaluation, are pleased to see so much thoughtful discussion about the impact of Healthy Start in Oregon. Below, we respond to the concerns raised by Joyce Edmonds (*The Probe*, Summer 2004), and offer additional information.

Issues of Random Assignment and Scientific Rigor

First, the article makes the argument that Healthy Start would be best served by an evaluation using a randomized study design. Randomized designs are often touted as the "gold standard" for evaluation research, though this point has been widely debated (cf., McCall & Green, 2004; Patton, 2004). Most professional evaluators would agree that evaluation methods, measures, and statistical approaches must be tailored to fit the needs of the program and interested stakeholders, and that appropriate methods vary widely depending upon the purpose of the evaluation. Randomized evaluation approaches are often not the best choice for providing data aimed at improving program performance, which is one of the primary goals of Oregon's Healthy Start evaluation.

Healthy Start's legislatively mandated goal to provide universal services for all first-birth families makes a randomized comparison group infeasible. Instead, state policymakers have opted for a performance-measurement approach, which provides data over time about participating families, and information for continuous program improvement.

Use of Appropriate Statistical Approaches

Edmonds suggests that one weakness of the evaluation is its reliance on "raw numbers, percentages, and frequencies." The Healthy Start annual evaluation report does, in fact, include logistic

regression, odds ratios, repeated measures analysis of variance, and other statistical techniques, but we agree the report relies heavily on straightforward reporting of easy-to-understand outcome figures. The major audiences for this report, state legislators and Healthy Start program staff, are not typically statisticians or researchers. Our main goal is to report findings that are accessible for counties and policymakers to use in their ongoing work related to this program.

Further, key questions raised by readers are usually straightforward: How many families did you serve this year?

Our main goal is to report findings that are accessible for counties to use in their ongoing commitment to the program

What percentage of your clients received substance abuse treatment? To what degree did parents improve their parent-child interactions? These kinds of questions are best answered, and understood, with simple numbers.

Child maltreatment data are admittedly more complex, and readers of the annual evaluation report will notice that we report maltreatment incidence based on population norming – a commonly accepted method for comparing incidence rates in large populations – along with logistic regression, and a repeated-measures design to examine longitudinal data.

Funding Issues

Although we understand Edmonds' concern about programs trying to "squeeze their services to fit available funding," Healthy Start follows a model program of services. Thus, funding shortfalls affect the number of families that

can be reached and provided with home-visiting services, but not the quality of the services. In an ongoing effort to maintain this effective program model, Oregon's Healthy Start has been working on a Quality Assurance Protocol (since 2002), and is currently in the process of applying for national accreditation through Healthy Families America.

Edmonds leads the reader to believe that Oregon's Healthy Start program has been receiving annual increases in funding, when the reverse is true. Budget cuts over the last two years have significantly decreased Healthy Start funding for sites. Funding levels for service have declined from 80% of first births in participating counties, to only 47% of first births. Despite such a drastic reduction in funding, Healthy Start continues to demonstrate strong program implementation and positive family outcomes.

Child Maltreatment Data

Edmonds charges the Healthy Start report with using "an inflated denominator for its maltreatment statistics." She also asserts that families provided with universal basic services are not an appropriate part of the Healthy Start program group, and only families receiving intensive-service home visiting should be used to evaluate maltreatment outcomes.

Actually, the status report does report maltreatment rates for families who received basic vs. intensive services (the "logical group" Edmonds suggested we identify – see *Healthy Start of Oregon 2001-2002 Status Report*, p.137, Table 22). Additionally, the report includes child abuse and neglect statistics for several other groups, including higher-risk parents who did not meet eligibility requirements for intensive services, and lower-risk families.

Child maltreatment data is available for the general population, but comparisons to Healthy Start subgroups are inappropriate, because families in general include both high and low risks. By including basic-service families in the

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analyses, we assure that we are not just comparing high-risk, high-stress Healthy Start families to the general nonserved population.

Universal Prevention

A universal approach to child abuse prevention is supported in a recent research report on preventing child maltreatment (NCIPC, 2004), which states, “a universal program potentially benefits all parents through multiple levels of intervention tailored to parents who experience a range of problems” (p. 1). Levels of intervention can range from basic parenting information, like Healthy Start’s basic services, to more intensive services for families with more problems.

Not all families receive long-term intensive services, because not all families need it. In times of limited funding, targeting intensive, costly services to those most at risk makes good sense. At the same time, recognizing that all new parents need support, Healthy Start implements a standardized protocol to make decisions about the level of support most appropriate for each family.

Edmonds challenges Healthy Start’s intensive service, stating that “only 9% of first-birth families received service.” In fact, of the 4,620 first birth families who consented to Healthy Start services and sharing their data with DHS and the evaluation team, 1,574 of those families (34%) received intensive service.

Maltreatment and Birth Order

Edmonds raises the concern that Healthy Start’s evaluation compares rates of maltreatment for Healthy Start families (primarily first births) to the general population of 0-2 year olds (which includes subsequent births). A few articles have found maltreatment rates to be higher in families with more children (Zuravin, 1988; Center for Law and Social Policy, 1998). From data made available through the Department of Human Services, the evaluation team was unable to identify a comparison group of non-

Healthy Start children who are also first-births. The status report mentions this variation as a caution in interpreting the study results.

Some Healthy Start programs do serve subsequent births, and these families are included in the Healthy Start service group in the analysis of maltreatment rates. It is worth noting however, that there are few studies on the influence of birth order on maltreatment rates, and this literature tends to focus on specific populations (e.g., teen moms). More consistent in the maltreatment literature is the finding that the highest rates of abuse and neglect involve young children, specifically those under age 3 (NCCANI, 2002). For this reason, the focus on abuse rates for this population is appropriate.

Other Issues

Two additional assertions warrant comment. First, the evaluation of Oregon’s Healthy Start program is conducted by a disinterested party. NPC Research is a private, professional evaluation firm and we take considerable pride in our ability to provide timely, useful, and objective information to our clients. We adhere strictly to American Evaluation Association standards of practice (Newmann et al., 1994), which include systematic inquiry using the most appropriate technical standards, along with standards to avoid bias, including disclosure of conflicts of interest and full disclosure of findings.

Second, Edmonds mistakenly interprets articles in the June 2004 issue of *Child Abuse and Neglect* as indicating that Healthy Start, in general, shows little evidence of positive effects. That article series, conducted on a home-visiting program in Hawaii, is a single-site evaluation, with uncertain applicability elsewhere. The Hawaii program is different from Oregon Healthy Start in several ways, perhaps most significantly by relying on paraprofessional home visitors. Many Oregon program staff have at least a bachelor’s degree in a

social service field, and a number are public health nurses.

In closing, we welcome opportunities to discuss our state’s Healthy Start program and its evaluation. No evaluation is perfect, and we certainly would not argue that this one is any exception. However, we firmly believe the Healthy Start evaluation, and its associated reports, are grounded in solid research methodology, produce useful and understandable information for stakeholders, and continue to show that the Healthy Start program is successful in helping to reduce the risk for and incidence of child abuse and neglect among participating families.

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Health benefit costs hammer U.S. nonprofits

FROM THE LISTENING POST PROJECT
CENTER FOR CIVIL SOCIETY STUDIES
JOHNS HOPKINS UNIVERSITY

Nonprofit organizations in the USA are being especially hard hit by escalating health-benefit costs, according to a new report by the Center for Civil Society Studies. Looking at a nationwide sample of over 250 nonprofit agencies that serve children, the elderly, community development, and the arts, the Johns Hopkins survey documents for the first time the impact of exploding health benefit costs on U.S. charitable organizations.

Determined to avoid negative impacts on those they serve and unable to raise additional funds, nonprofits found it necessary to shift more costs onto their employees, who already make less than private-sector workers.

Escalating health-benefit costs are particularly damaging to nonprofit organizations because health benefits are one of the most important attractions of nonprofit employment.

"While much has been written about the impact of rising health benefit costs on small businesses, the fact is that the

impact has been even greater on nonprofit organizations, and this has a serious ripple effect on the quality of community life," said Audrey Alvarado, executive director of the National Council of Nonprofit Associations, a Listening Post Project partner.

"Recent proposals to fix the health insurance crisis by offering tax breaks to small businesses provide no relief to nonprofit organizations," observed Larry Minnix, president and CEO of the American Association of Homes and

Services for the Aging, another Listening Post Project partner organization. "We need to be more inventive if we want to fashion policy approaches that can effectively shield nonprofit organizations and those they serve from the crippling effects of continued health insurance cost increases."

The Listening Post Project Health Benefits Report is available online at www.jhu.edu/listeningpost/news

Massachusetts legislature moves to make health care a constitutional right

In July, a Kaiser Family Foundation passed in its daily health policy news that the Massachusetts house and senate in a joint session voted 153-41 to approve a proposed state constitutional amendment that would make "comprehensive and affordable health care" a right. The amendment states that it "shall be the obligation and duty of the Legislature and executive officials ... to enact and implement such laws as will ensure that no Massachusetts resident lacks comprehensive, affordable and equitably

financed health insurance coverage for all medically necessary preventive, acute and chronic health care and mental health care services, prescription drugs and devices."

The proposed amendment was initiated after more than 70,000 registered voters in the state signed a petition in its favor. By state law, the amendment must be approved a second time by the legislature in its 2005-2006 legislative session in order to reach the ballot in 2006.

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