

**Social Indicators of Child and Family Well-Being:  
A Profile of Six State Systems**

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## **Foreword**

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This special report was originally prepared for the May 1997 “Workshop on Social Indicators of Child and Family Well-Being in the Age of Devolution: Defining Next Steps,” organized by Child Trends, Inc., and the State and Local Data Committee of the Federal Interagency Forum on Child and Family Statistics. The workshop focused on the growing use of social indicators at the state and local level. (The workshop, supported by contributions from the Pew Charitable Trusts, was held on May 29 and 30, in Washington, D.C.) One premise of the workshop was that, as responsibility for social policy continues to devolve from Washington, D.C., social indicators of child and family well-being are emerging as critical management tools for state and community governments.

The development and use of social indicators has become a seminal issue in Washington and the states. Uses of social indicators range from simple monitoring for planning purposes to the tracking of social goals. On occasion, these uses encompass higher-level policy and program accountability purposes. Moreover, to a limited extent, indicators are looked at as a potential substitute for conventional experimental studies for policy evaluation. In consequence, the need for high-quality social indicator data, and the technical assistance required to use them effectively, is expected to grow substantially during the next several years. These needs are now being addressed in piecemeal fashion by various federal agencies, interstate organizations, research institutions, and private foundations. Some state and local governments are developing informal networks to exchange insights about how to solve common data concerns.

The purpose of the workshop, and of several papers discussed at it, was to develop strategies for directing and coordinating the work of these groups in the coming years.<sup>1</sup> A constructive dialogue among key players determined that progress is being made to address emerging needs for more and higher-quality social indicator data, and for the information and training to use them effectively.

The workshop reflected the increasing urgency of developing child well-being indicators. In the United States, powerful reforms are transforming government and the management of social policy. Welfare reform, for example, became a reality in 1996 with passage of the *Personal Responsibility and Work Opportunity Reconciliation Act*. This legislation was signed into law amidst furious claims and counterclaims about its impacts. Welfare reform is merely a singular expression of a larger transformation in social policy governance, best reflected in what are termed the *devolution* and *reinvention* movements. Essentially, devolution constitutes a shift in the locus of program authority from higher levels of government to levels closer to the problems purportedly being addressed (e.g., from the national government to states to local communities). Devolution, proponents argue, will substantially increase the flexibility afforded states to design, coordinate, and administer social programs affecting children, youth, and their families.

Similarly, the reinvention movement in government purports to shift public sector management from a focus on process and inputs—that is, what organizations and programs do—to a focus on outcomes, or what organizations and programs accomplish. This new focus, proponents argue, gives managers greater freedom to restructure the ways they shape and deliver services with the goal of enhancing efficiency and effectiveness. Taken together, these themes could alter policy making and management by facilitating the emergence of outcomes-based accountability strategies; of systems-wide

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<sup>1</sup>The three papers commissioned by the Pew Charitable Trusts and discussed at the workshop are “Social Indicators and Public Policy in the Age of Devolution,” by Brett V. Brown and Thomas J. Corbett, Institute for Research on Poverty Special Report No. 71 (Madison: University of Wisconsin, July 1997); “Indicators as Tools for Managing and Evaluating Programs at the National, State, and Local Levels of Government—Practical and Theoretical Issues,” by Jeff Koshel (forthcoming 1997); and this paper. Partial support for preparing this paper for the Special Report series comes from the Helen Bader and Joyce Foundations as part of the “Informing the Welfare Debate” project.

program coordination and integration efforts; of performance-based competitive service models; and of public sector privatization and democratization schemes.

The common thread running through the proposed reforms is the premise that results, not process, count. All of the design and management changes encompassed by the policy revolution focus on achieving certain results rather than merely guaranteeing exposure to certain services, opportunities, or obligations. This focus on results suggests, and in fact requires, an advanced use of what we broadly think of as social indicators.

Renewed interest in developing social indicators as policy-monitoring and management tools emerged early in the 1990s. The Annie E. Casey “Kids Count” project began routinely publishing national indicators on the status of children and eventually supported similar efforts in each of the states. Over the years, the number of organizations that became actively involved in the indicator “movement” grew.<sup>2</sup> The intensity of attention and efforts also evolved.

In 1993, the Institute for Research on Poverty, Child Trends, Inc., and the Office of the Assistant Secretary for Planning and Evaluation sponsored a one-day planning workshop. From that effort developed plans for a national conference on child and family indicators, which was held in November 1994. (The papers prepared for the conference were later released as an IRP special report.<sup>3</sup>)

Since 1994, several activities in Washington have moved the federal statistical agencies toward improving the on-going measurement of children’s well-being. The Office of the Assistant Secretary for Planning and Evaluation, U.S. DHHS, created the annual publication *Trends in the Well-Being of*

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<sup>2</sup>Some of the key organizations include Child Trends, the Institute for Research on Poverty (IRP), the National Institute for Child and Health Development (NICHD), the Office of the Assistant Secretary for Planning and Evaluation (ASPE) and the Administration for Children and Families (ACF) in the U.S. Department of Health and Human Services (DHHS), the Board on Children at the National Academy of Sciences, Chapin Hall (University of Chicago) and UC-DATA (Berkeley), the Joint Center on Poverty at Chicago/Northwestern, and others.

<sup>3</sup>The papers are compiled in IRP Special Report 60a, “Indicators of Children’s Well-Being: Background Papers and Rapporteurs’ Comments,” Special Report 60b, “Indicators of Children’s Well-Being: Child Health, Education, and Economic Security,” and Special Report 60c, “Indicators of Children’s Well-Being: Cross-Cutting Issues: Population, Family and Neighborhood; Social Development and Problem Behaviors” (Madison: University of Wisconsin, May 1995). Revised versions of these papers are forthcoming in book form from Russell Sage.

*America's Children and Youth*, a volume that reports measures yearly and challenges the federal statistical system to improve and expand its array of measures.

In addition, the recently created Federal Interagency Forum on Children and Family Statistics carries on the work begun at the November 1994 conference. The Forum fosters coordination, collaboration, and integration of federal data collection on children and the reporting of children's conditions. The Forum is filling the gaps in the federal statistical system which limit our capacity to monitor the condition of children even as profound social policy transformations occur. The Forum recently released its first report, "America's Children: Key National Indicators of Well-Being."

Another key development since 1994 is the shift of attention to the states and localities as they begin to undertake major changes in the safety net for children. These changes have increased the need for measurement of child well-being at the state and local levels. Recognizing this trend, IRP in December 1995 brought together a number of states in perhaps the first forum where exciting state-level activity was reported to a federal audience. (See *Focus* 18(1) for an in-depth report on the conference.)

## LIGHTHOUSE STATES

The states described in this report—California, Florida, Massachusetts, Minnesota, Oregon, and Vermont—are among the most advanced in using indicators for a variety of monitoring and management purposes, ranging from simple monitoring to goals-setting and accountability.<sup>4</sup> Other states of course might have been included, but these six have long been among that handful of *lighthouse* states at the cutting edge of social indicator development and use.<sup>5</sup> Their successes and failures, if adequately

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<sup>4</sup>Although this report focuses on state-level indicator development, exciting work is also going on at the substate level. The National Neighborhoods Indicators project, an Urban Institute initiative under the direction of Tom Kingsley, is coordinating and encouraging several community-level social indicator projects.

<sup>5</sup>In fact, California, Minnesota, Oregon, and Vermont were among the states invited to the December 1995 workshop held by IRP at the National Academy of Sciences to discuss states' progress in developing and using indicators.

documented and understood, could be invaluable to other states and local communities embarking on a similar path.

Serious thought should be given to using these states in a true “lighthouse” fashion, as laboratories through which to solve common technical and management problems and as mentors to other jurisdictions. This will require that steps be taken to facilitate the exportation of emerging technologies and insights from the more advanced states to others. One small initiative would involve facilitating ongoing communication among these states, and perhaps a handful of others which, though not included in this report, are fairly far along. If done correctly, the advances described in this report can spread to other states and perhaps even inform and motivate further work at the federal level.

The present interest in social indicators has been sustained because all involved realize that change involves opportunity and risk. Shifting the responsibility for social welfare programs from the federal government to the states opens up possibilities for great innovation and experimentation.

Whether children fare well or poorly in the context of all the changes taking place is an empirical, not a normative, question. But it will remain normative, partisan, and probably inconclusive if we do not have the data with which to decide. This report describes some remarkable efforts underway in several states, initiatives that may well serve as guideposts to future activity. A generation or so ago, during the War on Poverty, a litmus test against which new policies were judged had a certain currency—what does it do for the poor? Today, perhaps a new litmus test is emerging—what does it do for the children? Perhaps this volume will help us reach the place where we can answer that question.

## **Social Indicators of Child and Family Well-Being: A Profile of Six State Systems**

### INTRODUCTION

During the 1990s an increasing number of states have become interested in social indicators as basic tools of governance, supporting state and local comprehensive planning activities, goals-driven benchmarking initiatives, and accountability efforts to measure the performance of agencies, private contractors, and whole communities. This trend has only been strengthened by the recent pace of devolution of governmental authority from the federal government to the states. Devolution gives states more flexibility in basic program design, and more responsibility for planning and results.

Traditional state data systems, developed in an era when more decisions were being made at the federal level, usually do not provide the breadth and quality of social indicator data needed for effective governance by state and local governments.

Many states have been working aggressively to develop programs and initiatives that make systematic use of social indicators, and to develop the underlying data system to measure and track such indicators. In this report we review developments in six of those states: California, Florida, Massachusetts, Minnesota, Oregon, and Vermont.<sup>6</sup> Collectively, their experience can serve as guidance to other states that proceed down this path.

There have been a number of efforts in the last several years to profile state efforts at benchmarking, comprehensive planning, and accountability. Where these efforts have focused on the initiatives themselves, this report focuses more on the underlying data systems, and on the efforts to make the data accessible to a variety of users.<sup>7</sup>

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<sup>6</sup>Of the six, California has concentrated the least effort specifically on social indicators. Nevertheless, it was included because of its advanced integration of administrative data systems, potentially a very fruitful source of social indicator data.

<sup>7</sup>See, for example, the following publications: Council of Chief State School Officers, *Moving toward Accountability for Results: A Look at Ten States' Efforts* (1995), and *Changing Decision Making to Improvements Results for Children and Families: How Ten States Are Tackling Tough Governance Issues* (1996); Harvard Family Research Project, *Resource Guide of*

### *Structure of the Reviews*

Each state review includes: a description of major programs which use social indicator data; descriptions of the survey and administrative data sources used to measure and track social indicators; an assessment of the strengths and weaknesses of the overall data system; a list of existing Internet sites and major publications reporting social indicator data; a description of the training programs to educate users and staff in both the collection and proper use of social indicator data; and a brief description of current challenges and future plans regarding the further development and use of social indicator data in the state. Throughout, the focus is on social indicators of child and family well-being. Order information for publications and contacts for each program and data source mentioned are listed in the appendices.

Programs Related to Social Indicators. These include comprehensive benchmark initiatives such as Oregon Benchmarks; cross-agency initiatives devoted to children and families, such as Vermont's Framework for Collaboration; and other, more specific programs including various state education assessment efforts and Healthy People 2000 initiatives.

Available Data Sources. The data source descriptions are organized into four types: (1) federally coordinated voluntary state surveys, such as the Youth Risk Behavior Survey; (2) state-sponsored surveys (e.g., the Oregon Population Survey); (3) administrative data (e.g., educational assessments; innovative vital statistics and health surveillance systems); and (4) linked administrative data systems. For each survey or administrative data source there is a basic description of the purpose and contents, data quality (e.g., whether the data are biased in some way), the geographic levels at which estimates can be generated (e.g., state, county, school district) the frequency at which measures are taken, the name of the

collecting agency, and, in many instances, the approximate cost to collect the data. Contact persons for the various data sources are listed in Appendix B.

Contents and Coverage. This section provides a brief assessment of the state's social indicator data system, identifying major strengths and weaknesses. The assessment is made based on the breadth of measures available, the level of geographic detail, and the quality of the data.

Accessibility. This section reviews social indicator data available over the Internet and in print format, including preformatted reports and flexible on-line databases that allow for the construction of custom reports. Internet addresses are listed in the body of each review. Exact titles and ordering information for reports are listed by state in Appendix A.

Training to Use and Develop Data. Social indicators are tools and, like any tool, require skill to develop and use properly. Training is considered an essential component of any state effort to expand the use of social indicators in the service of governance.

Current Challenges and Plans for the Future. In this section we discuss plans for future development of the social indicator data system, including new measurement and data developments, and plans to expand accessibility. Potential threats to existing capacities are also discussed.

### *Selected Highlights and Observations*

Below we offer some highlights and observations based on the six state reviews.

*States may follow a number of viable paths to develop their capacity to track child and family well-being.*

- Oregon has clearly demonstrated that a comprehensive approach, such as its *Benchmarks* initiative, can, when pursued consistently and over time, substantially improve the breadth and quality of social indicator data, as well as the capacity to use such data productively. More than any other state reviewed here, Oregon has produced new sources of data to meet its emerging needs, and new ways to make those data more accessible. The Oregon Population Survey, for example, provides the state with biennial estimates of demographic and socioeconomic indicators that no other state enjoys. Other innovative data developments include the on-line immunization registry, the decision to participate in the Third International Mathematics and Science Survey, and the on-line Geographic Information System (GIS) database, developed by the Oregon Option Health Cluster, which displays indicators related to early school readiness in comparative maps of all 36 counties.

- Vermont provides an alternative but perhaps equally fruitful path. Vermont's Agency of Human Services (AHS) has actively promoted the use of social indicator data for planning and accountability purposes, as illustrated in its comprehensive report on the well-being of Vermonters, produced since 1992; the agency is now producing annual community profiles of well-being for all 60 of Vermont's Supervisory Unions. The Framework for Collaboration is a joint effort of the AHS and the state Department of Education in which the two organizations coordinate cross-agency service planning. They are also coordinating social indicator data development, dissemination, and training efforts. The Department of Employment has also recently become involved in this collaboration. The AHS exemplifies how an agency can develop its social indicator capacities while collaborating with other agencies, and can then build a coordinated system of program design and data development from the ground up.
- Massachusetts' Department of Public Health (DPH) has produced a sophisticated on-line data system (MassCHIP) that allows users to access community-level social indicator data from 18 data sets, with the capacity to produce custom reports. This system is open to the public over the Internet. In addition, the department has produced comprehensive reports of child well-being in its role as the data partner for the Massachusetts "Kids Count" project. The department is currently developing cooperative relationships with the departments of Education and Social Services in order to produce annual reports, similar to "Kids Count," to be made available via MassCHIP. The Massachusetts DPH demonstrates what individual departments can accomplish in developing their own data capacities.

*Innovative surveys that fill important gaps in a state's system of social indicators can be produced at minimal cost. In fact, an investment of rather small amounts of money in a carefully chosen set of surveys can substantially improve a state's capacity to track child and family well-being at the state and local levels.*

- Oregon derives critical demographic, socioeconomic, and opinion data every other year from its Population Survey, at an estimated cost of \$200,000 per survey.
- Every three years the state of Minnesota fields its Student Survey to 133,000 high school students, and then analyzes and reports results for a total estimated cost of \$150,000. For this sum, the state and all participating school districts can track risk behaviors and social asset development of Minnesota youth.
- Vermont and Oregon participate in the National Assessment of Educational Progress (NAEP), which can supply cross-state comparisons, at a cost of about \$75,000 to Vermont, and \$100,000–\$150,000 to Oregon.
- Oregon fields its own immunization survey of 2-year-olds, which provides state estimates and separate estimates for five substate geographic regions, at a cost of about \$140,000.
- Minnesota conducts a crime survey, which tracks public opinion regarding perceived safety in neighborhoods and schools. This survey was fielded specifically to track one of Minnesota's broad goals, or *milestones*, to create "safe, caring communities." The 1996 survey of about 1,300

Minnesotans cost only \$10,000 (a larger sample had been fielded three years earlier), yet allowed the state to continue tracking progress toward one of its key social goals.

*Other innovative data collection efforts across the six states include the following:*

- Vermont has for several years conducted the Survey of Kindergarten Teachers and Parents. Teachers are asked to rate the school-readiness of children along multiple dimensions including physical well-being, general knowledge, emotional development, and moral awareness. As currently administered, the survey is not based on a representative sample, so it is of limited use in tracking trends over time. It does, however, attempt to measure important dimensions of school readiness that are, by and large, not well tracked in other states.
- Oregon has made tremendous strides in making vital statistics data available in a very timely manner. State and county estimates based on birth certificate data are available over the Internet with only a six-month lag, as compared to lags of from one to two years in most other states. Such timeliness is critical, particularly when data are being used to assess policy and program effectiveness.
- Some, but not all of the states reviewed, produced their own county-level child population estimates by age group. This is a very important feature of any social indicator data system, since it allows one to produce accurate population rates for many different sorts of indicators (e.g., the percentage of all teen females who had a birth last year). (The federal government does not regularly produce county-level estimates.) California produces separate estimates by race/ethnic group. Oregon, Florida, and Massachusetts also produce county-level estimates of the child population for specific age groups (e.g., 0–4, 5–9, 10–14, and 15–19).
- Vermont designed its education assessment system so that assessment data are comparable across school districts, while allowing school districts the flexibility to design and administer additional assessments which meet their particular needs. This approach is meant to meet both state and local needs in a way that is not overly burdensome to the schools or the students.

*Linked administrative data systems are potentially very important sources of social indicator data. All state benchmark and accountability efforts desire to go beyond the well-being of the general population, to demonstrate how programs, alone and in combination, affect the well-being of the children and families who come into contact with them. Such data systems are difficult to create, however, because of costs, confidentiality issues, and, in some circumstances, a reticence on the part of agencies to share data.*

- Both Oregon and Minnesota attempted to develop linked data systems focusing on programs that impact children, but shelved those plans when they proved to be too difficult and expensive.
- California *has* produced several linked administrative data systems, and there is substantial interest in their use to support social indicator development and tracking. Oregon has also

developed a linked system covering employment and social support administrative data which can be used to support some child-relevant measures.

*Most of the states reviewed in this report are working hard to make social-indicator data on children available to communities in formats useful to a variety of audiences, including agency staff and citizens.*

- Vermont, Oregon, and Minnesota each produce separate comprehensive reports for individual communities which are made available over the Internet and in printed form. These reports are used for general information and to support the work of local planning commissions such as Oregon's local commissions on children and families, Vermont's regional teams for children and families, and Minnesota's local family service collaboratives.
- Several states have flexible on-line databases that allow any user to produce custom reports on local communities. The MassCHIP system may be the most advanced system of this sort. The Oregon Options' child health cluster work group has produced a very useful database of this sort focussing on indicators related to early school readiness.

**STATE REVIEWS**



**California**  
**State Statistical System and Indicators of Child Well-Being**

California's state statistical system produces a diverse set of information that can be used to track child well-being. This activity is not devoted to one particular initiative or agency, because, given the nature of California's efforts, there is a need to rely on multiple sources to get a clear picture of child well-being in the state.

California's strength is the linking of administrative data systems. Although to date they have been used primarily to support research, they have great potential as important sources of social indicator data on children and their families, especially those who receive government services.

I. PROGRAMS RELATED TO SOCIAL INDICATORS

Education Accountability Efforts. Beginning in the 1989–90 school year, the governing boards of all California school districts have been required to issue a School Accountability Report Card for each elementary and secondary school under their jurisdiction. These report cards are required by law to include 13 specified school conditions, including student achievement; progress toward reducing dropout rates; estimated per pupil expenditures; progress toward reducing class sizes and teaching loads; the availability of qualified personnel for counseling, support services, and substitute teaching; and the total number of instructional minutes offered. Although the law does not require specific or comparable data be used, the state defines an assessment to include descriptive or statistical information. The state does suggest a model School Accountability Report Card that lists specific indicators in some areas and it is unclear how many schools provide comparable data. Schools are required to make the report available at no more than the costs associated with duplication and they are encouraged to provide it at no cost to parents upon request and to the local media.

California's school districts do not administer any statewide assessment tests. The state had administered assessment tests until political controversy led to abandonment of the testing program. In 1991, a test called the California Learning Assessment System (CLAS) was designed to replace the existing assessment test. Implementation began in 1993, but CLAS was quickly caught up in controversy over the content of the test. By 1994, there was also controversy over the scoring system and test administration. In the fall of 1994, Governor Pete Wilson vetoed the bill authorizing renewal of the testing program. In 1995, Assembly Bill 265 authorized a new program for student assessments. This included a voluntary testing program that provided financial incentives for school districts to administer a test from a state-approved list. The state recommends that schools report assessment-test results in their School Accountability Report Card, although this does not allow for comparisons across tests and districts. At present, the state is developing a new statewide assessment program for select grades and subjects which the Department of Education hopes to implement in the next few years. However, any testing program they devise will likely be the subject of intense political debate and will be implemented only if the state legislature provides the necessary funds.

Monitoring Health Outcomes. The Center for Health Statistics in the California Department of Health Services serves to facilitate the collection, validation, analysis, and dissemination of health data. The Center is divided into two sections: Vital Statistics, and Planning and Data Analysis. Vital Statistics produces the annual report, "Vital Statistics of California," and makes vital statistics data available in electronic format for mainframes and personal computers.

Planning and Data Analysis maintains, analyzes, and disseminates data used to assess the health status of Californians. The Data Analysis Section is responsible for assembling and distributing data related to the Healthy People 2000 effort. The section produces an annual report, "County Health Status Profiles." These profiles compare counties to each other and to the state on a selection of indicators, most of which were selected from those recommended by the Federal Centers for Disease Control and

Prevention Committee that was convened as part of Healthy People 2000 to identify key health-status indicators.

Youth Pilot Program for Outcome-Based Services. This five-year pilot program, implemented on July 1, 1995, is testing greater county flexibility in administering funds for child and family services. No new state funds are allocated for the project; instead, the pilot counties have more flexibility in spending their current allocation. The five participating counties—Alameda, Contra Costa, Marin, Placer, and San Diego—are required to create a plan listing the goals and outcomes of the services to be provided through the available funds. Each of the five counties has chosen to focus on high-risk children, with emphasis on child welfare services. Outcome-based reports will be forthcoming in the next few years.

A Local Effort at Measuring Child Well-Being. California has no statewide effort that focuses on benchmarks or child outcomes. However, Contra Costa County has begun an effort to examine child and community well-being. The county has formed a task force to decide which measures to include; this is part of a larger effort within Contra Costa to focus on outcomes. Thus far, the county has produced a children's services budget, which notes the cost of each program, basic program information, and outcome indicators or outcome data that are available. In the initial budget only some programs have outcome data available. Many agencies in the county are just beginning to focus on outcomes and the importance of having outcome data. The effort to produce a children's services budget and to focus on community well-being has resulted in more agencies thinking about outcome data. One of the goals of this focus on child and community well-being is to help county residents recognize that improving the lives of children and others in the county requires not only government action, but also the involvement of the whole community.

## II. AVAILABLE DATA SOURCES

### *Voluntary Federal Surveys*

Youth Risk Behavior Survey (YRBS). The YRBS is a biennial survey of students in grades 9–12, covering a variety of behaviors including tobacco, alcohol, and drug use; sexual behavior; dietary behavior; physical activity; and violence. The YRBS was developed by the Federal Centers for Disease Control and Prevention (CDC). In 1995, 39 states, 16 cities, and 4 U.S. possessions fielded the survey. A national survey is also fielded.

Although California has participated in the YRBS since it was initiated in 1990, its sample has never been certified as representative by the CDC at the state level, which limits its use for tracking trends in youth behavior in the state.

Certain cities are eligible to participate in the YRBS and separate samples of schools are drawn in order to attempt to achieve representativeness. San Francisco and San Diego have participated since 1990. With the exception of 1990, San Diego has had citywide representative samples in the other years the survey has been administered (1991, 1993, and 1995). San Francisco has never had a representative sample. Los Angeles participated for the first time in 1995, but did not obtain a representative sample.

National Assessment of Educational Progress (NAEP). NAEP is an assessment of children in grades 4 and 8. Areas of assessment include math, reading, writing, and science. In 1996, some 44 states and the District of Columbia participated in the survey, and a national survey was also fielded, allowing for national comparisons and comparisons among states. California has participated in the state-level tests since they began in 1990. Trend data are available for 8th grade math with tests administered in 1990, 1992, and 1996, and 4th grade reading, with tests administered in 1992 and 1994 and planned for 1998. There are also results for 4th grade math for 1996 and 8th grade science for 1996.

*State Surveys*

Pregnancy Risk Assessment for Infants and New Mothers. California participated in the CDC's Pregnancy Risk Assessment Monitoring System (PRAMS) from 1993 to 1996. In June 1996, the state discontinued data collection under PRAMS. The state is developing a new effort similar to PRAMS, with a request for proposal to be issued in the summer of 1997. The estimated start-up date is January 1998.

PRAMS surveys new mothers about risk-related behaviors such as cigarette and alcohol consumption during pregnancy, prenatal care, well-baby care, and stressful events during pregnancy. Sample selection is designed to provide an oversample of populations with an increased risk of poor birth outcomes (low birth-weight babies, mothers who received inadequate prenatal care, and/or minority groups). The CDC provides a core set of questions and states can add supplemental questions of their own. When it participated in PRAMS, California added about 17 questions to the CDC core. The standard PRAMS methodology calls for sampling off birth certificates, but because in California the wait to get birth certificate data was very long, the state sampled from hospital records.

The California PRAMS survey covered 3 out of 11 perinatal regions in the state, accounting for about 20 percent of the state's births. The new study being planned will be statewide. There is discussion of whether the sample can be done to obtain representative data for all of the perinatal regions, but no final decision has yet been made.

The state has issued some reports using PRAMS data and is continuing to do analyses. Regional offices and county health departments have expressed strong interest in current analyses comparing teen and adult mothers as well as studies of unintended pregnancies.

The Biennial California Student Substance Use Survey. California has conducted the biennial California Student Substance Use Survey (CSS) of 7th, 9th, and 11th graders since the 1985–86 school year. The survey is sponsored by the Office of the Attorney General, the Department of Alcohol and Drug Programs in the Health and Welfare Agency, the Healthy Kids Program Office in the Department

of Education, and the Office of AIDS in the Department of Health Services. The survey asks about use of alcohol, marijuana, cocaine, LSD, inhalants, cigarettes, and a variety of other drugs. Students are also asked about the use of two or more drugs on one occasion, experiences and attitudes relevant to substance use, personal problems associated with the use of alcohol and other drugs, perceptions of harm associated with frequent use, the availability of drugs, and awareness of drug use among adults.

Prior to the 1995–96 survey, the CSS followed a passive parental consent procedure. Parents were informed about the survey and told to notify the school if they did not want their child to participate. In 1995, the procedure was changed because of growing public concern over youth surveys and talk of legislation to require active parental consent. Students can now take the survey only if they have brought in a signed consent form from a parent or guardian. The difference in methods of consent means that data from the 1995–96 survey are not comparable with earlier years. The survey report advises that the data should be treated as a new baseline and compared to future, but not past, surveys.

The 1995–96 survey was completed by 5,775 total students, or approximately 1,925 students in each grade. This represents 62 percent of the students who were selected in the sample. There was a wide variation in the percentage of completed consent forms across schools and within classrooms in the same schools. The response rate was lower in schools with higher proportions of students from families who receive public assistance and was higher in schools with higher proportions of students taking college preparatory courses.

The CSS has been an excellent resource for monitoring substance use among California students. But questions about the representativeness of the most recent sample and future surveys will have to be addressed when the data are used.

*Administrative Data\**

The most innovative work on administrative data in California has been in the area of linking administrative data sets.

Population Estimates. The Demographic Research Unit of the California Department of Finance produces population estimates for the state of California. They represent the state in the Federal-State Cooperative Program for Population Projections and Estimates. Annual estimates and projections are issued for state and county population by age, race/ethnicity, and sex. The unit also estimates births by county, school enrollment for kindergarten through grade 12, the number of high school graduates, and postsecondary education enrollment.

*Linking Administrative Data*

There are two major efforts to use data from linked administrative records. Though both efforts are housed outside of state government, they would be impossible without the strong support of the California Department of Social Services, Research Branch.

One of the ongoing projects is a collaborative effort of the California Department of Social Services, Research Branch; the University of California Data Archive and Technical Assistance (UC-DATA); and the Survey Research Center at the University of California. This project is focusing on welfare reform. Statewide data from Medicaid files are linked to AFDC, food stamps, and unemployment insurance records for sites where welfare reform is being evaluated. These records are linked with survey data from the California Work Pays Demonstration Project. Using these data, researchers are able to obtain detailed information about low-income families and children, and can then address questions about links between family stability and income and federal and state program participation. Most of the

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\*Administrative data systems that are mandated by the federal government and thus common to all states are not covered here. These include elements of the National Vital Statistics System (birth- and death-certificate data and various communicable-disease reporting systems); the Uniform Crime Report system; education data contained in the Common Core of Data System; and the mandatory reporting associated with various federal programs.

data are on the economic circumstances of the family and program participation. There is limited information on the well-being of children. However, it would be possible to combine a linked administrative records strategy with a survey that got more detailed information on children in these families.

The California Children's Services Archive is an effort to build a comprehensive longitudinal data set bringing together an array of information on children and the services they receive. The archive builds upon work at the Center for Social Services Research, School of Social Welfare at the University of California, Berkeley, which is creating a longitudinal data set from individual foster care and child abuse records. Currently the archive includes the following statewide data: all live birth records and death records since 1970; California Youth Authority records on assessment, incarceration, and parole; placement records for foster care and group care cases; adoption records; and records for special education disability categories and placement settings. There are data that are not yet statewide for MediCal (California's Medicaid program); probation; child abuse and neglect; and neighborhood and community indicators from the Census. The five-year work plan calls for adding statewide child abuse and MediCal data, AFDC/TANF information, employment data, and special education history. University of California researchers meet regularly with state research staff to decide what issues to focus on and how they can most inform policy debates.

The archive's work is funded from a variety of sources, but the plan for a comprehensive archive has yet to be fully funded. One of the long-term goals is to make the data widely available. However, additional money will have to be raised and confidentiality issues will have to be addressed if a public-use database is to be made available.

The California Children's Services Archive has been used to produce the reports "Performance Indicators for Child Welfare in California." The first edition was issued by UC-Berkeley's Center for Social Services Research in 1994 and there is a contract to produce a report each year through 1998. The

report focuses on indicators of child abuse, entry into foster care, foster care caseloads and placements, length of stay, children who reenter foster care, placement stability, and permanence.

California also is moving to make it easier to link health data. In June 1996, the Department of Health Services ordered that all new data sets and any established data set undergoing changes include five core data elements: the birth name of the client, date of birth, mother's first name, place of birth, and gender. The department further requested that seven confirmatory data elements, including the client's social security number, be included whenever possible. All data sets in the department are scheduled to fully implement this change by June 1998. Core elements will have standard definitions and formats, making it considerably easier to link records across programs.

A Move toward the Electronic Reporting and Availability of Education Data. The California School Information Services (CSIS) is an effort that began in 1992 to study the feasibility of creating a system for electronically sharing and reporting student-level information. One of its goals is to reduce the number of reports schools and local education agencies need to file for pupil data collection purposes. The goal is to produce data that are more uniform, comparable, accurate, timely, and accessible.

The state has done feasibility studies of the electronic reporting of data and aggregation of student information, and has completed demonstration projects designed to test the CSIS model. The tests indicate that the model is workable. The data-gathering demonstration project was the Automated Information Retrieval System (AIRS), which included 331 school sites in 38 districts. According to the study, basic demographic data were available in existing district data systems, as were program participation data on major state and federal programs, but outcome data were considerably more difficult to obtain. Current plans are to begin a pilot implementation in the 1997–98 fiscal year and then continue a phased implementation until 2001–2002. Implementation plans are dependent on funding from the state legislature.

### III. CONTENTS AND COVERAGE

One of the great strengths of California's data system is the potential of its linked administrative data systems to monitor the well-being of children and their families, particularly those who are at greatest risk. To date these data sources have not been exploited for such purposes, though work in this area has begun at UC-DATA.

California, like most states, has the standard set of comparable vital statistics and health data. In addition, it has fielded several state-level health surveys to monitor pregnancy risk behaviors (PRAMS), youth risk behaviors (YRBS), and drug use (CSS). Unfortunately, none of these surveys fields a sample representative of the state population, making them of little or no use for tracking trends over time. The successor to PRAMS, the Risk Assessment for Infants and New Mothers, is supposed to have a representative state sample and possibly samples by region, but it has yet to be fielded. The CSS did provide valid state estimates, but the change in 1995–96 requiring active parental consent has almost certainly biased the sample substantially.

As for educational assessment, the state does require school districts to produce and distribute system report cards, which are to include student assessment results. Although the value of the report cards should not be underestimated, the lack of comparable assessments across school districts limits the utility of the data even for the school districts, since they cannot necessarily compare their efforts to those of other similar school systems.

Finally, like most states, California does not have the data necessary to track general demographic and socioeconomic characteristics of children and their families between decennial censuses. Because of the state's large population, reasonably sensitive estimates for the state as a whole can be made from the U.S. Current Population Survey. Below the state level, however, estimates are limited to those for annual county-level population. These are available by age, race, and sex subgroups, which is far more detailed than what is available in other states. Even so, there is a large hole in

California's social indicator data system. Some within state government are considering fielding a state survey modeled on the federal Survey of Income and Program Participation (SIPP) to monitor the effects of welfare reform. Such a survey would have the added benefit of providing more detailed and accurate annual demographic and socioeconomic data for the population as a whole, at least at the state level.

#### IV. ACCESSIBILITY

California makes available a considerable amount of data both on-line and in print. The following data are available on the World Wide Web.

- The California High School Performance Report and some other student performance data are available via the State and School Finance, Research and Statistical Information Home Page. The report includes data on the four-year completion rate, the percentage of students who score above the national average on the SAT or ACT, averages on the SAT, the percentage of seniors taking the SAT, the percentage of juniors and seniors who have obtained advanced placement credits for college, and the dropout and graduation rates. This is also a good place to find out about ongoing developments regarding education data. **<http://goldmine.cde.ca.gov/pg2finstats.html>**
- Additional education data are available over the Internet as part of the Ed-Data Education Data Partnership. This joint effort of the Alameda County Office of Education and four divisions within the California Department of Education enables access to data on individual school districts. Data include the ethnic makeup of the school, percentage of students from families on AFDC, expenditure per pupil, and percentage of limited English proficient (LEP) students. This Web site also lists school districts with similar percentages of minority students, students on AFDC, LEP students, and average daily attendance. The Ed-Data Web site is located at: **<http://www.ed-data.k12.ca.us/welcome.html>**
- The home page for the California Department of Health Services, Center for Health Statistics, provides links to some data as well as information about health statistics and how to order health publications. **<http://www.dhs.cahwnet.gov/stats/chs/index.htm>**
- State and County vital statistics are available at: **<http://www.dhs.cahwnet.gov/stats/chs/index.htm>**
- A selection of tables from the County Health Status Profiles are available at: **<http://www.dhs.cahwnet.gov/stats/chs/profiles/intro.htm>**
- The Health California 2000 Progress Report presents data on California's performance in relation to the Healthy People 2000 goals. When available, trend data reaching back to 1987 are provided. **<http://www.dhs.cahwnet.gov/stats/chs/yr2000/yr2000.htm>**

- The California Department of Finance, Demographic Research Unit, does not provide on-line population estimates. State estimates are available from the California Department of Health Statistics home page, noted above. The Demographic Research Unit does provide links to the Web pages of the State Census Data Center's regional centers. A number of the regional centers do provide on-line population estimates along with other data.  
**<http://www.dof.ca.gov/html/demograp/scdcreg.htm>**
- The report of the Sixth Biennial California Student Substance Use Survey is available. It includes a description of the survey, main findings, and 20 tables and 10 figures illustrating the findings.  
**<http://caag.state.ca.us/cvpstats/csspress.htm>**
- The questionnaires used in the California Student Substance Use Survey can be downloaded from the following site: **<http://www.wested.org/hd/pdfsurveys.html>**
- A codebook for one of the linked administrative data files used by UC-DATA in the California Work Pays Demonstration Project can be downloaded from:  
**<http://ucdata.berkeley.edu/CWPDPdata.html>**  
Updates about this project and other data-related projects at UC-DATA can be accessed via their home page at: **<http://ucdata.berkeley.edu/>**
- A set of diverse child well-being indicators is available in a single location: the Internet site of Children Now, the organization funded by the Annie E. Casey Foundation to produce the state "Kids Count" Report. Data are available for the state as a whole and at the county level for the population under age 18. Some of the data featured are median income, teen births, college-bound seniors, juvenile arrests, child abuse reports, foster care placement, youth homicide, infant mortality, mothers with late or no prenatal care, and high school dropouts.  
**[http://www.childrennow.org/california/SOC\\_96/SOC96.html](http://www.childrennow.org/california/SOC_96/SOC96.html)**

Most of the data available over the Web are also available in published form. A number of publications that cannot be accessed via the Internet are available by contacting the appropriate source (see the appendices for contact and order information).

## V. TRAINING TO USE AND DEVELOP DATA

Both the Department of Health and Department of Education work with local offices to insure proper data collection and to make data available for local use. The regional centers associated with the State Census Data Centers provide technical assistance for a wide range of data issues—helping with census data, updating population estimates, assistance using technology associated with local Geographic Information Systems (GIS), and so on.

The Center for Social Services Research at the University of California, Berkeley, works with counties that request assistance to improve the quality of administrative data. It also helps counties interpret the results of analysis and tease out policy implications.

## VI. CURRENT CHALLENGES AND PLANS FOR THE FUTURE

The great strength of California's state data system lies in its efforts to integrate and link state administrative data systems. There is serious consideration being given to fielding a state survey similar to the federal Survey of Income and Program Participation (SIPP), and linking the data from that survey to employment, welfare, and other administrative data. The state could then follow families' movement through various program services over time, allowing for the development of crucial indicators of policy and program effectiveness.

At present, California's system of social indicator data is quite fragmented, with a great deal of noncomparability across counties, due in part to the strength of the state's county governments. Although the state is attempting to restore comparable educational assessment measures, it is unclear whether that effort will be successful.



**Florida**  
**State Statistical System and Indicators of Child Well-Being**

Florida is making extensive use of child well-being indicators. These efforts include statewide benchmarking, and the use of outcome indicators and goals in state agencies' performance reports and in school accountability reports. The state is producing and compiling data that could be used for a variety of purposes.

I. PROGRAMS RELATED TO SOCIAL INDICATORS

Florida Commission on Government Accountability to the People (GAP). This commission was established by executive order in December 1992 and its functions were written into law as a result of the passage of the 1994 Government Performance and Accountability Act. The commission was given the dual role of measuring the effect of state government on the well-being of Floridians and serving as a citizens' board whose task is to help state government improve the efficiency and effectiveness of government services. GAP members chose to produce a benchmarks report to get a sense of where Florida was and where people thought it should be going.

During its initial meetings, commission members developed a list of topics they wanted to cover. They then turned to a Technical Task Force (TTF), made up of measurement experts from business, academia, government, and a public interest organization, to review available measures. The TTF, assisted by close to three hundred consultants, produced a list of 268 benchmarks published in the initial report. The decision was made to focus exclusively on trends in the first report and then focus on setting goals for the future after the initial report was released. Florida issued its first "Benchmarks Report" in February 1996. It covered seven areas: families and communities; safety; learning; health; the economy; the environment; and government. Except for the sections on the environment and the government, each includes direct measures of child well-being.

Since issuing its initial report, GAP has continued to refine its measures. Originally, the commission selected 32 critical benchmarks. GAP has since decided to do a more detailed review and is in the process of setting goals for 60 critical indicators. These indicators were selected on the basis of the number of people affected, the severity or frequency of the condition being measured, and the statewide impact of what was being measured. Some of the measures that were published in the “Benchmarks Report” will be replaced because better data sources or better measures were located.

In July 1997, GAP released a report on the 60 critical goals, including performance targets for the years 2000 and 2010. The targets were selected by sending out a survey to businesspeople, community organizations, educators, local governments, and others who were active in the areas covered by the benchmarks. Survey participants received data available on the benchmarks in their area, along with information on the lowest- and highest-ranking counties in the state, and they were asked where they thought the state should be in the years 2000 and 2010.

The GAP Commission has struggled to perform its mission with a limited budget. In the 1995–96 fiscal year, GAP experienced a 22 percent budget reduction and the loss of two positions. As a result of these budget cuts, the commission eliminated its “Best Practices in State Government” project, which recognized state agencies for implementing processes or engaging in activities focusing on outcomes important to citizens.

The GAP Commission is planning to release the second Florida “Benchmarks Report” in 1998, with future reports issued every two years. GAP is also planning cross-agency studies to look at particular outcomes. The purpose is to determine which agency activities contribute to particular outcomes, whether agencies’ functions overlap or conflict, and to recommend actions agencies can take to improve outcomes for state residents.

School Improvement and Accountability. Florida is using indicators as part of its System of School Improvement and Accountability, which is also referred to as Blueprint 2000. The School

Improvement and Education Accountability Act, passed by the Florida legislature in 1991, established seven state education goals: readiness to start school; graduation rate and readiness for postsecondary education and employment; student performance; learning environment conducive to teaching and learning; school safety and environment; ensuring professional teachers and staff; and adult literacy. Data are drawn from the Department of Education's Management Information System (MIS). The 1996 Legislature added an eighth goal: parental involvement.

The 1991 legislation also created the Florida Commission on Education Reform and Accountability as an advisory body to the State Board of Education. The board has selected 16 indicators to measure progress within the districts. Schools are required to issue a "School Public Accountability Report" to all parents, guardians, and adult students, and to the general public upon request. In addition to the accountability reports, schools are required to issue a larger "School Advisory Council Report." Starting in 1997 these reports will include all of the indicators in the "School Public Accountability Report" broken down by sex and racial/ethnic groups. Schools have done "Public Accountability Reports" since 1995.

The state has compiled some of the information from the 1996 reports into *Vital Signs for School Improvement*. This document includes data for individual schools and state medians on school size, graduation rate, achievement test scores, dropout rates, out-of-school suspension rates, students absent for more than 20 days, percentage of poor and minority students, percentage of students who transferred in or out of the school, percentage who were Limited English Proficient students, and the rate of staff turnover.

The School Improvement and Accountability Process includes the development of school improvement plans which make use of state and local indicators. School advisory councils work with each school to develop a school improvement plan including goals-setting and definitions of what constitutes adequate progress. Schools with critically low student performance which fail to improve or

any school that has made inadequate progress in one or more of the state education goals are subject to state intervention that may include the provision of additional resources, a school reorganization under a new principal with the authority to hire new staff, or implementation of school choice so parents can send their children to another district school.

Florida's Comprehensive Assessment Test (FCAT). As noted above, student performance is one focus of Florida's system of school accountability. Current state requirements are as follows: (1) Local districts must choose from a list of "norm-referenced tests" in reading and math, to be administered at the elementary and middle-school levels. These tests will be phased out at the end of the 1996-97 school year. (2) A state-designed Grade 10 Assessment Test (GTAT), which is also being phased out. (3) The state-designed Florida Writes! test for 4th, 8th, and 10th graders. This test will be included in the state's new assessment system. (4) The state-designed High School Competency Test is required for students beginning grade 11; students must pass it to graduate. This will be incorporated into the new assessment system. Florida reports the results of these assessment tests on the Internet and in published reports.

In addition to the tests being retained from the previous system, the state will implement the Florida Comprehensive Assessment Test (FCAT). FCAT will be given to 4th, 8th, and 10th graders beginning in the 1997-98 school year. There will be a special emphasis on reading, writing, and mathematics. Comparisons of students and of districts that were problematic under the old norm-referenced tests will now be possible.

Agency Strategic Plans. Florida government agencies must produce strategic plans that indicate specific outcomes. The Florida Department of Health and Rehabilitative Services (HRS) has worked on strengthening its focus on outcomes since the early 1990s. HRS was recently reorganized and, as of January 1, 1997, was split into the Department of Children and Family Services (DCF) and the Department of Health. Both departments are using outcomes within their strategic plans and departmental performance evaluations.

Outcome measurement within government agencies has long been an interest in Florida, and state law has required such a focus since the mid-1980s. In 1993, the Department of Health and Rehabilitative Services underwent a restructuring that decentralized authority in the department and increased responsibility among the agency's service delivery districts. The service districts cover anywhere from between one and eleven counties. District Health and Human Services Boards (HHSB) were given the responsibility for establishing local priorities and to engage in an ongoing evaluation of district performance. As a result of the 1993 reorganization, it became clear that HRS needed to focus more on outcomes. The strategic planning process was redesigned with that in mind.

Each year the department issues a strategic plan highlighting goals and key initiatives for the next five fiscal years. These plans include a list of key outcome indicators chosen to monitor progress. After the fiscal year has ended, the agency issues a performance evaluation that includes state- and district-level data on the key indicators. HRS organized its Agency Strategic Plan by core priority outcomes. Outcomes that directly affected children in the 1995–2001 plan included providing a healthy start for children; protecting children from abuse and neglect and building stable families; facilitating recovery of children with mental illness; enabling children to enter school ready to learn; and reducing teen pregnancy. Each goal was accompanied by key indicators and intervention strategies. The indicators come from various data sources including the Vital Statistics System and the administrative data systems maintained by various program offices within the department. Indicators are regularly reviewed and evaluated to determine whether they are useful and reflect agency performance. Attempts to devise better measures and to detect flaws in particular indicators have been discussed in the “Agency Performance Reports.” Reports have also been issued summarizing HRS District Performance. Some districts included additional performance indicators in their reports to the state. Plus, each district was required to publish its own strategic plan and performance reports based on priorities selected by the district Health and Human Services Board.

The first strategic plan for the Department of Children and Family Services, which was organized by target client group, represented a break with the HRS format. In the 1996–2002 Strategic Plan the target groups among children were: families with children at risk of abuse and neglect; children who have been abused or neglected by their families; child victims of abuse or neglect who have become eligible for adoption; children with an emotional handicap, serious emotional disturbance, or mental illness; children with or at serious risk of substance abuse problems. Also included were persons who do not have sufficient income to support themselves and their children and families with children in child care. Most of the outcome measures were the same as those in the final HRS Strategic Plan. The department is continuing to review and refine its client groups and outcome measures. Indicators are still undergoing revision as the department moves toward full implementation of performance-based budgeting.

The reorganized Florida Department of Health has produced its first strategic plan with goals set for the year 2001. Among its goals for children are reducing the rates of communicable diseases, infant mortality, teen birth, and number of children requiring special education. The plan also sets a goal for increasing the percentage of children with a physical impairment who are “mainstreamed” in the classroom and increasing the percentage of the total school population with supplemental school health services.

Health Indicators. Florida has established numerous health goals and indicators. In the next few years, the Department of Health will be incorporating its outcome-monitoring into a performance-based budgeting system. Data are collected as part of the Vital Statistics System, disease surveillance systems, and administrative record-keeping.

Florida’s Health Department is expanding access to its data by creating an intranet for internal use. This will make it easier to share confidential data within the department and with county staff. The department is also developing access to data via the Internet, with the intention of increasing the availability of searchable databases for public use.

## II. AVAILABLE DATA SOURCES

### *Voluntary Federal Surveys*

Youth Risk Behavior Surveillance System (YRBS). The YRBS is a biennial survey of students in grades 9–12, covering a variety of behaviors including tobacco, alcohol, and drug use; sexual behavior; dietary behavior; physical activity; and violence. The YRBS was developed by the Federal Centers for Disease Control and Prevention (CDC). In 1995, 39 states, 16 cities, and 4 U.S. possessions fielded the survey. A national survey is also fielded.

Although Florida participated in the YRBS in 1991 and 1993, the Florida sample was not certified as representative by the CDC in either year. In 1995, the Florida Department of Education declined to participate. In 1997, however, the Florida Department of Health assumed main responsibility for the survey. Interviews were being conducted and a representative at the Department of Health was hopeful that the response was high enough to generate a representative sample.

In addition to the state survey, Fort Lauderdale and Miami have conducted local surveys since the initiation of YRBS in 1990. With the exception of Fort Lauderdale in 1990, these localities have obtained representative samples in each year that the survey was done. In 1995, 100 percent of sampled Fort Lauderdale schools participated, with a response rate among students of 82 percent. In Miami, the 1995 school response rate was 83 percent and the student response rate was 82 percent. Both cities are participating again in 1997.

National Assessment of Educational Progress (NAEP). The NAEP is an assessment of children in grades 4 and 8. Areas of assessment include math, reading, writing, and science. In 1996, some 44 states and the District of Columbia participated in the survey, and a national survey was also fielded, allowing for national comparisons and comparisons among states. Florida has participated in the state-level tests since they began in 1990. Trend data are available for 8th grade math, with tests administered

in 1990, 1992, and 1996, and 4th grade reading, with tests administered in 1992 and 1994 and planned for 1998. There are also 1996 results in 4th grade math and 8th grade science.

Pregnancy Risk Assessment Monitoring System. Florida participates in the Pregnancy Risk Assessment and Monitoring System (PRAMS) sponsored by the CDC. PRAMS surveys new mothers about risk-related behaviors such as cigarette and alcohol consumption during pregnancy, prenatal care, well-baby care, and stressful events during pregnancy. Sample selection is designed to provide an oversample of populations with an increased risk of poor birth outcomes. In Florida, minority and low birth-weight infants are oversampled. The CDC provides a core set of questions, to which states can add supplemental questions. Florida began participating in 1993 and has issued a report on the 1994 results.

The standard PRAMS design takes a sample of birth certificates and sends out a mail survey to new mothers. There is a telephone follow-up for nonrespondents. The Department of Health reports receiving 2,501 surveys, for a response rate of almost 80 percent. They are able to weight the data based on information from the nonrespondents' birth certificates. The PRAMS data report lists the distribution of births by parents' education and income. Topics covered in the survey include intendedness of pregnancy; infant's exposure to tobacco and alcohol during pregnancy and at age 3 to 5 months; percentage of mothers experiencing stressful events such as fights, domestic violence, arrest, or jailing of husband/partner; and data on the infant's health and health care.

#### *State Surveys*

None apparent.

*Administrative Data\**

The Department of Education's Management Information System. The Florida Department of Education collects data on many indicators using its Management Information System (MIS). Data are entered on students and staff at the school and district level. The database is maintained by the Office of Education Information and Accountability Services (EIAS). The primary purpose of the centralized system, in use since 1987, is to collect data needed to fulfill reporting requirements for various state and federal programs. EIAS has added elements into the data set as reporting requirements have been added, or as the state has requested data on new areas. The most recent additions to the database are reports on incidents of violence, weapons violations, vandalism, substance abuse, and harassment on school buses, school campuses, and at school-sponsored activities. The MIS is very flexible and can produce data at the school, district, or state level and can cross-classify data by race or gender. The data from the MIS are published in regular reports and are the source for the indicators used in the "School Public Accountability Reports" discussed earlier.

The Public Health Indicators Data System. Public health officials throughout the state of Florida are able to access health data through the state's Public Health Indicators Data System (PHIDS). PHIDS includes annual data on all the indicators in the state's public health plans for which data are available plus related indicators. This includes a total of over two hundred indicators from the Strategic Plan, the Florida Public Health Plan, county outcome indicators, and county quality-improvement indicators. There are child-related data include data on birth risk factors, weight, age of mother, infant mortality, immunization, and others. Data are available for most indicators from 1970 onward. For some indicators, mostly vital statistics, data are available back to 1960.

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\*Administrative data systems that are mandated by the federal government and thus common to all states are not covered here. These include elements of the National Vital Statistics System (birth- and death-certificate data and various communicable-disease reporting systems); the Uniform Crime Report system; education data contained in the Common Core of Data System; and the mandatory reporting associated with various federal programs.

Florida's Statewide Public Health Information Network. A more recent effort that takes advantage of improvements in technology is the Statewide Public Health Information Network (SPHIN). Its primary objective is to create a network that connects county health departments, Children's Medical Services, and the State Health Office, thus enabling the exchange of a wide range of electronic information among public health professionals. All 67 county health departments are now connected through SPHIN. As part of the project which established SPHIN, the Department of Health is seeking to expand the amount of data it makes available via the Internet.

Geographical Information Systems. Florida is expanding its Geographical Information Systems (GIS) capabilities. Although there are now limited data available on children, efforts are underway to incorporate indicators related to children and children's services into the GIS. Existing data are being coded geographically so indicator data can be produced by various types of service district or census tract. The Department of Children and Family Services (DCFS) is expanding the availability of data that are compatible with a GIS system. The most advanced effort is taking place in south Florida. DCFs District 11a, which is made up of Dade County, is using a GIS to map data on service providers, social service caseloads, and demographic variables.

Population Estimates. Florida's official population estimates and projections are done by the Bureau of Economic and Business Research at the University of Florida in Gainesville. Estimates are done at the state and county levels. County estimates and projections are given for children ages 0-4, 5-9, 10-14, and 15-17.

#### *Linking Administrative Data*

The Florida Education and Training Placement Information Program (FETPIP) collects data from a number of Florida government agencies to follow up on individuals who have been through the Florida education system. Among the groups followed are high school graduates and dropouts, all community college associate degree and vocational students, all secondary and postsecondary vocational students,

adult education and GED students, and all correctional system releases, including those from the Correctional Education School Authority.

FETPIP links identifying information from the education and other institutions to various state and federal data sources including the State Department of Corrections; the U.S. Department of Defense (military enlistments); the Federal Office of Personnel Management (for federal employment records); the state Department of Management Services (for state employment records); and the Florida Department of Labor and Employment Security (for unemployment insurance records).

Reports produced for each educational institution show the total number of individuals who have been through the institution or dropped out who are employed in Florida, with wage and hours information included; the total number employed in the federal or state government; the percentage in continuing education; those receiving Medicaid, AFDC, or food stamps; and the total in prison, on parole, or on probation. Coverage is more complete for residents of Florida than those who have moved out of state, but this database does provide some very interesting follow-up information on graduates. The state plans to use FETPIP to evaluate the success of various education and training programs.

### III. CONTENTS AND COVERAGE

Florida's benchmark report is an excellent source of data on a wide range of indicators. The report also lists topics with no data because a data source did not exist, there was data but GAP did not think it was valid or reliable, the information was too costly or difficult to collect, or there were data but not at the state level. The indicators where no data was published include the following related to children's lives: percentage of babies born to families receiving Aid to Families with Dependent Children (AFDC); percentage of parents who were satisfied with their child care arrangements; percentage of children leaving foster care who returned within two years; percentage of all children entering public school ready to learn; percentage of public high school graduates with basic computer skills; percentage

of parents who volunteered time at their child's school; percentage of parents who felt welcome at their child's school; number of babies born with birth defects and fetal alcohol syndrome; percentage of youth who are physically fit; percentage of youth who are overweight; percentage of youth who drink alcohol or abuse drugs; and percentage of youth who smoke.

Florida provides outstanding access to data on its school system and on student performance. There is extensive coverage of education topics and the state's MIS produces timely data. The Department of Health also provides good coverage, which is likely to improve once the department completes its transition from being part of HRS to being a separate state agency.

Like most states, Florida does not have the capacity to monitor basic demographic and socioeconomic characteristics of children and their families between federal censuses. Due to its large population, estimates for these characteristics can be produced at the state level from the U.S. Current Population Survey, though even those are not very sensitive to change over time. Estimates below the state level are limited to basic, age-specific population counts by county. This constitutes a major hole in any state's system of social indicators.

#### IV. ACCESSIBILITY

Florida offers access to a considerable amount of data on its children and families. The following data are available over the World Wide Web.

- The Florida Benchmarks Report can be downloaded from:  
**<http://www.eog.state.fl.us/govdocs/gapcomm/benchmks.htm>**
- Other publications and additional information about the GAP Commission are located at:  
**<http://www.eog.state.fl.us/govdocs/gapcomm/gaphome.htm>**
- The home page of the Student Assessment Services Section (SASS) provides links to information and data on the assessment tests administered within Florida's school system.  
**<http://www.firn.edu/doe/sas/sasshome.htm>**

- The Research and Statistics page of the Florida Department of Education Web site provides data on a number of indicators including dropout and graduation rates by district.  
**<http://www.firn.edu/doe/menu/research.htm>**
- The Department of Education is developing a new Web page, which promises continuous updates on statistical reports and published educational research.  
**<http://www.firn.edu/doe/rshome.htm>**
- Additional data on education indicators in Florida are available from the Web site for the Education Information and Accountability Services Office of the Florida Department of Education. **<http://www.firn.edu/doe/bin00050/home2.htm>**
- The Vital Signs for School Improvement report provides outcome data for individual schools in Florida as well as comparable data for the state as a whole.  
**<http://www.firn.edu/doe/bin00018/vital/intro.htm>**
- The Florida Department of Health home page provides links to various health-related programs in Florida including reports that cover the well-being of children and families.  
**<http://sun6.dms.state.fl.us/health/>**
- A description of public health outcome measures and goals is located at:  
**[http://sun6.dms.state.fl.us/health/public\\_html/phealth/outcomes.htm](http://sun6.dms.state.fl.us/health/public_html/phealth/outcomes.htm)**
- County indicators for health outcomes are available at:  
**<http://sun6.dms.state.fl.us/health/statistics/qa96/#co>**
- The Department of Children and Families recently set up a new Web site. Reports and information, including data, will be available soon. **[http://sun6.dms.state.fl.us/cf\\_web/](http://sun6.dms.state.fl.us/cf_web/)**
- Although the Bureau of Economic and Business Research does not provide on-line population estimates, information on ordering those estimates and other publications with Florida data is available at: **<http://www.cba.ufl.edu/bebr/bbrpub.htm>**
- The Florida Department of Commerce used to compile statistical tables that compared Florida counties in a number of areas. These were available on-line and in a published document, *Florida County Comparisons*. Although the topics covered were mostly economic issues, there were a number that were relevant to children and families, including the population under age 18 and school enrollment. The Florida Department of Commerce was abolished on July 1, 1996, and its duties were taken up by a public-private partnership known as Enterprise Florida. As of this writing, it is unclear whether Enterprise Florida will continue to produce a document similar to *County Comparisons*. As of May 1997, *Florida County Comparisons 1995* was still available to be downloaded at:  
**[http://www.state.fl.us/commerce/public\\_html/html/publications/entcomp.html](http://www.state.fl.us/commerce/public_html/html/publications/entcomp.html)**
- Follow-up information on participants in education and training in Florida are available on the Florida Education and Training Placement Information Program (FETPIP) home page.  
**<http://www.firn.edu/doe/fetpip/fetpip.html>**

Many of the data available over the Web are also available in published form. Plus, many publications that cannot be accessed via the Internet are available by contacting the appropriate source. PRAMS reports and agency strategic plans, for example, can be ordered directly (see the appendices for contact and order information).

## V. TRAINING TO USE AND DEVELOP DATA

Most Health Department data are collected by county health departments. The data are then submitted electronically to the state, which compiles the data and produces reports. State field staff work with counties to insure that personnel are trained in data reporting and getting access to data. The Health Department is requesting additional money for staff to do more field work so counties can make better use of the available data.

School district staff are trained by state personnel in the use of the Department of Education's MIS and in the methods used for calculating various data elements. There are annual data workshops that focus on particular aspects of the system such as special education or equal employment opportunity reporting requirements. EIAS staff visit local school districts to train new personnel in the use of the data reporting system.

## VI. CURRENT CHALLENGES AND PLANS FOR THE FUTURE

Florida is moving ahead with the implementation of performance-based budgeting. This will require state agencies to use outcome data to determine how at least part of their budget is spent. But to do so, outcome indicators must either be available or developed. The exact details of how performance-based budgeting will work and the pace at which implementation will proceed is unclear. The legislature continues to debate the issue and the amount of discretionary funds that will be subject to performance

budgeting has not been established. However, there is a commitment to make greater use of outcome data in the budgeting process, which has forced various agencies to think about the data they produce and how it can be used. The GAP Commission is also putting more emphasis on the relationship between what state agencies do and the outcomes covered in the benchmarking process. By incorporating an emphasis on outcomes into both the budget and strategic planning process, Florida has created a means by which outcome-based governing can be institutionalized.

The state has built extensive tracking systems in health and education. These systems are highly automated and enable the state to report data on a wide range of social indicators. The development of outcome measures within other areas is less well advanced. Data on social services has tended to focus on process and less on outcomes. However, through efforts such as the strategic planning process and performance-based budgeting, the state is emphasizing the development of outcome measures. This suggests that Florida's statistical system will continue to increase the range of indicators available, though the pace of this improvement may be hampered by a tight state budget.



**Massachusetts  
State Statistical System and Indicators of Child Well-Being**

Massachusetts' statistical-system capacity for producing and reporting child well-being indicators is expansive and expanding. The initiatives involving social indicators are exclusively monitoring and accountability systems developed by individual departments. Although there is no statewide goal-setting initiative focused on children, departments are working to strengthen their own data systems and to coordinate and integrate data. The programs described below were developed during the 1990s and a number of departmental systems are just now making the transition to advanced and integrated data systems. Massachusetts appears poised to build a strong, extensive statistical framework from which indicators on children could be readily available.

I. PROGRAMS RELATED TO SOCIAL INDICATORS

Community Health Network Areas (CHNAs) and Health Status Indicators. Community Health Network Areas (CHNAs) began in 1992 as a pilot initiative in the three areas of New Bedford, Salem/Lynn, and Springfield. Starting in 1994, every one of the state's 351 cities and towns was integrated into one of 27 networks established by population. The CHNAs were formed by the Department of Public Health (MDPH) to broaden the health-planning perspective of communities, to create a means for greater communication and collaboration among health providers and community members, and to improve the understanding and use of health data in the planning process.

The networks serve to capitalize on the strengths of local-level planning within a state-administered system. The Department of Public Health sets policies and the broad agenda for health services, but the majority of services are contracted out to nonprofit providers. This has created a scattered delivery system with communication between contracted providers and the department but with little lateral coordination at the local level. The structure of the CHNAs has improved communication

among providers by including all of the department's contracted providers within each network area. All contractors are required to participate in the CHNA and other groups—including churches, schools, and community organizations—are also encouraged to join the network. Each CHNA has a regular meeting schedule; many have a steering committee and subcommittees that plan activities and that develop and monitor public health initiatives.

Health status indicators are a critical part of the CHNAs' planning. The department began building the set of health status indicators with the indicators from Healthy People 2000, for which data were universally collected across the 50 states and were readily available. Additional state-collected health data and some programmatic measures, such as Medicaid participation, were then added. Of the over 50 indicators compiled for each CHNA, 8 are perinatal and child health indicators compiled largely from the department's registry of vital records and statistics, with a handful of demographic and infectious disease indicators presented for children under 18 years of age.

A report of the health status indicators is compiled for each CHNA, with the data presented in graphs and tables. For contextual and comparative purposes, data are also presented for the state and, where applicable, Healthy People 2000 goals are identified. As part of the data package, the department also includes a community health decision-making tool that poses a series of questions regarding problem areas and priorities to guide CHNA members in their planning process. Each CHNA is encouraged to use these indicators, as well as other sources, in selecting one or two priority areas on which to focus their efforts. After examining indicators as part of its planning process, the Community Health Network of the Greater Milford Area, for example, decided to focus on substance abuse among adolescents by organizing a local conference and an awareness campaign in schools, churches, health agencies, and community organizations. The greater Quincy area is focusing on preventive health care for asthmatic youth and reducing school absenteeism rates due to asthma.

Health status indicators are now used in the contracting process by providers and by the department. Providers present specific indicators in their proposals to demonstrate need and to explain how their proposal fits into the planning process of their health network. (Because CHNAs are still in the developing stages, providers continue to contract directly with the department instead of submitting comprehensive community plans as a network.) The department, in turn, considers the information conveyed by health status indicators when making their allocation decisions.

The collection of health data has improved as a result of feedback from the community, either formally through the CHNAs or through mechanisms that predated them. For example, birth certificate data has been substantially expanded to collect information more helpful to local administrators and providers. This includes more detailed information on insurance coverage and type as well as specific information on the child's health condition at birth. The latter is particularly helpful for targeting early intervention efforts. Through the CHNAs, the department is continually learning which information local providers and health planners find particularly useful, and it will apply this feedback to future data-collection efforts.

In addition, CHNAs have begun to develop their own methods for collecting local data on key issues. In the Springfield area, for example, local youth and students at the University of Massachusetts School of Public Health at Amherst developed a youth survey to gather and analyze data on teens' knowledge of sexually transmitted diseases and on their sexual behavior. The impetus for this effort was the network area's high rate of STDs, nearly twice the rate of any other area in the state.

"Kids Count." Nearly every state has a data-monitoring project for indicators of child well-being, entitled "Kids Count," which is funded by the Annie E. Casey Foundation. Unique to only a handful of states, including Massachusetts, is the significant role of a public agency in this effort. Most of the "Kids Count" grantees are private, nonprofit organizations within each state; in Massachusetts, the

Massachusetts Committee for Children and Youth and the Massachusetts Advocacy Center share this role.

A major goal of each “Kids Count” project is to institutionalize the data-monitoring process. To accomplish this goal, the two children's organizations in Massachusetts turned to the Department of Public Health as their data partner in the “Kids Count” project. The department was very receptive to taking on this role because of its core function in monitoring child health and its staff's commitment to making information available to providers, community organizations, and citizens.

In 1994, the department received approximately \$50,000 from the Massachusetts Committee for Children and Youth and the Massachusetts Advocacy Center as a subcontractor on the project. Together, the three groups developed a list of indicators. The department then led the effort in compiling data from various state agencies to produce two volumes of data on children, *Massachusetts Children and Youth: A Status Report*. Volume 1 presents nearly 100 indicators for children and families at the state level and volume 2 presents over 30 indicators by each city and town as well as by CHNA, where possible.

The department clearly committed funds beyond the original one-time only award of \$50,000 and has an internal commitment to institutionalizing the reporting of child status indicators in the future. This will be accomplished in stages through MassCHIP (discussed below) and will include efforts to integrate data from other agencies, including the departments of Education and Social Services.

Massachusetts Comprehensive Assessment System (MCAS) and the School and School District Accountability System. In Massachusetts, local control of education has been the norm for many years, with the state's role in data collection limited to what was necessary for federal reporting requirements. This has changed, however, with the passage of Massachusetts' Education Reform Act of 1993. This legislation approved additional state funding of nearly \$1.3 billion for school finance over a seven-year period, for the purpose of equalizing spending among school districts. As is often the case, funding comes with accountability both when it is federal to state and state to local.

The Education Reform Act set in process the development of broad, statewide educational goals for all students, followed by development of curriculum frameworks in seven academic areas to assist teachers in providing standard knowledge and concepts, and culminating in the creation of a comprehensive assessment system to measure individual student, school, and district performance. The previous assessment system—the Massachusetts Educational Assessment Program—has been replaced by the Massachusetts Comprehensive Assessment System (MCAS). The most important effect of this change is that the new assessment system will produce individual student scores beyond just the school and school district performance information gathered under the old system.

All tests will be based on the new curriculum frameworks and will be administered in the 4th, 8th, and 10th grades. Students will be required to pass the 10th grade examination in order to graduate from high school. Schools will also offer a Certificate of Advanced Mastery that will be based on a combination of a student's scores on the MCAS exams, Advanced Placement tests, and the Scholastic Aptitude Test (SAT), as well as their GPA. Field testing of the system began in the spring of 1997 and will be fully phased-in by 1999. The actual performance standards for students have not yet been finalized but are expected to be high.

Results from the MCAS exams will be incorporated with additional measures of school performance to provide information for a school and school district accountability system. Through this system, school and district administrators and state-level policy makers will be able to track and assess the quality of educational programs across the state. Schools and districts that perform well will be able to use the system as a quality check from year to year in much the same way that the state uses the National Assessment of Educational Progress exams to assess its performance in comparison with other states. In addition, the Department of Education recently released for public comment proposed regulations regarding underperforming schools and school districts. Under the proposed regulations, a school or school district would be classified as underperforming based on one or more conditions of

below minimum academic performance of students, high dropout rates, low attendance rates, loss of accreditation, operational deficiencies, or noncompliance with state or federal laws. Underperforming schools would be subject to state intervention and control.

## II. AVAILABLE DATA SOURCES

### *Voluntary Federal Surveys*

Massachusetts Youth Risk Behavior Survey (YRBS). The YRBS is a biennial survey of students in grades 9–12, covering a variety of behaviors including tobacco, alcohol, and drug use; sexual behavior; dietary behavior; physical activity; and violence. The YRBS was developed by the Federal Centers for Disease Control and Prevention (CDC). In 1995, 39 states, 16 cities, and 4 U.S. possessions fielded the survey. A national survey is also fielded.

Massachusetts has participated in the survey since it was initiated in 1990. The survey was administered by the Department of Education's AIDS/HIV Prevention Program in 1990, 1993, and 1995. In 1995, 4,159 students in grades 9–12 from 59 randomly selected public high schools participated in the survey to produce a state representative sample of public school students. Reports of the results for all years are available from the department and survey results for the most recent year are available over the Internet.

The results from the Massachusetts YRBS survey have become especially useful with the increase in formal preventive health programs in schools as a result of the Health Protection Fund created by an excise tax on tobacco products in 1993. Monies available from this fund finance a health coordinator and a health advisory board in each school district. The final YRBS results are reported to every district to help them focus their health education programs, particularly those targeted at tobacco and AIDS prevention. The department also conducts four regional training sessions to discuss the major findings and assist district officials in interpreting the data. Districts are encouraged to conduct surveys

for their own needs assessments. The state YRBS serves as a guide in local survey development and provides the rationale for inclusion of specific and targeted questions.

National Assessment of Educational Progress (NAEP). The NAEP is an assessment of students in grades 4 and 8. Areas of assessment include math, reading, writing, and science. In 1996, some 44 states and the District of Columbia participated in the survey, and a national survey was also fielded, allowing for national comparisons and comparisons among states. Massachusetts participated in the state voluntary component of NAEP in 1992, 1994, and 1996 and plans to continue its participation in the future. In general, the results are used as a benchmark for the Department of Education to gauge how the state compares with others. Massachusetts' students have consistently performed well against other states; the goal within the state is to keep up such performance. The results are reported through briefings to the governor, the Board of Education, and the press.

#### *State Surveys*

Adolescent Tobacco Use in Massachusetts. Since 1984, the state has fielded this survey every three years to examine the prevalence of tobacco and other substance use among public school students across the state. With funding from the Tobacco Control Program, the Department of Public Health, in cooperation with the Department of Education, oversees the study, which is contracted out to a private research firm for administration. The fifth and most recent survey, completed between November 1996 and January 1997, included a representative sample of 6,844 students in grades 6–12 from 171 public schools in 90 communities. This was the first year in which 6th grade students were part of the sample.

Results are used to assess trends in tobacco use among students within the state, with the intention that such information will assist in designing effective smoking-prevention programs.

*Administrative Data\**

Massachusetts Community Health Information Profile (MassCHIP). MassCHIP is an information service developed by the MDPH which provides state and community-level data from 18 data sets covering vital statistics, communicable disease, sociodemographics, MDPH program utilization, and other focused health areas. The system was completed for internal departmental use in January 1997 and was made available on-line to public users in March 1997.

MassCHIP grew out of the DPH's long-held commitment to providing health data at the community level. Before it issued health status indicator and child status indicator ("Kids Count") reports in 1994 and 1995, respectively, the department produced community perinatal packets to coincide with the release of the state advanced birth and death data. These packets launched the department's effort to empower localities in their understanding and use of health data. The perinatal data packets began to have a domino effect, repeated later with the release of health status indicator reports and the "Kids Count" data. Demand for community-level data increased and requests for the reports from local health departments, private providers, and advocates mushroomed with each data release. The escalating demand served as the impetus in creating MassCHIP.

Development of the system began in the early 1990s when the department needed data warehousing technology. At that time, the Bureau of Family and Community Health received a three-year grant of \$150,000 from the Maternal and Child Health Bureau of the U.S. Department of Health and Human Services, and the Bureau of Health Statistics, Research and Evaluation, received a separate multiyear grant of \$50,000 from the Public Health Foundation. The bureaus decided to combine

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\*Administrative data systems that are mandated by the federal government and thus common to all states are not covered here. These include elements of the National Vital Statistics System (birth- and death-certificate data and various communicable-disease reporting systems); the Uniform Crime Report System; education data contained in the Common Core of Data System; and the mandatory reporting associated with various federal programs.

resources and these funds served as the seed money in launching MassCHIP. Since that time, the department has provided the largest balance of funding to complete the \$2 million effort.

MassCHIP has served to standardize the way data are collected and organized across databases within the department. Administrators believe that it has also improved data quality, the result of having more users and, in turn, greater scrutiny of the data. Most importantly, the system provides both broader access and technical support to data users. User support is largely automated: there are on-line help and trouble-shooter programs. A staffed help line is available, as are data specialists throughout the department who serve as contacts for specific data sets.

The system can issue both standard and custom reports. The standard reports, which pool pertinent data on a subject from all 18 databases, now include the Health Status Indicators, a perinatal health report, smoking and breast cancer reports, and two Healthy People 2000 objective reports, one on chronic disease and one on maternal and child health. A “Kids Count” standard report is currently under development. All of the standard reports can be specified by geographic level, including user-defined groupings of cities and towns, regional groupings such as CHNA or counties, and some specific neighborhoods in Boston, Springfield, and Lowell. The custom report options within each database are extensive, including choices of topic area, geographic area subgroups, and data elements.

Information from MassCHIP is used by administrators, health providers, and students. For example, data are used for research and policy analysis within the DPH, by local providers in their health planning and proposal processes, and by schools of public health to conduct assessments of community needs.

Department of Education’s Information Management System (DOE IMS). The Department of Education is in the process of creating a new information management system (DOE IMS) with approximately \$17 million in state funding. This new system will enable integration of individual

student, staff, school, and district data across separate information-collection systems. The department currently produces 50 stand-alone reports based on data submitted by schools and school districts.

Through the process of creating a new system, the department has come to appreciate that buy-in on data collection and dissemination efforts is critical from the local level to ensure use. To gain all the information requested of schools and districts and build the collaboration necessary to convert the system, the department is committed to providing information out of the system that will be structured for local use.

Population Estimates and Projections. The Massachusetts Department of Public Health has assumed responsibility for producing state population estimates. The department contracts with the Massachusetts Institute for Social and Economic Research (MISER) to generate population projections based on age, gender, and race for the mid-census years (e.g., 1995). Linear interpolations to produce estimates for the years between the census estimates and the MISER projections are calculated within the department by the Office of Statistics and Evaluation, Bureau of Family and Community Health, and the Research and Evaluation Division, Bureau of Health Statistics. In general, the department has determined that census projections underestimate the population of Massachusetts, particularly with regard to minority populations and older adolescents. Statewide and community estimates are produced for each gender in five-year age groups.

#### *Linking Administrative Data*

Family Net. The Department of Social Services is creating a new information management system, Family Net, that will include case practice and case management information on child abuse and neglect, foster care and adoption, as well as basic demographic information on clients. The system will be linked with other state departments including Revenue, Transitional Assistance, and Motor Vehicles to access information on such items as child support, food stamps, and welfare receipt for the children and families in the department's caseload.

The department anticipates that the launch of Family Net in August 1997 will provide a rich assessment tool for workers in helping clients, for supervisors in supporting workers, and for management in developing policy. Family Net, developed through a federal grant with a 75/25 matching rate of federal to state funds, will be the most advanced State Automated Child Welfare Information System (SACWIS) in the country.

Department of Revenue. The Child Support Enforcement Division of the Department of Revenue has led the effort to build an integrated administrative data system in Massachusetts. In the early 1990s, a researcher in the department initiated an ad hoc data-gathering expedition. With departmental support of \$10,000, a group of academics were gathered for a two-day strategic planning session to determine how to develop and fund an integrated database. With a plan in hand, the department applied for and received a grant of \$100,000 from the Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services to develop a data-warehousing system. The department itself then contributed an additional \$400,000 toward the effort.

The system now in place receives and links data from child support, wage reporting and tax, vital statistics, the registry of motor vehicles, the Department of Medical Assistance, and the Department of Transitional Assistance (including cash assistance and food stamps). The Department of Social Services has not provided data due to the current changes in its information system. Most of the data have a five-year history, with some data from the Department of Transitional Assistance extending back to 1990 or 1991. Data updates occur on a weekly or monthly basis. Interagency Service Agreements are currently in process to further solidify and ensure agency participation and provision of data over the long term.

These data will be used mainly for research. Consistent descriptive or monitoring uses of the data have not been considered at this time. A steering committee, made up of the heads of all the agencies involved, is being formed. In addition, a research committee, mostly academics, will review research proposals for uses of the data and make final access decisions.

### III. CONTENTS AND COVERAGE

Massachusetts is making great strides in organizing its social indicator data for use by local communities. MassCHIP provides easy and flexible access to a wide variety of local health data, and attempts are being made to incorporate data from the Department of Education and other state agencies. The Department of Education is designing its own information system that will provide similar levels of data access. In addition, departments are pursuing several administrative data linking efforts (described above) which will open up new possibilities for tracking well-being and for monitoring program performance.

Health statistics are the most highly developed and readily available social indicator data in Massachusetts. Through the Department of Public Health's annual statistical publications, including births, deaths, and adolescent births and the health status indicators, major infant and mother characteristics and prenatal care issues are extensively covered. The data have comprehensive geographic information, although there is limited information regarding child health issues such as immunizations and blood-lead levels for children up to age 5, depending on the topic. The Massachusetts Youth Risk Behavior Survey complements this health data with information for adolescents, though that capability does not extend below the state level.

At present, there are few social indicators relating to student educational performance beyond the National Assessment of Educational Progress, which does not provide data below the state level. Although the Massachusetts Comprehensive Assessment System will soon produce comparable estimates on educational performance for the state and all localities, the state does not appear to have the data to monitor early school readiness or to track youth after they finish high school.

Finally, like most states, Massachusetts is limited in its ability to track basic demographic and socioeconomic characteristics of children and their families between censuses. The state does produce annual estimates of the number of children by gender for five-year age groups for the state and for

communities. In addition, some state estimates can be produced using the U.S. Current Population Surveys, but not below the state level.

#### IV. ACCESSIBILITY

The Department of Public Health is the leader in both data coverage and accessibility.

- Most recent health data at the state, city, town, county, and CHNA level can be obtained from the department's World Wide Web site at: <http://www.magnet.state.ma.us/dph/>
- The department's data gem is MassCHIP. MassCHIP currently has no access charge, although a password must be obtained from the department to download the system from the World Wide Web. Subscription information for MassCHIP is also available from the site noted above.

Volumes 1 and 2 of the "Kids Count" report produced by the Department of Public Health are the most comprehensive statistical reports on children available from the state. The two volumes cover the demographics of children and families; economic indicators for children and families; prenatal, birth, and infant characteristics; child and adolescent health status and behavior; education; and selected support services. Volume 1 provides state-level information and volume 2 provides summary data by city and town. (For ordering information, see Appendix A.)

Although the data systems of the departments of Education and Social Service are not yet integrated, each department publishes valuable annual reports. From the Department of Education these include "Dropout Rates," "Plans of High School Graduates," and "Public School Exclusions," which present data by school and school district. "School District Profiles" provide summary information on community characteristics, enrollment, specialized programs, school finances, and results from the Massachusetts Educational Assessment Program. The Department of Social Services produces two annual statistical reports including "Child Maltreatment Statistics" and the "DSS Demographic Report on Consumer Populations." Child maltreatment statistics are presented by state, county, city, and DSS

geographic region. The demographic report covers caseload dynamics as well as family and child characteristics. (For ordering information, see Appendix A.)

- The Department of Education provides data for the state, school districts, and individual schools from the reports noted above through its publications Web site at:  
**<http://info.doe.mass.edu/doedocs/>**
- Data from the 1996 Massachusetts Educational Assessment Program are also available from this site; these data will be replaced when the new assessment system is in place.

## V. TRAINING TO USE AND DEVELOP DATA

The Department of Public Health provides extensive technical assistance and support to increase and improve the use of health data at the local level. In the 1980s, the department began outreach training with community perinatal packets. DPH staff used the community data reports in presentations meant to help familiarize local planners with the data.

This model was later extended to and expanded by the Health Status Indicator reports prepared for the CHNAs. These health status reports were presented in booklet form by CHNA, with a chapter devoted to using the data for setting priorities. In addition, training sessions covered basic concepts (when are rates more meaningful than percentages?) as well as more complex issues, such as how to standardize measures collected from other sources. As activities within the CHNAs have expanded, the department has made itself available for more advanced technical assistance with local data gathering techniques, including survey development and data analysis.

In their work with citizens, the nonprofit “Kids Count” partners parallel the DPH’s services to local health departments and private providers. Volume 2 of the Department of Public Health’s “Kids Count” component, described earlier, was the first effort at compiling comprehensive local information across departments and topic areas. The Massachusetts Committee for Children and Youth (MCCY) and the Massachusetts Advocacy Center (MAC), the nonprofit partners in the “Kids Count” project, wanted

to ensure citizen access to the valuable community indicator data to increase action on children's issues. Companion pieces to the state reports produced by MCCY and MAC were targeted to do just this by making the connection between data and action. Their reports present broad goals in the areas of child health, education, and family support and use the indicator data to illustrate where Massachusetts is in achieving these goals. Action plans accompany each goal to encourage local understanding of the issues and participation in bringing about suggested change. This approach removed the politics of advocacy from the state role in providing the data and yet allowed the advocacy organizations to highlight and act on an agenda for children.

## VI. CURRENT CHALLENGES AND PLANS FOR THE FUTURE

The key to having robust data that can enable systematic uses of indicators is a strong infrastructure for gathering and managing information. The departments of Public Health, Education, and Social Services are at different stages of developing such infrastructures but each mentioned this issue as a challenge within their particular context. The Department of Public Health, as the most advanced department in the process of building an infrastructure, sees that a greater role—both financially and technically—at the federal level would have enhanced their progress. Technical assistance at the front end in data development efforts would improve the consistency and uniformity that is important in enabling cross-state comparisons.

The departments of Education and Social Services face very different challenges. They are now ready to build new information management infrastructures that will greatly improve their data-gathering, integration, and reporting capacities. Their challenge is managing this change both within their departments and with their constituencies, be they providers or schools. With the knowledge that information gathered by the departments will have an impact on how either providers or schools are assessed, there is a tentativeness about the new systems that needs to be alleviated.

Plans for the future in Massachusetts are largely extensions of efforts already under way. The Department of Public Health is working to build alliances, particularly with Education and Social Services, to establish a child status indicator (“Kids Count”) report as a standard feature on MassCHIP. DPH representatives plan to make presentations to these and other state-level agencies to encourage contributions to the MassCHIP system as an easy way for departments to expand utilization of their data. The Department of Revenue's administrative data integration effort is also continuing its outreach to other departments and is planning to include DSS data when they become available.

**Minnesota**  
**State Statistical System and Indicators of Child Well-Being**

Minnesota's capacity and, perhaps, more importantly, commitment to produce indicators of child well-being has benefitted from two converging themes on Governor Arne H. Carlson's agenda: results-oriented government and a policy focus on children. Early in his administration, Governor Carlson launched the statewide goal-setting initiative, "Minnesota Milestones," which set the stage for an emphasis on the use of indicators as monitoring tools. At the same time, the governor established the Action for Children Commission, which produced recommendations leading to the creation of a Children's Cabinet, the reorganization of the state Children's Services to form the Department of Children, Families, and Learning, and the development of children's indicators.<sup>10</sup>

These initiatives were able to capitalize on an already-existing infrastructure that included a state-sponsored student survey and an on-line statistical information system. In essence, policy makers were able to draw on the strengths of the existing statistical structure to expand its capacity.

I. PROGRAMS RELATED TO SOCIAL INDICATORS

Minnesota Milestones. Minnesota Milestones was initiated by Governor Arne H. Carlson shortly after he took office in 1991 to involve citizens in identifying goals for the state and to focus state government action on accountability to the citizens in achieving these goals. With Oregon Benchmarks as a model, Carlson moved to tailor a goal-setting program reflective of the values of Minnesotans. At 45 public meetings held throughout the state, thousands of Minnesotans helped identify 5 main principles and 20 broad goals that formed the basis of a 30-year state plan.

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<sup>10</sup>The Department of Children, Families, and Learning was created on July 1, 1995. DCFL includes all functions formerly administered by the Department of Education and some children's services that were provided by the Department of Economic Security, the Department of Human Services, the Department of Corrections, the Department of Public Safety, and the Minnesota Planning Agency.

Indicators were selected to help monitor progress toward milestones (or targets) that were set to quantify each of the 20 goals. Teams of experts within government and academia selected the specific indicators on the basis of objectivity, reliability over time, and ease of understanding. Although data availability was a consideration, they did not limit the choice of indicators to readily available data. A component of the Milestones effort is to improve measurement of results and outcomes; therefore, data needs are cited in Milestones reports with recommendations for data collection. The indicators for which data were not available decreased from 27 in the 1992 report to approximately 20 by the 1996 update, due to data collection enhancements.

Of the 20 goals, 3 are directly targeted toward children, including (1) children will not live in poverty; (2) families will provide a stable environment for their children; and, (3) all children will come to school ready to learn. Other goals are inclusive of broader populations but have specific indicators focused on children. For example, the goal “Minnesotans will be healthy,” includes the infant mortality rate, percentage of low birth-weight babies, and the percentage of children who are adequately immunized among the 5 indicators monitoring progress toward this goal.

The first Minnesota Milestones report, released in 1992, presents the 20 long-range goals and 79 accompanying indicators. For each indicator, data are presented (where available) from 1980 for a historical perspective, with 1990 as the baseline, along with targets—or milestones—to achieve by 1995, 2000, 2010, and 2020. Each measure has a rationale for its relevance and a discussion of its importance, as well as information about the data source. Progress reports were released in 1993 and 1996. These follow-ups “grade” trends for specific goals as either positive or negative according to the group of indicators that monitor the progress of that goal. To be considered a positive trend, at least half of the goal’s indicators must be moving toward the milestone, as measured from the base year of 1990.

Minnesota Milestones is managed by the state planning agency, Minnesota Planning. This office is responsible for gathering and integrating the necessary data from various state agencies to update

indicators and to produce the Milestones progress reports. Because the Milestones initiative is integrated into the mission and role of the agency, making a direct cost assessment of the project is difficult.

The emphasis of Minnesota Milestones is to focus on results and outcomes within the state. Although government cannot be solely responsible for the direct achievement of each goal, the Milestones initiative does serve to create an environment of a government accountable to the people. In its initial 1992 Milestones report, Minnesota Planning recommends that the state government become more results-oriented, link spending with results, refocus data collection on assessing outcomes, and assume monitoring responsibility toward the established milestones.

The Milestones reports are intended to be used by state agencies as tools for establishing priorities. It remains unclear just how much of the benchmarking approach has been adopted by state agencies. State legislation was passed in 1993, however, requiring agencies to develop performance measures based on outcomes that would support, and potentially justify, their budget requests. Only statewide measures are presented in the Milestones reports, limiting use at the local level to agenda-setting.

Children's Services Report Cards. Children's Services Report Cards are an outgrowth of Minnesota Milestones which focus on monitoring the progress of goals relating to social and educational services for children at the county level. The report cards consist of 21 indicators that present data on child well-being from birth to age 18, ranging from the infant mortality rate, to children on AFDC, to the percentage of students who perform volunteer work or community service. Eleven of the indicators are taken from the Minnesota Student Survey (discussed below) and 10 are provided by various state agencies, including the departments of Health, Human Services, and Children, Families, and Learning. The report cards were first released in 1994 and updated in 1996. Minnesota Planning's 1996 update includes data for the state as a whole for 1994 and 1996 to show the direction of movement on each indicator. County rankings are presented for 12 highlighted indicators.

The report cards were first developed to assist the then newly created Family Service Collaboratives (1993) in their community planning processes, which were required to compete for state funding. The collaboratives, each made up of a school district, county government, and public health agency, were established to assess needs and to restructure services to better address perceived gaps in children's and family services in the community. Although a competitive process for funding no longer exists, the current 50 collaboratives—whose services cover 80 percent of all children in the state—still rely heavily on the report cards to monitor progress and to continually reassess community needs.

The report cards also serve broader functions. Advocates and providers use the county-level indicators to convince county boards to support specific programs; nonprofit service providers use the indicators to support grant applications to foundations; and county boards can use the report cards to redirect some county resources.

The most striking use of the report cards has been as descriptors. In the two months after the release of the first report card, more than 60 news articles reported the data in the state's newspapers. In Cass County, which had the lowest ranking in many of the areas covered by the report cards, one goal was to increase public awareness and improve public understanding of the need to address children's issues. The family services collaborative in Cass County used the indicators to convince local papers that articles on the well-being of the county's children were a vital first step in garnering public support.

Minnesota Public Health Goals. For 30 years, Minnesota's Regional Coordinating Boards have engaged in a planning process to identify and/or reassess public health goals. Every four years, each coordinating board, of which most are countywide, assesses local health needs and develops health plans to address them. Community members and health providers participate in this process through public forums and meetings. County-level data from the Department of Health's annual statistical report serve as the foundation for making community health decisions.

In 1994, the MDH took the process one step further by identifying and publishing statewide public health goals for the first time. Information gathered through the local planning processes was assessed with the national Healthy People 2000 goals, as well as with Minnesota Milestones, to develop 17 statewide public health goals. Similar to the Milestones format, each goal has objectives that can, in most cases, be measured by readily available data and that have targets to achieve by the year 2000. A statewide goals report will be published every four years, with the next one due for release in October 1998. Biennial interim reports will provide data updates and describe progress toward the identified goals. Monitoring of goals is already conducted every two years at the local level.

Many of the data are provided through the Minnesota Center for Health Statistics, the Minnesota Student Survey, and the Behavior Risk Factor Surveillance System. Some objectives are presented without data to emphasize the need for data collection in these areas. For example, there are no measures of school-aged health and developmental outcomes for children within the low birth-weight categories nor is there information on the prevalence of mental disorders among children and adolescents under age 18.

Three of the state's 17 public health goals come under the heading "Health System Development Goals" and include objectives to improve data collection, integration, and dissemination. The second of these goals—"Improve the effectiveness and efficiency of Minnesota's public health infrastructure"—includes objectives for establishing a set of health status indicators for monitoring the health of Minnesota citizens and for developing data collection methods to measure both health status indicators and year 2000 health objectives.

Graduation Standards. Minnesota's version of the national Education 2000 goals—Minnesota 2000—was the guiding force that led to the development of Graduation Standards. In 1989, the State Board of Education directed the Department of Education (now part of the Department of Children, Families, and Learning) to develop graduation requirements for all students which would clearly define

what students would be expected to know in order to graduate from high school. Full force was added to this directive in 1993 when the state legislature passed a law requiring the development of results-oriented graduation standards. School district staff and administrators must now participate in eight days of training on the graduation standards and submit a plan for implementation of the standards within their district curriculum in order to access federal Goals 2000 funding from the state.

The state's role is to define the targets and basic requirements for graduation. The graduation standards do not mandate a specific curriculum or teaching method nor does the state prescribe one single assessment test. Districts have the flexibility to develop their own assessment tests that measure student performance by the basic standards set by the state.

The basic standards for math and reading became effective April 1, 1996, meaning that every student who entered the 9th grade in the 1996–97 academic year must pass these tests in order to graduate from high school. Basic standards for the writing exam are expected to become effective in 1997 so that all students entering 9th grade in the 1997–98 academic year will also need to pass this exam to graduate. Passing scores in both reading and math are set at 70 percent for students entering the ninth grade in 1996 and increase by five percentage points each subsequent academic year until 1998–99. Beginning in 1998, passing scores will be set at 80 percent in both subject areas. Although there have been discussions of an accountability measure for schools and districts which would be tied to state funding, no such policy has been formulated.

Although this assessment system establishes basic standards for graduation, it does not lend itself to the collection of student performance data that can be compared across schools or districts. First, in the absence of one state test, comparability between districts using different assessment tools will be limited. However, the state legislature is expected to require the administration of the same test statewide in order to permanently establish a common base of comparison. Second, schools decide when to administer the tests. The state does set parameters on when the tests can be administered to students for the first time,

ranging from the spring of the 8th grade to the fall of the 10th grade. The varied timing of the tests is likely to loom as a larger issue regarding the comparability of results.

Even in the absence of comparable data, schools and districts can use the information on student performance to improve their own systems. Some schools have already begun remedial programs to assist students who did not receive passing scores. The Department of Children, Families, and Learning encourages schools to consider broader systemic changes if a large number are failing to pass the basic standards.

## II. AVAILABLE DATA SOURCES

### *Voluntary Federal Surveys*

National Assessment of Educational Progress (NAEP). The NAEP is an assessment of children in grades 4 and 8. Areas of assessment include math, reading, writing, and science. In 1996, some 44 states and the District of Columbia participated in the survey, and a national survey was also fielded, allowing for national comparisons and comparisons among states. Minnesota has participated in the state voluntary component of this nationally administered survey since its inception in 1990. Tests in selected subject areas were conducted in 1990, 1992, 1994, and 1996. Results from the exams are distributed primarily through the Department of Children, Families, and Learning's Best Practices Networks and are used on an informational basis but not as formal benchmarking.

### *State Surveys*

Minnesota Student Survey. The Department of Education initiated the Minnesota Student Survey in 1989 in an effort to ensure a greater degree of accountability by school district for the health and social well-being of children. At the time, the University of Minnesota Adolescent Health Survey fulfilled some of the state's data needs, but administrators within both the departments of Education (now the

Department of Children, Families, and Learning) and Health wanted more detailed information on the behaviors and activities of youth.

Existing instruments, particularly the Adolescent Health Survey and an asset-building survey of the Search Institute, informed the development of the new survey.<sup>11</sup> The Minnesota Student Survey asks about volunteerism, sexual activity, and use of cigarettes, alcohol, and drugs. The survey is administered every three years to public school students in the 6th, 9th, and 12th grades. Participation by school districts is voluntary, but in each year of administration at least 90 percent of all districts have participated. Parents are informed in advance about the survey, and the parent or the student has the option to decline participation. In 1995, the most recent survey year, 133,000 public school students participated in the survey. In 1996, a survey was administered in alternative schools and area learning centers to collect information on youth not in the public school system.

State funds from the Department of Children, Families, and Learning cover all costs for the survey design, data analysis, and dissemination of results, which amounts to approximately \$1.00 per student (\$150,000 in 1995). Each participating school district receives results for the state as well as their district.

The Minnesota Student Survey is fully enumerated, which ensures a large sample of student participants. These large sample sizes allow the state to conduct small-area analyses of the data by counties and school districts (although results by school district are restricted for school use only). This is the most significant advantage of the state survey over the state voluntary component of the national Youth Risk Behavior Survey (YRBS), which covers many of the same issues. The disadvantage is that data from the Minnesota Student Survey are not comparable to the YRBS's national or state-level data.

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<sup>11</sup>The Search Institute is an independent, nonprofit organization based in Minneapolis ; it promotes the well-being of children and adolescents through research and evaluation. The institute's survey Profiles of Student Life can be used by states and localities to assess the health and well-being of middle- and high-school age youth. The survey collects information on developmental assets, including external assets such as networks of support and available opportunities that nurture positive development, and internal assets reflected through the commitments, values, and competencies of participating youth.

Beginning with the 1992 Student Survey, however, data for 12th grade students were designed to be comparable to results from the University of Michigan's national Monitoring the Future Study, with some caveats regarding sample size and Minnesota's exclusion of nonpublic school students.<sup>12</sup>

Survey results can be used by school districts and counties in developing prevention and intervention programs targeted at youth, as well as youth development activities. In addition, data collected from the survey account for 11 indicators in the Children's Services Report Cards as well as a number of the Minnesota Milestones.

Minnesota Crime Survey. This state survey was developed to gather information on Minnesotans' feelings and perceptions of safety in their neighborhoods and schools to measure progress toward the Milestones goal of "Creating safe, friendly and caring communities." The crime survey is the most significant data collection development to emerge from the Minnesota Milestones initiative.

Minnesota Planning administered the survey in 1993 and 1996 and plans to continue the statewide survey every three years. In 1993, 6,029 Minnesota residents age 15 and older participated in the survey and 1,295 participated in 1996. Because of the small sample sizes, subgroup analyses are limited; although some data are presented by age group, gender, and type of community (with a higher margin of error). Data available on 15–24-year-olds includes the percentage that responded "yes" to having a fear of walking alone at night and the percentage that reported that they were victims of crime, violent crime, and/or property crime.

The advantage of the small sample sizes is the correspondingly low cost. In 1996, the survey was funded through a combination of federal and state funds for a total cost of just under \$10,000.

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<sup>12</sup>The Monitoring the Future Study, conducted annually since 1975, gathers information on the prevalence and incidence of illicit drug use of high school seniors. In addition, it contains questions designed to describe changes in many important values, behaviors, and life-style orientations of American youth. This is a national survey of high school seniors in approximately 125 public and private schools with final sample sizes that are generally between 16,000 and 17,000. Funding is provided by the National Institute on Drug Abuse. (Smaller samples of 8th and 10th grade students were added in 1991.)

*Administrative Data\**

DATANET. DATANET was created in 1983 to serve as a central location for commonly used statistical information produced by state agencies. Its goals are to “(1) prevent repetitive data processing, (2) reduce the time and cost to access data, (3) promote sharing and integration of data among agencies, (4) enhance the value of the data electronically, and (5) provide governmental agencies, decision-makers, and the public with the summary information to use in planning and decision-making.” The Land Management Center of Minnesota Planning administers DATANET.

Initially, the system included only demographic and natural resource data. With financial assistance from a revolving fund of state monies, other agencies were able to contribute their data modules to the system. Up to 15 different state agencies—including Health, Human Services, Economic Security, Public Safety, and the State Demographer’s Office—participate in DATANET. Twenty databases are now available through the system; the most recent addition is the Children’s Services Report Card, one of the few databases on DATANET that is integrated by Minnesota Planning from multiple agency sources. Of particular interest for measures of child well-being are the Substance Abuse Monitoring System, School District Profiles, and Children’s Services Report Cards.

The databases within DATANET function independently, as it is not a fully relational database. Users are asked questions when they begin which direct them to the most relevant database. Once a user has entered one of the databases, he or she can customize a number of basic computations, such as choosing a geographic unit and calculating percentage changes in the data from year to year. Although users cannot create customized reports that include data across databases, DATANET staff have developed many report options based on the demand for custom reports.

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\*Administrative data systems that are mandated by the federal government and thus common to all states are not covered here. These include elements of the National Vital Statistics System (birth- and death-certificate data and various communicable-disease reporting systems); the Uniform Crime Report System; education data contained in the Common Core of Data System; and the mandatory reporting associated with various federal programs.

All data are available by county. Smaller geographic breakdowns vary depending on the database, but include school district, census tract, and zip code. Some databases supply data prior to 1990. The Children's Services Report Cards presents data from 1991 to 1994; the Substance Abuse Monitoring System presents data from 1991 to 1993. Most databases are now updated annually.

The Land Management Information Center, a leader in the development and use of Geographic Information Systems (GIS), has made DATANET fully compatible with mapping software. Because mapping capabilities are not built into the DATANET system, additional GIS software is necessary for the spatial display of the data. A subscription to DATANET is free to all Minnesota government organizations, libraries, schools, and nonprofit groups; DATANET Plus Mapping software is available for \$500.

There is no active effort to add new data modules at this time. Agencies now approach Minnesota Planning for inclusion in DATANET and decisions are based on the geographic coverage of the data, consistency of updates, and applicability to a large audience of users. State agencies are asked to contribute funding to cover the costs of adding new information to the system, but, with the infrastructure in place, these costs are minimal. DATANET staff are currently working with the Department of Health on the newest addition to the system, Minnesota Health Profiles.

Population Estimates and Projections. The Office of the State Demographer produces estimates of the total state population and number of households by county, city, and township predominantly for the purposes of allocating state aid. The state relies on the U.S. Census Bureau for age-specific estimates.

#### *Linking Administrative Data*

Social Services Information System (SSIS). The Department of Human Services is working to enhance this computer-based system beyond the collection of child abuse and neglect data into a dynamic and efficient case-management system for case workers and program managers. The system, still being refined, is currently in use in 67 of the state's 83 counties. Future plans for the SSIS include building

interfaces with other divisions and state departments to access data on public assistance and use of other public programs by child-welfare clients. Access issues are also being examined with the goal of making information from the system available to both the Family Services Collaboratives and Children's Mental Health Collaboratives for use in their local planning efforts.

Children's Integrated Database. Early reports of the Action for Children Commission (1992) recommended the creation of an integrated children's database. State legislation was passed to put more force behind these recommendations and the Children's Services Redesign Committee was formed with a goal of developing this integrated system. But with little funding and no clear demand for such a system, the concept faded. Some policy makers believed that the move to consolidate children's programs in the new Department of Children, Families, and Learning would serve the purpose of integrating information on children. An integrated database continues to have potential, given that the department has an individual-student record system that can be expanded. At this time, however, the department is in a period of transition, and data integration is not a high priority.

### III. CONTENTS AND COVERAGE

Through the Minnesota Milestones initiative, the state is building its capacity to gather state-level information across topic areas. DATANET, with its requirements for data at the county level and for smaller geographic areas where possible, is a plentiful data source that covers varied topic areas. The state has made significant progress in recent years, specifically in the area of child well-being. Through the Minnesota Student Survey, the state has cultivated a rich source of information on the health and behaviors of public school students that allows for small-area analysis. The Children's Services Report Card integrates information from this survey with vital statistics and service-receipt data from other departments to provide the most comprehensive picture of the well-being of children at the state and county levels.

Health and education data, however, are only now being more broadly developed. The Department of Health is working toward on-line access of county health profiles containing vital statistics data. Through the Graduation Standards, the Department of Children, Families, and Learning is improving student and school performance data, but it remains to be seen whether this data will be comparable across districts.

#### IV. ACCESSIBILITY

Minnesota Planning's World Wide Web site provides the most extensive access to data on the state's children and families. The full publications listing can be found at their home page:

**<http://www.mnplan.state.mn.us>**

- Minnesota Milestones progress reports presenting state data (where available) on 79 indicators can be downloaded from Minnesota Planning's Web site. The 1996 report of the Minnesota Crime Survey results can also be downloaded from this site.
- State and county-level data from the Children's Services Report Cards, with mapping capabilities to visualize the county distribution of each measure, can be accessed on-line through DATANET's Web page. Additional information on DATANET and an on-line registration are also available from this site at: **<http://www.Lmic.state.mn.us/dnet/datanet.htm>**
- Annual demographic estimates, including racial populations by age (from the U.S. Census) and population and household estimates by county, city, and township (produced by the state), can be accessed at: **<http://www.mnplan.state.mn.us/demography/index.html>**

The Department of Children, Families, and Learning also has a World Wide Web site from which departmental reports and data can be accessed: **<http://www.educ.state.mn.us/>**

- District Profiles present the percentage of students with passing scores on the basic standards exams in both reading and math, by 8th grade and for combined grades 9–12 (1996 and 1997), as well as additional comparison items including the percentage of students with limited English proficiency, those enrolled in special education, those who receive free or reduced lunches, and those who receive AFDC. Enrollment figures and per pupil expenditure are also reported. Only those districts that made use of the state test are reported.  
**<http://children.state.mn.us/grad/results.htm>**

- Additional DCFL reports such as “Dangerous Weapons in Minnesota Schools (1995–96)” are available from the publications and resources page of the Web site at:  
**<http://www.educ.state.mn.us/pub&res.htm>**

Minnesota Goals 2000 reports and results from the Minnesota Student Survey will be available from this site in the future.

These and other reports containing social indicator data are available as publications from the appropriate agency. (See the appendices for contact and order information.)

## V. TRAINING TO USE AND DEVELOP DATA

DATANET staff provide technical assistance in database development to state agencies; counties receive technical assistance only for the development of GIS systems. Most of these efforts have focused on environmental analysis, but attention is now shifting to socioeconomic analyses.

Each department offers technical assistance relevant to lower levels of government. For example, the Department of Health advises Regional Coordinating Boards on the use and interpretation of county-level data as part of the public health goals planning process. The Department of Children, Families, and Learning also provides training for local school districts on the implementation of graduation standards through a program known as the Minnesota Educational Effectiveness Program (MEEP).

Perhaps the most innovative training in the development and use of data from the state to the local level originates in the Department of Human Services. Beginning in 1993, the Community Services Division of the Department of Human Services made a conscious choice to change the focus of the activity within the division from that of a top-down process approach to a bottom-up approach focused on the outcomes of services. Each year county human service departments are required to submit service plans to the state department. For the 1994–95 planning year, the department changed its role in this planning process: it has shifted from monitoring compliance with state policy to encouraging local departments to set their own goals based on client outcomes. To enhance the process, the Community

Services Division developed a guidebook for local planners which provides a framework for developing and using client-focused outcomes. In addition, the division will provide staff for on-site training and to facilitate decision-making sessions. The movement toward results-oriented outcomes continues to build as local data gathering and data applications have improved. In the long term, although consistency at the state level and across counties may be sacrificed, this effort could improve the breadth and depth of available county-level indicators.

## VI. CURRENT CHALLENGES AND PLANS FOR THE FUTURE

Initiatives such as the Minnesota Student Survey, DATANET, and Minnesota Milestones are the backbone of Minnesota's strong framework for gathering, using, and disseminating indicators of child well-being. The challenge for Minnesota is to maintain the momentum to build on these strengths.

The scheduled 1997 Minnesota Milestones update will entail a full-scale revision of each indicator: each will be reassessed for its continued relevance and reliability in measuring progress toward the state's intended goals. But the future of Minnesota Milestones could be precarious, unless it gains the legislative support that will ensure its use as a state planning tool in years to come. Like Oregon Benchmarks, Minnesota Milestones was launched at the governor's initiative. It remains to be seen whether the Minnesota model can continue to prosper, as Oregon Benchmarks has, beyond its originator's administration, which will end in 1998.

There is still a lot to do to coordinate and integrate data from different departments. Minnesota Milestones has successfully set an environment for a focus on results statewide, and the departments with an emphasis on children appear successful in their efforts to support and cultivate the use of indicators at the local level. Minnesota's next step toward an optimal statistical system to support child indicators is increased data sharing and integration among state departments. The infrastructure, in part, exists through DATANET to accomplish this task although data links between the databases in the system are limited at

this time. A policy initiative to broaden DATANET's capacity does not exist; databases are added on an ad hoc basis as departments perceive a demand for their data. Some state administrators felt that this was indeed an advantage in that turfism is avoided as no division or department is "forced" to provide their data.

Perhaps the greatest challenge in states like Minnesota, where county governments are strong, is to transcend the tension that exists between standardization and individualization of service delivery and data collection. For example, it was only in 1994 that the Department of Health developed statewide Public Health Goals that built on the community-planning processes which have been in place for years. Graduation standards also reflect this tension: the state sets standards, but districts decide how to achieve and, more importantly, test these standards. This tension is, perhaps, strongest in the Department of Human Services, where the emphasis on outcomes and the visibility of welfare reform are forcing the department to increase accountability. But, accountability in human services often relies on soft measures that, when set by top-level administrators, can threaten local service providers. The department's approach to outcomes decided at the county level is an effort to build shared accountability, which may be at the sacrifice of standardized indicators.

The most obvious plans for the future emanate from the Department of Health. The department is moving to add Minnesota Health Profiles to DATANET, further increasing data access for local departments, community planners, and citizens. As discussed above, the department has included data collection and analysis goals as part of the statewide public health goals document and is developing health status indicators to improve information on the health of Minnesotans.

## **Oregon State Statistical System and Indicators of Child Well-Being**

Since 1989 the state of Oregon has put substantial energy into reorganizing government activities at all levels to take a more comprehensive and goals-oriented approach to service design and delivery. The Oregon Progress Board has identified key *benchmarks* of child and family well-being, has specified goals related to those measures, and has developed new sources of data to track progress toward those goals where necessary. The Oregon Commission on Children and Families (OCCF), created in 1993, helps state agencies and local communities incorporate these benchmarks into their planning and assessment activities. The Oregon Option facilitates work across agencies and across levels of government in ways designed to enhance Oregon's capacity to meet its social goals.

Since its inception in 1989, the Progress Board has been instrumental in developing the state's capacity to measure and track its benchmarks at the state and local levels. As a result, Oregon has perhaps the most comprehensive system of social indicator data of any state in the country. The state has used many complementary strategies in developing this system. These include taking full advantage of federally organized state social surveys, designing and fielding its own surveys, and enhancing its administrative data capacities.

Both the OCCF and the Oregon Option have been training local community leaders and planning staff to understand and use social indicator data, and how to incorporate it successfully into service planning and community development.

### **I. PROGRAMS RELATED TO SOCIAL INDICATORS**

Oregon Benchmarks. The Oregon Benchmarks initiative is a comprehensive attempt to organize the activities of Oregon's state and local governments and the wider community around a shared vision of the future. Related to this shared vision is a broad collection of measurable indicators: as many as 259

in the original program, recently revised to 92. Of these 92, 20 are directly related to child well-being. Specific goals are set for each indicator, and progress toward that goal is monitored on a regular basis. State and local agencies are expected to organize their own programs and budgets around benchmarks relevant to their mission, and to develop performance measures directly linking their activities to progress in meeting the benchmark goals. To date, most state agencies and many local governments have incorporated the monitoring and goals-setting functions in their planning and monitoring activities. A high priority for the Oregon Benchmarks initiative is the development and use of performance-related indicators for accountability purposes.

The common vision underlying the Benchmarks initiative was first laid out in 1989. *Oregon Shines*, the report of a task force of over 150 persons appointed by Governor Goldschmidt, identified three broad goals for the state: a superior workforce, an attractive quality of life, and an international frame of mind. The Oregon Progress Board was established that year to develop these goals. The board was to identify activities, identify and develop indicators for tracking progress, and issue regular reports to the public. Over time the board identified 259 indicators related to the components of the original vision; it then developed new measures and new data sources (e.g., The Oregon Population Survey), when existing data sources were inadequate and now produces a comprehensive biennial report, "Oregon Benchmarks."

In 1996, Governor Kitzhaber appointed a new task force to work with the Oregon Progress Board to update the Benchmarks and their underlying vision, in light of changed circumstances within the state and of what had been accomplished. This task force, after consulting with hundreds of business and civic leaders around the state, presented a revised plan that is more directly concerned with the well-being of families and communities, and with healthy, sustainable surroundings. In addition, it cut the number of benchmarks to 92 and created a developmental list of additional benchmarks for which adequate data must be developed within two years or the benchmark will be dropped. Further, the Oregon Progress

Board is now charged with developing local measures for all benchmarks by the year 2002, and with developing a system or model demonstrating how the dimensions of well-being represented by the various benchmarks affect each other. (For more details, see “Oregon Shines II: Updating Oregon’s Strategic Plan.”)

Several organizations have been developed to help state agencies and communities incorporate benchmarks into program planning and monitoring. Three are of particular relevance to the well-being of children and their families: the Oregon Commission on Children and Families, the Oregon Option, and the Community Partnership Team. The Oregon Commission on Children and Families (OCCF) was created in 1993 to encourage comprehensive planning at the local level, with an emphasis on integrated service provision and accountability based on outcomes for children. The OCCF established local commissions in each of the state’s 36 counties. These local commissions are made up primarily of lay citizens. The local commissions focus on 11 common indicators of child well-being, plus other indicators that each may choose to pursue in its own county strategic plan. Local OCCF funds can be used to support new programs and to better integrate existing programs supporting children and their families. Local commissions that are not meeting expected goals are given additional technical support by the state OCCF, but are not as yet subject to funding reductions for failure to perform.

The Oregon Option was established in 1994 to break down barriers and facilitate cooperation between levels of government (federal-state, state-local) and across agencies within the same level of government, and to promote an outcomes-based approach to planning. The Oregon Option has operated in large part by developing workforce clusters in specific areas including child health, the workforce, family stability, juvenile justice, and natural resources. Each cluster draws its members from federal, state, and local agencies. The child health cluster has focused on a broad goal of having all Oregon children enter kindergarten ready to learn, and it has adopted 9 benchmarks related to early child health. It has produced a GIS-based data system to easily track trends in these indicators in every county, has

held regional workshops on the use of such data, and is working closely with local agencies and private organizations in several counties to further develop local data capacities.

The Community Partnership Team is a multi-agency group within the Oregon Department of Human Resources which has the task of better integrating benchmarks into the planning and evaluation efforts of the member agencies at the state and local levels. Relevant issues include budgeting to meet benchmarks, developing agency-specific performance measures related to the benchmarks, and developing the data to track these measures.

The Oregon State Assessment Program. This is a statewide assessment program for public school students. Students are tested in mathematics, reading, and writing, and on a rotating basis in language arts, health, physical education, and science. Testing is done in grades three, five, eight, and eleven.

From 1991 through 1995 these assessments were used primarily for program evaluation and public information, with average scores for each school and school district reported in published reports and over the Internet. Starting in 1996, however, the program focus has shifted from program assessment to individual student assessment. The Department of Education is developing new tests geared for the attainment of Certificates of Initial and Advanced Mastery. The Certificate of Initial Mastery (CIM) will cover 11 academic areas: to attain a CIM, students must demonstrate basic mastery in 9 of 11 areas around the 10th grade. Exams for earlier grades are to be redesigned to track progress toward developing the knowledge and skills necessary to pass the CIM.

Test averages will still be produced for schools and school districts, and will be the basis for targeting technical assistance by the state Department of Education, though relatively more of the department's attention will be given to individual students, rather than to school systems. In addition, these measures have been incorporated into the Oregon Benchmarks program, as will the percentage of students who attain the CIM. Plans are to make such information available around 1999.

Healthy Oregonians 2000. This program was founded in 1989, but was absorbed into the larger Benchmarks effort and ceased to operate as a separate entity. Partly in response to the elimination of some health indicators from the recently revised and reduced Benchmarks, a new Healthy Oregonians 2010 program will be initiated. Current plans are to use the Oregon Option Health Cluster as the forum for training and for disseminating data related to health goals adopted under the new program.

## II. AVAILABLE DATA SOURCES

Since 1990 Oregon has worked hard to develop its data capacities to track child and family well-being at the state and local levels. The state has adopted many strategies to develop its data capacity, including participation in voluntary federal data programs, fielding surveys, developing new administrative data sources, and linking administrative databases.

### *Voluntary Federal Surveys*

Youth Risk Behavior Survey (YRBS). The YRBS is a biennial survey of students in grades 9–12, covering a variety of behaviors, including tobacco, alcohol, and drug use; sexual behavior; dietary behavior; physical activity; and violence. The YRBS was developed by the Federal Centers for Disease Control and Prevention. In 1995, 39 states, 16 cities, and 4 U.S. possessions fielded the survey. A national survey is also fielded.

The YRBS has been fielded in Oregon every other year since 1991. In 1995 nearly 14,000 students in grades 9–12 were surveyed from 50 public schools. The resulting data were not representative at the state level, but were representative for many, though not all, of the participating schools. This lack of representativeness at the state level limits use of the YRBS for tracking trends in meeting state benchmark goals. The survey was paid for with a combination of federal and state monies.

Public School Drug Use Survey (PSDUS). Oregon's Office of Alcohol and Drug Abuse Programs has fielded the PSDUS on a biennial basis since 1986. The 1996 survey included over 10,500 children in grades 6, 8, and 11. The survey provides representative estimates at the state level, and for each of five geographic regions within the state. Many of the measures, which focus on drug use, perceived risks associated with drug use, and family and peer influences, are comparable to those in the national Monitoring the Future Survey,<sup>13</sup> allowing for national comparisons. The survey costs approximately \$90,000 to produce.<sup>14</sup>

National Assessment of Educational Progress (NAEP). The NAEP is an assessment of children in grades 4 and 8. Areas of assessment include math, reading, writing, and science. Oregon participated in the 1990 mathematics assessment for 8th graders, and in the 1996 mathematics assessment for both 4th and 8th graders. Estimates are representative at the state level, but cannot be produced below the state level. In 1996, some 44 states and the District of Columbia participated in the survey, and a national survey was also fielded, allowing for national comparisons and comparisons among states. In 1996, it cost between \$100,000 and \$150,000 to field the NAEP in Oregon.<sup>15</sup> It is unclear whether Oregon will participate in the NAEP in 1998.

Third International Mathematics and Science Survey (TIMSS). The International Association for the Evaluation of Educational Achievement has organized these math and science assessments, which are being fielded in some 45 countries and in several states, including Oregon. Oregon is fielding the assessments in 1997 to a sample of several thousand 8th graders in 58 schools. Participation in the survey

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<sup>13</sup>The Monitoring the Future Survey has been fielded on an annual basis since 1975 by the Institute for Social Research, University of Michigan, with funds from the National Institute on Drug Abuse (NIDA).

<sup>14</sup>Personal communication from Clint Goff, Senior Researcher, Oregon Office of Alcohol and Drug Use Programs.

<sup>15</sup>Personal communication with Barbara Wolfe, Assessment Coordinator, Office of Assessment and Evaluation, Oregon Department of Education.

reflects Benchmark goals to produce an internationally competitive workforce. The cost of the survey to Oregon is approximately \$100,000.<sup>16</sup>

### *State Surveys*

The Oregon Population Survey. This general-purpose survey has been fielded biennially since 1990. It is intended to supply the state with the means for tracking a variety of state population characteristics between decennial censuses. Where possible, questions have been taken directly from the federal decennial census and Current Population Survey instruments, allowing for national comparisons. The survey covers basic information on household and family composition, employment, education, migration, income, expenditures, and disabilities. In addition, questions are asked regarding library use, language proficiency, and lottery participation. In 1996 a special supplemental survey was fielded that asked questions about computer ownership and connection to information services, worker skill and safety training, and levels of satisfaction within the state and the home community. An earlier supplemental study asked opinions on a variety of public issues (e.g., controlling drug use and providing public parks).

The survey is conducted by telephone. In 1996 over 5,000 households were interviewed, with special oversamples for African-American, Asian-American, American Indian, and Hispanic households. The survey provides estimates, for the state and for each of 8 regions, of the noninstitutionalized population who have telephones.<sup>17</sup> Future surveys may offer to field samples that would support city or community-level estimates at a cost to those localities. The survey is sponsored by 18 state agencies, and in 1996 cost approximately \$200,000.<sup>18</sup>

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<sup>16</sup>Personal communication with Barbara Wolfe, Assessment Coordinator, Office of Assessment and Evaluation, Oregon Department of Education.

<sup>17</sup>Approximately 95 percent of all Oregon households had telephone service in 1990.

<sup>18</sup>Personal communication with Deirdre Molander, Oregon Progress Board, April 1997.

Oregon Immunization Survey of Two-Year-Olds. In 1994 and 1997 the Oregon Health Division conducted surveys of parents of two-year-olds to estimate rates of immunization coverage. Sample sizes were 2,500 in 1994 and 3,100 in 1997. The samples were based on birth certificates. The 1997 sample included oversamples for major racial and ethnic minority groups. Immunization rate estimates are produced for the state and for 5 of the state's 8 geographic regions. The survey is scheduled to be repeated approximately every two years.

The survey is funded primarily by a private consortium of health providers called Oregon Health Systems, with additional funding from the Oregon Health Division and Multnomah County. The total cost for the 1994 survey was estimated to be \$140,000.

Where Have All the Graduates Gone: Survey of the Oregon High School Graduating Class. This biennial survey, first carried out in 1993 by the Oregon State System on Higher Education on a sample of 800 graduates, gathers data on the percentage who were attending college in the fall following graduation.

Oregon Early Childhood Development Assessment. This survey was conducted in 1993 for the Oregon Progress Board in order to provide baseline data for benchmarks related to school readiness. The survey carried out in-depth assessments of 814 five-year-olds in 11 areas of physical, language, and literacy development. It was completed by the Northwest Regional Education Lab at an estimated cost of between \$100,000 and \$200,000. There are currently no plans to field this survey again. A state survey of kindergarten teachers is being considered, however, as a more cost-effective means of collecting data in these areas.

*Administrative Data\**

Oregon On-Line Immunization Registry. An on-line immunization registry has been developed that records both private and publicly administered immunizations. Data will be available at the state and county levels. At present all but 6 public clinics participate, as well as 70 percent of private physicians. The goal is to achieve at or close to 100 percent participation, at which point it can be used to track immunization rates down to the county level. The registry is being paid for with a combination of federal and private funds.

Oregon State Assessment Program. Since 1991 the state of Oregon has annually tested students in grades 3, 5, 8, and 11 in the areas of math, reading, and writing. In addition, students in these grades have been tested on a rotating basis in language arts, health, physical education, and science. Through 1995, the tests were used primarily for program assessment purposes, tracking the percentage of students in each school, school district, and the state as a whole who were making satisfactory progress. The math, reading, and writing scores are also part of Oregon Benchmarks.

The program and its constituent tests are now being redesigned to support individual rather than program assessments. Beginning in 1998–99, students in grade 10 are to be tested for a Certificate of Initial Mastery (CIM). To receive a CIM, a student must demonstrate proficiency in 9 of 11 academic areas. Tests for grades 3, 5, and 8 are also being redesigned to measure progress in the skills covered by the CIM. Average scores will still be reported by school, school district, and state. Assessment results in math, reading, and writing will be comparable with those fielded prior to the redesign.

Population Estimates. As mandated by state law, the Center for Population Research and Census at Portland State University produces annual population estimates for the state and for each of Oregon's

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\*Administrative data systems that are mandated by the federal government and thus common to all states are not covered here. These include elements of the National Vital Statistics System (birth- and death-certificate data and various communicable-disease reporting systems); the Uniform Crime Report System; education data contained in the Common Core of Data System; and the mandatory reporting associated with various federal programs.

36 counties. Separate estimates are made for children and youth ages 0–4, 5–9, 10–14, and 15–17, and 18–19, by sex.

### *Linking Administrative Data*

Shared Information System (SIS). The Oregon Employment Department has developed an integrated data system that links data from 10 agencies. Databases are linked using the social security numbers of clients, and participating agencies are encouraged to adopt common definitions of client characteristics. The system is intended to support better client service, evaluation research, and program performance measures. It allows one to identify the constellation of services received simultaneously or sequentially by individual recipients and their families, and to follow them over time. For example, one can follow former welfare recipients to estimate workforce success after leaving the program.

The data systems comprising the SIS are concerned primarily with adult service receipt, employment, education, etc. However, because some of the databases include information on children living in the household, it would be possible to develop child-relevant social indicator measures from the SIS.

Children’s Information Exchange (CIX). The 1993 legislation that created the Oregon Commission on Children and Families (OCCF) mandated that it work with the Department of Human Resources (DHR) to “re-engineer and integrate the data processing systems related to children’s programs with the objective of making management information more accessible.” The CIX was intended to support program evaluation, outcomes monitoring, and system performance as well as basic program planning and design at the community level. The system was to include administrative data from 9 DHR agencies (e.g. Health Division, State Office for Services to Children and Families), data from other agencies (e.g., education), demographic data, and child and family well-being measures from various sources.

Members and staff of the local commissions on children and families were to be the prime users of this new data source, through a network called the Wellness Information System (WISE), developed by the OCCF.

The DHR commissioned a planning study to determine the design and cost of the proposed Children's Information Exchange (CIX). The study recommended an "Information Warehouse" approach in which all data are warehoused in a central computer to which users direct their requests for information. The costs were estimated at between \$2.9 and \$4.2 million in one-time start-up costs, and between \$360,000 and \$569,000 per year to maintain the system. Funds have never been appropriated to create the CIX, though modest efforts to better integrate administrative data across DHR agencies are being pursued.

### III. CONTENTS AND COVERAGE

Oregon has put a great deal of effort into developing a comprehensive data system for monitoring the well-being of children and families. Oregon Benchmarks, with its holistic approach to the identification and monitoring of social goals, is in no small part responsible. In addition, the emphasis on local decision making has pushed the state to develop its data resources in ways that allow for the production of county and regional estimates. Oregon's accomplishments are due, in part, to active participation in federally sponsored survey programs, and to development of its own innovative surveys and administrative databases.

The Oregon Population Survey provides basic demographic and socioeconomic data at the state and regional level on a biennial basis. To our knowledge, Oregon is the only state to field such a survey. It regularly fields two surveys of adolescent health-related behaviors, and has developed its own

immunization survey, all of which are designed to provide regional as well as state estimates.<sup>19</sup> Oregon is also rich in educational assessment data. State assessments can track performance of individual schools and can compare across schools for many grades. Participation in the NAEP allows comparison with other states, and the TIMSS assessments allow for comparison with other countries.

Although much of Oregon's population-based social indicator data are available for public use, social indicator data related to program use are not as easily accessed. Unfortunately, the Children's Information Exchange never got beyond the planning stages, and there appear to be no plans to develop anything like it. Such data are very important for those seeking to document the relationship between government policies and the well-being of Oregon's children, a link which goes to the heart of the Benchmarks program.

#### IV. ACCESSIBILITY

The state of Oregon has worked hard to make its data on children and their families accessible to a variety of audiences. The following data are available over the World Wide Web:

- State-level trend data for all of the Benchmarks are available on-line at the Oregon Progress Board Web site: <http://www.econ.state.or.us/opb>
- Data for the core benchmarks chosen by the Oregon Commission on Children and Families are available for each county: <http://www.ccf.state.or.us>
- Data for the 9 benchmarks adopted by the Health Cluster of the Oregon Option are available from its Web site, displayed comparatively for each of the 36 counties on data maps: [http://www.econ.state.or.us/opb/OR\\_OPT/maps.htm](http://www.econ.state.or.us/opb/OR_OPT/maps.htm)
- The Oregon Department of Education provides trend data for its math, reading, and writing assessments by county and school: <http://www.ode.state.or.us>

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<sup>19</sup>The YRBS does not currently produce estimates that are representative at the state level due to sample bias problems.

- The Division of Health/DHR displays trend data by county for selected vital statistics measures (e.g., birth, death, abortion, teen birth, AIDS). Preliminary data related to births are available on-line within six months after they are collected:  
**<http://www.ohd.hr.state.or.us/statinfo.htm#facts>**
- State and county population estimates for persons under age 18 are available on-line (some of the more detailed age groupings may be available only in print form):  
**<http://www.upa.pdx.edu/CPRC/coage96.html>**
- Data for the entire Oregon Population Survey for all years (1990, 1992, 1994, 1996) can be downloaded for analysis. There are plans to develop an on-line capacity for users to produce customized frequencies and cross-tabulations from this database on-line.  
**<http://www.econ.state.or.us/opb>**

Most of the data available over the Web are also available in published form through the sponsoring organizations. Written reports of benchmarks are available through the Oregon Progress Board. The Department of Education puts out reports for each grade and assessment area that report average scores by school. Detailed written reports are also available for the Youth Risk Behavior Survey, the Public School Drug Use Survey, Vital Statistics, and Population Estimates. For a list of titles and contacts, see Appendices A and B.

For those who are interested in finding out more about the many data sources that make up Oregon's social indicator data system, the Oregon Progress Board and the Oregon Center for Health Statistics have both produced data directories related to the Benchmarks and Healthy People 2000 objectives. These include brief descriptions of the data source, sponsoring agencies, and contact persons. These publications are also listed in Appendix A.

## V. TRAINING TO USE AND DEVELOP DATA

The Oregon Commission on Children and Families (OCCF) provides extensive training to all local commission staff in the use of social indicator data to support policy and program development, local accountability, and community mobilization around issues affecting children. To support these training activities, it has produced the "Outcome Measurement Notebook." This detailed notebook offers

general guidance in the use of indicators for these purposes, detailed information on each of the 11 core indicators adopted by OCCF, and information on 10 additional areas of possible assessment including family functioning, parenting success, self-esteem, child development, and potential child abuse. Each indicator is accompanied by a discussion of its importance, of risk and support factors, examples of model programs intended to improve outcomes, and recent research on the topic.

The Child Health Cluster of the Oregon Option has also been holding community workshops around the state to train local partners in the use of the 9 health indicators they have adopted. Training includes suggested programmatic strategies that communities may adopt to improve each of the 9 indicators.

## VI. CURRENT CHALLENGES AND PLANS FOR THE FUTURE

Oregon has been quite successful in developing data resources to measure and track the fundamental social goals embodied in its Benchmarks. The state is now turning attention to developing *intermediate indicator* measures, which are more sensitive to short-term change and more easily connected to particular program and policy efforts. Many of Oregon's state and local agencies are attempting to develop agency-specific performance measures that are related to the Benchmarks. The Oregon Option is working with researchers at Portland State University to develop such measures and is organizing a statewide conference on the subject to be held in the fall of 1997.

Oregon is struggling to take the difficult step from using social indicators for monitoring and goals-setting to using them for accountability and evaluation. Indicators used for these purposes have considerably more stringent technical and political requirements, making them much more difficult to

develop and employ.<sup>20</sup> Nevertheless, the state needs to take this critical step if it is to develop a system that can hold agencies and communities accountable for the results of their efforts.

A major challenge facing all levels of government in Oregon is the budget restrictions resulting from the passage of a new tax limitation law, Proposition 47. This law cuts existing property taxes and limits future increases. The state government can replace lost local revenues resulting from these restrictions, but is likely to do so only selectively, which will squeeze local services. Given these circumstances, it seems unlikely that local governments will be devoting new monies to social indicator monitoring activities, and they may even have to reduce their efforts. Similarly, to the extent that they add strains to the state budget, existing data development efforts may also come under increased fiscal pressure.

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<sup>20</sup>See Brett V. Brown and Thomas J. Corbett, "Social Indicators and Public Policy in the Age of Devolution." Institute for Research on Poverty Special Report No. 71 (Madison: University of Wisconsin, 1997).



**Vermont**  
**State Statistical System and Social Indicators of Well-Being**

Vermont's Agency of Human Services and the Department of Education have been driving forces behind the tracking of social indicators and their employment in planning, budgeting, and goals-setting exercises. In the last several years they have formally joined forces—as the Framework for Collaboration—to encourage an integrated approach to service planning for children and families at the state and local levels. Other agencies are being incorporated into this effort, and the state is considering whether to institute a comprehensive benchmarking effort involving most or all state agencies.

These agencies and collaboratives have put substantial efforts into making the most of existing social indicator data, developing new sources of data, and making those data accessible to local communities and to the public at large. In addition, they are putting in place a system for training local community leaders and planning staff to understand, interpret, and use social indicator data for a variety of purposes related to governance.

I. PROGRAMS RELATED TO SOCIAL INDICATORS

Vermont's Framework for Collaboration. Vermont has developed a number of integrated child and family-focused service initiatives over the last several years which involve a great deal of cross-agency collaboration at the state and local levels.<sup>21</sup> The Framework for Collaboration began in 1994 as a joint initiative of the Agency of Human Services and the Department of Education to create and develop a single coordinated framework for the delivery of services to the children and families of Vermont, one

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<sup>21</sup>For a description of these programs, see Agency of Human Services/Department of Education Partnership, "Vermont's Framework for Collaboration: Developing Community Resources and Supports for Children and Families." January 1996.

which addresses common themes and processes across these initiatives. The Department of Employment and Training has also become involved in the project.

This initiative is coordinated at the state level by the State Team for Children and Families. The state team has worked to develop and nurture 12 regional teams covering the state. Each region may have any number of local-community partnerships. At every level the focus is on developing a more integrated, family-focused approach to social service provision. Representatives from the regional teams meet on a regular basis with each other and with members of the state team.

Social indicators of child and family well-being will play many important roles within this collaborative framework, including goals-setting and tracking, measuring service system performance, and as part of the budgeting process. Some discretionary funds may be allocated according to performance as measured by social indicators. The state team has identified 40 indicators that can currently be tracked at the regional level to measure progress. These measures have been published as Community Profiles, available separately for 60 supervisory unions, and for counties as well. A second tier of indicators requiring some measurement and/or data development is being developed. Plans also call for identifying a third tier of social indicators that will be particular to each regional team.

An annual report on these and other social indicators at the state level is produced by the Agency of Human Services. This report predates the Framework for Collaboration by several years, but was renamed and reorganized last year to reflect the goals of the State Team for Children and Families. The most recent issue is "The Social Well-Being of Vermonters, 1997: A Report on Outcomes for Vermont's Citizens." The report portrays Vermont's performance relative to past trends, and makes comparisons with the nation and with other states.

There have been no new state monies allocated directly to support this ambitious initiative. Funding is supplied through the budgets of existing agencies. The Annie E. Casey Foundation, through

its Caring Communities Initiative, has provided some funds to support the development of the regional teams.

Vermont Benchmarking Collaborative. Beginning in 1996, the Vermont Economic Progress Council began exploring the possibility of establishing a comprehensive, statewide benchmarking effort to guide state program planning. A study group, whose members represent state government agencies, the governor's office, the legislature, and business, advocacy, and academic groups, was formed late in 1996 to review existing state activities and develop a vision for benchmarking. A final report with recommendations is due out in late 1997.

Vermont Comprehensive Assessment System. For the past three years Vermont has been developing a system for assessing the academic performance of Vermont public school children across a variety of areas. The State Board of Education has adopted a "Framework of Standards and Learning Opportunities" that identifies specific competencies by grade and academic area which are to function as the basis for all academic testing in Vermont. All public school students will be assessed on a regular basis using standardized tests in reading, language, mathematics, science, history/social studies, and geography. In addition, a sample of students will be tested using portfolio-based assessments in writing and mathematics. Results from the standardized tests will be reported at the school, regional, and state levels.

In addition, school districts are strongly encouraged to adopt and field their own standardized tests in language, mathematics, and other areas which the locality may decide. Whereas the state tests are administered in grades 2, 4, 8, and 10, the local tests are to be administered in grades 5, 9, and 11. These tests must be linked to the Framework of Standards and Learning Opportunities. In addition, portfolio-based assessments in writing and mathematics, locally scored, are also encouraged. The mix of mandatory state assessments and local optional assessments is intended to allow the assessment system to

meet local needs while still assuring a high level of comparability of goals and measurement across the state.

Assessments for some grades have already been fielded, with results at the school and community levels available both in published form and over the Internet through the Department of Education's "School Report" series.

The State Board of Education is currently designing a system that will use these assessments to foster professional and curriculum development at the local level. The board is emphasizing bringing performance problems to the attention of the affected communities rather than imposing sanctions for poor performance. Schools making strong progress as measured by the assessments and other information will be paired with schools that are beginning to change their practices and looking for models. Schools that are struggling will be offered technical assistance to improve performance. At present there are no sanctions associated with poor performance over time.

Healthy Vermonters 2000. Vermont's Healthy People 2000 initiative is centered in the Department of Health, but numerous organizations, including the Vermont Legislature, academia, and private organizations, are actively involved. In 1992 the advisory committee for the initiative identified 11 priority areas for action, and identified several measures of well-being that could be tracked to monitor progress in each area. The initiative focuses on Vermonters of all ages, though indicators for children and youth are included in most of the 11 priority areas.

Participating agencies and organizations focus at least some of their activities on improving health in one or more of the 11 priority areas. Indicators are used to identify areas of need and to monitor general progress toward specific health goals. Many of the participating organizations are also involved in the Vermont Framework for Collaboration; there is overlap between the social indicators used by these two initiatives.

Healthy Vermonters 2000 publishes a report on trends in indicators for each of the 11 priority areas at the state level, most recently in 1996. The priority areas are alcohol and other drug use, cancer rates, environmental health, incidence of heart disease and stroke, HIV, immunization and infectious diseases, maternal and child health, nutrition and physical activity, tobacco use, unintentional injuries and occupational health, and violent and abusive behavior.

## II. AVAILABLE DATA SOURCES

### *Voluntary Federal Surveys*

Youth Risk Behavior Survey (YRBS). The YRBS is a biennial survey of students in grades 9–12, covering a variety of behaviors including tobacco, alcohol, and drug use; sexual behavior; dietary behavior; physical activity; and violence. The YRBS was developed by the Federal Centers for Disease Control and Prevention (CDC). In 1995, 39 states, 16 cities, and 4 U.S. possessions fielded the survey. A national survey is also fielded.

Vermont has been fielding a YRBS every other year since 1993. In 1995 over 21,000 students in grades 8–12 were surveyed. Vermont is unusual among states in extending the survey to students in the 8th grade. The total sample size for 1997 is expected to be about 25,000, with over two-thirds of all high schools participating. The 1997 sample includes a representative state sample of over 10,000, plus an additional 15,000 students from other schools who have volunteered to participate. Results are published at the state level. Estimates at the supervisory union level are also produced, and are included in the Community Profiles produced by Vermont's Framework for Collaboration.

National Assessment of Educational Progress (NAEP). The NAEP is an assessment of children in grades 4–8. Areas of assessment include math, reading, writing, and science. State assessments have been fielded every other year since 1990. In 1996, 44 states and the District of Columbia participated in

the state assessments. Vermont participated for the first time in 1996. The assessment was for 4th and 8th grade students in mathematics. The cost to Vermont is estimated at \$75,000.<sup>22</sup>

### *State Surveys*

Vermont Survey of Kindergarten Teachers and Parents. This is an annual survey of kindergarten teachers and parents of children in kindergarten, first fielded in 1993. It is a joint project of the Vermont Department of Education and the Agency for Human Services. Teachers and parents are asked to identify child characteristics most critical to being an active learner in kindergarten, and the critical resources that a child must have prior to school entry in order to be ready for school. Teachers are asked to rate the school readiness of children in their classes along a number of dimensions including physical well-being, social confidence, language, general knowledge, emotional development, and moral awareness. The survey is mailed to all public school kindergarten teachers in the state. In 1995, 160 teachers and 1,154 parents responded to the survey. The resulting survey is not representative at the state or local levels, which limits its use as a tool for tracking changes in perceived school readiness over time. Even so, results are summarized in reports for the state as a whole, and for the 60 supervisory unions of the state.

The Senior Survey. This survey asks high school seniors about their plans for continuing their education and for work in the year following high school graduation. Those who plan to continue are asked about the institution they will attend, anticipated major, associated expenses, and reasons for picking the institution. Those not planning to continue their schooling are asked when and why they decided not to continue, and about job plans. All are asked about work and educational aspirations in the short and long term, about current work and extracurricular activities, and family socioeconomic background characteristics.

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<sup>22</sup>Personal communication with Robert MacNamara, Research and Assessment, Vermont Department of Education.

The survey was fielded every four years beginning in 1986. Later the frequency was increased to every two years. Beginning in 1997 it will be fielded annually. The survey has a 75–80 percent response rate, and is representative at the state level. It includes students from both public and private schools. In addition, there is a one-year follow-up survey to see what respondents actually did in terms of schooling, employment, and earnings. Due to the lower response rate (32–42 percent), these data must be weighted to maintain representativeness. There is discussion of fielding a 5-year follow-up to the survey in order to look at longer-term outcomes.

The survey is fielded by the Vermont Student Assistance Corporation for the Vermont Department of Education. Results are reported to local school superintendents and high school principals, members of the Vermont legislature, and the governor's office. In addition, the Department of Education incorporates results from the survey into its "School Report Card" Series.

Vermont Lead-Poisoning Survey. This survey was conducted in late 1992 and 1993 by the Vermont Department of Health in order to estimate the percentage of 2-year-olds with blood-lead levels exceeding the levels defined by the U.S. Centers for Disease Control and Prevention as being cause for concern. The survey drew its sample from Vermont birth records, with a special sample of children receiving Medicaid. Sample sizes were 523 from the birth certificate population and 527 from the Medicaid population.<sup>23</sup> Results are representative of these two populations. Since this survey was taken, Vermont has set up a blood-lead surveillance system which it is using to track blood-lead levels of young children.

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<sup>23</sup>One hundred and thirty-one children were represented in both samples, bringing the combined sample size to 919.

*Administrative Data\**

Vermont Comprehensive Assessment System. The Vermont Department of Education is developing standardized assessments in the areas of reading, language, mathematics, science, history/social studies, and geography, which will be administered to all public school students on a regular basis. Testing will take place in grades 2, 4, 8, and 10. Assessments for some grades have already been fielded, with results at the school, community, regional, and state levels reported along with other school data as part of the Department of Education's "School Report Card" series.

Localities are also encouraged to develop and field their own tests in language, mathematics, and other areas. It is unclear in what form the resulting information will be made available.

Vermont Blood-Lead Surveillance System. In 1994 the Vermont Department of health set up a blood-lead surveillance system, to which testing laboratories report the results of all blood-lead tests of young children. This system, which is funded by a grant from the Federal Centers for Disease Control and Prevention, is tracking changes in blood-lead levels in young children over time. Legislation is being considered to make screening of 1-year-olds mandatory, which would improve the representativeness of the data. Similar efforts are underway in other states.

*Linking Administrative Data*

The Office of Health Access, within the Agency of Human Services, recently awarded a grant to design a decision-support system that will link data on medical access and quality to enhance medical Management Information Systems (MIS). The system will probably include vital statistics data, as well as demographic and health survey information from other sources.

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\*Administrative data systems that are mandated by the federal government and thus common to all states are not covered here. These include elements of the National Vital Statistics System (birth- and death-certificate data and various communicable-disease reporting systems); the Uniform Crime Report System; education data contained in the Common Core of Data System; and the mandatory reporting associated with various federal programs.

### III. CONTENTS AND COVERAGE

Vermont's system of social indicators is quite strong in the areas of education and health. In education, they have developed a system that includes readiness and assessment indicators for children of all ages. Their survey of kindergarten teachers and parents tracks readiness among children entering kindergarten, and their system of assessment regularly tests children across the state in grades 2, 4, 8, and 10. Participation in the NAEP allows Vermont to gauge its performance relative to other states and to the nation as a whole for children in grades 4 and 8. The Senior Survey helps them to follow high school graduates into early adulthood.

The state has expanded participation in the Youth Risk Behavior Survey to cover over two-thirds of all high schools. This allows the state to track important measures of youth well-being at the state level, and for many individual schools and school districts as well. In addition to the careful use of standard vital statistics data, Vermont has been aggressive in developing a blood-lead surveillance system, an issue of particular importance to a state with an aging housing stock.

Areas of relative weakness include basic demographic and socioeconomic measures related to children and their families. There is nothing like a Current Population Survey to provide such information for Vermont between censuses, and the CPS itself does not include enough respondents from Vermont to produce very useful estimates even at the state level. In addition, Vermont does not produce its own population estimates, relying instead on the U.S. Bureau of the Census. The Census Bureau does not produce estimates of the child population for counties on a regular basis, though there are plans to do so in the future.

#### IV. ACCESSIBILITY

The state of Vermont has made a substantial amount of social indicator data available through the Internet and accessible publications. The following data are available through the World Wide Web:

- “The Social Well-Being of Vermonters, 1997: A Report on Outcomes for Vermont’s Citizens,” is the most recent edition of the annual report from Vermont’s Agency of Human Services. It is Vermont’s most comprehensive social indicator report at the state level and is available at the following site: **<http://www.dsw.state.vt.us/ahs/swb97/subcover.htm>**
- “Community Profiles,” which report trends in 40 indicators of well-being identified by Vermont’s Framework for Collaboration, are available for the state, for each of 60 supervisory unions, and counties on an annual basis.  
**<http://www.dsw.state.vt.us/ahs/commprof/commprof.htm>**
- “School Reports” containing student assessment results and other school characteristics are available for each school and by county, supervisory union, and for the state:  
**<http://crs.uvm.edu/schlrpt/index.htm>**
- The Substance Abuse Monitoring System (SAMS) has been set up by the Vermont Office of Alcohol and Drug Abuse to monitor drug use and related social trends. Most of the data presented are at the state level, though some are available at the county level as well. Selected results from the Vermont Youth Risk Behavior Survey are reported here, along with adult drug use, treatment admissions, drug-related fatalities, crime, and child abuse. Data in the SAMS are to be updated on an annual basis: **<http://www.cit.state.vt.us/adap/samstats.htm>**
- Like many states, Vermont has a state home page from which one can access on-line information from all state agencies: **<http://www.state.vt.us>**

With the exception of data from the Substance Abuse Monitoring System, all of the reports listed above are also available in print form. In addition, there are several important publications reporting trends in child and family well-being which are not currently available on the Internet. These include “Healthy Vermonters 2000: Progress Report 1996,” the latest report from the Healthy Vermonters 2000 project, and the report from the Youth Risk Behavior Survey titled “1995 Vermont Risk Behavior Survey.”

## V. TRAINING TO USE AND DEVELOP DATA

As part of Vermont's Framework for Collaboration, the Family and Professional Development Committee of the State Team for Children and Families has recently developed a training module designed to help community leaders and planning staff to understand, interpret, and use outcome assessment data (social indicators). They are used to train members of the 12 regional teams, and will be provided to teams below the regional level as well in the near future. The state team plans to provide on-going technical assistance to regional and community teams in the use of the Community Profiles for budgeting, planning, and goals-setting.

## VI. CURRENT CHALLENGES AND PLANS FOR THE FUTURE

The state of Vermont has made steady progress in developing initiatives to utilize social indicator data to improve program planning and design at the state and local levels. At the same time it has been making excellent use of existing data sources, and has been working to develop new data in response to emerging needs.

Largely in response to the expressed desire of Vermont's communities to plan based on social indicators that better reflect individual and community strengths, the state is considering fielding a youth survey to be designed by the Search Institute<sup>24</sup> called the Youth Attitude and Behavior Survey. This survey would identify the strengths of youth, rather than their problems. It is unclear whether this will be a statewide survey or offered to individual communities.

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<sup>24</sup>The Search Institute is an independent, nonprofit organization based in Minneapolis, Minnesota, that promotes the well-being of children and adolescents through research and evaluation.

There is also a strong desire to identify better measures of school readiness than those currently available through the survey of kindergarten teachers and parents. As of yet, however, no suitable set of survey questions has been identified.

Finally, there is a recognized need to link the administrative data systems of different state agencies, and to make that data accessible to planners at the community level.

**Appendix A**

**State Publications and Ordering Information**



## CALIFORNIA

**Cross-Cutting Reports**

- These reports are available by contacting Children Now at (510) 763-2444.

Children Now. 1996. "California: The State of Our Children 1996." Oakland, CA: Children Now. (Note: This report is available from Children Now at <http://www.childrennow.org>)

Children Now. 1995. County Data Book. Oakland, CA: Children Now.

**Education**

- The following reports are available by contacting the California Department of Education at (916) 657-2451.

Educational Demographics Unit, Research Evaluation and Technology Division, California Department of Education. Public School Summary Statistics 1995–96.

Educational Demographics Unit, Research Evaluation and Technology Division, California Department of Education. "California High School Performance Report."

- Reports on school enrollment projections and estimates are available by contacting the California Department of Finance at (916) 322-4651

Demographic Research Unit, California Department of Finance. "State Public K–12 Projected Enrollments by Ethnicity." (Note: This report is published annually in November.)

Demographic Research Unit, California Department of Finance. "State and County Projected K–12 Enrollment and High School Graduates." (Note: This report is published annually in November.)

**Health**

- For the following PRAMS publication and for information on research using PRAMS data, contact the California Department of Health Services at (916) 657-0324.

Epidemiology and Evaluation Sections, Maternal and Child Health Branch, Department of Health Services. 1997. *Pregnancy Risk Assessment Monitoring System (PRAMS) 1994: Perinatal Risk Profile of California Women*. Sacramento, CA: Department of Health Services.

- For California Department of Health Services publications, call (916) 445-6355.

California Department of Health Services, Center for Health Statistics. 1997. "1997 County Health Status Profiles." Sacramento, CA.

Department of Health Services. 1996. "Health Data Summaries for California Counties: 1996." Sacramento, CA.

California Department of Health Services, Health Information and Strategic Planning, Center for Health Statistics, Planning and Data Analysis Section. 1995. "Healthy California 2000: California's Experience in Achieving the National Health Promotion and Disease Prevention Objectives." Sacramento, CA. (Publication No. R94-08001.)

Department of Health Services, Health and Welfare Agency. 1995. "Advance Report: California Vital Statistics 1995." Sacramento, CA.

Department of Health Services, Health and Welfare Agency. 1994. "Vital Statistics of California 1994." Sacramento, CA.

Department of Health Services, Health and Welfare Agency. 1994. "Analysis of Health Indicators for California's Minority Populations." Sacramento, CA.

- For a copy of the following publication, contact Daphne Hom (916) 322-2591 or visit the Office of the Attorney General Web site at: <http://caag.state.ca.us/cvpcstats/>

Office of the Attorney General, California Department of Justice. 1996. "Sixth Biennial California Student Substance Use Survey, Grades 7, 9, and 11, 1995-96: Preliminary Findings." Published biennially.

#### **Child Welfare/Social Services**

- For a copy of the following publication, contact Sara Hoffman at (510) 335-1090.

County Administrator's Office, Contra Costa County. 1996. "Children & Family Services Budget: County of Contra Costa."

- For a copy of the following, contact the Center for Social Services Research at (510) 642-1899.

Needell, B., D. Webster, R. P. Barth, and M. Armijo. 1996. "Performance Indicators for Child Welfare Services in California: 1995." Berkeley, CA: University of California at Berkeley, School of Social Welfare, Child Welfare Research Center.

#### **Population**

- For copies of the following, contact the California Department of Finance at (916) 322-4651.

Demographic Research Unit, California Department of Finance. 1993. "Population Projections for California Counties 1990-2040 with Age/Sex and Race/Ethnicity." (Report 93 P-3)

Demographic Research Unit, California Department of Finance. "City and County Population Estimates for January 1." (Note: This report is published annually in May.)

Demographic Research Unit, California Department of Finance. "County Population Estimates for July 1." (Note: This report is published annually in February.)

## FLORIDA

**Cross-Cutting Reports**

- The following data and publications are available from the GAP commission's Web site:  
<http://www.eog.state.fl.us/govdocs/gapcomm/gaphome.htm> or by calling (904) 922-6907.

The Florida Commission on Government Accountability to the People (GAP). Executive Office of the Governor. 1996. "The Florida Benchmarks Report." Tallahassee, FL.

The Florida Commission on Government Accountability to the People (GAP). Executive Office of the Governor. 1995. "The Annual Progress Report: 1994–1995." Tallahassee, FL.

**Education**

- For the following report and information on other reports on education, contact the Office of Communications, Florida Department of Education, at (904) 488-9698 or send e-mail to: [schieln@mail.doe.state.fl.us](mailto:schieln@mail.doe.state.fl.us)

Florida Department of Education. "The Vital Signs for School Improvement Report." Tallahassee, FL. Published annually.

- Contact the Florida Commission on Education Reform and Accountability for the following publication by calling (904) 922-7173.

Florida Commission on Education Reform and Accountability. Florida Department of Education. 1996. "Florida's System of School Improvement and Accountability." Tallahassee, FL.

**Health**

- For Department of Health publications, contact the Florida Department of Health at (904) 487-2546.

Florida Department of Health. "Agency Strategic Plan: 1996–2002."

Department of Health, Office of the Secretary Office of Planning, Evaluation, and Data Analysis. 1996. "Public Health Indicators Report: County Health Department Workbook."

Department of Health and Rehabilitative Services. State Health Office of Public Health Statistics and Program Assessment. 1996. "Health Status Indicators."

Florida Department of Health and Rehabilitative Services, Office of Vital Statistics. 1996. "Florida Vital Statistics Annual Report: 1995." Jacksonville, FL.

Department of Health and Rehabilitative Services. 1996. "FY 1994–95 Agency Performance Evaluation." Tallahassee, FL.

Department of Health and Rehabilitative Services. 1996. "Agency Strategic Plan 1995–2001." Tallahassee, FL.

Department of Health and Rehabilitative Services. 1996. "Annual Performance Report: FY 1995–96." Tallahassee, FL.

Department of Health and Rehabilitative Services. 1993. "Progress in Public Health."

**Social Services/Child Welfare**

- For Department of Children and Family Services Strategic Plans and Performance Reports, contact the Department of Children and Families, Office of Standards and Evaluations, at (904) 488-0809.

Department of Children and Family Services, Office of Standards and Evaluation. 1996. "District Performance: FY 1995–96." Tallahassee, FL. Published annually.

Florida Department of Children and Families 1997. "Performance Report: Second Quarter FY 96/97." Tallahassee, FL. Published quarterly.

Florida Department of Children and Families. 1996. "Strategic Plan: 1996–2002." Tallahassee, FL. Published annually.

## MASSACHUSETTS

**Cross-Cutting Reports**

- The status reports listed below provide the most recently updated data along with some trend data, where possible. To obtain copies of Volume 1 and/or data on selected cities/towns from Volume 2, call the Bureau of Family and Community Health at (617) 624-5070. At this time there is no update; however, the department is working to institutionalize the report and make it available through MassCHIP.

Massachusetts Department of Public Health. 1995. "Massachusetts Children & Youth, A Status Report, Volume 1 & Volume 2." Boston, MA.

- The remaining publications under this category are available from the Massachusetts Committee for Children and Youth: (617) 742-8555.

Massachusetts "Kids Count" Project. 1996. "Massachusetts Campaign for Children: All Our Children, Citizen Action Kit." Boston, MA: Massachusetts Committee for Children and Youth.

Massachusetts "Kids Count" Project. 1996. "State of the Child 1996." Boston, MA: Massachusetts Committee for Children and Youth.

Massachusetts "Kids Count" Project. 1994. *All Our Children: Massachusetts "Kids Count" 1994*. Boston, MA: Massachusetts Advocacy Center, the Massachusetts Committee for Children and Youth, and Massachusetts Councils for Children.

Massachusetts "Kids Count" Project. 1994. *All Our Children: The Massachusetts Agenda*. Boston, MA: Massachusetts Committee for Children and Youth.

**Education**

- All of these Department of Education reports are available in print form by calling: (617) 388-3300, ext. 306. They can also be accessed through the Department's World Wide Web site at: <http://info.doe.mass.edu/doedocs/>

Massachusetts Department of Education. 1997. "Dropout Rates in Massachusetts Public Schools: 1996." Malden, MA. (Note: Prior years are also available.)

Massachusetts Department of Education. "School District Profile 1996–1997." Malden, MA.

Massachusetts Department of Education. "1996 School FACTS." Malden, MA.

Massachusetts Department of Education. 1996. "1995 Massachusetts Youth Risk Behavior Survey Results." Malden, MA. (Publication No. 17817-58-4M-4/96-DOE) (Note: Select prior years are also available.)

Massachusetts Department of Education. 1995. "Plans of High School Graduates: The Class of 1995." Malden, MA. (Publication No. 17766-30-500-9/95-DOE) (Note: Prior years are also available.)

Massachusetts Department of Education. 1995. "Student Exclusions in Massachusetts Public Schools: 1995–96." Malden, MA. (Note: Prior years are also available.)

### **Health**

- Printed copies of health statistical reports can be obtained by calling the Bureau of Health Statistics at (617) 624-5699, or the Bureau of Family and Community Health at (617) 624-5070. Many are also available through the department's World Wide Web site at:  
**<http://www.state.ma.us/dph/dphhome.htm>**

Health data reports are also available in standard and customized formats through MassCHIP. Additional information on MassCHIP and how to subscribe is available by calling: (617) 624-5541 or toll free within Massachusetts at 1-888-MASCHIP.

Executive Office of Health and Human Services, Massachusetts Department of Public Health. 1997. "Adolescent Tobacco Use in Massachusetts: Trends among Public School Students, 1984–1996." Boston, MA.

Massachusetts Department of Public Health. 1997. "Advance Data: Births 1995." Boston, MA. (Note: Prior years are also available.)

Massachusetts Department of Public Health. 1997. "Advance Data: Deaths 1995." Boston, MA. (Note: Prior years are also available.)

Massachusetts Department of Public Health. 1995. "Adolescent Births: A Statistical Profile, Massachusetts 1994." Boston, MA. (Note: Prior years are also available.)

Massachusetts Department of Public Health, Bureau of Health Statistics, Research and Evaluation Division of Research and Epidemiology. 1996. "Massachusetts Health Status Indicators by Race and Ethnicity." Boston, MA.

Massachusetts Department of Public Health. 1994. "Health Status Indicators by Community Health Network Area." Boston, MA. (Note: Presented in separate publications for each network area.)

Massachusetts Department of Public Health, Bureau of Family and Community Health. 1996. "Maternal and Child Health Services Block Grant, Fiscal Year 1997" (Interim Application—draft). Boston, MA.

### **Child Welfare/Social Services**

- These reports are available only in printed form at this time by calling (617) 727-3171, ext. 570. The department produces numerous specialized reports on such topics as substance abuse and family violence, adoption and guardianship, support services, and needs assessment. A full publications listing is available from the same number provided above.

Massachusetts Department of Social Services. 1996. "1995 Child Maltreatment Statistics." Boston, MA. (Note: Prior years are also available.)

Massachusetts Department of Social Services. 1996. "Demographic Report on Consumer Populations: 1995." Boston, MA. (Note: Prior years are also available.)

## MINNESOTA

**Cross-Cutting Reports**

Minnesota “Kids Count.” “Minnesota Kids: A Closer Look, 1996 Data Book.” Minneapolis, MN. (Note: Available from the Children’s Defense Fund—Minnesota (612) 227-6121.)

- The following reports are available from the Minnesota Planning World Wide Web site at: <http://www.mnplan.state.mn.us>, or by contacting Minnesota Planning at (612) 296-3985.

Minnesota Planning. 1996. “Minnesota Crime Survey: Changing Perceptions.” St. Paul, MN.

Minnesota Planning. 1996. “1996 Children’s Services Report Card.” St. Paul, MN. (Note: Data by county available through DATANET.)

Minnesota Planning. 1996. “Summary Minnesota Milestones: 1996 Progress Report.” St. Paul, MN.

Minnesota Planning. 1994. “Minnesota Milestones: 1993 Progress Report.” St. Paul, MN.

Minnesota Planning. 1994. “First Steps: Kids Can’t Wait 1994 Progress Report.” St. Paul, MN.

Minnesota Planning. 1992. “Minnesota Milestones: A Report Card for the Future.” St. Paul, MN.

Minnesota Planning, Action for Children Commission Staff. 1992. “Kids Can’t Wait: Action for Minnesota’s Children.” St. Paul, MN.

- Information and data from the Minnesota Student Survey are not currently available electronically. Publications are available from the Department of Children, Families, and Learning at (612) 296-6104.

Minnesota Department of Children, Families, and Learning, Minnesota Department of Human Services, Performance Measurement and Quality Improvement Division. 1997. “1996 Minnesota Student Survey: Alternative Schools and Area Learning Centers.” St. Paul, MN.

Minnesota Department of Children, Families, and Learning, Office of Community Collaboration. 1995. “Minnesota Student Survey 1989, 1992, 1995: Perspectives on Youth.” St. Paul, MN.

Minnesota Department of Children, Families, and Learning. “Minnesota Student Survey: 1995 State Tables.” St. Paul, MN.

**Education**

- The following data and publications are available from the Department of Children, Families, and Learning’s World Wide Web site: <http://www.educ.state.mn.us/> or by calling (612) 296-6104.

Minnesota Department of Children, Families, and Learning. “Information on Minnesota High School Graduates and Dropouts: 1994–95.” St. Paul, MN.

Minnesota Department of Children, Families, and Learning. Office of Community Services, Prevention and Risk Reduction Team. 1996. "Dangerous Weapons Incident Report in Minnesota Schools: 1994–95 School Year." St. Paul, MN.

Minnesota Department of Children, Families, and Learning. "Graduation Standards."  
<http://www.educ.state.mn.us/grad/gradhom.htm>

Minnesota Department of Children, Families, and Learning. "Minnesota Basic Standards Tests—District Profile Report. Results from January 1997." St. Paul, MN. (Note: Customized data accessed online and presented by district.)

### **Health**

- The following publications are available from the Department of Health: (612) 623-5353.

Center for Health Statistics, Minnesota Department of Health. 1997. "1995 Minnesota Health Statistics." Minneapolis, MN.

Minnesota Department of Health. 1995. "Minnesota Public Health Goals: Executive Summary." Minneapolis, MN. (Publication No. A-022)

Minnesota Department of Health. 1995. "Minnesota Public Health Goals." Minneapolis, MN. (Publication No. A-021)

### **Social Services/Child Welfare**

- The following reports are available from the Department of Human Services: (612) 296-6117.

Minnesota Department of Human Services, Community Services Division and the Family and Children's Services Division. 1997. "Child Maltreatment: A 1995 Minnesota Report." St. Paul, MN. (Note: Prior years also available.)

Minnesota Department of Human Services, Community Services Division, Family and Children's Services Division. 1996. "Children in Out-of-Home Placement: A 1993 Minnesota Report." St. Paul, MN. (Note: Prior years also available.)

Minnesota Department of Human Services, Community Services Division. 1996. "Focus on Client Outcomes: A Guidebook for Results-Oriented Human Services." St. Paul, MN.

## OREGON

**Cross-Cutting Reports**

- The following publications may be ordered from the Oregon Progress Board: (503) 986-0123.

Oregon Progress Board. 1997. "Oregon Shines II: Updating Oregon's Strategic Plan. A Report to the People of Oregon." Salem, OR: Oregon Progress Board.

Oregon Progress Board. 1996. "Data Directory Oregon Benchmarks." Salem, OR: Oregon Progress Board.

Oregon Progress Board 1994. "Oregon Benchmarks, Standards for Measuring Statewide Progress and Institutional Performance. (A report to the 1995 Legislature)." Salem, OR: Oregon Progress Board.

- Copies of the following report may be available from the Department of Human Resources through John Cuddy: (503) 945-5747.

Solutions Consulting Group, LLC & Public Knowledge, Inc. 1993. "Children's Information Exchange." Salem, OR: Solutions Consulting Group, LLC & Public Knowledge, Inc..

- Copies of the following report can be ordered from the Oregon Commission on Children and Families: (503) 373-1283.

Oregon Commission on Children and Families. 1995–1997. "Outcome Measure Notebook." (Rev. 11/95). Salem, OR: Oregon Commission on Children and Families.

- The following report can be ordered from the Oregon Department of Education: (503) 378-5965, ext. 695.

Bolt, D. H., and J. Miller. 1996. "Profiles of Oregon Counties: Human Resources, Educational and Economic Indicators Associated with Young Children and Families, 2nd ed." Salem, OR: Oregon Department of Education.

**Education**

- The following report can be ordered from the Oregon Department of Education: (503) 378-5965, ext. 695.

Paulus, N. 1996. "Dropout Rates in Oregon High Schools." Salem, OR: Oregon Department of Education.

Oregon Department of Education. 1995a. "Guide to Interpreting 1995 Oregon Statewide Assessment Results for Reading, Mathematics and Science." Salem, OR: Oregon Department of Education.

Oregon Department of Education. 1995b. "Guide to Interpreting 1995 Oregon Statewide Assessment Results for Reading, Mathematics and Science." Salem, OR: Oregon Department of Education.

Oregon Department of Education. 1995c. "Guide to Interpreting 1995 Oregon Statewide Assessment Results for Writing." Salem, OR: Oregon Department of Education.

### **Health**

- For information on ordering the following reports, contact Lore Lee, Epidemiologist, Center for Health Statistics: (503) 731-4479.

Center for Health Statistics. 1996. "Data Directory for Health-Related Oregon Benchmarks and Healthy People 2000 Objectives." Assessment Initiative Project, Center for Health Statistics, Center for Disease Prevention and Epidemiology, Oregon Health Division.

Center for Health Statistics. 1996. "Oregon Vital Statistics Annual Report, 1994 (Vols. 1 and 2)." Portland, OR.

- The following report can be ordered from the Oregon Health Division: Joyce Grant-Worley (503) 731-4449, ext 351.

Riddell, C. 1996. "1995 Oregon Youth Risk Behavior Survey. (Summary Report)." Portland, OR: Oregon Department of Human Resources Health Division, Center for Disease Prevention and Epidemiology.

- The following report can be ordered from the Oregon State Office of Alcohol and Drug Abuse Programs: (503) 945-6186

Finigan, M. 1995. "The 1994 Oregon Public School Drug Use Survey." Paper prepared for the Office of Alcohol and Drug Abuse Programs, Department of Human Resources.

- The following report can be ordered from the Immunization Section, Oregon Health Division: (503) 731-4135.

Diermayer, M. 1994. "1994 2-Year-old Immunization Survey (Final report)." Portland, OR: Oregon Health Division.

### **Population**

- The following report can be ordered through the Center for Population Research and Census, School of Urban and Public Affairs, Portland State University: (503) 725-3922.

Wineberg, H. 1995. "Population estimates for Oregon: July 1, 1995." Portland, OR: Center for Population Research and Census.

## VERMONT

**Cross-Cutting Reports**

- The following publications can be ordered from the Vermont Agency for Human Services: (802) 241-2227.

The Agency of Human Services Department of Education Partnership. 1996. "Vermont's Framework for Collaboration: Developing Community Resources and Supports for Children and Families." Waterbury, VT.

Vermont Agency of Human Services. 1997. "The Social Well-Being of Vermonters, 1997: A Report on Outcomes for Vermont's Citizens." Waterbury, VT.

Vermont Agency of Human Services 1996. "The Social Health Status of Vermonters 1996." Waterbury, VT.

Vermont Agency of Human Services 1995. "Community Profile for the Community Served By: Montpelier School District." Waterbury, VT. (Note: Community profiles are available for all school districts in the state.)

- The following report can be ordered from the Vermont Economic Progress Council: (802) 828-3383.

Vermont Economic Progress Council. 1997. "A Plan for a Decade of Progress: Actions for Vermont's Economy: 1996 Report." Montpelier, VT.

**Education**

- The following report can be ordered from the Vermont Agency for Human Services: (802) 241-2227.

Vermont Agency Human Services 1996. "Helping Young Children in Vermont to be Ready for School: Experiences and Perspectives of Kindergarten Teachers and Parents in Vermont." Waterbury, VT.

- The following reports can be ordered from the Vermont Student Assistance Corporation, Champlain Mill, Box 2000, Winooski, VT 05404.

Vermont Student Assistance Corporation. 1996. "Survey of Plans for Education and Careers: Vermont High School Class of 1994, Actual Activities after High School." Winooski, VT.

Vermont Student Assistance Corporation. 1995. "Survey of Plans for Education and Careers: Vermont High School Class of 1994." Winooski, VT.

The following series of reports are available to be downloaded over the Internet:

**<http://crs/uvm.edu/schlrpt>**

Vermont Department of Education. 1996. "School Report Card Series." Waterbury, VT. (Note: Report cards are available in published form and over the Internet for individual schools, school districts, and for the state as a whole.)

**Health**

- The following reports can be ordered from the Vermont Department of Health: (802) 863-7281.

Vermont Department of Health. 1996. "Healthy Vermonters 2000." Burlington, VT.

Vermont Department of Health. 1992. "Healthy Vermonters 2000." Burlington, VT.

**Appendix B**

**State Contacts for Programs and Data**



## CALIFORNIA\*

- For publications and information about education data, contact:

California Department of Education  
 PO Box 944272  
 Sacramento, CA 94244-2720  
 (916) 657-2451

- For information on existing administrative data linking efforts in California, contact:

Henry Brady or Barbara Snow  
 UC DATA  
 Survey Research Center  
 2538 Channing Way #5100  
 Berkeley, CA 94720-5100  
 (510) 642-2337  
 (510) 643-8292 (fax)

- For reports on health including vital statistics data, contact:

California Department of Health Services  
 Center for Health Statistics  
 304 S Street, Third Floor  
 P.O. Box 942732  
 Sacramento, CA 94234-7320  
 (916) 445-6355

- For copies of Performance Indicators for Child Welfare Services in California and information about the Children Services Archive, contact:

Center for Social Services Research  
 School of Social Welfare  
 120 Haviland Hall #7400  
 Berkeley, CA 94720-7400  
 (510) 642-1899  
 (510) 642-1895 (fax)

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\*All contact information is current as of August 1997.

- For information about Contra Costa Counties Children and Family Services Budget or Benchmarking effort, contact:

Sara Hoffman  
Senior Deputy County Administrator  
Office of the County Administrator  
651 Pine Street, 10th Floor  
Martinez, CA 94553-1229  
(510) 335-1090  
(510) 646-1353 fax

- For information about the Youth Risk Behavior Survey in California, contact:

Gail Maurer  
California State Department of Education  
Healthy Kids, Healthy California  
721 Capitol Mall, Third Floor  
P.O. Box 944292  
Sacramento, CA 95814  
(916) 657-2810

- For publications using Public Risk Assessment Monitoring System (PRAMS), contact:

Department of Health Services  
Maternal and Child Health Branch  
714 P Street, Room 476  
Sacramento, CA 95814  
(916) 657-0324

- For information about California's new risk assessment program for mothers and infants, contact:

Tamara Anderson  
Epidemiology and Evaluation Section  
Maternal and Child Health Branch  
Department of Health Services  
714/744 P Street  
P.O. Box 942732  
Sacramento, CA 94234-7320  
(916) 654-0596

- For information about the Biennial California Student Substance Use Survey, contact:

Daphne Hom  
Office of the Attorney General  
California Department of Justice  
Sacramento, CA 94203  
(916) 322-2591

- For population estimates, school enrollment estimates, or birth estimates, contact:

California Department of Finance  
Demographic Research Unit  
915 L Street  
Sacramento, CA 95814  
(916) 322-4651  
(916) 327-0222 (fax)  
ficalpop@dof.ca.gov

- For publications and information on Children Now, contact:

Children Now  
1212 Broadway, Suite 530  
Oakland, CA 94612  
(510) 763-2444  
(510) 763-1974 (fax)  
children@dnai.com

FLORIDA\*

- The Florida Benchmarks Report and other publications of the GAP Commission can be ordered by contacting:

The Florida Commission on Government Accountability to the People  
Executive Office of the Governor  
The Capitol  
Tallahassee, FL 32399-0001  
(904) 922-6907  
(904) 921-2215

- For information on statistical reports on education, contact:

Office of Communications  
Florida Department of Education  
PL 08, The Capitol  
Tallahassee, FL 32399-0400  
(904) 488-9968  
(904) 413-0378  
schieln@mail.doe.state.fl.us

- For publications and information regarding Florida's System of School Improvement and Accountability, contact:

Florida Commission on Education Reform and Accountability  
107 West Gaines Street, Suite 124  
Tallahassee, FL 32399-0400  
(904) 922-7173

- For publications and information concerning the Florida Department of Children and Families Strategic Plans or Performance Reports, contact:

Department of Children and Families  
Office of Standards and Evaluation  
1317 Winewood Boulevard  
Building 1, Room 306  
Tallahassee, FL 32399-0700  
(904) 488-0809

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\*All contact information is current as of August 1997.

- For Florida Department of Health publications, contact:

Florida Department of Health  
1317 Winewood Boulevard  
Tallahassee, FL 32399-0700  
(904) 487-2546

- For information about the Youth Risk Behavior Survey in Florida, contact:

Julia Pallentino  
Executive Director  
Comprehensive School Health Services  
Florida Department of Health  
1317 Winewood Boulevard  
Tallahassee, FL 32399-0700  
(904) 414-5618

- For population estimates and other publications about Florida, contact:

Bureau of Economic and Business Research  
College of Business Administration  
University of Florida  
221 Matherly Hall  
PO Box 117145  
Gainesville, FL 32611-7145  
(352) 392-0171  
(352) 392-4739 (fax)

- For publications or information about FETPIP, contact:

Florida Education and Training Placement Information Program  
325 West Gaines St.  
832 Turlington Building  
Tallahassee, FL 32399-0400  
(904) 487-0900  
(904) 488-2405 (fax)

- For reports and information about the Pregnancy Risk Assessment Monitoring System in Florida, contact:

Scott Hoecherl  
Risk Surveillance Unit Supervisor  
Florida Department of Health  
1317 Winewood Boulevard  
Tallahassee, FL 32399-0700

MASSACHUSETTS\*

- For information on Community Health Network Areas, contact:

Cathy O'Connor  
Director  
Community Health Network Initiative  
Department of Community Health  
250 Washington Street  
Boston, MA 02108-4619  
(617) 624-5255

- For information on “Kids Count,” contact:

Jetta Bernier  
Executive Director  
Massachusetts Committee for Children and Youth  
14 Beacon Street, Suite 706  
Boston, MA 02108  
(617) 742-8555

- For information on the Massachusetts Comprehensive Assessment System, contact:

Mr. Steve Chrostowski  
Accountability and Evaluation Services  
Department of Education  
350 Main Street  
Malden, MA 02148  
(617) 388-3300

- For information about the Youth Risk Behavior Survey in Massachusetts, contact:

Dr. Carol Goodenow  
Research Director  
HIV/AIDS Program  
Department of Education  
350 Main Street  
Malden, MA 02148  
(617) 388-3300, ext. 403

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\*All contact information is current as of August 1997.

- For information and publications on the Adolescent Tobacco Use in Massachusetts survey, contact:

Massachusetts Tobacco Control Program  
Department of Public Health  
Bureau of Family and Community Health  
250 Washington Street, 4th Floor  
Boston, MA 02108-4619  
(617) 624-5900

- For information and publications on health statistics and population estimates, contact:

Massachusetts Department of Public Health  
Bureau of Health Statistics  
250 Washington Street, 4th Floor  
Boston, MA 02108-4619  
(617) 624-5699

- For information on Massachusetts Community Health Information Profile (MassCHIP), contact:

Marlene Anderka  
Bureau of Family and Community Health  
Massachusetts Department of Public Health  
250 Washington Street, 5th Floor  
Boston, MA 02108-4619  
(617) 624-5500

- To receive a publications list and place an order for publications from the Department of Social Services, contact:

Phyllis Ward  
Department of Social Services  
24 Farnsworth  
Boston, MA 02210  
(617) 727-0900, ext. 570

MINNESOTA\*

- For information and publications relating to Minnesota Milestones, the Children's Services Report Cards, the Minnesota Crime Survey, contact Minnesota Planning:

Minnesota Planning  
658 Cedar Street  
St. Paul, MN 55155  
(612) 296-3985

- For health publications relating to the Minnesota Public Health Goals, contact:

Minnesota Department of Health  
Health System Development Section  
Metro Square Building - Suite 460  
P.O. Box 64975  
St. Paul, MN 55164-0975  
(612) 296-9661

- For information on DATANET and the Children's Services Report Cards, contact:

Richard Fong  
Land Management Information Center  
Minnesota Planning  
658 Cedar Street  
St. Paul, MN 55155  
(612) 296-6866

- For information on the Minnesota Student Survey, contact:

Jim Colwell  
Office of Community Services  
Department of Children, Families, and Learning  
550 Cedar Street  
St. Paul, MN 55101-2273  
(612) 296-5119

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\*All contact information is current as of August 1997.

- For information and publications regarding the Graduation Standards and Minnesota Goals 2000, contact:

Graduation Standards  
Learning Programs  
Minnesota Department of Children, Families and Learning  
550 Cedar Street  
St. Paul, MN 55101-2273  
(612) 296-1447

- For information on population estimates, contact:

James Hibbs  
Office of the State Demographer  
Minnesota Planning  
658 Cedar Street  
St. Paul, MN 55155  
(612) 296-9036

- For information on the state “Kids Count” project, contact:

Diane Benjamin  
“Kids Count” Director  
Children’s Defense Fund—Minnesota  
550 Rice Street  
St. Paul, MN 55103  
(612) 227-6121

OREGON\*

- For information related to Oregon Benchmarks, and the Oregon Population Survey, contact:

Oregon Progress Board  
775 Summer Street, N.E.  
Salem, OR 97310  
(503) 986-0039  
[www.econ.state.or.us.opb](http://www.econ.state.or.us.opb)

- For information on state and local Commissions on Children and Families, contact:

Oregon Commission on Children and Families  
530 Center Street, N.E.  
Suite 300  
Salem, OR 97310  
(503) 373-1283  
(503) 378-8395  
<http://www.ccf.state.or.us>

- For information on the activities of the Oregon Option, contact:

The Oregon Option  
775 Summer Street, N.E.  
Salem, OR 97310  
(503) 986-0244  
(503) 581-5115 (fax)  
[www.econ.state.or.us/opb/OR\\_OPT](http://www.econ.state.or.us/opb/OR_OPT)

- For information on the Oregon State Assessment Program, and Oregon's participation in the National Assessment of Educational Progress and Third International Mathematics and Science Surveys, contact:

Barbara Wolfe  
Assessment Coordinator  
Office of Assessment and Evaluation  
Oregon Department of Education  
255 Capitol Street, N.E.  
Salem, OR 97310-0203  
(503) 378-5585, ext. 223

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\*All contact information is current as of August 1997.

- For information on the Oregon Public School Drug Use Survey, contact:

Clint Goff  
Senior Researcher  
Office of Alcohol and Drug Abuse Programs  
Human Resources Building  
500 Summer Street, N.E.  
Salem, OR 97310  
(503) 945-6186

- For information on Vital Statistics data, and on the Oregon Option Health Cluster, contact:

Lore Elizabeth Lee, MPH  
Epidemiologist  
Center for Health Statistics  
Oregon Health Division  
Department of Human Resources  
800 N.E. Oregon, Suite 215  
Portland, OR 97232  
(503) 731-4479  
(503) 731-4084 (fax)

- For information on the Oregon Immunization Survey of Two-Year-Olds and the Oregon Immunization Registry, contact:

Elaine Duncan  
Immunization Program  
Oregon Health Division  
800 N.E. Oregon Street  
P.O. Box 14450  
Portland, OR 97214-0450  
(503) 731-4135

- For information on Oregon population estimates, contact:

Center for Population Research and Census  
School of Urban and Public Affairs  
Portland State University  
Portland, OR 97207-0751  
(503) 725-3922  
(503) 725-5199 (fax)

- For more information on the Oregon Employment Department's Shared Information System, contact:

Brian Conway  
Oregon Department of Employment  
(503) 378-8652

VERMONT\*

- For more information on Vermont's State Team for Children and Families, contact:

Alice Maynard  
Interagency Teams Administrator  
(802) 241-2609

- For general information on social indicators efforts within the Agency for Human Services, and for information regarding Vermont's Framework for Collaboration, contact:

David Murphey  
Senior Policy Analyst  
Planning Division  
Agency of Human Services  
103 South Main Street  
Waterbury, VT 05671-0203  
(802) 241-2238  
(802) 241-2979 (fax)

- For more information regarding the potential development of a Vermont Benchmarking Collaborative, contact:

Gordon MacFarland  
Vermont Economic Progress Council  
109 State Street  
Montpelier, VT 05609-0501  
(802) 828-5256  
(802) 828-3383 (fax)

- For information regarding Vermont's Comprehensive Assessment System, contact:

Robert Macnamara  
Research and Assessment  
Department of Education  
(802) 828-2238

- For more information regarding Vermont's Survey of Kindergarten Teachers and Parents, contact:

David Baker  
Agency of Human Services  
103 South Main Street  
Waterbury, VT 05671-0203  
(802) 241-2228

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\*All contact information is current as of August 1997.

- For information regarding the Healthy Vermonter's 2000 program, contact:

Pam Erickson  
Vermont Department of Health  
108 Cherry Street, P.O. Box 80  
Burlington, VT 05402  
(802) 863-7285

- For more information on Vermont's Youth Risk Behavior Survey, contact:

Kelly Hale  
YRBS Coordinator  
Office of Alcohol and Drug Abuse Programs  
Vermont Department of Health  
108 Cherry Street  
Burlington, VT 05402  
(802) 651-1557