Healthy Families Montgomery

Twenty Year Longitudinal Study

1996 - 2016

- *Promoting positive parenting*
- *Enhancing child health and development*
- *Preventing child abuse and neglect*

Healthy Families Maryland™
Montgomery County

Over 100 Years of Service

Family Services, Inc.

PART OF THE SHEPPARD PRATT HEALTH SYSTEM

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EXECUTIVE SUMMARY

The long-term negative impact of child maltreatment has been well researched over the past twenty years. Children who have experienced abuse and neglect are at increased risk for poor health and mental health outcomes, including obesity, depression, suicide, substance abuse, post-traumatic stress disorder, attention difficulties, and delinquency
Research has shown that home visiting is an effective method of preventing child maltreatment, health and mental health issues, and delinquency, with considerable savings for states and localities. The Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV, 2009) funded by Congress conducted a review of nineteen home visiting models and their outcomes. Researchers (2016) concluded that the *Healthy Families America* model had the greatest breadth of favorable total findings, with positive impacts identified in each of the eight domains such as child development, school readiness, and positive parenting practices.

The HFM program and its partners have had a tremendous positive impact on the health and well-being of families in Montgomery County and the State of Maryland. Twenty years ago, child maltreatment rates were at their highest and were on the rise. Additionally, there were low rates of screening for child developmental delay, a lack of parenting resources and supports, poor access to health care for low-income families, a high teen birth rate, and low educational and employment levels among at-risk families. Over the past twenty years, HFM has worked with local, state and national partners to address these issues, resulting in most notably in decreases in child maltreatment. The rate of founded cases of child abuse and neglect for families who participated in the HFM program has been less than 1% (ranging from 0.0%-0.9%) for each year of HFM program operation. HFM efforts have resulted in increased identification and services for child developmental delay, an increase in the number and range of parenting resources and supports, significant improvements in parenting knowledge and parent-child interaction, decreased teen birth rate, access to health care for all children and most mothers, and increased education and employment levels of participating mothers. These accomplishments were achieved despite a rapidly changing demographic within Montgomery County and the State of Maryland, and the high level of risk of participating families.

In June 2016, HFM marked its twentieth year of service to families at-risk for child abuse and neglect in Montgomery County, Maryland. For the past twenty years, *Healthy Families Montgomery* has addressed the impact that family, community, and culture have on child development and risk for child maltreatment. HFM has long targeted the risk/protective factors associated with child maltreatment and provided comprehensive, multi-level prevention services to high-risk families using a cost-effective home visiting strategy. With a focus on promoting positive parenting, optimal child health and development, long-term health and family self-sufficiency, home visitors provide expectant and new parents with guidance, information, and support using a culturally responsive and competent approach that reflects the most current best practice research. To ensure HFM continues to implement evidence-based effective practices and adhere to quality standards, the *Healthy Families America* accreditation process has been successfully completed within the first three years of operation and every four years thereafter. The HFM program has been

accredited since November 1999, when it received the first national credential of all the Healthy Family America sites in the State of Maryland. Most recently, HFM successfully completed the updated, more rigorous accreditation process, received their credential in January 2017, and are now accredited through March 2021.

The HFM program has had a longstanding partnership with the Montgomery County Department of Health and Human Services (DHHS). As the major provider of reproductive health and social services to income-eligible families in the County, DHHS County Health Department conducts universal screenings of all prenatal, perinatal and postnatal female clients. Positive screens are reviewed by the HFM Family Resource Specialist (FRS), who completes an in-depth assessment interview using a standardized instrument, the Parent Survey. Since program inception, over 15,760 positive screens for risk of child maltreatment have been referred to HFM and over 2,680 in-depth assessments have been completed. Over the past twenty years, the HFM program has provided comprehensive home visiting services to 1,081 families at risk for child maltreatment. The majority of families have been Hispanic, about half had a high school degree or higher, and about one-quarter were employed at the time of enrollment.

The cornerstone of HFM's success has been the use of a home visiting strategy and the trust and bond that develop between the Family Support Worker (FSW) and the family. The principal aim of the home visits is to ensure that children are healthy and ready for school by conducting developmental activities with children and modeling positive parent-child interaction. In addition, FSWs focus on the parents' needs, goals, stressors, and strengths to empower them to provide the best possible care for their children. In utilizing empowering, strength-based techniques, parents come to see their FSW as an individual who advocates for their best interests. This makes it essential to utilize highly trained staff with strong interpersonal skills and cultural competence. Using a strength-based approach, home visitors provide education and support services to families who face a number of social, cultural, economic and situational risk factors that compromise their health, quality of life, and opportunities for success.

Healthy Families Montgomery has tracked achievement of its goals and measured program outcomes each year since program inception. Over the past twenty years, the program has consistently demonstrated success at meeting or exceeding its targets for key outcomes, as well as comparative rates for the nation, Maryland and Montgomery County. Highlights include:

- All children (100%) have a health care provider, are enrolled in MCHIP if eligible (99%), and are current with their immunizations (98%).
- Almost all mothers (98%) complete their postpartum visit and do not have a subsequent birth in less than 24-months (100%).
- Most children are born with a healthy birthweight (95%), are screened regularly for developmental delays (97%), and receive early intervention services if eligible (100%).
- Over the past twenty years, almost all families (99.8%) have not had an indicated report of child maltreatment.

- Parents make significant improvements in their knowledge of child development and home safety, have positive interactions with their child, and decrease their risk for maternal depression.
- Parents are more likely to increase their level of education and improve their employment status while in the HFM program. In fact, almost twice as many mothers were employed at annual follow-up than were at enrollment.
- Participant annual ratings of program quality, impact on parents' ability to bond with their children, teach their children in a way that promotes optimal development and school readiness, and to be self-sufficient have been consistently high over the past twenty years.
- Staff annual ratings of the HFM program rate the program highly in several key areas: the dedication and preparedness of staff, the strength-based approach of the program, and the respect for cultural diversity and the ability to connect with families.

HFM has played a key leadership role in the state by operationalizing its vision for healthy families. With relatively few resources and within a short period of time, HFM achieved all of its primary objectives and demonstrated significant improvements on major standardized measures of health, child maltreatment, parenting skills, risk for maternal depression, and family self-sufficiency. The program's early successes led to statewide replication and infrastructure for early childhood home visiting. Through its advocacy efforts, HFM increased awareness in the community of the serious public health issue posed by child abuse and neglect and forged long lasting partnership to address the issue. HFM has continued to provide leadership by repeatedly incorporating the most current research and practice on risk and protective factors, research on the impact of child maltreatment on the child's developing brain and the deleterious effects of abuse and neglect on lifelong health and well-being. The program has translated this research into practice through extensive training, intensive supervision, and maintaining its accreditation. HFM successes can demonstrate to legislators the cost benefits of prevention.

As HFM looks forward they should: 1) leverage program successes to secure funding for expansion of services to meet the outstanding need for prevention services in the community, resulting in significant savings in public health and welfare costs; 2) continue to provide leadership within the county and across the state that bolsters the quality, fidelity, staff training, program evaluation, and achievement of outcomes, as well as advocate for policies and practices that support these goals; 3) continue to collaborate with other early childhood home visiting programs to implement and meet the MIECHV benchmark measures; 4) continue to expand partnerships that help meet evolving needs of diverse families; and 5) continue to develop and implement strategies that address the recommendations from the accreditation review.

I. INTRODUCTION

The Healthy Families Montgomery Program was launched in 1996 with funding from the Freddie Mac Foundation. Initially operating as a pilot program, HFM conducted a rigorous

process and outcome evaluation. After two years of implementation, evaluation results were so compelling that the Maryland State legislature approved funding for 15 replication sites across the state. Additional sustainable funding was received from local city and county governments in 1998 and continues to this day. In June 2016, HFM marked its twentieth year of service to families at-risk for child abuse and neglect in Montgomery County, Maryland. As such, a longitudinal review of its implementation and outcomes over the past decade (2007-2016) was commissioned. A similar ten-year retrospective analysis was completed in 2006 and that data is included in the current review.

Statement of the Problem

Child Maltreatment

When the HFM program was founded, child maltreatment rates were on the increase. At the national level, 2 million cases were reported in 1990. This number had risen to 3 million cases of abuse and neglect in 1995, with 1 million children identified as victims.[1] In Montgomery County, the number of child abuse and neglect investigations rose 28% between 1996 and 1997, and 45% between 1997 and 1998. There had been several high profile child deaths due to abuse and there was a public cry for a coordinated response to this public health crisis. Following the passage of the *Child Abuse Prevention and Treatment Act (CAPTA)*[2] by Congress in 1988, the Children's Bureau established a national data system to collect information on reports of child abuse and neglect from all 50 states, the *National Child Abuse and Neglect Data System (NCANDS)*. Subsequently in 1993, in order to shed light on the complexities of child maltreatment, the National Research Council (NRC) issued its landmark report, *Understanding Child Abuse and Neglect*[3]*,* which provided an overview of the research to date on child abuse and neglect, and called attention to the scope of the problem and a lack of research on causes, services, and dimensions of child maltreatment.

Further examination of data on child maltreatment revealed that about 80% of the perpetrators of child maltreatment were the parents of the victims. Another 10% of the perpetrators were other relatives of the victims. About 2% were persons in other caretaking roles (e.g., foster parents, facility staff, and child care providers). Case-level data also suggested that the majority of deaths due to abuse were children 3 years of age or younger. These alarming statistics suggested that prevention and intervention programs should target parents with young children. It was in response to these data that the Healthy Families Model was created, initially known as the 'Hawaii Healthy Start' program. Using a prevention approach, Healthy Families targeted new parents at risk for child maltreatment. Aligned with the national epidemiological strategy outlined by the Centers for Disease

[1] NCANDS Child Maltreatment *Child Maltreatment 1995: Reports From the States to the National Child Abuse and Neglect Data System* (NCANDS).

[2] Child Welfare Information Gateway. (2011). *About CAPTA: A legislative history.* Washington, DC: U.S. Department of Health and Human Services, Children's Bureau. https://www.childwelfare.gov/pubs/factsheets/about/

[3] Institute of Medicine and National Research Council, Understanding Child Abuse and Neglect, 1993. Available at https://books.google.com/books?hl=en&lr=&id=qnxZpAeYVtMC&oi=fnd&pg=PT13&dq=1993+report+on+child+abuse+and+neglect+rates&ots=mBPHNh0IPV&sig=l5G1z0unGFqlSWSsqTxDkinP9hQ#v=onepage&q=1993%20report%20on%20child%20abuse%20and%20neglect%20rates&f=false

Control and Prevention (CDC-P)[4], home visiting programs like Healthy Families identified family risk factors (e.g., poverty, immigration, maternal depression, substance abuse, mental health disorder, child developmental delay, and low birth weight) and provided program activities that improve school readiness, health, self-sufficiency and parenting and reduce child abuse and neglect. Healthy Families specifically targets the parent-child relationship and positive parenting skills. In 2003, the Task Force on Community Preventive Services at the CDC issued a report in which they determined home visiting programs like Healthy Families to be effective in reducing risk of child maltreatment in high-risk families.[5]

When the *Healthy Families Montgomery Ten-Year Longitudinal Report* was published in 2006, national statistics indicated a trend for decline for some types of child abuse and neglect. Several forms of child maltreatment decreased from 2004 to 2005, adding to more than a decade's worth of declines.[6] Rates of substantiated sexual abuse dropped by 2% in 2005 compared to the previous year, capping a 51% total decline since 1991. Rates of physical abuse declined by 5% (2004 to 2005), and by 46% from 1992 to 2005. Neglect, however, did not decrease over the long term. Researchers believed the declines were related to a variety of factors. They cited economic improvements, greater numbers of child protective workers and police, more awareness about child maltreatment, improved parenting practices, and more effective treatment for family and mental health problems, including the increased use of psychiatric medications.

Currently, national rates of child maltreatment show an overall increase from 8.8 per thousand in 2011 to 9.2 per thousand in 2015.[7] These statistics varied by state and by whether the state was implementing an 'alternative response' victim disposition. For this most recent Child Maltreatment Report (2015), NCANDS did not include alternative response dispositions in its victim counts. Although only a few states report children with this disposition, excluding these children may account for some of the decline in the national rates. The State of Maryland has used alternative response dispositions since 2014, and has seen its rates for child victimization decrease 51% in 2015, from 10 per thousand in 2011 to 5 per thousand in 2015.

Experts convened by the National Research Council in 2012 suggested several reasons for recent decreases that reflect the interaction between social trends and child maltreatment data trends. American families have been undergoing major changes in demographic structure, economic status, and health care coverage, all of which can influence child maltreatment. Many sources of data point to a substantial reduction in the incidence of child physical and sexual abuse, but not neglect or fatalities, over the past two decades. Differences in the reliability of data sources and variance in definitions and reporting practices of child maltreatment across states and localities raised concerns that many cases are not being counted by data systems. The causal factors behind changes in child

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[4] Center for Disease Control and Prevention. "Strategic Direction for Child Maltreatment Prevention: Preventing Child Maltreatment Through the Promotion of Safe Stable and Nurturing Relationships Between Children and Caregivers." 2005. Available at https://www.cdc.gov/ViolencePrevention/pdf/CM_Strategic_Direction--Long-a.pdf

[5] Center for Disease Control and Prevention, "First reports evaluating the effectiveness of strategies for preventing violence: early childhood home visitation: findings from the Task Force on Community Preventive Services 2003. Available at www.cdc.gov/mmwr/preview/mmwrhtml/rr5214a1.htm. *MMWR* 2003;52(RR-14):1-9.

[6] Finkelhor, D. "Trends in Childhood Violence and Abuse Exposure". Child Maltreatment, CDC 2007;

[7] Administration for Children and Families. https://www.acf.hhs.gov/sites/default/files/cb/cm2015.pdf#page=20

maltreatment rates are difficult to untangle, but an increased emphasis on prevention may be responsible for the reduction in physical and sexual abuse. Despite some positive trends, pockets of severe unmet need continue to exist throughout the United States.[8]

The long-term negative impact of child maltreatment has been well researched over the past twenty years. In an updated report, *New Directions in Child Abuse and Neglect Research (2013)*, the Institute of Medicine and the National Research Council summarizes the research describing the impact on victims, families, and society.[9] Children who have experienced abuse and neglect are at increased risk for poor health and mental health outcomes, including obesity, depression, suicide, substance abuse, post-traumatic stress disorder, attention difficulties, and delinquency.[10] Findings in biology and neuropsychology have highlighted the impact of abuse and neglect on early brain functioning and development.[11] However, the long-term impact on child victims is mediated by the severity, frequency and timing of the abuse, as well as the protective factors that exist for the child and family. Findings such as these have led to the development of evidence-based treatment and prevention strategies and programs that are multifaceted and implemented in a community setting. As a public health issue, the report calls for a systemic, comprehensive, and multidisciplinary approach to child abuse and neglect research. For the past twenty years, Healthy Families Montgomery has addressed the impact that family, community and culture have on the healthy development of children, as well as on risk for child maltreatment. The program has long targeted the risk and protective factors associated with risk for child maltreatment, and provided comprehensive, multi-level prevention services using a home visiting strategy.

Home Visiting

There is a strong evidence base for home visiting that supports its effectiveness in the promotion of positive child health and development, parenting, and family self-sufficiency. Research has shown that home visiting is an effective method of preventing child maltreatment, health and mental health issues, and delinquency, with considerable savings for states and localities.[12] In light of this, Congress approved funding of the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV, 2009) to support home visiting programs implemented by states and localities.[13] To ensure the effectiveness of programs implemented under MIECHV, the US Department of Health and Human Services funded a thorough review of the research literature on home visiting to assess its

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[8] Board on Children, Youth, and Families; Institute of Medicine; National Research Council. Washington (DC): National Academies Press (US); 2012 Apr 5. Child Maltreatment Research, Policy, and Practice for the Next Decade: Workshop Summary. Social Trends and Child Maltreatment Trends. (2011). Available at https://www.ncbi.nlm.nih.gov/books/NBK201120/

[9] Institute of Medicine and the National Research Council 2013. New Directions in Child Abuse and Neglect Research. Available at http://www.nationalacademies.org/hmd/Reports/2013/New-Directions-in-Child-Abuse-and-Neglect-Research.aspx

[10] Felitti, V. et al, 1998. Relationship of Childhood Abuse and household dysfunction to may of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study. American Journal of Prevention Medicine. 1998 May; 14(4):245-58. Available at https://www.ncbi.nlm.nih.gov/pubmed/9635069

[11] Bernstein et al, 1986; U.S. DHHS, 2003; Zuckerman, 1993; Shonkoff, 2000).

[12] Center on Budget and Policy Priorities. Effective, Evidence-Based Home Visiting Programs in Every State at Risk if Congress Does Not Extend Funding. 2015. Available at http://www.cbpp.org/research/effective-evidence-based-home-visiting-programs-in-every-state-at-risk-if-congress-does-not

[13] Maternal and Child Health Bureau, Health Resources and Services Administration. “Home Visiting Overview”, 2015. Available at https://mchb.hrsa.gov/maternal-child-health-initiatives/home-visiting-overview

effectiveness and identify evidence-based models for replication. In its preliminary report, Home Visiting Evidence of Effectiveness (HomVEE) researchers found that home visiting models have multiple favorable effects, have sustained impacts, are successful with diverse populations, but it is uncommon for them to demonstrate favorable effects in replication. Of the nineteen models that were examined, only seven were found to have high quality evidence and be successful in replication. Healthy Families was one of the models endorsed by the reviewers. In September 2016, HomVEE updated its review of home visiting models and their outcomes, focusing on outcomes within eight domains: child health; child development and school readiness; family economic self-sufficiency; linkages and referrals; maternal health; positive parenting practices; reductions in child maltreatment; and reductions in juvenile delinquency, family violence, and crime. After reviewing evidence from nineteen evidence-based home visiting models, researchers concluded that the Healthy Families America model had the greatest breadth of favorable *total* findings, with favorable impacts on primary and/or secondary measures in all eight domains. Favorable impacts were identified in each of the eight domains used as criteria. Outcomes include primary measures, such as child development and school readiness and positive parenting practices, which were collected through direct observation, direct assessment, administrative records, or self-report using a standardized (normed) instrument—or secondary measures (all other self-reported).[14]

Healthy Families America was founded in 1992 in response to the national crisis of child abuse and neglect. With funding from Ronald McDonald House Charities, the National Committee for Prevention of Child Abuse (NCPCA) formulated the Healthy Families America (HFA) Initiative based on the Hawaii Healthy Start program. What emerged was a voluntary prevention program that provided intensive, comprehensive, long-term (3-5 years), flexible, and culturally appropriate services. The program was designed to promote positive parenting, child health and development, and prevent child abuse and neglect. Over the past 25 years, the number of HFA program sites has grown from 25 to 624 programs serving 100,000 families across 35 states. HFA is the only national home visitation initiative that requires its programs to successfully complete a rigorous accreditation process every four years.[15] In addition to the recent review through the HomVEE project, research on the effectiveness of the HFA model has been conducted by over twenty states, including 12 randomized trials, which have documented positive outcomes in all six benchmark domains required under the MIECHV legislation.[16] These included: improvement in maternal and newborn health; reduction in child injuries, abuse and neglect; improved school readiness and achievement; reduction in crime or domestic violence; improved family economic self-sufficiency; and improved coordination and referral for other community resources and supports.

Healthy Families Montgomery has conducted annual evaluations since program inception. Each year, HFM has demonstrated a high level of quality implementation and program fidelity, as well as successful achievement of outcomes in each of the eight domains

[14] Sama-Miller, E., Akers, L. Mraz-Esposito, A., Avellar, S., Paulsell, D., and Del Grosso, P. (2016). *Home Visiting Evidence of Effectiveness Review: Executive Summary.* Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services. Washington, DC. Available at http://homvee.acf.hhs.gov/HomVEE_Executive_Summary_2016_B508.pdf

[15] Healthy Families America. "History", 2015. Available at http://www.healthyfamiliesamerica.org/history/

[16] Healthy Families America. "Research", 2015. Available at http://www.healthyfamiliesamerica.org/research-articles/

identified by HomVEE researchers, as well as in all of the benchmark domains required for MIECHV funding. Findings over the past twenty years of HFM operation have been summarized each year in annual report, but are consolidated into this Year 20 Longitudinal Report.

Cost of Child Maltreatment

In addition to the impact of child maltreatment on health and mental health outcomes, direct and indirect costs associated with abuse and neglect are significant for both victims and society. In 2001, the total estimated cost of child abuse and neglect was $94 billion per year.[17] Direct costs, such as hospitalization and the child welfare system, were estimated to be $24 billion. Indirect costs resulting from abuse and neglect, including mental health, juvenile delinquency, special education and adult criminality, were estimated to be $70 billion.[18]

By 2012, the total estimated cost decreased to $80.3 billion, while direct costs (e.g., hospitalization, childhood mental health care costs, child welfare system costs, law enforcement costs) increased to $33.3 billion per year and indirect costs (e.g., special education, early intervention, adult homelessness, adult mental and physical health care, juvenile and adult criminal justice costs, lost work productivity) decreased to $46.9 billion. Two new categories were added for this analysis: indirect costs of early intervention and emergency/transitional housing.[19]

In a study published by the CDC in 2012, researchers found that the total lifetime estimated financial costs associated with just one year of confirmed cases of child maltreatment (physical abuse, sexual abuse, psychological abuse and neglect) was approximately $124 billion. In a sensitivity analysis, the total burden was estimated to be as large as $585 billion. Using an incidence-based approach, the study examined confirmed child maltreatment cases, including 1,740 fatal and 579,000 non-fatal cases, for a 12-month period in 2008. Findings showed that each death due to child maltreatment had a lifetime cost of about $1.3 million, almost all of it in money that the child would have earned over a lifetime if he or she had lived. The lifetime cost for each victim of child maltreatment who lived was $210,012, which was comparable to other costly health conditions such as stroke with a lifetime cost per person estimated at $159,846, or Type 2 diabetes, which was estimated between $181,000 and $253,000. However, these health issues have garnered far more research funding and public attention than child maltreatment. Given the substantial economic burden of child maltreatment, the benefits of prevention would likely outweigh the costs for effective programs. The cost benefits of prevention were investigated by the Heckman Equation Project (2016) in an analysis of the long-term effects of two high quality pre-school programs. Results showed that investing in high quality comprehensive early childhood programs can deliver a 13% return on investment.[20]

[17] Fromm, S. (2001). Total estimated cost of child abuse and neglect in the United States. Chicago: Prevent Child Abuse America.
[18] Prevent Child Abuse America. Estimated Costs of Child Maltreatment, 2002.
[19] Gelles, Richard J., & Perlman, Staci (2012). Estimated Annual Cost of Child Abuse and Neglect. Chicago IL: Prevent Child Abuse America.
[20] Garcia, J. L., Heckman, J.J. & Pradas, M. J. "The Life-cycle Benefits of an Influential Early Childhood Program." (2016):n. pag. Web

For the past twenty years, the Healthy Families Montgomery program has provided high quality, comprehensive services utilizing highly trained paraprofessionals. The program has demonstrated success at achieving both short-term and intermediate outcomes.

History

In 1995, the Freddie Mac Foundation awarded a grant to the Family Services Agency, Inc. (FSAI) to establish the first Healthy Families site in the State of Maryland. Simultaneously, FSAI received funding for the first Early Head Start program positioning the agency to become a pioneer and leader in the provision of home visiting services to high-risk families.

HFM started serving families in June 1996, and by the end of its first year had served 45 families in Upper Montgomery County. There was no affiliation process established by the National Healthy Families America office at that time, nor was there public funding from the County or State. Initially, the program received funding only from Freddie Mac and in-kind support from the Montgomery County Department of Health and Human Services. Several Community Health Nurses were trained to do screenings and assessments for the program and two Public Health Services staff were trained to become half time Family Support Workers (FSW). Thus, HFM began with one Program Director/Supervisor, two full time and two half time FSWs, with the nurses responsible for the screenings and assessments.

Equipped with positive evaluation findings in 1998, HFM successfully advocated the Maryland State legislature, who subsequently allocated $3.5 million dollars to replicate the program in 15 counties statewide. Healthy Families Montgomery received its first national credential in November 1999 and received an expedited re-credential in December 2003. As the first credentialed Healthy Families America site in the State of Maryland, HFM led the way for all of the other 14 sites to receive their credentials.

Community Context

When the HFM program was established, Montgomery County was experiencing a dramatic shift in population demographics. As the largest jurisdiction in Maryland and historically considered affluent, Montgomery County became home to an increasingly poor and more diverse population. Due to a tremendous wave of immigration, the County hosted the largest minority population (40%) in the state and the largest Latino population in the greater metropolitan Washington DC area. There were an estimated 16,000 to 20,000 undocumented immigrants.[21] Recent Census data indicates that Montgomery County's population of over 1 million residents has continued to grow over the past twenty years. Between 2000 and 2012, the County's population grew more than 15%, largely due to immigration. The number of immigrants from Central America increased by 25%; from South American by 13%; and from other areas by 20%. By 2012, the County's minority population accounted for 52.2% of the total. Of the children aged 5 years and older, 39% speak a language other than English at home, and 40% report not speaking English very well.[22]

[21] U.S. Census Bureau, American Community Survey, 2002.
[22] Family Services, Inc. "Discovery Station Early Head Start Community Assessment: Program Year 2015-2016" Family Services, Inc., Gaithersburg, MD. 2016.

The largest segment of population growth was children one year old or less (2000-2012). Overall, 9.4% of all children live below the federal poverty line. However, according to the 2012 Self-Sufficiency Standard, Montgomery County requires an income four times the federal poverty level to afford basic necessities. The poverty rate for children under age 5, who live below 300% of the federal poverty level, is 38%. The number of Montgomery County children living in single, female head of households increased 46% from 2000-2012.

The demographic trends of families served by HFM have reflected those of the County's. The largest ethnic group served over the past twenty years has been Hispanic, with percentages steadily increasing over time. In 2000, 56% of program families were Hispanic. This percentage rose to 60% by 2006, and to 92% by 2016.

Recognizing these population trends and the implications for social services, HFM worked hard to ensure that it developed into a culturally competent program that was responsive to diverse families and their needs. This is evident in the diversity of the HFM Family Support Workers, most of whom are Spanish-speaking and immigrants themselves. HFM has focused on alleviating many of the problems inherent to its immigrant families, such as post-traumatic stress syndrome, mental health issues, and the social isolation and acculturation difficulty that stems from limited English skills. Special emphasis has also been placed on helping these families prepare their children for entering school ready to learn.

As a result, HFM has also developed a core of expertise in cultural competence, specifically among the Hispanic population and has developed a network within the Hispanic community that helps reach new families. As many are newly immigrated, guidance in navigating the "system" provides their only means of access to necessary local resources. HFM has become recognized as the program of choice in working with, building trust and reducing social isolation among the Spanish-speaking population and in providing Hispanic families with the fundamental assistance they need to resolve their challenges and work toward self-sufficiency.

National Accreditation

The HFM program was founded on research-based best practices and has incorporated new effective practices as research has emerged over the years. HFA best practices are organized around twelve critical elements (see **Appendix J. HFA Critical Elements of Successful Home Visitation Programs**). As with all Healthy Families programs, HFM was required to complete the initial affiliation process that reflects the community's commitment to implementing the HFA model with fidelity by successfully implementing each of the twelve critical elements. To ensure that sites implement evidence-based effective practices and adhere to quality standards, they must complete the HFA accreditation process within their first three years of operation and every four years afterward in order to be considered an official Healthy Families site. During this intensive process, sites prepare a lengthy written self-assessment that is submitted to a team of peer reviewers for evaluation prior to a three-day site visit. It is through the self-assessment and site visit that the trained reviewers are able to assess the program's adherence to the 12 research-based critical elements, a set of guidelines for best practices in a home visitation program.

The HFM program has been accredited since November 1999, when it received the first national credential of all the Healthy Family America sites in the State of Maryland. In 2003 (Year 8 of the program), HFM received a rare expedited credential with no follow-up work required, based on exemplary scores on the Preliminary Credentialing Report. In 2008 (Year 13), HFM underwent the new accreditation process, during which revised standards and criteria were applied, and once again received an expedited accreditation. Accreditation standards were revised again in 2012 and HFM successfully completed the rigorous new process during Year 17 (2012-2013) and received consistently strong ratings in several program areas, including: high screening rate of over 90%; reduced caseload weight of 25 per FSW; the hiring of an Early Intervention Consultant; a high 36-month retention rate of 48.5%; and a high home visitation completion rate of 88.9%.

The HFA Best Practice Standards: July 2014-December 2017 was published by Prevent Child Abuse America in 2014 and updated in 2015. This manual provides detailed definitions of terms, descriptions of standards, procedures for documentation and measurement of compliance, scoring criteria, and directions for completing the updated Accreditation process. The HFM program completed their self-study report during 2016, which provided the necessary evidence of program policies, procedures and practices used to meet each of standards. September 18-20, 2016, HFM underwent the accreditation review process and site visit by a team of specially trained peers, after which they received the Accreditation Site Visit Report (SVR) summarizing ratings for each of the standards reviewed. Strengths noted in the report included: staff and participants had clear expectations of program operations from the intake forward; a strong Advisory Board that supports and recognizes staff; and staff mastery of CHEEERS parent-child observation tool *(Cues, Holding, Expression, Empathy, Environment, Rhythmicity/Reciprocity, Smiles)* and consistent documentation. The program met all standards, including initiation of services prenatally or at birth; use of a standardized assessment tool; services are voluntary; service intensity is appropriate; services are culturally competent; services support parent-child interaction and child development; services promote optimal health and development; caseload sizes are appropriate to meet needs of families; selection of appropriate service providers for partnering; staff training is role specific; staff is provided wrap around training; staff supervision; and program governance and administration. Several recommendations were made to increase the program's high quality implementation. These included: increase documentation of voluntariness of consent and release of information forms; revise retention analyses; expand supervision documentation to include clinical content discussed; explore ways to include new ethnic groups into program; and increase service level change documentation. By December 2016, the HFM program had responded to all recommendations, conducted training with staff, and implemented strategies to address recommendations. HFM received their new credential in January 2017 and are now accredited through March 2021.

II. METHODS

Healthy Families Montgomery is the longest-running Healthy Families America (HFA) program in the State of Maryland, and thus possesses valuable information and insight into

the strengths and challenges of the HFA home visiting model. While the HFM program promotes positive parenting in order to both minimize child abuse and neglect and ensure optimal child development, the long-term impact of the program on community indicators of child health, development, and parenting outcomes should be examined also. Having concluded its 20th year of operation, Healthy Families Montgomery stands poised for such an analysis.

The primary purposes for conducting the Year 20 longitudinal evaluation were to examine trends in program impact over time, both on participants and the community, to identify program practices leading to successful outcomes, and to determine fidelity to best practice standards affecting outcomes. Recommendations from the Office of Planning, Research, and Evaluation (OPRE) in its *Home Visiting Review of Effectiveness (HomVEE)* indicated more research and reports were needed that document program effectiveness, particularly with immigrant families that have diverse cultural backgrounds or who do not speak English as a first language. Additionally, authors recommended larger sample sizes to allow for analysis by subgroup. [23]

To that end, research methodology and data analysis procedures employed for the Year 20 longitudinal evaluation differ from the previous years' approach to include aggregate data analyses of participant demographics and performance on outcomes. Annual reports for the Healthy Families Montgomery program have typically followed a standard evaluation protocol that focused on analysis of implementation and outcome indicators within a given time frame. Findings, while informative, spoke primarily to current trends and progress achieved during that fiscal year. In contrast, data presented here on the participant population, program implementation, and outcomes reflect program changes and response patterns that have occurred since the program's inception in 1996.

To its credit, Healthy Families Montgomery (HFM) has conducted an external evaluation of the program annually since its inception, creating a detailed historical record of the program's implementation, adaptations, and outcomes. Coupled with the use of the same evaluation company, *Klagholz & Associates, LLC*, this has resulted in a consistency of methodology and analysis, increasing the credibility of longitudinal outcomes and decreasing any potential result bias.

Procedure

The comprehensive evaluation of the HFM program is a quasi-experimental pre/post-test research design without comparison group that utilizes both qualitative and quantitative data and methods. In addition to annual updates of the program's implementation and outcomes, HFM also uses internal monitoring mechanisms that enable management to evaluate program operations and fidelity, staff training, quality assurance of data integrity, service utilization and home visiting compliance. Participant data is collected on all enrollees and updated each year. The Family Support Workers (FSW) are trained to

[23] Sama-Miller, E., Akers, L., Mraz-Esposito, A., Avellar, S., Paulsell, D., and Del Grosso, P. (2016) *Home Visiting Evidence of Effectiveness Review: Executive Summary.* Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services. Washington, DC. Available at http://homvee.acf.hhs.gov

administer all measures and standardized instruments following a schedule of assessment that includes a baseline (within 60-90 days of enrollment or birth of the baby), and then follow-ups at 6 months, 12 months and annually thereafter. The Data Specialist and Program Manager ensure the consistency and quality of data entry. Quality Assurance is monitored regularly and data entry is reconciled monthly. The Team Leader reviews all scoring of standardized measures. As reports are run from the program's database, the Program Manager reviews them for completeness and accuracy. Through monthly tracking of screening, assessment and enrollment data, HFM is also able to identify gaps in service. Furthermore, the tracking of outcome measures in the program database has enabled the program to monitor compliance to the measures administration schedule, as well as to report on participant progress and program outcomes on a more frequent basis.

The Program Information Management System (PIMS) developed by the HFA national office is the primary repository of program data and outcome measures. HFM began using PIMS in 2001 and since that time the external evaluators have relied on data exports and reports from the PIMS database for the bulk of participant data. In 2013, HFM transitioned to the PIMS7 version. The repository for all evaluation data, from program inception to the present, is an SPSS longitudinal dataset created by the evaluators in 1996.

The evaluators have worked with HFM to develop and implement mechanisms for participant protection, including consent and confidentiality procedures. Evaluation components were implemented consistently across all program years. The consent forms for program participation are written at an appropriate reading level for the target population and also available in Spanish. Consent forms were also given to parents of those under the age of 18 years in order to allow minors to participate in the HFM program. Finally, clients were given consent forms for participation in the program evaluation, which were also written at an appropriate reading level and provided in Spanish. (see ***Appendix E. Parental Consent for Participation***; ***Appendix F. Parental Consent for Participation of a Minor***; and ***Appendix G. Parental Consent to Participate in Program Evaluation***).

For the purposes of this longitudinal report, data is aggregated and reported in several different ways: 1) results are summarized across the past twenty years (1996-2016); 2) results are summarized by decade (Years 1-10 and Years 11-20); and 3) results for Year 20, FY2016 are reported for all outcomes. Results and trends are compared to those identified in the HFM Year 10 Longitudinal Report (1996-2006). Annual data from Years 1-20 was graphed to illustrate trends over time in screening, assessment, enrollment, attrition, demographics, and risk levels at enrollment, and most outcomes. Comparative data from the County, State and National levels were used in each annual report and those have been updated for the past twenty years and reported where possible. Additionally, relevant local community data from the recent FSI. Early Head Start Community Assessment[24] is included. These data help contextualize HFM demographic and programmatic trends, and compare HFM outcomes to community outcome indicators.

[24] Family Services, Inc. "Discovery Station Early Head Start Community Assessment: Program Year 2015-2016" Family Services, Inc., Gaithersburg, MD. 2016.

Theory of Change

The logic model provides a useful framework for conceptualizing the program model and evaluation. It clearly links the key program components and activities to targeted change in the participants and to intermediate and long-term outcomes. **Appendix D. Healthy Families Montgomery Logic Model** provides a graphic illustration of the theory of change for the HFM program. Although modified slightly over the past twenty years, the plan was developed at program inception and has been implemented consistently since that time.

Population

The HFM program targets first-time parents residing in Montgomery County who receive prenatal care through Montgomery County Health Department and who are screened while pregnant or at the time of birth. These parents are identified to be at risk for child abuse and neglect based on a standardized screening and assessment process. Almost all HFM families screened and assessed over the past twenty years were identified at one of three Montgomery County Health Centers (Germantown, Silver Spring or Piccard). As initial points of entry for the majority of pregnant women throughout the county who are in need of government health assistance for themselves and their unborn babies, these health centers are ideal screening locations for HFM's target population. Additionally, Baby Steps nurses conduct screens of newborns and mothers in order to determine medical risk, which could lead to eligibility for the HFM program. A much smaller number of screens are completed on women who utilize other community resources.

Women with a positive screen indicating multiple stressors (i.e., single parent, self-report of depression or history of abuse) are contacted by the HFM Family Resource Specialist (FRS) to schedule a home visit to complete an in-depth assessment. The *Parent Survey* is designed to assess risk in ten domains, including substance abuse, self-esteem and depression, as well as perceived expectations about childrearing and bonding and attachment. Families who score at or above 25 are considered overburdened and at risk for poor outcomes.

For inclusion in the longitudinal sample, participants needed to be active between July 1, 1996 and June 30, 2016; this includes 988 mothers and 937 target children. The research samples for Years 1-10 includes 546 mothers and 525 children, and for Years 11-20, from July 1, 2006 to June 30, 2016, includes 427 mothers and 405 children. Comparable data from the Year 20 sample includes 131 mothers and 128 children. For some variables, data was not available or unknown; therefore, the sample size (*n)* varies within the report.

Implementation Evaluation

The evaluation has documented the evolution and implementation of the program annually for the past twenty years. Two major sources of data were used for this task: 1) existing program reports; and 2) the PIMS database. Reports and data to support this include DHHS Quarterly Reports, and staff and participant satisfaction survey data. This data was collected by HFM staff and provided to evaluators. On an annual basis, results have been used to provide feedback to program management, to assist in the interpretation of mediating influences on outcomes, and to document the program's implementation for accreditation and replication.

The HFM program database (PIMS7) includes data on enrollment, demographics, dates of home visits and other services, number and types of referrals for outside services, and program management (administration, staffing, and organizational linkages). This data was imported into SPSS by the evaluator and analyzed with outcome measures data. Date of First Home Visit is used to define when the family is officially engaged and enrolled. Likewise, the last home visit date is used to determine retention and duration of enrollment.

Outcome and Impact Evaluation

A brief description of the standardized measures and the schedule of assessment are provided in **Appendix H: HFM Description of Evaluation Measures** and **Appendix I: HFM Evaluation Administration Schedule.** In addition, **Table 1.** outlines the data collection measures, domain, administration and data points. The schedule is determined by the date of enrollment for most measures but by the age of the baby for the ASQ and ASQ:SE. Thus, there are no fixed data points; data collection is ongoing as determined by those dates. Baseline data is collected within two months of enrollment or infant date of birth with follow-up data collected at 12 months and annually thereafter for all measures.

Table 1. HFM Instrument Administration Matrix

Measure	Domain	# Items/ Admin Time	Source	Data Points
Ages & Stages Questionnaire (ASQ)	Child Development	30 items/ 30 min	Parent & child	Baseline (baby 4 months old)/ every four months
Ages & Stages: Social Emotional (ASQ: SE)	Child Social Emotional Development	30 items/ 30 min	Parent & child	Baseline (baby 6 months old)/ every six months
Center for Epidemiologic Studies (CES-D)	Mental Health/ Maternal Depression	20 items/ 15 min	Parent	Baseline (prenatally and/or postnatally baby 2-3 months)/annually
Home Safety Measure-Version 5	Home Safety	9 items/ 5 min	Parent	Baseline (enrollment) and annually
Healthy Families Parenting Inventory (HFPI)	Parenting skills and behavior (9 subscales)	63 items/ 20-30 min	Parent	Baseline (baby's birth) /annually

Frequencies and descriptive statistics were the primary data reduction tools, while *Linear and Logistical Regression* were the primary longitudinal analysis tools. *GLM Repeated Measures* analysis examines performance on a given measure across multiple time points. When collapsed across all participants, the results indicate the significance of changes in parenting skills, knowledge of child development, depression symptomology, and knowledge of home safety while enrolled in the program. Repeated Measures analysis is particularly useful in that it can provide an accurate profile of performance with only a few time points. It also helps to identify critical dosage (duration of enrollment and intensity of service) for affecting change in family status.

In addition to the univariate analysis described above, *Covariate Analysis* and *Multivariate Analysis* were also performed to investigate potential relationships among various outcome measures as well as with program variables (i.e. dosage) and participant characteristics, such as initial risk status or demographics. This type of analysis investigates mediating

effects such as the impact of the amount of service (number of home visits) or mother's risk level at entry on outcomes. Finally, an analysis of the characteristics of successful participants was conducted to develop a profile of the type of participant with whom the HFM program may be most successful.

Goals and Objectives

As with all HFA accredited programs, HFM's project objectives are grounded in research and structured around five overarching goals:

- Promote preventive health care
- Reduce the incidence of child maltreatment
- Optimize child development
- Promote positive parenting
- Promote family self-sufficiency

See ***APPENDIX P. HFM Goals and Objectives*** *f*or a detailed list of program goals and objectives.

III. RESULTS

Program Operations

As a nationally accredited Healthy Families site, the HFM program follows rigorous best practice standards in operating its program. With a focus on parenting, child health and development, and the reduction of psychosocial risk factors associated with child maltreatment, home visitors provide expectant and new parents with guidance, information, and support to promote optimal child development, positive parenting practices, long-term health and family self-sufficiency. Program activities are aligned to meet these goals, to be culturally responsive and competent, and to reflect the most recent best practice research.

Screening and Assessment: Eligibility for the program is based on the results of standardized screening and assessment tools administered throughout Montgomery County and in collaboration with partnering agencies. The screening/assessment process also plays a vital role in identifying the amount of outstanding need in the community, as well as determining the individual families' levels of need. Families may not be eligible for home visitation services or they may refuse home visiting services, but may still have referral needs that can be met through linkage to other community supports. Over the past twenty years, HFM has enhanced its ability to conduct an increased number of assessments by hiring and training additional staff.

Most families are referred to the program through one of three Montgomery County Health Centers, including Germantown, Silver Spring, and Piccard. HFM receives screens monthly from these sources and based on the risk criteria of the screen, identifies families who may receive a more in-depth assessment. Since most target families are Spanish speaking, HFM retains a bi-lingual Family Resource Specialist (FRS) to conduct the initial home visit and assessment. The highly trained FRS conducts individual family interviews (assessments) with potential HFM families to identify family strengths and challenges. Through the use of the standardized Parent Survey (formerly the Kempe Family Stress

Checklist - FSC), the assessment process offers one-on-one time with the family so that they can discuss stressors in their lives and potential concerns for welcoming a new baby into the world, as well as identify those families most in need of supportive services and offer them home visitation services. If the FRS is unable to enroll families into the HFM program due to full caseloads, the family is presented with the best available service at that time which includes a number of community resources. In addition to referrals, the FRS provides families with a Parent Packet filled with enrichment materials. Due to the voluntary nature of the program, families may decline services if for any reason they do not wish to participate. Furthermore, a family may terminate services at any time during their program participation.

HFA Leveling System: Through the HFA Leveling System (*see **Appendix K: HFM Service Levels**)*, HFM ensures that families are seen regularly and frequently, especially early in their program engagement. During pregnancy, families are seen at least bi-weekly, if not weekly, depending on the family's situation and the trimester in which they enrolled. All families are seen weekly beginning three months before the baby's due date. If a family has received 6 months of intensive weekly home visits (Level I) after the birth of the baby and the family situation is stable, the family may be promoted to Level II, with visits every other week. If the family is promoted to Level III, visits take place once a month. Families promoted to Level IV receive quarterly home visits. When families are temporarily unavailable to accept visits due to a temporary change in their work or school schedule, or are out of the service area temporarily, or if the FSW has been unable to locate or contact the family for three weeks, families are placed on Creative Outreach service level that allows up to three months for the family's situation to stabilize. HFM monitors the number of home visits expected and completed based on the FSW's caseload on a monthly basis and consistently exceeds national standards for intensive home visiting compliance.

Home Visiting: The cornerstone of HFM's success has been the use of a home visiting strategy and the trust and bond that develop between the Family Support Worker and the family. The principal aim of the home visits is to ensure that children are healthy and ready for school by conducting developmental activities with children and modeling positive parent-child interaction. In addition, FSWs focus on the parents' needs, goals, stressors, and strengths to empower them to provide the best possible care for their children. In utilizing empowering, strength-based techniques, parents come to see their FSW as an individual who advocates for their best interests. This makes it essential to utilize highly trained professionals and paraprofessional staff with strong interpersonal skills and cultural competence. Using a strength-based approach, staff provides education and support services to families who face a number of social, cultural, economic and situational risk factors that compromise their health, quality of life, and opportunities for success.

Program Activities: The program activities have remained essentially the same for the past twenty years, with some adaptations and refinements. In the first ten years of implementation, HFM focused its efforts on core program components, fidelity to the model, and building infrastructure to assure quality. Once these systems were in place, HFM expanded program capacity and enhanced the core model with a child development specialist, topical support groups, and partnerships with local mental health, school system, and health organizations. Expansion efforts were in direct response to evaluation findings

which documented an enormous number of high risk families in Montgomery County in need of HFM program services. Additionally, sustained levels of maternal depression, parental stress, and the high incidence of teen mothers in the program led to the initiation of program enhancements and linkages with other agencies to provide, for example, expert mental health consultation, child development expertise, and a fatherhood specialist.

Although the HFM program has continually adapted its core program model to the evolving needs of the high-risk population it serves, it recognized that as a prevention program model, it was not equipped to provide the intervention services needed by many of its families. This realization, coupled with a significant rise in health, mental health, housing, education and employment resources in Montgomery County, has enabled HFM to focus on its core program components and primary objectives.

Group Activities: The HFM program also offers group activities each year to provide opportunities for families to interact, share information and resources, and socialize. In the first ten years, the HFM program offered families opportunities to participate in a range of group socialization activities, such as a New Mom Support Group, Early Literacy Learning Parties, Father-focused groups, nutrition and cooking classes, health education workshops, graduation celebrations, and annual picnics. The program has continued to offer group activities; some years only quarterly, but in Year 20 monthly groups were offered. In addition to the annual picnic, activities may include a family day at a county pool or a trip to the Smithsonian Museum of American History. In Year 20, HFM sponsored trips or group activities almost every month, including: the local Water Park in August 2015; the National Zoo in DC in September 2015; a Harvest Theme group activity in October 2015; a Thanksgiving theme gathering in November 2015; a Tradition Sharing group activity in December 2015; a Family get-together in February 2016; and a trip to Imagination Stage in April 2016. Additionally, HFM held its annual Graduation celebration in May 2016, and its Annual Picnic at a local park in June 2016. All group activities were well-attended, with an average attendance of 14 parents and children. The Picnic draws the most families, with 39 parents and 32 children in attendance in Year 20. Also, through its host agency, Family Services, Inc., and other partnerships, HFM is able to provide access to families to other child development and group activities, including the Family Discovery Center, which holds ESOL and parenting classes for parents and child care for the children while the parents are attending classes; and the Kids Spot, a child-friendly waiting center for children 2-12 years of age whose families have business at the Montgomery County Circuit Court.

Parenting Activities: For most of the past twenty years, the HFM program relied primarily on the Parents as Teachers (PAT) curricula to build positive parenting skills. FSWs supplemented the PAT curriculum with a variety of resources including the Nurturing Curriculum. In 2007, PAT required standardized training from their nationally certified trainers and HFM staff were formally trained on the PAT curriculum in October 2007, and re-trained in May 2010 on the updated version of the PAT curriculum. HFM continued to implement the PAT curricula until 2014, when it was replaced with the Growing Great Kids (GGK) curriculum. GKK was selected based on recommendations from the HFA national office and due to its emphasis on attachment and bonding and alignment with the HFA program model. Staff were trained in the GGK curriculum in June 2014 and full implementation began at the start of Year 19 in July 2014. HFM is utilizing the *Growing*

Great Kids Prenatal-36 Months Home Visiting version of the curricula, which focuses on parenting, attachment, child development, and family strengthening. The skill-driven curriculum provides home visitors with research informed, strength-based and solution-focused 'conversation guides'. FSWs typically read the lessons to the family; which are intensive in the beginning with concepts and skills within a risk and resiliency framework. Following the 40 hour GGK core training, staff continues to build their expertise by means of the GGK Tier 2 certification process. The Tier 2 certification occurs over the course of six months and includes skill development exercises guided by the supervisor who also conducts shadow visits to aid in coaching staff in their skill development.

Child Development: To further promote positive child development, HFM has utilized the Ages and Stages Questionnaire (ASQ) for the past twenty years. This screening tool is administered to all target children using age appropriate developmental questionnaires. The screening process provides parents the opportunity to increase and solidify their knowledge of developmental milestones and to ensure that they have realistic expectations of child behavior. To provide additional support in identifying potential delays, in 1999 the HFM program began using an Early Intervention Consultant (EIC) on a consultant/as-needed basis. In recent years, a Program Support Specialist (PSS) has also been hired to coordinate parent education groups that promote healthy parent-child interaction, assist in completing scheduled developmental screenings in the absence of the assigned FSW, assist with training on typical and atypical development, and the preparation of materials for developmental activities. The EIC is responsible for attending agency meetings, intake information following referral, case presentations, and assessments on an as needed basis. The EIC also accompanies FSWs on home visits upon request, conducts staff trainings on child development, and coordinates referrals with Montgomery County Infants & Toddlers Program (MCITP) for families that have children with a suspected developmental delay.

Self-Sufficiency Activities: In the first ten years of implementation, HFM used quarterly Family Support Plans (FSP) for self-sufficiency goal setting. The program also increased linkages to community resources, such as mental health and substance abuse services; health consultations with a Registered Nurse, to assist families in achieving their goals. Reframed as Family Goal Plans (FGPs), these are completed with each family on an ongoing basis throughout their participation in the HFM program. Initially completed within 30 to 45 days of enrollment, FGPs help the family focus on short-term goals. FSWs encourage families to choose goals that are realistically obtainable within a three to six month timeframe. Goals are then reviewed on an ongoing basis and when achieved, new goals are formulated.

Staff and Supervision: Throughout the past twenty years, key features of the HFM program are the attributes of the program staff and the quality and quantity of the supervision and trainings offered. HFM staff members are chosen based on a variety of factors including personal and professional experience, as well as education and personality traits that make them qualified to work with an overburdened population. Staff is supported by Baby Steps nurses, who provide staff training and support around medical issues and coordinate medical care if no nurse case manager is assigned to the family. Additionally, one of the HFM program supervisors was a board certified lactation consultant and provides consultation to mothers during home visits as needed.

HFA Best Practice Standards require ongoing supervision and staff training with a minimum of one-and-a-half hours per week of one-on-one supervision to all direct service staff. HFM provides at least two hours of supervision weekly. HFM believes that in order to prevent burnout and to ensure that staff members feel supported when working with families with multiple stressors, frequent strength-based supervision is a necessity. During both supervision and in-group training sessions, the staff is offered high-quality trainings in work-related areas. Topics such as domestic violence, cultural competency and burnout prevention are explored to ensure that staff members feel fully equipped in their roles. Additionally, supervisors may arrange for individual or group trainings based on specific needs or desires identified during supervision sessions.

Caseload: The HFM program also supports its staff members by assigning each a limited caseload. Each full-time FSW has a maximum caseload capacity of 15-25 families. A weighted system is used to determine the amount of time the FSW spends with a family based on their service level. This helps the FSWs to devote time and attention to each family without feeling overwhelmed or rushed.

Interagency and Community Meetings: Ongoing communication among program staff, host agency, community partners, and statewide Healthy Families and home visiting groups is essential to quality implementation. HFM holds a variety of regular meetings specific to roles and responsibilities, as well as specialized meetings on an intermittent basis. Regular meetings include weekly management team meetings and bi-weekly administrative team meetings, monthly clinical team meetings, quarterly Advisory Board meetings, monthly Early Childhood Division Leadership meetings, monthly Montgomery County Early Childhood Coordinating Council, and monthly Baby Steps Team meetings. These are supplemented with annual organizational retreats, Healthy Families Maryland (HFMd) site directors and networking meetings, conferences (Prevent Child Abuse Conference; Maryland Home Visiting Conference), and site visits by funders or peer reviewers. Conference calls are also used to share information and network regionally and nationally (HFA Trainers; HFA National Directors). During Year 20, HFM participated in a monthly Reflective Consultation Group from February to June 2016. HFM's participation in such a wide range of meetings contributes significantly to its ability to support families with community resources, maintain high standards of practice, provide accountability to leadership and funders, and retain quality staff.

Reporting: The HFM monitors its implementation and outcomes on a regular basis and completes reports to a variety of local, state, and private funders. This level of monitoring and accountability provides critical feedback to the program about participant characteristics, data integrity, achievement of outcomes, and implementation fidelity. Reports also keep funders apprised of the program's activities, service statistics, and outcomes. Monthly and quarterly reports are submitted to Montgomery County DHHS and to Montgomery County Collaboration Council. The *Monthly Reports* summarize data on screening, assessment, enrollment, ethnicity, pregnancy status, number of target children, scheduled and completed home visits, groups held, referrals for services, and calls to other agencies/professionals. Also included in the *Monthly Reports* is service data from the Baby Steps program, and updates on grant proposals, program events, accreditation, trainings,

staffing, and community/ interagency meetings conducted each month. Individual family success stories from the HFM and Baby Steps programs are also included. The *Quarterly Reports* provide performance measurement data for the program's healthcare and child maltreatment goals and objectives, as well as updated information on enrollment, home visit completion, staffing, and specialist role descriptions and quarterly service data (Family Resource Specialist; Early Childhood Consultant; Data Specialist; and Baby Steps Nurses). An expanded version of the quarterly reporting is completed twice yearly for the Maryland State Department of Education (MSDE). The *Semi-Annual Reports* include performance measurement data and outcomes analysis on child development, parenting, and self-sufficiency objectives. In addition to these reports to County and State funders, HFM submits reports to the City of Rockville on a quarterly and semi-annual basis, and to their foundation funders based on each foundation's specific timetable and requirements.

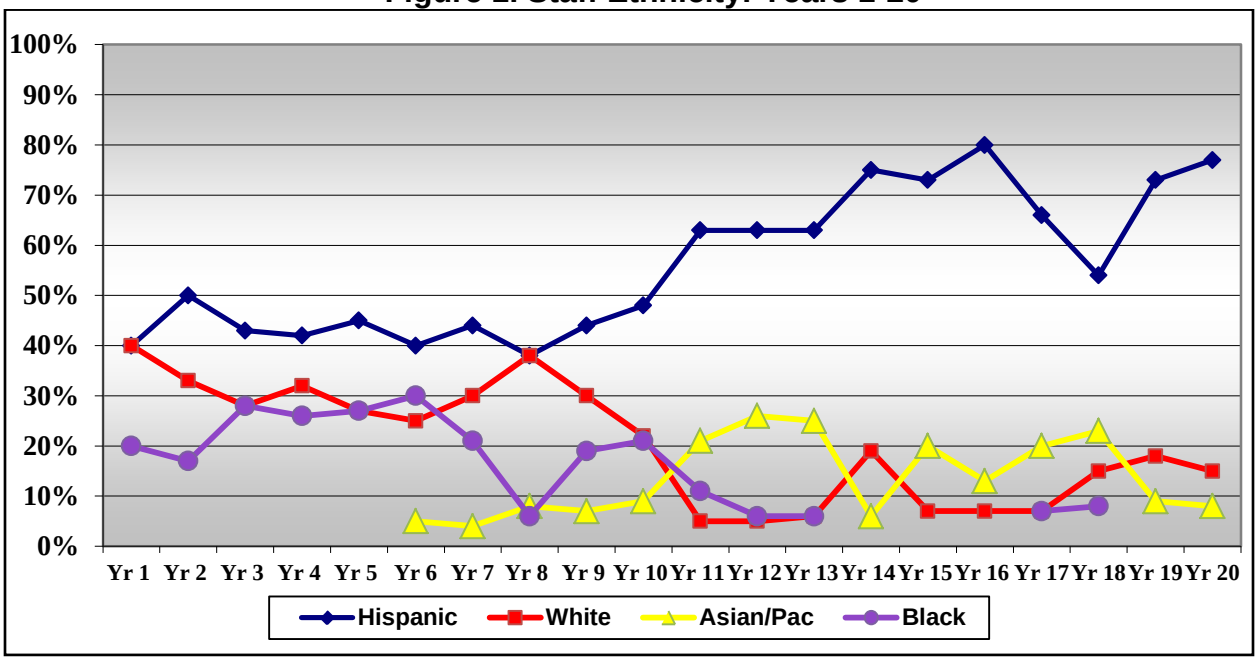
As HFM concluded its twentieth year of program operation, it continued to demonstrate that it was built on a solid foundation of research-based best practices and has adapted the program to reflect the most current research as it has grown over the years. The fidelity, quality, and consistency of program implementation over the years have ensured its consistent success at achieving outcomes.

Program Staffing

Over the past twenty years, the staffing structure has remained fairly consistent, but the number of staff members has varied depending on the level of funding and program capacity. Currently, HFM has eleven staff positions, including one Program Manager, one Team Leader, one Family Resource Specialist, one Program Support Specialist, five Family Support Workers, one part-time Data Specialist, and a part-time Early Intervention Consultant. The program also has two Baby Steps nurses and an RN consultant who are available to the HFM program on as needed basis. During Year 20, a total of 13 staff members were employed within 11 positions. Most were Hispanic (77%), while the remaining staff members were White (15%) or Asian/Pacific Islander (8%). All direct service staff were bilingual in English and Spanish (n=8), and two spoke Spanish and another language (Portuguese; French). Two staff members left the program during the fiscal year, one to return to school for a Master's degree and another who had completed a graduate degree and took an advanced position. This represents a 15% attrition rate for Year 20. Three new staff members were hired in Year 20, two FSW's and one Supervisor.

Staff Ethnicity: Over the past twenty years, the HFM program has ensured cultural and linguistic competence by hiring staff members that reflect the ethnic and cultural composition of the target population. As seen in **Figure 1. Staff Ethnicity: Years 1-20**, the ethnic composition of the staff has varied over time as it reflected changes in enrollee characteristics. In the first eight years of the program, there were relatively equivalent and steady percentages of Hispanic, White, and Black/African-American staff, which paralleled the participant population. However, between Years 6 and 8 there were some significant changes in ethnicity patterns. As the participants who enrolled in the program were increasingly of Hispanic origin, the percentage of staff increased proportionately. There was a corollary sharp decrease in Black/African-American staff, an increase in White staff, and for the first time Asian/Pacific Islander staff members were hired. All staff members have been female, with the exception of one male hired as a fatherhood specialist in 2001.

Figure 1. Staff Ethnicity: Years 1-20



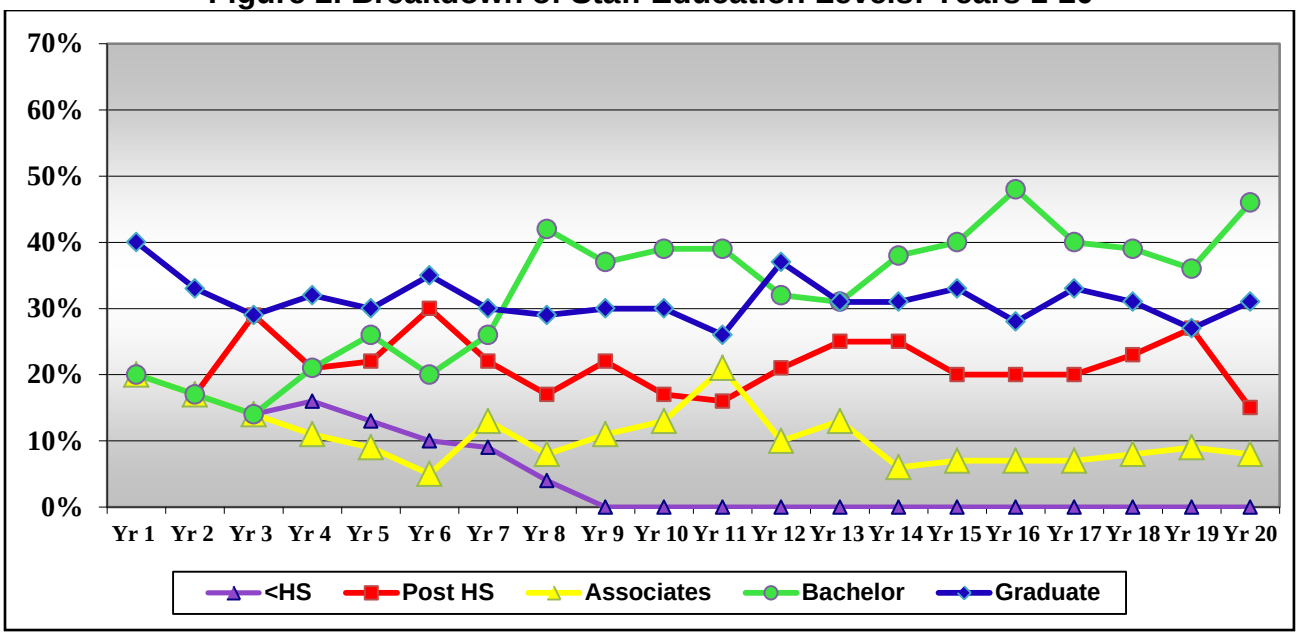
Staff Education: The HFM program's staff education levels have consistently exceeded best practice standards. In the first several years of HFA affiliation, FSWs could be paraprofessionals and were not required to have a high school degree. Subsequently, the minimum education level requirement was a high school degree with some post high school training or college. The HFA national percentage for this requirement is 74% of FSWs have some college or higher. The education levels of all staff were examined by decade and for Year 20, and are summarized in the table below with totals for the past twenty years. As seen in **Table 2. Summary of Staff Education Levels**, during the first decade a small percentage of staff (7%; n=4) had less than a high school degree. However, the majority of staff (93%; n=52) had post-secondary training or college and almost two-thirds (62%) had a Bachelor's or Graduate Degree. In the second decade and in Year 20, all (100%) of staff had post-secondary training or education, and the percentage with a Bachelor's or Graduate rose to 72% for Years 11-20 and 77% for Year 20.

Table 2. Summary of Staff Education Levels

	Years 1-10 N=56	**Years 11-20 N=20**	**Year 20 N=13**	**Years 1-20 N=76**
Education				
<HS Degree	7%	-	-	5%
Post HS/Some College	21%	17%	15%	20%
Associate Degree	9%	11%	8%	8%
Bachelor Degree	34%	42%	46%	38%
Post-Graduate/Degree	28%	30%	31%	29%
Post HS Training/ College or Higher	**93%**	**100%**	**100%**	**95%**

A more detailed examination of trends in staff education showed a steady increase in the percentage of staff members who attained a Bachelor's Degree, while the percentage of post-secondary training/college and graduate degrees remained fairly consistent over time. As seen in **Figure 2. Breakdown of Staff Education Levels: Years 1-20,** a sharp decline in staff members with less than a high school degree occurred between Years 4 and 8, dropping to zero in Year 9. The percentages of staff members with an Associate's Degree declined over time, possibly as staff achieved Bachelor's Degrees instead.

Figure 2. Breakdown of Staff Education Levels: Years 1-20

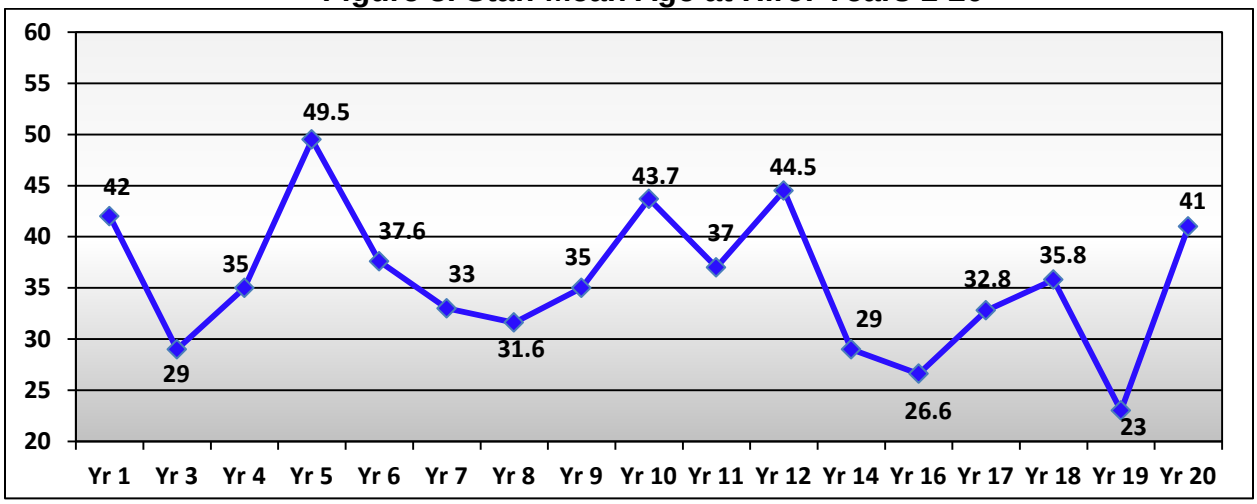


Staff Age Group at Hire: There has been a wide range of staff age at hire over the twenty years of HFM program operation that reflects both the range of mother's ages and the maturity and experience necessary for a high quality workforce. The youngest staff member hired was 20 years old, while the oldest was 64 years. Although the mean age of staff remained consistent over the duration of the program (see **Table 3. Staff Mean Age by Decade** below), there was some variation by year (see Figure 3. Staff Mean Age at Hire: Years 1-20). However, the variation in age was more strongly associated with staff position. Program managers were more likely to be older with a mean age of 48 years, but had the widest range in ages at hire (28-64 years). Staff members that worked directly with families were more likely to be younger. These direct service staff included Family Resource Specialists (FRS) who had the youngest mean age at 31 years, followed by Early Intervention Consultants (EIC) at 35 years, and Family Support Workers (FSW) at 36 years of age. Second to management in range of age, Support Staff and Data Specialists had widest range in ages (20-54 years) with mean ages of 38 years and 43 years respectively.

Table 3. Staff Mean Age by Decade

	Years 1-10	Years 11-20	Year 20	Years 1-20
Mean Age Range-at Hire	38 years 20-64 yrs.	37 years 20-54 yrs.	36 years 23-52 yrs.	37 years 20-64 yrs.

Figure 3. Staff Mean Age at Hire: Years 1-20



Staff Attrition/Retention

The HFM program has an excellent record of staff retention and retained several of its staff that was hired when the program first started. High levels of staff retention reflect a stable program that values its staff and provides opportunities for feedback and growth. Staff retention has also been linked to family retention, particularly retention of the Family Support Workers who engage the families and are directly involved with them on a regular basis. As seen in **Figure 4. Average Duration of Staff Tenure by Year of Hire: Years 1-20**, the mean duration of tenure for staff hired in Year 1 was 11-years, reflecting several staff members that have been with the HFM program since it began. Other than Year 1, staff hired in Years 6, 7 and 8 have the highest mean tenure; between 4-5 years. Over the twenty years of the program, the mean tenure for staff was 3 years, with a range of one month to 20 years.

At the conclusion of Year 20, there were 11 active staff members. Of these, two staff members had been with the program for at least six months, two staff were with HFM for one to three years, while two staff members had been with program for over seven years, and four staff members had been with the program for over ten years, one of whom has been employed by HFM since the program began in 1996. During Year 20, two staff members left for an 85% (n=11/13) staff retention rate. One staff member left to go back to school for a Master's Degree, while the other already had a Master's Degree and accepted a promotion to another position. See ***Appendix L. Staff Tenure Dates: Years 1-20*** for details on staff tenure.

Figure 4. Average Duration of Staff Tenure by Year of Hire: Years 1-20

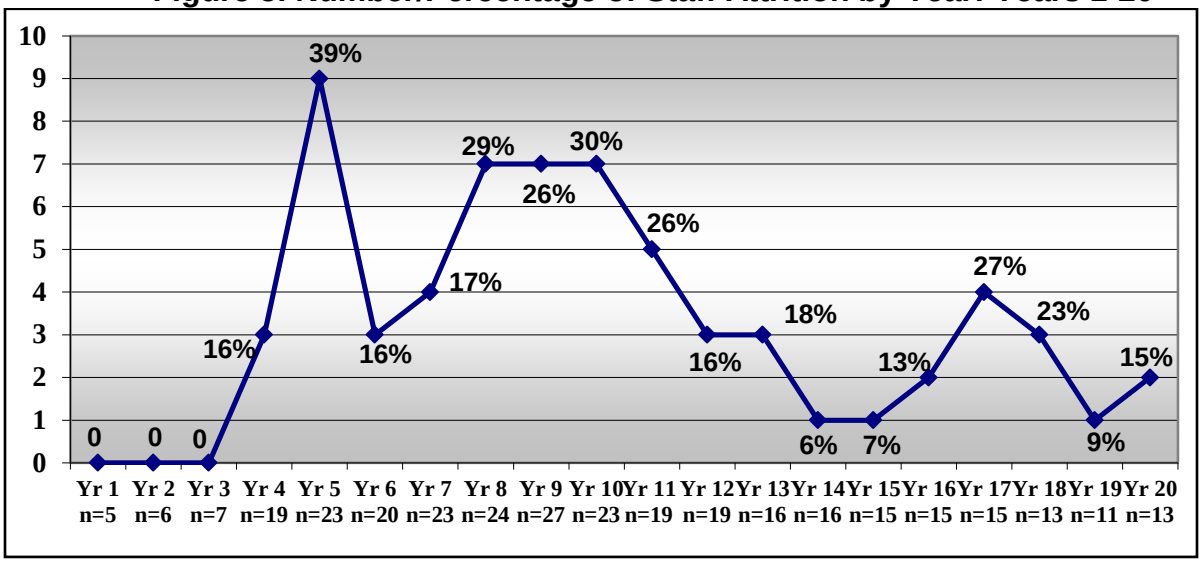
Mean length of staff tenure was compared for active staff members and those that left employment at HFM by decade and by Total Aggregate. As seen in **Table 4. Staff Tenure by Decade: Active and Exited**, when retained staff are included, the average tenure tends to be longer than when only staff who left employment are included. The exceptions observed in Years 11-20 and Year 20 are likely due to a number of staff who left the program after being employed for many years.

Table 4. Staff Tenure by Decade: Active and Exited

Years Active	Years 1-10	Years 11-20	Year 20	Years 1-20
Mean Length of Tenure-All Range of Tenure	3.9 years 1mo-10yrs	5.3 years 1mo-20yrs	7.5 years 1mo-20yrs	3.5 years 1mo-20yrs
Mean Length of Tenure-Left HFM Range	1.8 years 1mo-6 yrs.	7 yrs. 1.5-19 years	10 years 1-19 yrs.	2.8 years 1mo-19 yrs.

Staff attrition was also examined by program year. The number of staff members who were active each year is provided on the bottom axis, and the number of staff members who left during the program year is plotted on the chart. As seen in **Figure 5. Number/Percentage of Staff** Attrition **by** Year: Years 1-20**,** no staff members left the program in the first three years of operation, and only three left by the end of Year 4. However in Year 5, nine of the twenty-three staff members who were active that year left the program, representing the highest staff attrition rate for HFM (39%) over its twenty years.

Figure 5. Number/Percentage of Staff Attrition by Year: Years 1-20



Staff Training

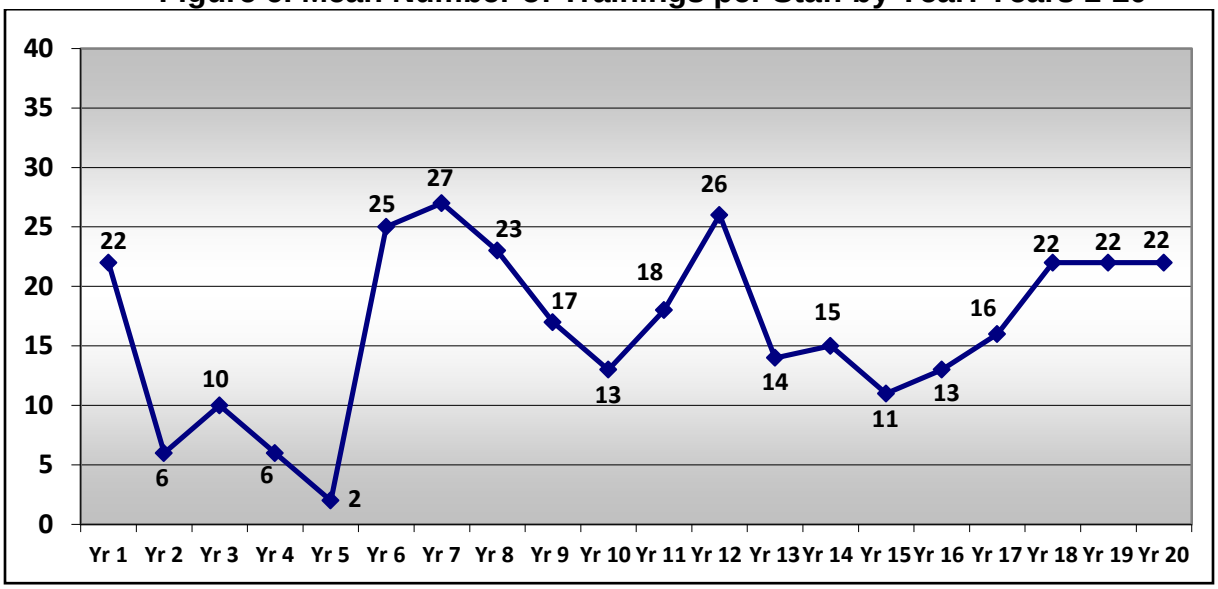
HFM provides rigorous, continuous and varied training as part of its commitment to supporting staff and ensuring that employees feel competent and prepared to deliver the highest quality service to their families. Staff training begins with the required 32-hour Healthy Families "Core Training" and initial training cover topics such as the history and philosophy of home visitation, the core strength-based approach of the Healthy Families model, identification of child abuse and neglect, professional boundaries, and limit setting and confidentiality.

As part of the HFA accreditation process, certain trainings have been identified as required at various timeframes. For example, some core trainings, such as those mentioned above, are required prior to FSWs completing any home visits with families. Other trainings are required within six months or one year of hire and include role-specific training. Additionally, "wrap-around" trainings are required on an ongoing basis. Beyond these required trainings, the HFM program provides trainings particular to its service population and staff makeup. For example, supervisors may identify a training area need based on a particular staff member's interest or request for additional information.

Training data was available for 23 staff members from Year 1 to Year 20. Over the past twenty years, 2,920 trainings were attended by the 23 staff members and covered a range of topics. Details of trainings by date and with number of staff who attended can be found in ***Appendix M. Healthy Families Montgomery Staff Trainings: Years 1-20***. The overall average number of trainings per staff member during their entire tenure at HFM was 127 trainings with a range from 25 to 372 trainings. As seen in **Figure 6. Mean Number of Trainings per Staff by Year: Years 1-20**, the average number of trainings per staff member varied by year. At project start-up in Year 1, staff attended an average of 22 trainings. Higher averages are also associated with years in which a larger number of employees were hired. For the past three years, the average number of trainings has remained consistent at 22 per staff member per year. Over the past twenty years, the

average number of trainings per staff member per year was 17 trainings with a range of 1 to 32 trainings.

Figure 6. Mean Number of Trainings per Staff by Year: Years 1-20



The training topics offered by HFM can be divided into six general areas: 1) Professional Development, 2) Topics related to Culture; 3) Parenting; 4) Family Mental Health/Well-Being, 5) Family and Child Health Care, and 6) Child Development. As seen in **Table 5. Summary of Staff Trainings by Category**, most of the trainings fell within the area of Professional Development, which includes topics such as the HFA core trainings; agency and program orientations; confidentiality and HIPAA compliance; evaluation and tools administration; FSW supports and stress reduction; home visitor safety; PIMS forms; Child Welfare/Child Abuse and Neglect indicators and reporting requirements; HFM service level definitions; supervision; professional boundaries; community resources; Family Support Plans; conferences/retreats; the 7 Habits of Highly Effective People; motivational interviewing; crisis training; workplace health; and sexual harassment/ discrimination prevention.

Family Mental Health/Well-Being trainings were the second most frequently offered and attended. This category includes topics such as prevention and treatment of Child Abuse and Neglect (CAN); infant and toddler mental health; domestic violence, substance abuse; prenatal/post-partum depression; suicide prevention; abusive head trauma; Post-Traumatic Stress Disorder; adoption; assessing/supporting child social emotional development; engaging fathers; and Trauma Informed Practice.

It is not surprising that Child Development was the third most frequently offered category of trainings since one of the major goals of all Healthy Families programs is to promote positive child development. Most of the trainings in this category focused on the use of the Ages and Stages Questionnaire (ASQ) and the Ages and Stages Questionnaire-Social Emotional (ASQ-SE) for developmental screening and parent education, but also included trainings on Autism, bonding and attachment; brain development; resiliency for infants and

toddlers; literacy; and use of the Parents as Teachers (PAT) and Growing Great Kids (GGK) curricula.

Also, as seen in **Table 5. Summary of Staff Trainings by Category**, the number and variety of trainings increased significantly from the first to the second decade, particularly in the professional development category. These findings are indicative of HFM's emphasis on developing highly professional staff that are well-equipped to focus on their family's mental health and helping parents optimize their child's well-being. The extensive number and type of trainings offered demonstrate the program's dedication to expanding the knowledge and skill set of its staff.

Table 5. Summary of Staff Trainings by Category

	Years 1-10	Years 11-20	Year 20	Years 1-20
Professional Development	94	112	33	165
Topics Related to Culture	11	17	6	23
Parenting	7	10	5	16
Family Mental Health/Well-Being	38	38	10	66
Family and Child Care	19	26	13	33
Child Development	29	40	5	59
TOTAL	**198**	**243**	**72**	**362**

**Note: Some of the trainings in both decades were the same and are counted separately for each decade, but were collapsed for Years 1-20 totals.*

The characteristics of HFM staff over the past twenty years are summarized in **Table 6. Profile of Staff Characteristics by Decade: All Staff Positions**. As seen in the table, other than the average age of staff ages at hire which has been fairly consistent, all characteristics have changed significantly over the two decades of program operation. The staff has become more likely to be Hispanic, bilingual in Spanish and English, have a college or graduate degree, and remain employed with the program for a longer period of time.

Table 6. Profile of Staff Characteristics by Decade: All Staff Positions

	Years 1-10 N=56	Years 11-20 N=20	Year 20 N=13	Years 1-20 N=76
Ethnicity				
Hispanic	44%	64%	77%	49%
White	29%	5%	15%	23%
Black	24%	14%	-	20%
Asian Pacific Islander	4%	17%	8%	8%
Bilingual (FSW/FAW only)				
English/Spanish	61%	80%	100%	67%
English/Other	-	13%	-	4%
Education				
<HS Degree	7%	-	-	5%

	Years 1-10 N=56	Years 11-20 N=20	Year 20 N=13	Years 1-20 N=76
Post HS/Some College	21%	17%	15%	20%
Associate Degree	9%	11%	8%	8%
Bachelor Degree	34%	42%	46%	38%
Post-Graduate/Degree	28%	30%	31%	29%
Mean Age	38 years	37 years	36 years	37 years
Range-at Hire	20-64 yrs.	20-54 yrs.	23-52 yrs.	20-64 yrs.
Mean Length of Tenure	1.8 years	4.3 years	7.5 yrs.	3.5 years
Range of Tenure	1mos-4 yrs.	5mos-19yrs	1mo-20yrs	1mo-20yrs

Staff Satisfaction-Year 20

In July/August 2016, twelve staff members completed a questionnaire designed to solicit feedback on HFM staff's perceptions regarding job satisfaction and work-related stress, views on program strengths and areas for improvement, as well as perceptions of support and benefits they have received while working for HFM (see Appendix N: Staff Satisfaction Survey). All respondents identified their position within the agency. Seven respondents identified themselves as either an FSW or FRS, while two were identified as a manager/team leader and three marked in the 'Other-Administrative' category.

The questionnaire consisted of 23 statements accompanied by a 5-point Likert scale, in which to indicate level of agreement for each item. As seen in **Table 7. Staff Agreement with Various Program Aspects**, most staff members agree or strongly agree with the positive statements about the program. However, areas that were not endorsed strongly were the responsiveness of management to needs of staff, the representativeness of program management of the target population, and notably, staff comfort working with culturally diverse families. Additional training may be necessary in building staff skill and comfort in working with diverse families.

Respondents: What is your job with HFM?

Family Support Worker or Family Resource Specialist	7
Manager/Team Leader-	2
Other (Early Intervention, Nurse, Administrative)	3

Table 7. Staff Agreement with Various Program Aspects

(n=12)

	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree	No answer/ N/A
I understand the goals and objectives of HFM.	12					
HFM is a strength-based and family centered program.	12					
HFM trainings have adequately prepared me for my position.	9	2	1			
My supervisor is responsive and supportive of my needs.	8	2				2
The program uses materials that						

	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree	No answer/ N/A
are culturally and linguistically appropriate.	10	2				
The program uses bilingual materials as appropriate.	10	2				
I feel comfortable working with the culturally diverse families served by HFM.	10	2				
I enjoy being part of the HFM team.	11					1
My work is worthwhile and has a positive impact on children and families.	12					
The work I do uses my skills, knowledge and experience.	11	1				
I generally feel safe in the communities I visit.	4	6	1			1
HFM management shows appreciation for the work I do for the program.	8	4				
I am adequately compensated for my position.	2	4	1	5		

Staff members were asked to indicate how often they feel stressed at work. As seen in **Table 8. Staff Report of Job Stress: Year 20**, most staff (n=10) 'Sometimes' feel stress associated with their work, while two respondents (n=2) "Rarely" feels stressed.

Table 8. Staff Report of Job Stress: Year 20

How often do you feel stressed at work?	Never	Rarely	Sometimes	Often	Every Day	No Answer
	-	2	10	-	-	-

Staff members were asked what benefits they had received as a result of their employment. Most reported an annual cost of living increase (n=9) and training certification (n=6). Remaining staff reported a staff appreciation event (n=4) and 'Smiles and Praises' (n=2). **Table 9. Staff Report of Employment Benefits Received: Year 20** shows staff reports of the employment in Year 20.

Table 9. Staff Report of Employment Benefits Received: Year 20

Have you received/taken part in any of these employment incentives during the past year?	Annual Cost of Living increase	Promotion	Training certification	Staff appreciation event	Smiles and Praises	Other Bonus
	9	-	6	4	2	-

In order to assess the staff's perception of the strengths and weaknesses of the program, they were presented with two open-ended questions. When asked what areas of the program are particularly strong, comments

"Due to trainings, I feel very well prepared to do my job."

focused on several key areas: the dedication and preparedness of staff, the strength-based approach of the program, and the respect for cultural diversity and the ability to connect with families. Respondents commented on the dedication and strength of staff to connect with families and empower them to be their child's best advocate. They also cited the strength-based program and a curriculum that provides services in a structured way. The training and organization management were also mentioned. **Table 10. Program Strengths Identified by Staff: Year 20** shows all current strengths noted by the staff and the frequency with which they were cited.

Table 10. Program Strengths Identified by Staff: Year 20
(n=8)

Strength	Frequency
Staff (well trained, dedicated, respect for cultural diversity, strong team and leadership; connecting, empowering families)	3
Program's strength-based approach (curriculum, structured model; adherence to HFA model)	2
Training/Resources (child development; mental health; GGK)	3

When asked which areas of the program need improvement, five staff members offered responses. Areas identified as targets for improvement included: 1) Reduce the amount of paperwork and evaluations cited by two staff; 2) Better compensation for home visitors; 3) Using English; and 4) Have a training on community resources.

Additional comments included, "More team building activities for program/sites."; "I am happy to be part of this institution. I feel I am supported." and "Annual cost of living is not compatible with the cost of living increase." One staff member requested that a more efficient and faster way of reporting CHEEERS be used, such as using a check mark instead of notes for concerns.

Program Participation

Screening, Assessment and Enrollment

The screening, assessment and enrollment procedures for the HFM program have remained essentially the same for the past twenty years. HFA has refined their implementation of these procedures to meet updated best practices. The HFM program has had a longstanding partnership with the Montgomery County Department of Health and Human Services. As the major provider of reproductive health and social services to income-eligible families in the County, DHHS conducts universal screenings of all prenatal, perinatal and postnatal female clients. The screen consists of 15 items measuring self-sufficiency and psychosocial factors, such as marital status, income, housing status, history of substance abuse, depression, etc. If the woman is single, has had late or no prenatal care, or unsuccessfully sought or attempted an abortion, the screen is positive. If any two factors are true, or if seven factors are unknown, the screen is also positive. Health Centers are asked to send all positive and negative screens for first-time mothers to the HFM

program for tracking. Positive screens are reviewed by the Family Resource Specialist (FRS), who completes assessments on families in the order of their due date.

Families who receive a positive score on their initial screen are referred for a more in-depth assessment interview, conducted by the FRS in the family's home. A standardized measure known as the Parent Survey, formerly the Kempe Family Stress Checklist-FSC, measures risk in ten domains, including self-esteem, depression, and substance abuse, as well as perceived expectations regarding childrearing, bonding and attachment. Therefore, there is no single eligibility requirement, but rather information is collected on a range of possible risk factors. Families must score 25 or higher to be eligible for the program. Since the program is voluntary, if eligible families decline home visitation services or if there is no available space in HFM for new families, the FRS uses in-depth knowledge of community resources to connect families to needed linkages immediately.

Table 11. Screening, Assessment and Enrollment: Years 1-20 shows the total screening and assessment data for the past twenty years of program implementation. In total, over 15,760 positive screens for risk of child maltreatment have been referred to HFM, and over 2,680 in-depth assessments have been completed. The program capacity has expanded and contracted over the past two decades, with a high of 160 spaces in Year 5. However, due to reductions in funding, the program capacity steadily declined and has remained at 130 spaces for the past several years. Variations in new enrollees each year correspond to changes in capacity and attrition numbers.

Table 11. Screening, Assessment and Enrollment: Years 1-20

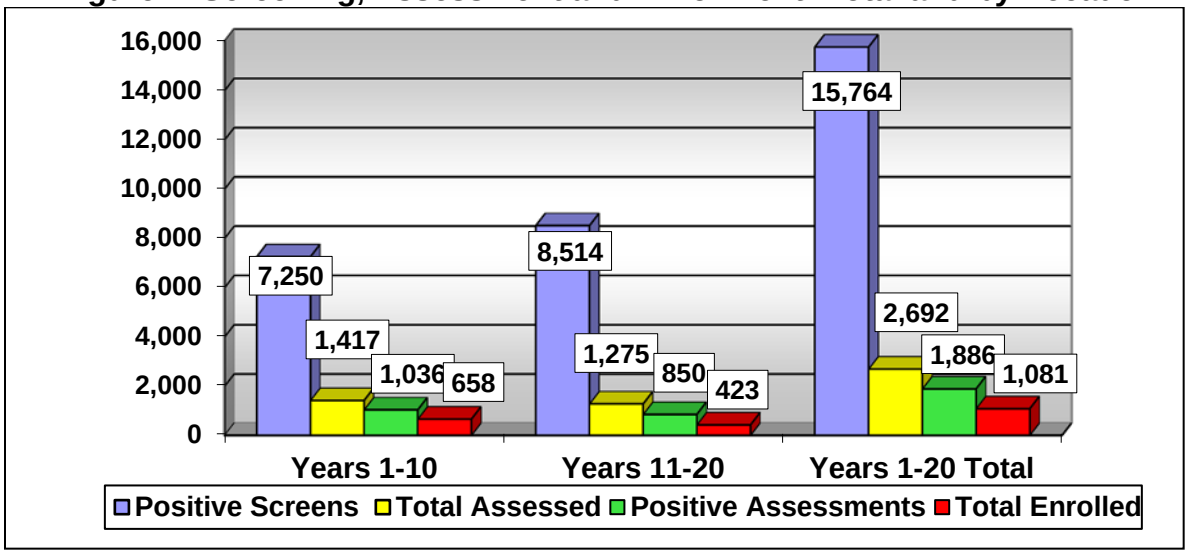
YEAR*	Total Positive Screens	Total Assessments Completed	Total Positive Assessments	Total Negative Assessments	Total New Enrollments	Total Refusals	Program Capacity
YR 1	-	-	-	-	48	-	50
YR 2	393*	-	-	-	50	-	75
YR 3	787	49	49	0	49	0	75
YR 4	824	110	108	2	104	4	150
YR 5	828	63	60	3	53	4	160
YR 6	854	153	133	20	86	34	150
YR 7	941	260	190	67	83	77	150
YR 8	934	191	137	54	39	54	150
YR 9	934	293	179	114	86	36	150
YR 10	755	298	180	118	60	15	140
YR 11	1090	162	110	49	65	26	130
YR 12	1244	165	100	52	43	25	130
YR 13	1144	148	80	64	33	4	130
YR 14	990	124	83	42	44	12	130
YR 15	777	131	82	40	38	23	130
YR 16	784	131	87	42	43	16	130
YR 17	687	57	36	15	15	10	120
YR 18	682	106	88	18	47	12	120

YEAR*	Total Positive Screens	Total Assessments Completed	Total Positive Assessments	Total Negative Assessments	Total New Enrollments	Total Refusals	Program Capacity
YR 19	635	131	97	34	39	30	120
YR 20	481	120	87	33	56	13	130
TOTAL	**15,764**	**2,692**	**1,886**	**767**	**1,081**	**395**	--

* Screening and Assessment Data from DHHS is incomplete for Years I and 2 of the program

Screening, assessment and enrollment data were compared by decade and with the aggregate for Years 1-20. As seen in **Figure 7. Screening, Assessment and Enrollment: Total and by Decade**, only a small percentage of families who have screened positive for risk were assessed; and only a small percentage of families with positive assessments were able to be enrolled in the HFM program. Over the past twenty years, of the 15,764 positive screens referred to the HFM program, only 17% were assessed. The percentage was slightly higher during Years 1-10 when 20% of positive screens were assessed, compared with Years 11-20 when only 15% of positive screens were assessed. This is not surprising given that, due to budget and program capacity limitations, for most of the past twenty years the HFM program has only had one or two Family Resource Specialists available to assess families. Of those families assessed in the past twenty years, 70% were found to be positive and eligible for the program, but only about half (57%) were enrolled due to space limitations. During Years 1-10, of the families that received an assessment, 73% scored positive and eligible for the HFM program. Of these positive assessments, about two-thirds (64%) were enrolled in HFM. Percentages were slightly lower for Years 11-20 as 67% of families who received an assessment scored positive, but only half (50%) were enrolled. These findings indicate that the screening and assessment processes are effective in identifying families at-risk for child maltreatment, but staffing and program capacity limitations make it impossible to assess and enroll all families in need. This reflects the ongoing gap in services for the at-risk population in Montgomery County. For those families who are identified to be at-risk by the assessment process but not enrolled, HFM refers them to other services and resources in the community as appropriate.

Figure 7. Screening, Assessment and Enrollment: Total and by Decade



Attrition and Retention

The HFM program measures its attrition and retention rates on an annual basis as part of its ongoing comprehensive external evaluation. Historically, intake and termination dates were used to calculate the attrition/retention, however, the most recent *HFA Best Practice Standards* required that first and last home visit be used for these calculations. Data for this report follows this methodology and annual data was re-calculated for the table below. Additionally, standards require that HFA programs comprehensively analyze retention by following a cohort of families who enrolled within a specified time period for at least two years post-enrollment. For HFM's accreditation process this past year, the 2013 and 2014 cohorts of enrollees were examined at 6, 12, 24, and 36-months.

Table 12. HFM Attrition: Years 1-20 shows annual attrition rates across the twenty years of the program. Attrition rates exclude the families who left due to graduation or the child reaching the maximum age for HFM. Therefore the attrition rate is calculated based on the number families who closed for other reasons. The HFM aggregate attrition rate of 28% is consistent with recent years and the program's average attrition rate of 27%.

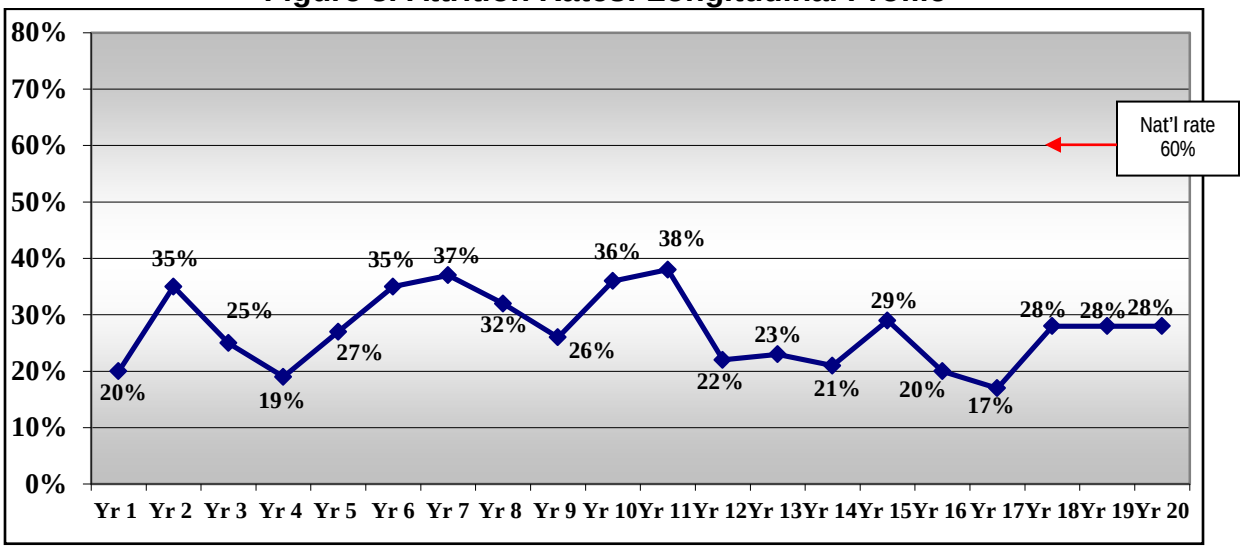
Table 12. HFM Attrition: Years 1-20

Year	Carryover from previous yr.	Enrolled in fiscal year	Total enrolled during fiscal year	Closed* during fiscal year	Graduated / Max Age	Attrition Rate*
Year 1	-	48	48	10	-	21%
Year 2	38	50	88	31	-	35%
Year 3	57	47	104	26	-	25%
Year 4	78	104	182	34	-	19%
Year 5	148	53	201	44	7	22%
Year 6	140	86	226	78	11	35%
Year 7	137	83	220	82	11	37%
Year 8	128	39	167	53	2	32%
Year 9	112	86	198	51	16	26%
Year 10	131	60	191	68	9	36%
Year 11	113	65	178	67	10	38%
Year 12	101	43	144	33	15	23%
Year 13	96	33	130	30	3	23%
Year 14	97	44	141	29	15	21%
Year 15	97	38	135	32	9	24%
Year 16	94	43	137	27	16	20%
Year 17	94	15	109	19	14	17%
Year 18	76	47	123	34	6	28%
Year 19	83	39	122	34	13	28%
Year 20	75	56	131	36	10	28%
Longitudinal						**X=27%**

**Does not include case closures due to program graduation or child 'aging out'*

As seen in **Figure 8. Attrition Rates: Longitudinal Profile**, over the past twenty years, attrition rates have ranged from a low of 17% in Year 17 to a high of 38% in Year 11. The average attrition rate of 27% is less than half of the national rate of 60% and the HF New York rates of 50%-70%[25].

Figure 8. Attrition Rates: Longitudinal Profile



Although attrition rates are relatively low, the HFM program strives to retain families by analyzing case closures and developing strategies to reduce attrition. A more in-depth analysis of attrition and retention was completed using best practice standards and following cohorts of enrollees over time. A summary of those results are provided after the Duration of Enrollment section.

Reason for Case Closure

For Year 20, a total of 131 families and 127 children were served. A total of 46 families were terminated during FY'16. *Of these, 17% (n=8) of families met all of their program goals and graduated from the program.* In addition to these graduating families, two families (4%) left because their child had reached the maximum age for participation in the HFM program. A total of 38 families left the program for a variety of other reasons. Most left the program due to scheduling conflicts with their job (37%) or moving out of the service area (20%). Some families refused services (11%) or were unable to be contacted by the program staff (7%)

Reasons for case closure were aggregated by decade and for the twenty years of the program. Percentages are summarized in **Table 13. Comparative Reason for Termination by Time Period,** and presented with the most recent year's results. As seen in the table, the percentage of mothers that leave the program due to work or school conflict has increased significantly over time so that in Year 20 two-thirds of mothers who left the program did so in order to work or finish school. This may reflect program efforts to

[25] Healthy Families New York, *Programs that Work, Promising Practices Network*. March 2011. Retrieved from http://www.promisingpractices.net/program.asp?programid=147

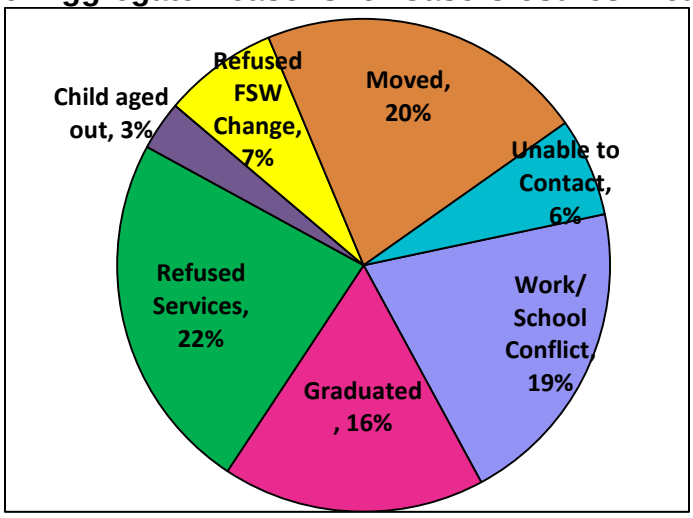
link mothers to job resources and support mothers to finish school. It also may indicate the increased availability of community resources for employment and job training. Also, the percentage of mothers who refused services and who refused a change in FSW have decreased over time and in Year 20 the percentages were less than half that of the first decade. This decrease may indicate that the HFM program has improved its ability to engage families at enrollment and to facilitate transitions in staffing. Percentages for families who may leave the program due a move out of the service area or being unable to contact have remained fairly consistent over time and may be associated with stable and affordable housing within the service area.

Table 13. Comparative Reason for Termination by Time Period

Reason for Termination	Years 1-10	Years 11-20	Year 20	Aggregate Years 1-20
Graduated	17%	13%	17%	16%
Moved	22%	19%	20%	20%
Work/School Conflict	13%	29%	37%	19%
Refused Services	25%	16%	11%	22%
Unable to Contact	6%	6%	7%	6%
Refused change in FSW	9%	5%	2%	7%
Child Aged out	2%	5%	4%	3%
Other	6%	7%	2%	7%

As shown in **Figure 9. Aggregate Reasons for Case Closures: Years 1-20**, in addition to the families who graduated (16%), the largest percentages of families who left the program over the past twenty years did so because they decided they did not want or need services any longer (22%), or due to a move out of the service area (20%). A number of families left to return to school or work and therefore did not have time for home visiting (19%). The remaining families were closed because they refused a change of FSW (7%), could not be contacted (6%), or the target child aged out at either 3 years or 5 years (3%), the maximum age for the HFM program.

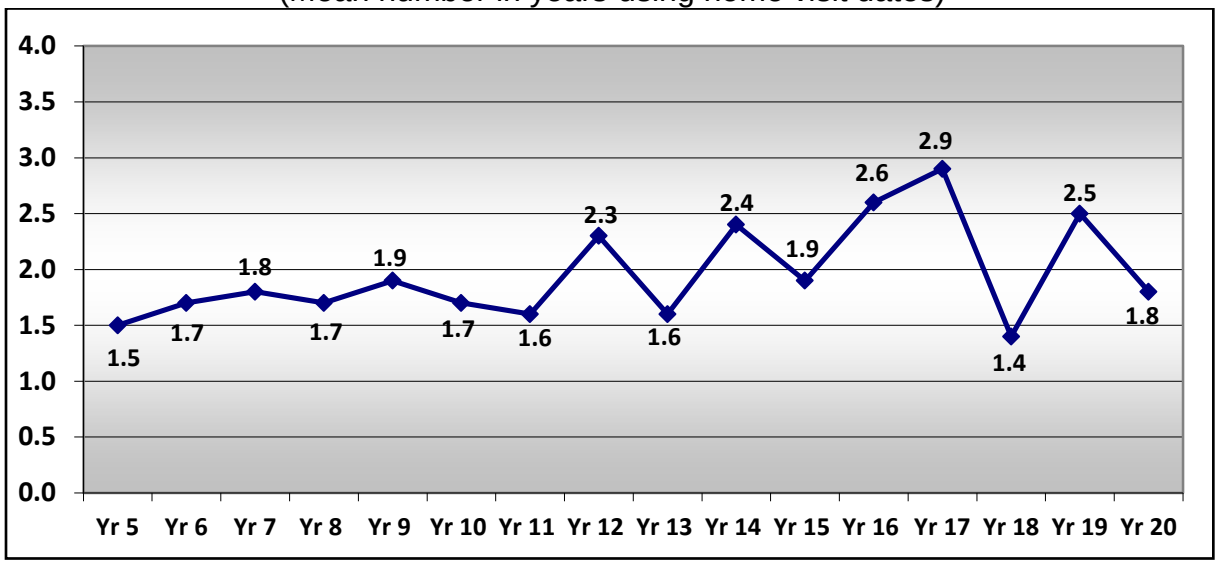
Figure 9. Aggregate Reasons for Case Closures: Years 1-20



Duration of Enrollment

Following the methodology in the most recent HFA Best Practice Standards, the length of time families participated in the program was examined by calculating the duration of time between the first and last home visits, where the last home visit date represents the last visit before the case was closed. Accurate home visit data was only available for Years 5 through Year 20; therefore only closed cases for those years are included in this analysis. As seen in **Figure 10. Duration of Enrollment Closed Cases: Years 5-20**, most families remain in the program for about two years. The longest mean durations of time were achieved in Year 16 (2.6 years) and Year 17 (2.9 years). The shortest mean durations were in Year 5 (1.5 years) and Year 18 (1.4 years).

Figure 10. Duration of Enrollment Closed Cases: Years 5-20
(Mean number in years-using home visit dates)



When examining duration of enrollment by decade, first and last home visit dates were used in calculations. For Years 5-10, the mean duration was 2.0 years with a range of.06 to 5.56 years. For Years 11-20, the mean duration was 1.7 years with a range of 0 to 5.26 years. The aggregate mean duration of enrollment is two years. This level of *participation, coupled with the percentage of families that stay until graduation (16%) or* the child's 3rd or 5th birthday (3%) indicate that the HFM program is retaining families for the periods of time necessary to achieve success in reaching both the program's and the families' goals.

Retention Analysis from Accreditation

FY 2014-Year 18 Retention Summary

A more in-depth analysis of attrition and retention data was completed following the HFA Best Practice Standards. Retention data was examined for the FY 2014 cohort of enrollees across the following categories: Age, Gender, Marital Status, Educational Status, Employment Status, and Language. Data were available through 36 months; to understand the course of attrition and retention, rates were calculated for 6, 12, 24, and 36 months. These analyses were accompanied by average retention length values for each of the categories.

Of the 47 families who enrolled in FY'14, thirty-four ended services before the end of FY'16. Most of these families terminated due to scheduling conflicts with job or school, which may indicate they were building self-sufficiency. Similarly, a high percentage refused services or couldn't be contacted, while a smaller percentage moved out of the service area. Although little can be done to prevent a family moving from the service area, there may be additional factors that impact other reasons for termination. Some of these factors may be related to differences in FSW retention, where scheduling conflicts were a common reason for termination across FSWs, but clear differences in FSW retention in regards to changes in FSW and being unable to locate of the family, or refusing services. Reasons for these differences should be further investigated.

For FY'14 enrollees, attrition was greatest for families on Level 1, when they are receiving weekly home visits and the most intensive services. It is unclear whether this is due to engagement issues or if the family is not available or ready for intensive services. Families on Level XA had the second highest attrition rate, which is not surprising as they were already having issues scheduling visits.

When mother's characteristics were examined, some differences in retention were found. The mean duration of enrollment increased with each ascending age group. Teen mothers had the lowest mean length of enrollment, while mothers over age 36 years had the highest. This trend is consistent with previous years. Mothers with a female child had slightly higher lengths of enrollment, but this is not interpreted to be significant. In contrast to FY'13 results, mothers who enrolled in FY'14 who were living with their partner had a slightly lower mean length of enrollment than single and married mothers. Single mothers had the longest mean length of enrollment. This may be indicative of a higher level of need as single mothers.

Most (n=35; 88%) mothers reported Spanish as their primary language while only three families reported English and four reported another language as their primary language. Due to the small number of English and Other speaking mothers, comparisons are difficult to make. However, mothers who reported 'Other' as their primary language had a longer mean length of enrollment than those reporting Spanish or English as their language. This may be indicative of a greater level of need when unable to communicate with others in the community and seek resources for themselves.

Consistent with previous years, mothers with less than a high-school diploma seem to have somewhat shorter retention times than mothers with a high school or post high school education. Mothers that had either an Associate's or Bachelor's degree had the highest mean length of enrollment. Education appears to be factor related to retention.
There were no significant differences in length of enrollment related to mother's employment status at enrollment, with the exception of mothers still in school. Student mothers who were unemployed at enrollment had a significantly shorter mean length of enrollment.

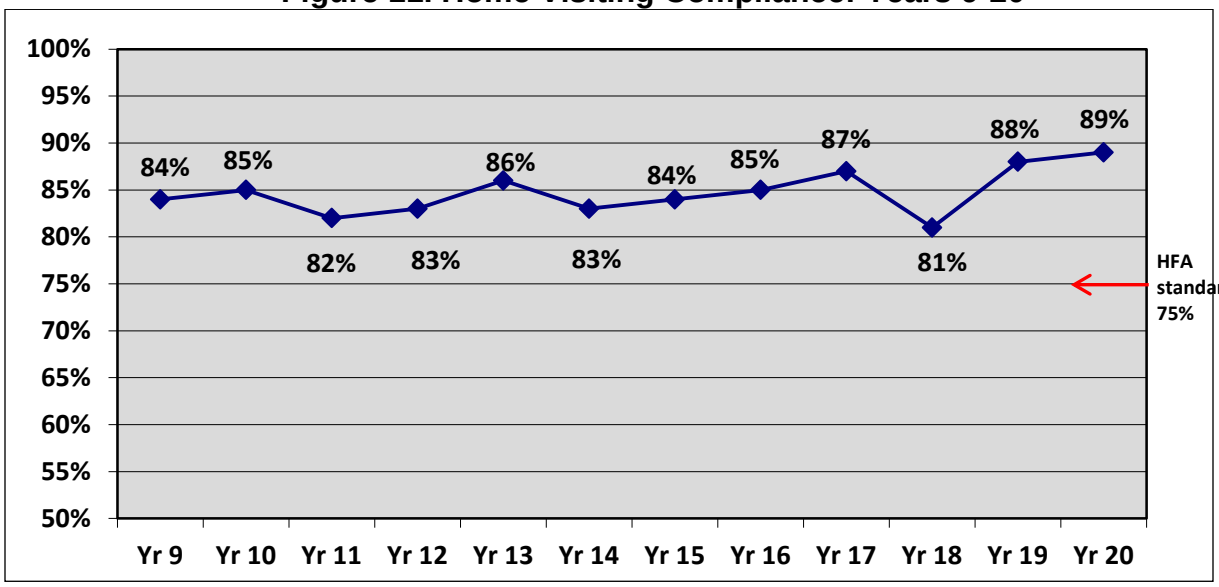
There is a trend for difference in retention length by city. This trend appears to be driven by the longer retention lengths of mothers living in Germantown and Montgomery Village,

relative to the moderate lengths of enrollment for Gaithersburg, Rockville, Silver Spring, and the shortest mean length for 'Other'. These results are not consistent with FY'13 differences in retention by city.

Home Visit Compliance

The HFM program monitors the number of expected home visits (HV) that are completed each month according to each FSW's caseload. The expected number of home visits per family is determined by their service level. As seen in **Figure 11. Home Visiting Compliance: Years 9-20**, most of the HV compliance percentages were very high and exceed Healthy Families America standards, which indicate a completion rate of 75%, is acceptable for intensive home visiting. All HFM compliance percentages are above 80%. The HFM program averaged a completion rate of 85% for the Years 9-20.

Figure 11. Home Visiting Compliance: Years 9-20



Population Demographics

The characteristics that define the program population are important because they act as mediating influences on the program effects. These demographics illuminate the risk, strength and resiliency factors with which families enter the program and assist in interpreting outcome-evaluation results. Population demographics, such as level of education and marital status; and measured risk factors, such as assessments from the Parent Survey or depression symptomology, can contribute to a participant's level of risk for child maltreatment and add to the strains on already stressed families.

The shifting national, state and local trends in population over the past twenty years are reflected in the changes in the HFM's program population. Further, the social and community context, represented in increased availability of community resources and health care, have impacted HFM's families. See **Table 14. Summary Table of Population Demographics at Enrollment** at the end of the Demographics Section for detailed comparisons by decade and for Year 20.

Mother's Age at Enrollment

Mother's age is an important factor influencing the way in which a mother parents. The younger a mother is, the more she at risk for maladaptive parenting.[26] Teen and young mothers face particular challenges in terms of completing educational goals, achieving self-sufficiency, lack of social supports and single parenting, and a lack of emotional maturity necessary for parenting. Additionally, the U.S. Department of Health and Human Services reports that girls who have a teen pregnancy are more likely to be poor as adults and cost taxpayers more in increased public assistance payments and health care costs.[27]

The good news is that the 2014 teen birth rate in the U.S. is at a record low. In 1990, before the HFM program was funded, the teen birth rate was 62 per thousand. This fell dramatically to 42 per thousand in 2007, and then again to 24 per thousand in 2014. Teen birth rates among blacks and Hispanics have fallen faster than among whites, but non-white teens had at least twice as high as whites. The Pew Research Center attributed the declining birth rate among teens to economic factors, such as the recession in 2007. Additional factors included more effective contraception, more information about pregnancy prevention, and less sex among teens.[28] At the state level, Maryland's teen birth rate dropped to from 46 per thousand in 1996 to 33.6 per thousand in 2006. By 2014, the rate dropped to 17.8 per thousand.[29] In Montgomery County, the teen birth rate was 22.6 per thousand in 1996 when the HFM program started. This dropped slightly to 21.6 per thousand in 2006, but then decreased significantly in 2014 to 12.3 per thousand. The County attributed the decreases to education about pregnancy prevention, as well as referrals to community health programs for home-based care. However, the number of teen births is among the highest of the 24 counties in the state.[30]

HFM data collected across all program years on mother's age at enrollment is shown in **Figure 12. Mean Ages of Program Enrollees: Years** 1 – **20.** There has been a general trend toward older participants entering the program, which is reflected in the steady increase in mean age. The sudden rise and drop of mean age in Year 2 reflects the creation of a separate "Teen Mothers Program" by the County. In addition to increased availability of other programs that specifically target teens, including Family Services, Inc.'s Early Head Start (EHS) program, HFM's decrease in teen mothers also reflects the decline in the teen birth rate overall.

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[26] Lewin, Amy, Stephanie J. Mitchell, and Cynthia R. Ronzio. Developmental differences in parenting behavior: Comparing adolescent, emerging adult, and adult mothers. *Merrill-Palmer Quarterly* 59.1 (2013): 23-49. Available at http://www.goodtherapy.org/blog/young-mothers-adolescence-parenting-0308131

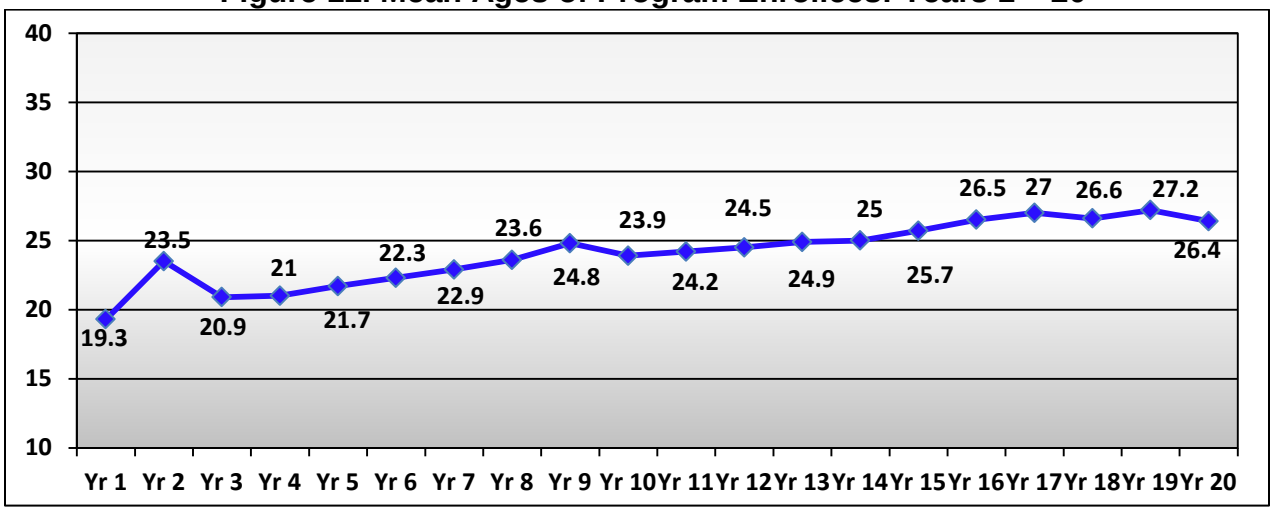
[27] Bethesda Beat. Teen Pregnancy Remains Low in Montgomery County, 2016 Available at http://www.bethesdamagazine.com/Bethesda-Beat/Web-2016/Teen-Pregnancy-Remains-Low-in-Montgomery-County/

[28] Pew Research Center, FactTank. "Why is the Teen Birth Rate Falling", 2016. Available at http://www.pewresearch.org/fact-tank/2016/04/29/why-is-the-teen-birth-rate-falling/

[29] U.S. Department of Health and Human Services, Office of Adolescent Health. "Trends in Teen Pregnancy and Childbearing". Available at https://www.hhs.gov/ash/oah/adolescent-health-topics/reproductive-health/teen-pregnancy/trends.html#

[30] Family Services, Inc. "Discovery Station Early Head Start Community Assessment: Program Year 2015-2016" Family Services, Inc., Gaithersburg, MD. 2016.

Figure 12. Mean Ages of Program Enrollees: Years 1 – 20



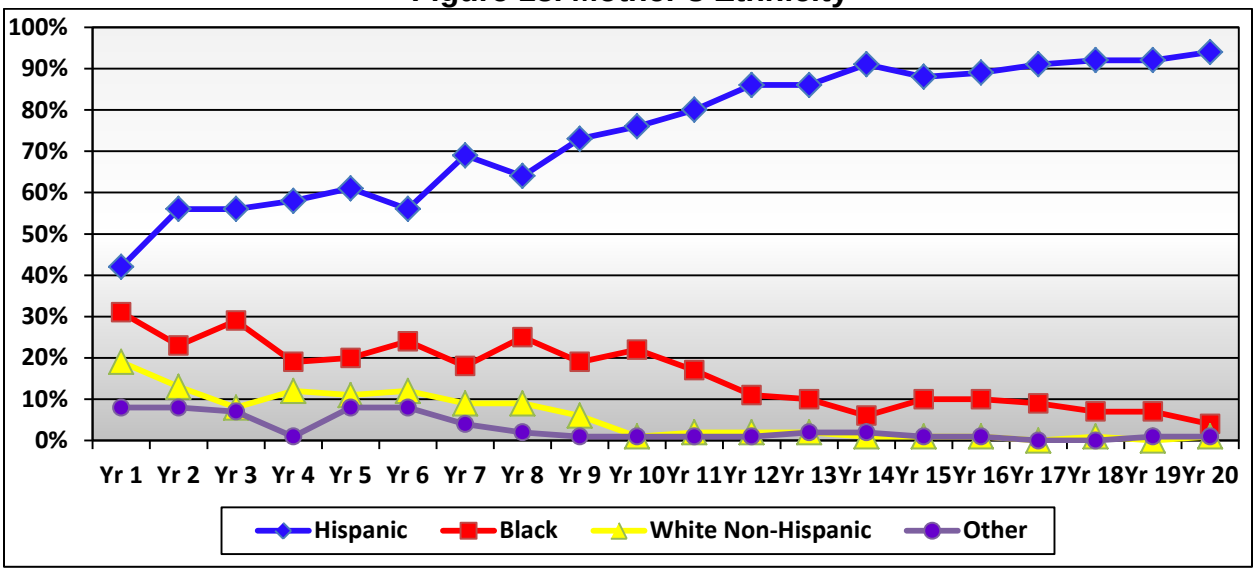
Mother's Race/Ethnicity

Ethnicity and cultural factors are potent mediators of parenting knowledge, values, and behavior, as well as parenting stress levels.[31] Risk and protective factors may also be influenced by race and ethnicity. Many newly immigrated families are at increased risk for social and cultural isolation due to language barriers and lack of access to community resources. HFM places particular emphasis on offering services that are sensitive and responsive to these factors and employs staff that is culturally representative of its participant population.

Over the past twenty years, the overwhelming majority of families in the HFM program have been Hispanic. The proportion of Hispanic enrollees has increased significantly so that by Year 20, almost all mothers reported Hispanic ethnicity. As seen in **Figure 13. Mothers Ethnicity Years 1-20**, in Year 1 there were fairly equivalent percentages of Black (31%) and Hispanic mothers (42%), with a small percentage of White and Asian/Pacific Islander, in the HFM program. However, the percentage of Hispanic mothers has steadily and significantly increased. By Year 10, less than one quarter of mothers were Black (22%) while most of the remaining were Hispanic (76%), almost doubling. Over the past decade the percentage of Hispanic mothers continued to increase so that in Year 20 the program was almost exclusively comprised of Hispanic mothers (94%). Although the population has largely been Hispanic, eighty birth countries and diverse cultures are represented.

[31] Nomaguchi, K. & House, A. N., *Racial-Ethnic Disparities in Maternal Parenting Stress: the Role of Structural Disadvantages and Parenting Values*. Journal of Health and Social Behavior. 2013; 54(3). Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3836435/

Figure 13. Mother's Ethnicity



Mother's Primary Language

Reflecting the race/ethnicity findings described above, the majority of participants speak Spanish as their primary language (72%; n=975). The percentage of mothers speaking Spanish increased significantly over time. In the first decade (Years 1-10), an average of 62% of mothers spoke Spanish as their primary language, while in the second decade this percentage rose to 83% of mothers. In Year 20, the overwhelming majority of mothers (90%) reported speaking Spanish as their primary language, while 13% spoke English. Those who cited 'Other' listed French, French-Malagasy, or Konkani/Hindi as their primary language. Of the mothers who report Spanish or another language as their primary language, many speak some English, but some do not speak any English at all, limiting their ability to access services and community supports, as well as to find employment. HFM provides bilingual staff and linkages to ESOL in order to address these communication issues.

Mother's Level of Education at Enrollment

Mother's level of education is strongly associated with positive outcomes for children in multiple areas, including educational achievement, healthy birthweight, nutritional status, and long term health behaviors such as smoking and drinking.[32] Mother's education level impacts her self-sufficiency, literacy, and parenting knowledge. Quality education also helps participants learn parenting skills and foster a love of learning in their children. Our past findings have noted a significant relationship between having a high school degree and increased scores on measures of parenting knowledge.

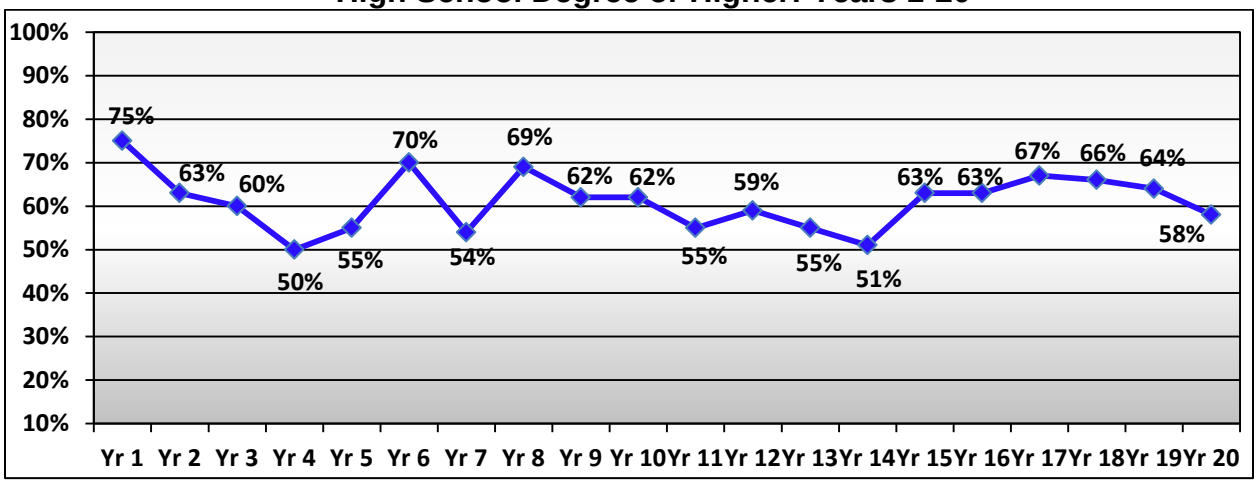
Over the past twenty years, mother's level of education at enrollment has varied. As seen in Figure 14. **Mother's Education Level at Enrollment-High School Degree or Higher: Years 1-20**, the percentage of mothers who had a high school degree or higher ranged

[32] Child Trends. *Databank Indicator: Parental Education*. 2014.Available at http://www.childtrends.org/indicators/parental-education/

from a high of 75% in Year 1 to a low of 50% in Year 4, with most percentages falling between 55%-65%. *Overall, the mean percentage has increased from Years 1-10 (47%) to Years 11-20 (58%) of mothers having a high school degree or higher.* Attainment of a high school degree is complicated for newly immigrated mothers from Latin America due to the lack of education offered many young women in their native countries. As adults, it is extremely difficult for them to increase their education level, particularly if they are not English speaking, but some do pursue a GED.

Analysis of education level by ethnicity indicated a significant difference (Pearson Chi-Square-F=54.026; df 5(1); p=.000; eta=.162) in whether mothers had a high school degree or higher by their ethnicity. Black (75%), White (54%) and Asian/Pacific (67%) mothers were significantly more likely to have at least a high school degree compared with Hispanic mothers (45%).

Figure 14. Mother's Education Level at Enrollment
High School Degree or Higher: Years 1-20



Mother's Employment Status at Enrollment

Mothers' employment status is indicative of economic stability and self-sufficiency. Conversely, mothers who are unemployed are more likely to be living in poverty, resulting in increased risk for negative health and developmental outcomes for their young children. Risks associated with poverty include environmental toxins, inadequate nutrition, maternal depression, parental substance use, premature and low birth weight babies, low-quality child care, and decreased cognitive stimulation. The U.S. Census Bureau 2015 percentages for children under 5 years living in poverty in the State of Maryland (15.5%) and Montgomery County (9.4%) are lower than the National average of 22.8%.[33] Nationally, poverty rates for Blacks (24.1%) and Hispanics (21.4%) are double that of Whites (11.6%). Additionally, the poverty rate is more than double for those without a high school diploma (26.3%) when compared to having a high school diploma, no college (12.9%).

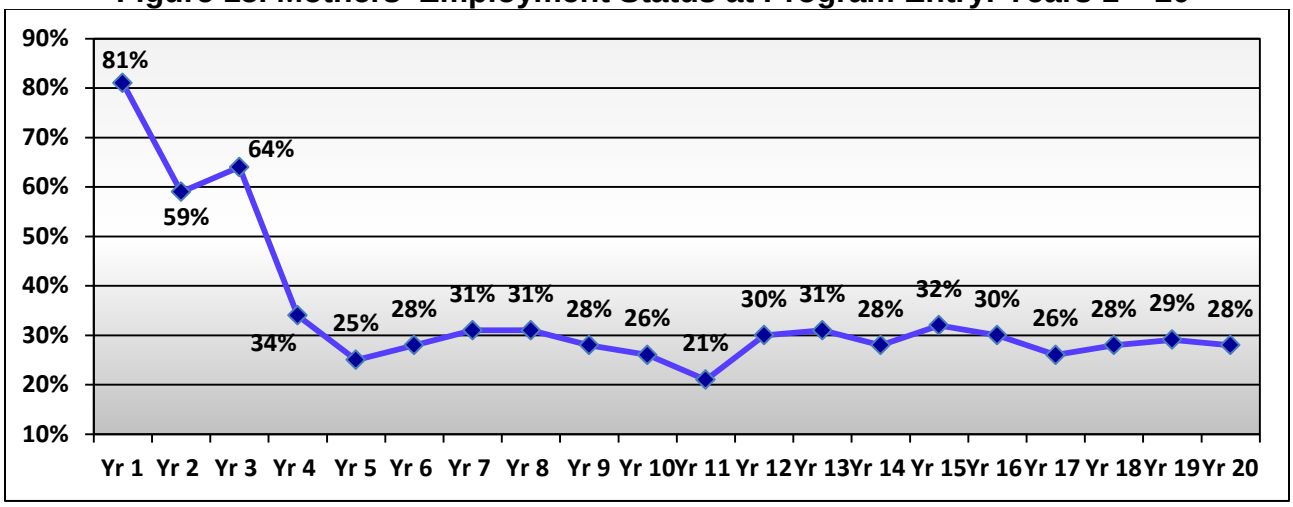
[33] U.S. Census Bureau, American Community Survey, 2016. https://www.census.gov/did/www/saipe/data/interactive/saipe.html?s_appName=saipe&map_yearSelector=2015&map_geoSelector=aa_c&s_USStOnly=y&menu=grid_proxy

The HFM program's population is particularly at risk for poverty due to the low percentage of high school graduates, the high percentage of Hispanic families with children under the age of 5 years, and low employment levels at enrollment. Mothers often become unemployed around the birth of their baby, or go on maternity leave.

As seen in **Figure 15. Mother's Employment Status at Program Entry: Years 1-20,** for most of the past two decades only about one-quarter of mothers (25%-32%) were employed either full or part-time when they enrolled in the HFM program. The higher percentages for Years 1-3 likely reflect the higher percentages of enrollees who were Black and had a high school degree. The mean employment percentage for Years 1-10 was 26%, for Years 11-20 it was 25%, and for Year 20 it was 28%. These percentages are about half the national rate of employment for mothers of children younger than 6 years (64.2%) from the 2015 Bureau of Labor Statistics Report.[34] The report further noted that mothers with infants had an employment rate of 59%.

The HFM program fosters financial stability by offering assistance with employment-related issues, connecting families to community resources and opportunities, as well as educational opportunities and job training.

Figure 15. Mothers' Employment Status at Program Entry: Years 1 – 20



Marital Status

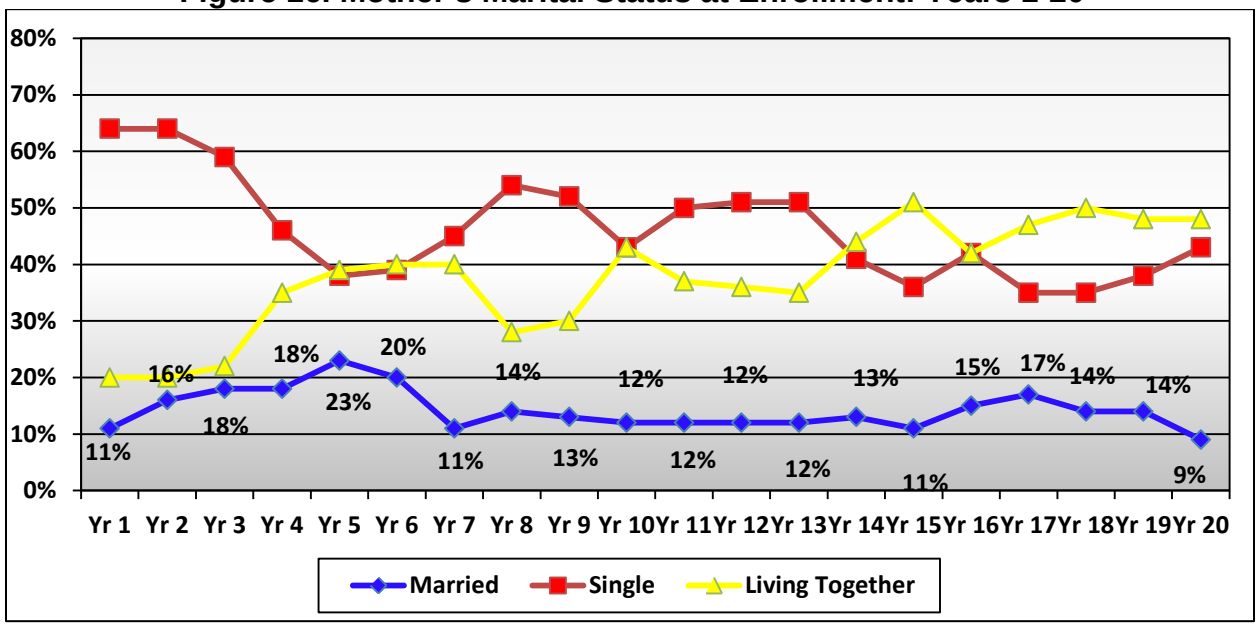
Marital status is associated with economic status, social and parenting support, and educational status. Single mothers are more likely to achieve lower levels of education, have lower paying jobs, and have more depressive symptoms than married mothers.

As depicted in **Figure 16. Mother's Marital Status at Enrollment: Years 1-20** below, Most mothers were single in the early years of the HFM program, while only small percentages were married or living together. Over time, the percentage of single mothers decreased across the two decades of the program (59% to 42%), while the percentage of mothers

[34] U.S. Department of Labor. *Bureau of Labor Statistics Report: Employment Characteristics of Families Summary, 2015.* https://www.bls.gov/news.release/famee.nr0.htm

living with the father of the baby increased (27% to 44%). The percentages for married status have remained fairly consistent over time, but trended toward a decrease.

Figure 16. Mother's Marital Status at Enrollment: Years 1-20

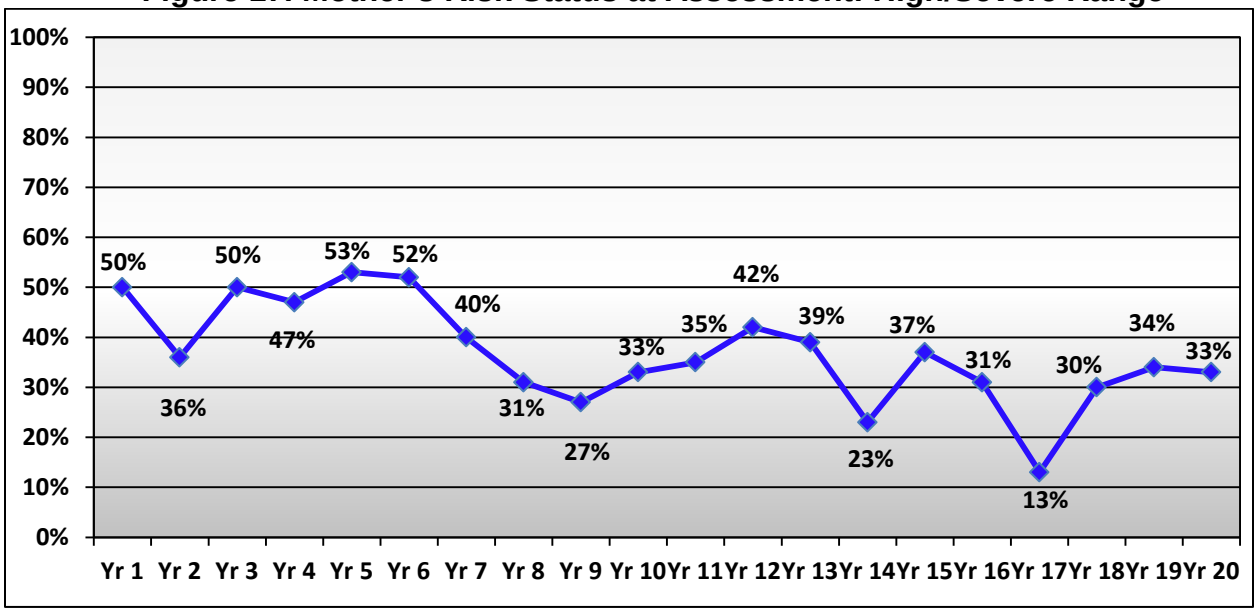


Risk Status at Enrollment

In addition to examining demographic data, the HFM program assesses participants' initial level of risk for child abuse and neglect. Risk factors such as maternal depression, maternal social isolation, and overall parental stress have been associated with heightened risk for child abuse, neglect and poor outcomes. Families are initially assessed for program eligibility using the Parent Survey, formerly the C.H. Kempe Family Stress Checklist (FSC), in order to identify the level of risk for child maltreatment. The survey assesses mothers' and fathers' current and historical functional status across ten domains including history of abuse, substance abuse, mental illness, criminality, self-esteem, violence potential, developmental expectations, child discipline and bonding/attachment. Scores are grouped into three categories of risk: High/Severe (=>40), Moderate (25-35), and Low (<25). Families with scores of 25 or greater are offered services if the program has availability.

As seen in **Figure 17. Mother's Risk Status at Assessment: High/Severe Range**, the risk pattern for the first decade, Years 1-10, indicates that the highest percentages of severe-risk participants enrolled in Years 5 and 6, with declining percentages through Year 9. Since then, percentages have remained fairly consistent at about one-third of mothers scoring in the High/Severe range.

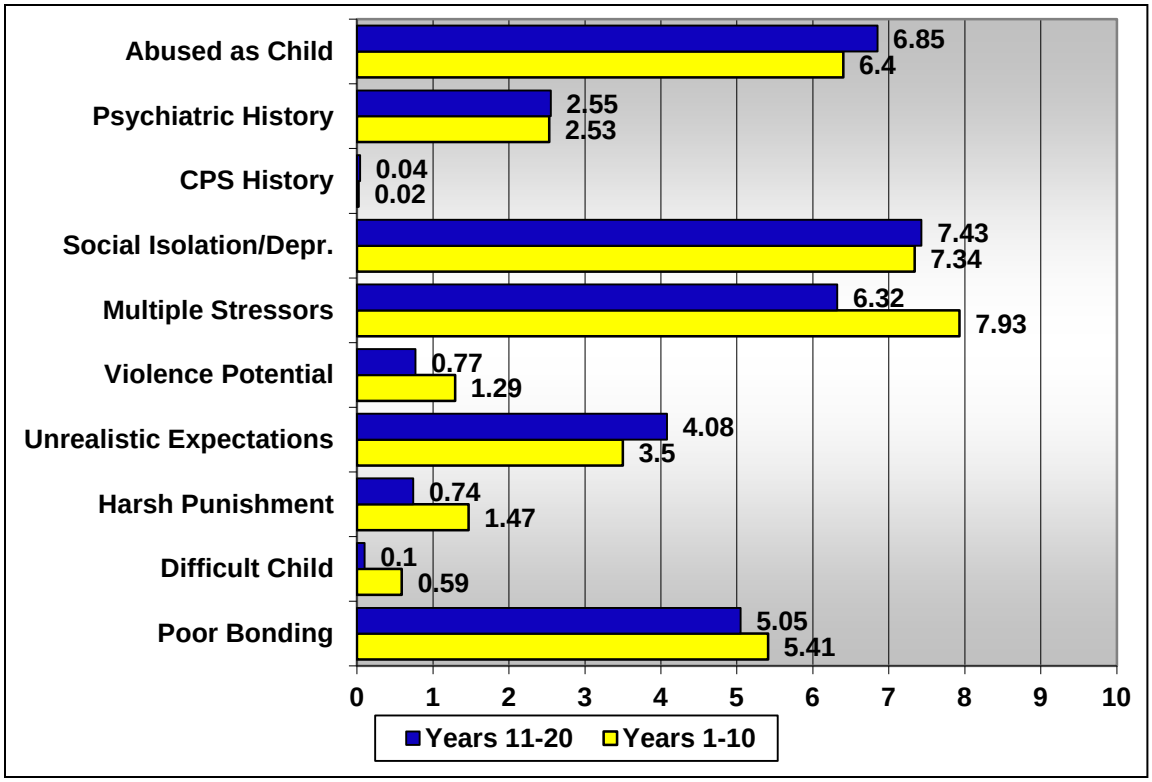
Figure 17. Mother's Risk Status at Assessment: High/Severe Range



Examination of risk range by age indicated a significant relationship between age of the mother at enrollment and High/Severe risk. [Pearson F=54.618; df 1(6); p=.000; eta=.216] Teen mothers (54%) were twice as likely to be in the high/severe risk range as mothers 26-30 years (27%) and older mothers (36-45 years; 22%). Significant differences were also found in risk range by marital status.[Pearson F=43.800; df1(12); p=.000; eta=.118] Single mothers (45%) were more likely to be in the high/severe risk range than mothers who were living with the father of the baby (30%) and married mothers (24%). Additionally, mothers without a high school degree at enrollment (43%) were more likely to score in the high/severe range than those with a high school degree or higher (32%) [Pearson-F=13.307; df 1(2); p=.001; eta=.117]

Psychosocial factors play a significant role in assessing the mother's level of risk. Examination of the individual factors addressed on the Parent Survey shows the areas associated with the highest levels of risk for the HFM mothers as they entered the program. The scores for each item, 0 (low risk), 5 (moderate risk), or 10 (severe risk), were averaged and their calculated means are shown below in **Figure 18. Parent Survey Item Mean Scores: Decade Comparison.** Results depicted are the mean scores for each subscale broken down for each ten-year period (Years 1-10 and Years 11-20). Overall, the same five risk factors were consistently high in each decade. These included, in rank order: social isolation/depression; mother abused as a child; multiple stressors; poor bonding with the child; and unrealistic expectations.

Figure 18. Parent Survey Item Mean Scores: Decade Comparison



The characteristics of the HFM participant population are profiled below in **Table 14. Summary Table of Population Demographics at Enrollment.**

Table 14. Summary Table of Population Demographics at Enrollment

Status at Enrollment	Years 1-10 N=546	Years 11-20 N=423	Year 20 N=131
Mother's Age (years)			
14-19	38%	18%	17%
20-25	39%	42%	34%
26-35	21%	35%	42%
36-45	2%	5%	7%
Mean Age	**23 years**	**25 years**	**26 years**
Marital Status			
Single	59%	42%	43%
Married	11%	12%	9%
Living Together	27%	44%	48%
Separated/Divorced	3%	2%	<1%
Race			
Black	23%	10%	4%
White-Non-Hispanic	8%	1%	1%
White-Hispanic	65%	88%	94%
Asian/Pacific Islander	3%	1%	<1%
American Indian/Eskimo	<1%	-	-
Multi-racial	1%	<1%	-
Ethnicity			
Central American	24%	20%	63%
South American	3%	4%	13%
Other Hispanic	37%	60%	13%

Status at Enrollment	Years 1-10 N=546	Years 11-20 N=423	Year 20 N=131
Hispanic/American	<1%	<1%	2%
Mexican	<1%	3%	2%
African	6%	4%	5%
African-American	11%	6%	<1%
American	12%	<1%	<1%
Asian/Pacific Islander	3%	1%	-
Caribbean Islander	<1%	-	-
European	<1%	<1%	-
Multi-cultural	1%	<1%	-
Other	<1%	<1%	-
Primary Language			
English	33%	13%	6%
Spanish	62%	83%	90%
Other (French; Russian; Amharic; Twi; Portuguese; Swahili; Vietnamese; Hindi)	5%	4%	4%
Education Level			
<7th grade	13%	15%	16%
Middle School (7th-8th)	6%	5%	5%
High School (9th-12th)	34%	22%	21%
HS Diploma/GED	26%	26%	29%
Post HS training/Some college	16%	21%	22%
Associate's Degree	2%	2%	<1%
Bachelor's Degree	2%	8%	7%
Graduate School	1%	<1%	-
HS Degree or Higher	**47%**	**58%**	**58%**
Employment Level			
Full Time	8%	10%	12%
Half Time	17%	9%	11%
Odd Jobs	1%	6%	5%
Unemployed-looking	3%	3%	2%
Unemployed not looking	60%	68%	64%
Unemployed-student	9%	2%	5%
Medical Leave/Other	2%	2%	<1%
Employed at least PT	**26%**	**25%**	**28%**
Housing Status			
Owns house/apt	2%	3%	4%
Rents house/apt	24%	19%	18%
Lives w/family-no rent	32%	15%	18%
Lives w/family-rent	22%	32%	24%
Lives w/friends-rent	8%	27%	32%
Guest-no rent	8%	3%	2%
Shelter/Foster Family	1%	<1%	<1%
Other	3%	<1%	-
Stable Housing	**91%**	**96%**	**97%**
Income Source			
Employment	10%	3%	<1%
Public Aid	14%	19%	10%
Employment & Public Aid	66%	76%	87%
Other	10%	2%	2%
FSC Assessment Risk			
Low	5%	7%	5%
Moderate	54%	60%	63%
High/Severe	41%	33%	32%

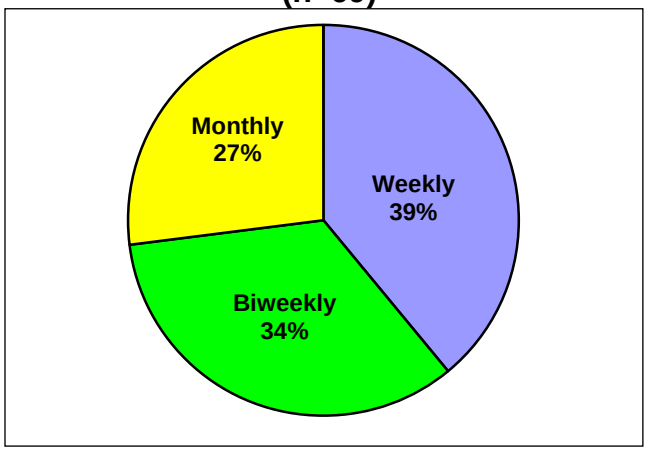
Status at Enrollment	Years 1-10 N=546	Years 11-20 N=423	Year 20 N=131
Trimester of Enrollment			
First	2%	-	-
Second	15%	1%	2%
Third	60%	50%	43%
Postnatal	23%	49%	55%
Mother Medical Insurance			
Yes-Medicaid (Regular)	11%	3%	2%
Yes-Medicaid (Emergency)	71%	93%	94%
Yes-Private/Other	10%	1%	-
No	8%	3%	4%

Participant Satisfaction - Year 20

The Healthy Families Montgomery program strongly values fidelity to its model and to providing its families with the best quality support, information, and services. To this end, HFM administers annual participant satisfaction surveys to gather anonymous information from families regarding various program areas (**see *Appendix O. HFM Participant Satisfaction Survey*** on page 119). As in past years, surveys in English and Spanish were distributed to all active participants during home visits. In Year 20, 70 participants returned the survey. The majority of respondents were between 16 and 20 years old (60%; n=42), while 33% (n=23) were between 21-30 years of age; and 6% (n=4) were 16 years of age or under.

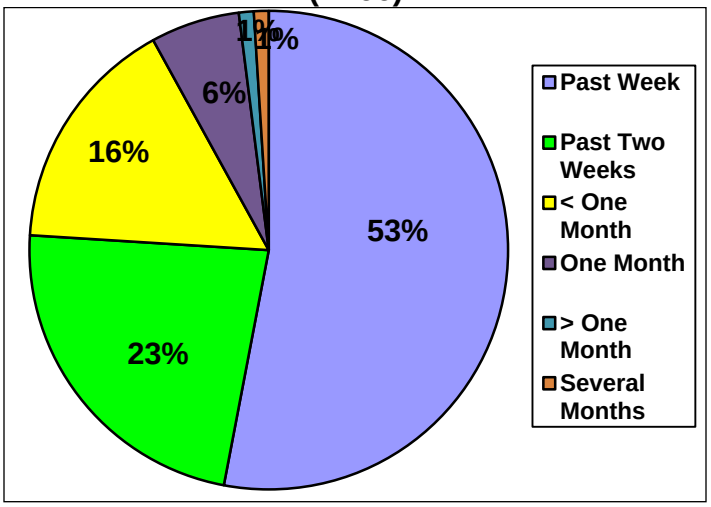
Survey results show that the majority of participants (39%; n=27/69) are visited on a weekly basis, while 34% (n=24/69) are visited bi-weekly, and 27% (n=19/69) are visited on a monthly basis (see **Figure 19. Frequency of Home Visits**). Almost all mothers (96%) reported that they received their first home visit before their babies were 3 months old, an important standard in HFA best practices. At the time of the survey, most babies were under one year of age at the most recent home visit (41%; n=27/66), and 17% (n=11/66) were 12-24 months old. The remaining babies were 2-years of age (18%; n=12/66), 3-years of age (3%; n=2), 4-years of age (15%; n=10) or 5 years of age (6%; n=4).

Figure 19. Frequency of Home Visits (n=69)



Participants were also asked when their most recent home visit occurred. Results for Year 20 indicate that more than half of respondents (53%; n=35/66) were visited within the week prior to survey completion. As seen in **Figure 20. Last Home Visit** below, 23% (n=15) reported being visited within the past two weeks, while 17% (n=11) reported being visited within the past month and 6% (n=4) were visited a month ago. The remaining participants reported being visited more than a month (1%; n=1) and several months ago (1%; n=1). Eight participants indicated their last home visit was more than one month ago and provided a reason. These included being away on vacation or on a service level that only requires once per month or less.

Figure 20. Last Home Visit
(n=66)



Year 20 participants were asked how effective they thought the program was in various areas by circling "Yes" or "No." **Table 15. Participant Perception of Program Effectiveness** below shows the percentage of "Yes" answers. Respondents unanimously perceived the program to be effective in almost all categories.

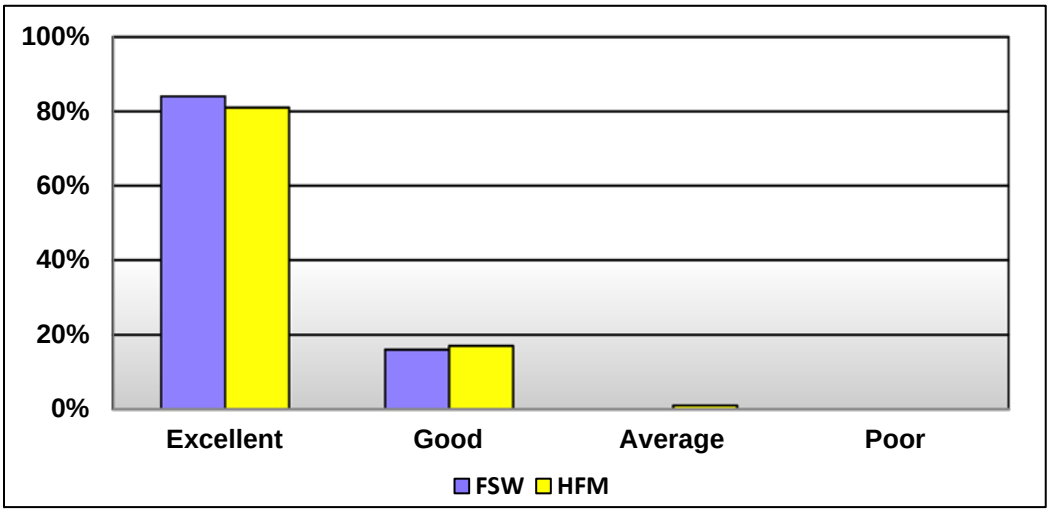
Table 15. Participant Perception of Program Effectiveness
(n=70)

1. My Family Support Worker visited me as agreed upon.	99%
2. My Family Support Worker gives me information on how to care for my baby.	100%
3. My Family Support Worker is helping me learn about my child's development.	100%
4. My Family Support Worker helps me with my needs and the needs of my baby and family.	100%
5. My Family Support Worker is respectful of my baby, my family and me.	100%
6. My Family Support Worker accepts and respects my culture.	100%
7. My Family Support Worker shows an interest in learning about my culture.	96%
8. My Family Support Worker gives me information that I can understand	100%

9. My Family Support Worker communicates with me in a way that I understand.	100%
10. My Family Support Worker helps me to be more independent by helping me make my own decisions.	100%
11. My Family Support Worker has helped me to become a better parent.	100%
12. Healthy Families has made a positive impact in the life of my baby.	99%

Families were also asked to rate their FSW and the HFM program. All but one of the respondents reported that both their FSW and the HFM program were either "Excellent" or "Good," as shown in **Figure 21. Participant Ratings of FSWs and HFM.**

Figure 21. Participant Ratings of FSWs and HFM (n=70)



All respondents (100%; n=70) agreed that they would recommend the program to a friend or relative, with 93% responding "Strongly Agree."

IV. OUTCOME/IMPACT RESULTS

Healthy Families Montgomery has tracked achievement of its goals and measured program outcomes each year since program inception. Over the past twenty years, HFM has consistently demonstrated success at meeting or exceeding its targets for key outcomes. Outcome results presented below are organized by program goals and include data by year or decade as appropriate. Comparative local, state and national statistics are presented where possible and are used to measure HFM's impact on community indicators. Outcome results for the past twenty years are summarized in two tables at the end of the Outcome/Impact Results section, and comparative statistics are presented in **Table 25. Summary of Goals, Objectives and Outcomes** on page 81 and **Table 26. Summary of Goals, Objectives, Outcomes and Comparative Statistics** on page 82.

Goal I: Promote Preventive Health Care

Health Care Provider

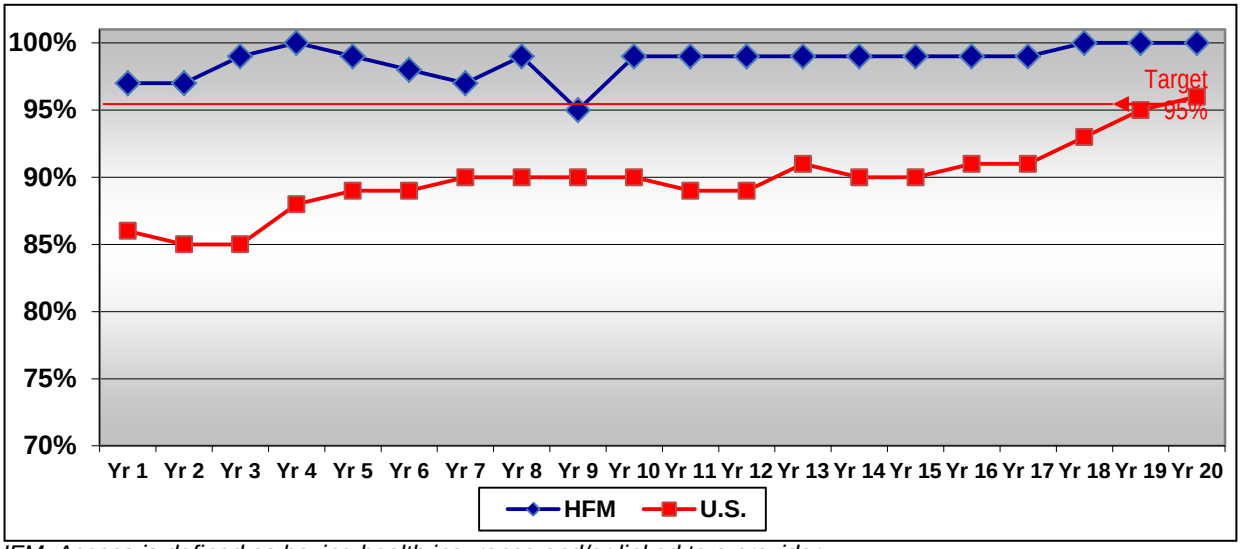
Access to comprehensive and affordable health care is critical to optimize children's health and development. Children with unmet health needs can fall behind developmentally and have a difficult time catching up physically, socially and academically. Therefore, an important goal of the HFM program is ensuring that mothers and children are linked with primary health care providers and health insurance, specifically Medical Assistance (MA) or private insurance. Nationally, Medicaid and the Children's Health Insurance Program (CHIP), as well as the more recent Affordable Care Act (ACA), have made it possible for 96% of all children in the U.S. to have access to health coverage. However, 69% of uninsured children in the U.S. who are eligible are not enrolled in Medicaid or CHIP.[35] The State of Maryland provides health coverage for low-income children through its MCHIP program. All mothers are covered prenatally, but medical coverage is generally not available for the working poor throughout the state, particularly for undocumented immigrants. The *Montgomery Cares* and *Project Access* programs were established in Montgomery County to fill these gaps, increasing coverage for the uninsured. HFM has consistently been able to link families to health insurance programs and primary care physicians since its inception in 1996.

Year 20: During Year 20, there were 123 children that were at least two months old by the end of the reporting period. *Of these, 100% (n=123/123) were linked with a medical provider by the end of the fiscal year or before termination from the program, exceeding the program's goal of 95%. Additionally, 99% of eligible children were enrolled in Medical Assistance (MA).* These results increase the likelihood that children will receive timely immunizations and well-child checkups.

Access to Health Care: As seen in Figure 22**. Child Access to Health Care Provider and Comparative Statistics: Years 1-20,** percentages achieved by the HFM program ranged from 95%-100%, with an average of 99% for Years 1-20, and have consistently exceeded U.S. Census Bureau and National Center for Health Statistics (NCHS) data from 1997-2015, which steadily increased from 85%-96%, with an average of 90%.

[35]Children's Defense Fund. *The State of America's Children. 20* http://www.childrensdefense.org/library/state-of-americas-children/2014-soac.pdf

Figure 22. Child Access to Health Care Provider and Comparative Statistics: Years 1-20

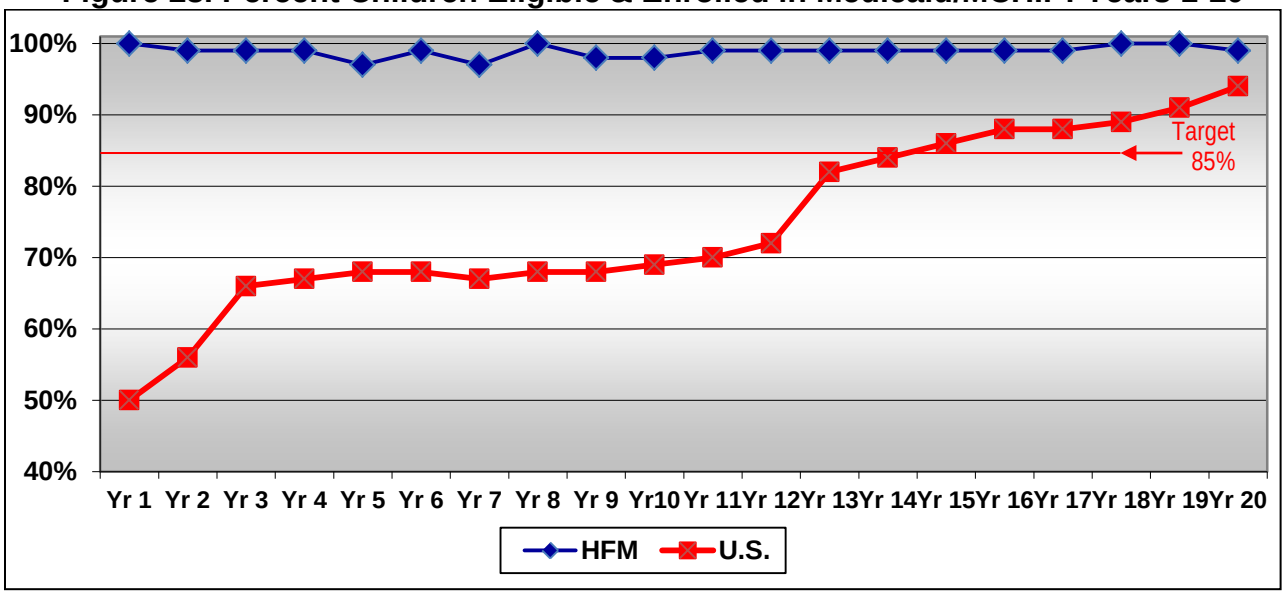


**HFM: Access is defined as having health insurance and/or linked to a provider.*
U.S. Data from Children's Defense Fund. Source U.S. Census Bureau, Current Population Survey and National Center for Health Statistics 2015. Available at https://www.cdc.gov/nchs/data/hus/hus15.pdf

Medicaid and CHIP Enrollment: A child's eligibility and enrollment in Medicaid and CHIP/MCHIP is significantly related to access to health care, utilization of health care services, and ultimately healthy children. Therefore, HFM provides assistance to families in completing the eligibility and enrollment process. Although implementation of the CHIP program in 1997 and the Affordable Care Act, signed in 2010 (fully enacted in 2013-2014), have made it possible for more children to be eligible, many are not enrolled.[36] As seen in Figure 23**. Percent Eligible & Enrolled in Medicaid/MCHIP with Comparative Statistics: Years 1-20**, over the past twenty years the HFM program has maintained a very high percentage of eligible children and families that are enrolled in the Medicaid/MCHIP programs. HFM percentages have ranged between 97%-100% over two decades, with an average of 99% for Years 1-20. HFM percentages also exceed its target of 90% and comparable national rates which have steadily risen from a low of 50% in 1995 to a high of 91% in 2015, with an average of 75% of families eligible are enrolled in Medicaid/ CHIP.

[36] Urban Institute and Robert Wood Johnson Foundation, *Children's Coverage Climb Continues: Uninsurance and Medicaid and CHIP Eligibility and Participation under the ACA*, May 2015. Tabulations of 2013 and 2014 American Community Survey (ACS) data from the Integrated Public Use Microdata Series (IPUMS). 2008-2010 data from Kenney et al. 2012; 2011 data from Kenney et al. 2013; 2012 data from Kenney et al. 2015; original 2013 data from Kenney and Anderson 2015. Available at http://www.urban.org/sites/default/files/publication/80536/2000787-Childrens-Coverage-Climb-Continues-Uninsurance-and-Medicaid-CHIP-Eligibility-and-Participation-Under-the-ACA.pdf

Figure 23. Percent Children Eligible & Enrolled in Medicaid/MCHIP: Years 1-20



Current Immunizations

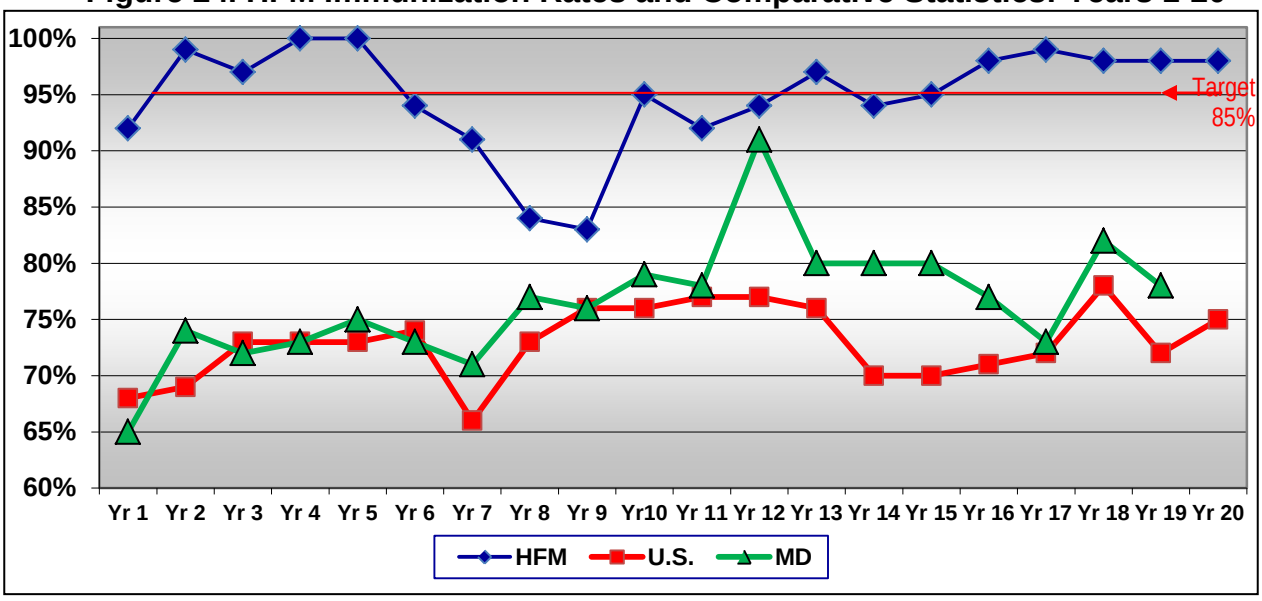
Current immunization status for young children is a positive predictor for avoidance of illness, death, or developmental delays associated with immunization preventable diseases. Newborns are immune to many diseases because they have antibodies from their mothers, but these diminish in the first year of life. Immunizing children also protects the health of the community, especially for those that cannot receive vaccinations. As a result, the HFM program staff work with families to ensure that babies are immunized in a timely fashion. This is accomplished through providing information to families on the importance of immunizations in preventing serious medical diseases and by assisting with linkage to healthcare providers; helping to set up appointments when needed, and giving reminders about appointments as necessary.

Over the past twenty years, HFM has achieved impressive success rates with target children receiving their immunizations on schedule. Families are more likely to follow up on immunizing their children if they have both health insurance and a medical provider. Consequently, this goal is closely linked to the previous goal of assisting families in securing medical homes and insurance. In examining current immunization status, it should be noted that the number of recommended vaccinations has changed over the past twenty years. As additional vaccinations have been added to the recommended series, the HFM program and evaluation updated its standards. From Years 1-6 (1996-2000), results are based on the percentage of children who received the 4:3:1:3:3 series, while from 2001-2010, the 4:3:1:3:3:1 series, which includes 6 key immunizations, was used. Although additional vaccinations were added to the recommended schedule in 2011 and 2014, the six series has been used in this reporting for comparative purposes.

Year 20: When examining children who were active during Year 20 and were greater than 4 months of age (n=111), HFM exceeded their goal by having *98% (n=109/111) of all target children current on their immunizations* as recommended by their medical provider.

As seen in **Figure 24. HFM Immunization Rates and Comparative Statistics: Years 1-20,** the HFM program has consistently exceeded comparative statistics for the U.S. and the State of Maryland. However, both the HFM program and national/state immunization programs saw percentages decline between 2001 and 2005. This uncharacteristic dip in immunization rates was due to shortages across the U.S. of a number of routinely recommended vaccines, such as the DTaP, MMR, varicella and pneumococcal conjugate vaccines, and tetanus and diphtheria toxoids.[37] The shortages were significant enough that recommendations for these vaccines were modified and it was several years before sufficient reserves were available again. Once they were, HFM continued to exceed its target. Additionally, HFM's average for Years 1-20 still exceeded its target with 95% of children current with immunizations, and was significantly higher than comparable averages for U.S. (73%) and Maryland (77%) averages for the past two decades.

Figure 24. HFM Immunization Rates and Comparative Statistics: Years 1-20



**Centers for Disease Control and Prevention (CDC-P). National Immunization Survey: Child ages 19-35 months-National and State data. Comparative percentages are based on the child receiving the 4:3:1:3:3:1 vaccination coverage. Data available at: https://www.cdc.gov/vaccines/imz-managers/coverage/nis/child/*

Additional Births

It is recommended that mothers wait a period of at least 24 months between pregnancies for health reasons. Additionally, teen mothers and their babies are at greater risk of adverse health consequences compared with older mothers. Not only are teens not prepared for the emotional, psychological, and financial responsibilities of parenthood, the overwhelming majority of teenage pregnancies are unintended. Research indicates that teen mothers are much less likely than older women to receive timely prenatal care and more likely to begin care in the third trimester or have no care at all. They are also more

[37] Santibanez, T.A, et al., *Differential Effects of the DTaP and MMR Vaccine Shortages on Timeliness of Childhood Vaccination Coverage. American Journal of Public Health, April 2006. Available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1470566/

likely to smoke during pregnancy. As a result of these and other factors, babies born to teens are more likely to be born preterm (less than 37 completed weeks of gestation) and of low birthweight (less than 5 lb. 8 oz.). Premature and low birthweight babies are at greater risk of serious and long-term illness, developmental delays, and of dying in the first year of life.[38]

The HFM program provides information on family planning to participants immediately upon enrolling in the program. FSWs alert new parents to the fact that additional pregnancies can happen at any time, even when the mother is breastfeeding just after the birth of the baby. The necessity of using family planning methods to prevent unwanted pregnancies is stressed. FSWs also assist mothers in scheduling and completing their postpartum visit, at which the physician discusses family planning methods. Related to its success in linking mothers to a health care provider and to health insurance, the HFM program has also been successful in educating mothers about family planning with the goal of decreasing unwanted pregnancies.

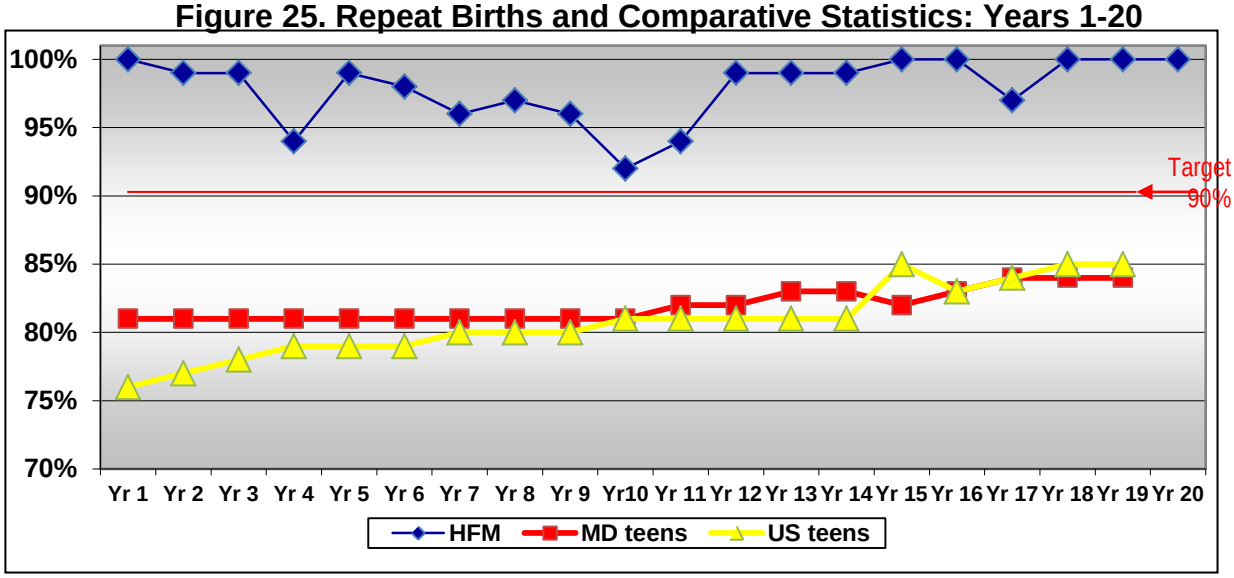
Year 20*:* By the end of Year 20, 127 of the 131 active mothers had delivered their babies. Of the remaining four mothers, three did not have their babies until Year 21, and one mother left the program before she had her baby. Of the 127 mothers who already had a child, 100% did not have a repeat birth within a 24-month period during their enrollment in the program. This includes 22 mothers who were teens when they enrolled (ages 16-19 years old). Additionally, there were 46 mothers whose first child had been born 24-months or longer by the end of Year 20. None of these mothers had a repeat birth.

As seen in **Figure 25. Repeat Births and Comparative Statistics: Years 1-20**, HFM's success rate in this area has consistently exceeded its target of 90% and both Maryland State (84%) and National statistics (82%) for teen repeat births.[39]

[38] Lorrie Gavin, PhD, Lee Warner, PhD, Mary Elizabeth O'Neil, MPH, Linh M. Duong, MPH, Cassondra Marshall, MPH, Philip A. Hastings, PhD, Ayanna T. Harrison, Wanda Barfield, MD, *Vital Signs: Repeat Births Among Teens-United States, 2007-2010.* April 2013. Division of Reproductive Health, National Center for Chronic Disease Prevention and Health Promotion, CDC.CDCP. Available at https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6213a4.htm

[39] Centers for Disease Control and Prevention: Morbidity and Mortality Weekly Report. *Vital Signs: Repeat Births Among Teens – United States, 2007-2010 (April 5, 2013)*. Available at *www.cdc.gov/mmwr/preview/mmwrhtml/mm6213a4.htm?s_cid=mm6213a4_w*

Figure 25. Repeat Births and Comparative Statistics: Years 1-20



Post-Partum Care

The American College of Obstetricians and Gynecologists (ACOG) recommends that mothers receive a postpartum care visit 4-6 weeks after delivery. Post-partum visits provide physicians with the opportunity to evaluate both the physical and emotional status of the mother postnatally, and to provide counseling on infant care and family planning options. Physicians may also screen and refer mothers for management of chronic conditions and may conduct a breast exam and discuss breastfeeding.[40] Nationally, 90.7% of women report completing their postpartum visit. However, there is variation by state, ethnicity, age, income level and education level. New Mexico has the lowest rate of postpartum care completion at 85%, while Illinois is the highest rate of 93.8%. The State of Maryland reports that 90.2% of mothers complete their postpartum visit. Postpartum visits are less common for younger mothers, non-Hispanic black mothers, mothers with less than a high school degree, and mothers on Medicaid.[41]

Year 20: There were 52 active mothers who gave birth to a target child during Year 20. Of these, 42 mothers were more than six weeks postpartum and due for their post-partum visit by the end of June 2016. *Of these mothers, 98% (n=41/42) completed their postpartum check-up.*

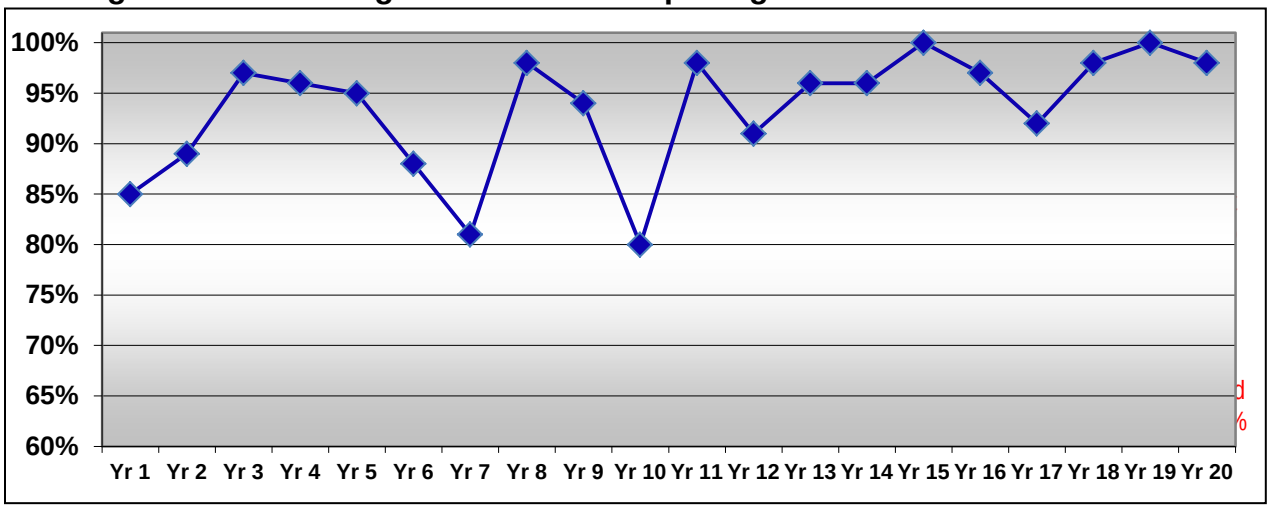
As seen in **Figure 26. Percentage of Mothers Completing Post-Partum Care: Years 1-20)**, the HFM success rate for this objective varied during the first decade of implementation, with percentages ranging from a low of 80% in Year 10 to a high of 98% in Year 8, with an average of 90% for Years 1-10. Success rates became more consistently

[40] U.S. Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau. *Child Health USA 2013.* Rockville, Maryland: U.S. Department of Health and Human Services, 2013. Available at https://mchb.hrsa.gov/chusa13/health-services-utilization/p/postpartum-visit-well-baby-care.html

[41] United Health Foundation. *America's Health Rankings: 2016 Health of Women and Children Report*. Available at http://www.americashealthrankings.org/explore/2016-health-of-women-and-children-report/measure/postpartum_visit/state/ALL

high in the past ten years, with percentages over 90% for all years (Years11-20). HFM achieved 100% completion rate for postpartum care in Years 15 and 19, and averaged 97% for Years 11-20. These percentages are particularly significant when compared to those reported for a similar Medicaid population in 2016 in which 63% of mothers completed postpartum visit. It is also important to note that HFM also exceeded the comparative national statistic for mothers with commercial insurance at 80% (NCQA 2013*)[42].

Figure 26. Percentage of Mothers Completing Post-Partum Care: Years 1-20



Healthy Birthweight

Babies born with low birthweight (less than 5.5 pounds) face a number of serious health risks, including: infant mortality, long-term disability, delayed motor and social development, learning disabilities, and a lower IQ. Being born with a low birthweight also incurs enormous economic costs, including higher medical expenditures, special education and social service expenses, and decreased productivity in adulthood. Very low birthweight babies (less than 1,500 grams, or 3.3 pounds) are most at risk for infant mortality with rates more than 100 times that of their heavier peers. Risk factors for low and very low birthweight include premature birth, multiple births (more than one fetus carried to term), maternal smoking, low maternal weight gain or low pre-pregnancy weight, maternal or fetal stress, infections, and violence toward the pregnant woman.[43]

The HFM indicator for healthy birthweight targets mothers who enrolled in the first or second trimester when there is the greatest likelihood of impacting the risk factors associated with low birthweight. However, almost all HFM participants enroll in the third trimester or immediately after the birth of the baby. Despite this, the program strives to educate participants about how to ensure the most positive health outcomes for their babies by encouraging all prenatal enrollees to attend their scheduled prenatal care visits and by providing information on healthy eating and lifestyle habits during pregnancy.

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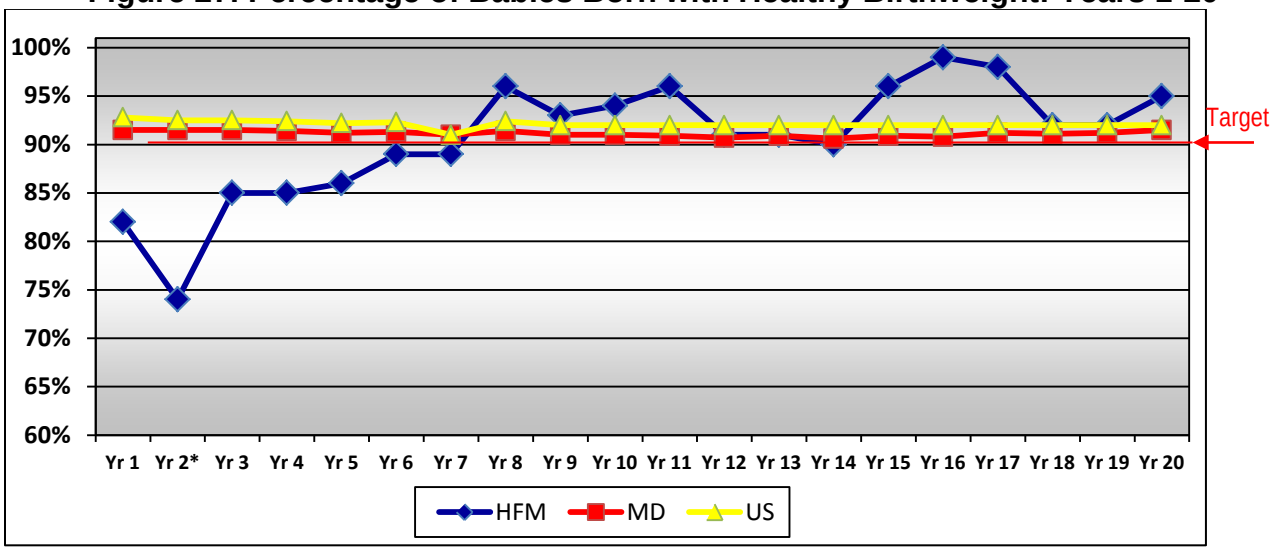
[42] National Center on Quality Assurance (NCQA).*The State of Health Care Quality 2013. Improving Quality and Patient Experience*. Available at: http://www.ncqa.org/Portals/0/Newsroom/SOHC/2013/SOHC-web%20version%20report.pdf

[43]Child Trends Data Bank. *Indicators on Children and Youth: Low and Very Low Birthweight.* December 2016. Available at https://www.childtrends.org/indicators/low-and-very-low-birthweight-infants/

Year 20: Of the mothers who were active (n=128) 95% had babies of healthy birthweight. Of mothers who delivered during Year 20 and for whom data is available (n=52), more than half of (60%; n=31) enrolled postnatally, while an additional 40% (n=21) enrolled in the third trimester. Of the 52 births during Year 20, *98% (n=51/52) were born at a healthy birthweight (>2500 grams or 5.5 lbs.).*

As seen in **Figure 27. Percentage of Babies Born with Healthy Birthweight: Years 1-20,** the percentages of babies born with a healthy birthweight were very low in the early years of the program and were lower than comparative rates for the U.S. and the State of Maryland. From Year 1 to Year 7, percentages of healthy birthweight ranged from a low of 74% in Year 2 to a high of 89% in Years 6 and 7. The low birthweights during this period are largely attributable to the number of premature births and sets of twins born in those years. In Year 1, there were 6 premature births and 2 sets of twins, while in Year 2 there were 15 premature births and 5 sets of twins. This trend for twins and premature births continued through Year 12 with at least one set of twins born each year. During Year 3, there were 10 premature births and 2 sets of twins; Year 4 had 4 premature births and 1 set of twins. Years 6, 7, 8, 10, 11, 16 and 19 each had 1 set of twins, while Years 9 and 12 each had 2 set twins. The average percentage of children born with a healthy birthweight for Years 1-10 was 87%, while in Years 11-20, 94% of children had a healthy birthweight. It is evident in the figure that HFM and its health partners had a positive impact on increasing the percentages of healthy birthweight, even in years when twins were born. From Year 8 to Year 20, the HFM percentages for healthy birthweight met or exceeded the 2015 National and Maryland rates of 92%.[44]

Figure 27. Percentage of Babies Born with Healthy Birthweight: Years 1-20



[44] *National-Centers for Disease Control and Prevention, National Vital Statistics Report-Births: Final Data for 2014. National data (December 23, 2015). Available at* https://www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_12_tables.pdf#i09

Goal II. Reduce Incidence of Child Maltreatment

No indicated reports of child maltreatment while enrolled

The overarching goal of the Healthy Families program is to prevent or reduce child abuse and neglect. Families found eligible for the HFM program are identified as experiencing multiple stressors and risk factors that place them at moderate to high risk for child maltreatment. In addition to monitoring this outcome through direct contacts with families and home visit records, HFM receives aggregated reports from Child Welfare Services semiannually. However, a significant change was made in how counties in the State of Maryland address referrals for abuse and neglect which impacts how HFM reports incidences of child maltreatment for families enrolled in the program.

Historically, Child Welfare Services (CWS) has utilized an "investigative approach" in following up on referrals of child abuse or neglect. Recent data, however, indicated that evidence of abuse or neglect was found in less than half of referrals. Such data, coupled with a decrease in resources available for CWS agencies, has led to many states adopting another course of action in addressing referrals: "alternative response". Alternative response is used in CWS referrals where there is little risk to the child's safety and an investigation would accomplish little. In carrying out an alternative response, CWS workers collaborate with the family in question, performing an assessment to determine the needs of the children and the family as a unit. Additionally, families have three months to appeal an 'indicated' report. The approach was adopted in the State of Maryland in 2012 when Governor Martin O'Malley approved House Bill 834, Child Abuse and Neglect-Alternative Response, thereby creating the dual system approach to addressing reports of abuse or neglect.

In counties where alternative response has been implemented, which included Montgomery County beginning in July 2013, referrals are evaluated by staff to determine whether it should receive an investigative response or an alternative response. If an alternative response is deemed most appropriate, the individual suspected of neglect or abuse will not be investigated nor will he/she be labeled as responsible for such treatment. Instead a CWS worker will conduct an assessment of the family and determine what services would best serve each member. In determining which response to use, CWS workers will examine factors of the case, including the type of suspected abuse/neglect, the injury or effect of the suspected abuse/neglect, and the suspected perpetrator's history with CWS, to determine which course of action is best suited for the child and the family. If workers determine that a particular case is better suited to a different response type than it was originally assigned, the worker may make a recommendation for reassignment. The assessment involved in the alternative response protocol includes safety and risk assessments, an evaluation of the child's living environment, a Family Strengths and Needs Assessment, a strength-based evaluation of the child's caregivers and family members and their individual needs, and the creation of a safety plan. Based upon his/her findings, the worker may refer the family or members of the family to any appropriate services in the interest of the child. Should the family require services beyond the 60 day maximum timeframe (after which the case would be closed) the family may be transferred to In-Home Consolidated Services for further services. If the family refuses to adhere to the

recommendations of the worker to ensure the safety of the child, the case may be reassigned to investigative response. Additionally, maltreatment is not identified and findings are not labeled as substantiated or not.

Year 20: Data from Montgomery County Child Welfare Services for the period between July 2015 and June 2016 indicates that of active families during Year 20, (100%; n=131) of families had no indicated Child Welfare Services (CWS) report.

Use of comparative statistics for this objective is complicated by the fact that national and state results for child maltreatment are reported as a 'rate per thousand' of the total population. In contrast, HFM has a much smaller total participant population and it is not possible to use the same method to report HFM results. Instead, a simple percentage is calculated using the number of families who did not have a report of child maltreatment out of the total number of active families in the fiscal year. This same method has been used for the past twenty years, enabling annual comparisons to be made. Additionally, trends across time relative to HFM, the State of Maryland, and the U.S. results can be seen and compared in the charts below. The first chart represents only HFM's results as percentages. The Chart below it illustrates the rates per thousand for both Maryland and the U.S. over the same time period from 1996 to 2016. The HFM target for this objective is that 95% of families will not have a confirmed report of child maltreatment.

As seen in **Figure 28. HFM No Report of Child Maltreatment - Percentages: Years 1-20** and **Figure 29. Comparative Statistics for U.S and MD - Rate per Thousand: 1996-2016**, the HFM program met its target in Year 1 and has consistently exceeded it every year since, with many years achieving 100%. The average percentage for both decades was 99.1%, while the total average for Years1-20 was 99.5%. When HFM trends are compared to national and state trends, the HFM program has had greater success at preventing child maltreatment within a population of families identified to be a very high risk for child abuse and neglect. Although rates of child maltreatment were comparable at the national and state levels in 1996 (15.2 per thousand), the rates of victimization for the U.S. decreased to a greater degree over the past twenty years than the rates for Maryland. From 1996-2006, Maryland averaged 12.2 child victims per thousand compared to 12.4 per thousand for the US. In the second decade, from 2006-2016, Maryland's average rate decreased to 10.5 per thousand, while the US average rate dropped to 9.4 child victims per thousand.[45] [46] In fact, child victimization rates for Maryland have increased over the past five years, from 10.0 per thousand in 2010 to 12.9 per thousand in 2015. Despite this increase in the state, the HFM program has remained at 99%-100% of their families did not have a report of child maltreatment.

[45] Child Trends, Databank, Child Maltreatment, 2014. Available at https://www.childtrends.org/indicators/child-maltreatment/; Kids Count, Data Center, Confirmed victims of child maltreatment, 2014. Available at http://datacenter.kidscount.org/data/tables/6221-children-who-are-confirmed-by-child-protective-services-as-victims-of-maltreatment?loc=1&loct=2#detailed/2/22/false/869,36,868,867/any/12943,12942

[46] Governor's Office for Children, Maryland Results for Child Well-Being, 2008. Available at http://forumfyi.org/files/Results_Book_2008.pdf

Figure 28. HFM No Report of Child Maltreatment - Percentages: Years 1-20

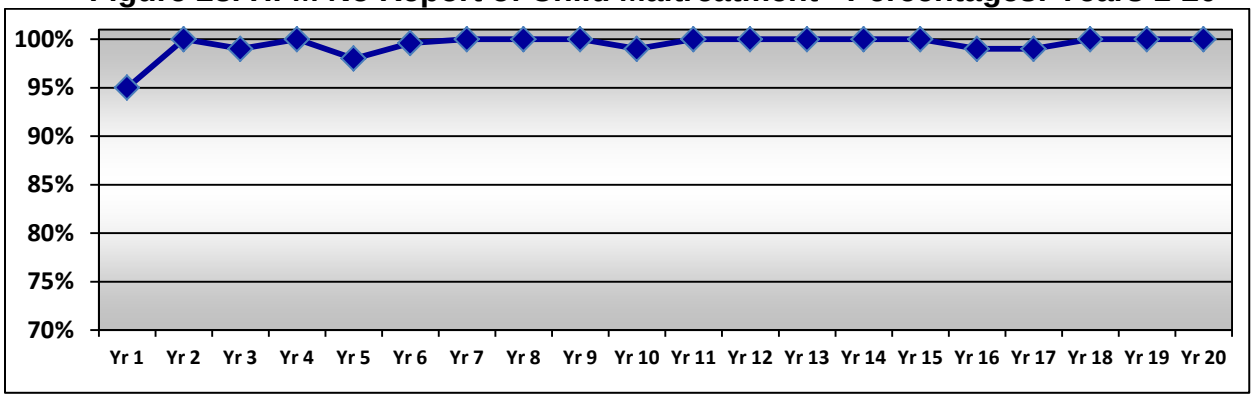
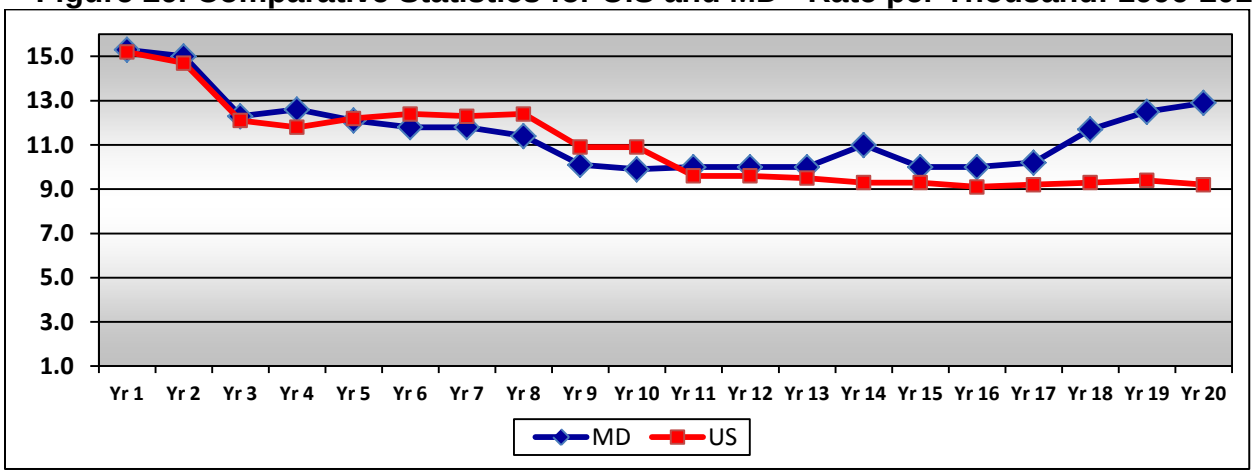


Figure 29. Comparative Statistics for U.S and MD - Rate per Thousand: 1996-2016



Goal III. Optimize Child Development

Child development is optimized when developmental milestones are reached by the child within an expected age range. Skills such as taking a first step, smiling for the first time and waving 'bye' are considered developmental milestones.[47] Children meet milestones in the way they play, learn, speak, act and move. The CDC recommends that parents, caregivers, and pediatricians follow a child's development by tracking milestones reached, and administering standardized screening instruments to identify developmental delays or disabilities early. If delays are identified early, early intervention services can be provided, greatly improving a child's development.

Healthy Families Montgomery focuses on two major activities within this domain: 1) ongoing and timely screening of all children, and 2) referrals to local child development programs for children identified with a potential delay.

[47] Centers for Disease Control and Prevention, National Center on Birth Defects and Developmental Disabilities, "Developmental Milestones", 2016. Available at https://www.cdc.gov/ncbddd/actearly/milestones/

Screening for Developmental Delay

Child Trends reports that nationally the rate for developmental screening increased by ten points from 19% in 2007 to 29% in 2012. In 2012, results of screening found 11% of children ages four months to five years to be at high risk for developmental delays. Boys were more likely to at risk, as were Hispanic children, followed by black children, with white children the least likely to have a high risk.[48] These compelling statistics clearly indicate the importance of early screening and referral for early intervention services.

HFM uses the Ages and Stages Questionnaire throughout a child's participation in the program to monitor social, emotional, cognitive, language and motor development. Administered at regular four month intervals throughout the child's early years, the tool is designed to identify, through a combination of observation and parental interview, development in five areas: 1) communication, 2) gross motor, 3) fine motor, 4) problem solving, and 5) personal-social. These screenings allow HFM staff and parents to monitor children's progress, provide appropriate stimulation at each stage, and identify potential delays. The ASQ is a hands-on assessment and parents are encouraged to perform the activities with the child. This not only informs parents of the kinds of activities that are appropriate for the child, but also encourages them to do these activities with them. For each area, the child is given a score of "yes," "sometimes" or "not yet" in order to determine individual levels of proficiency.

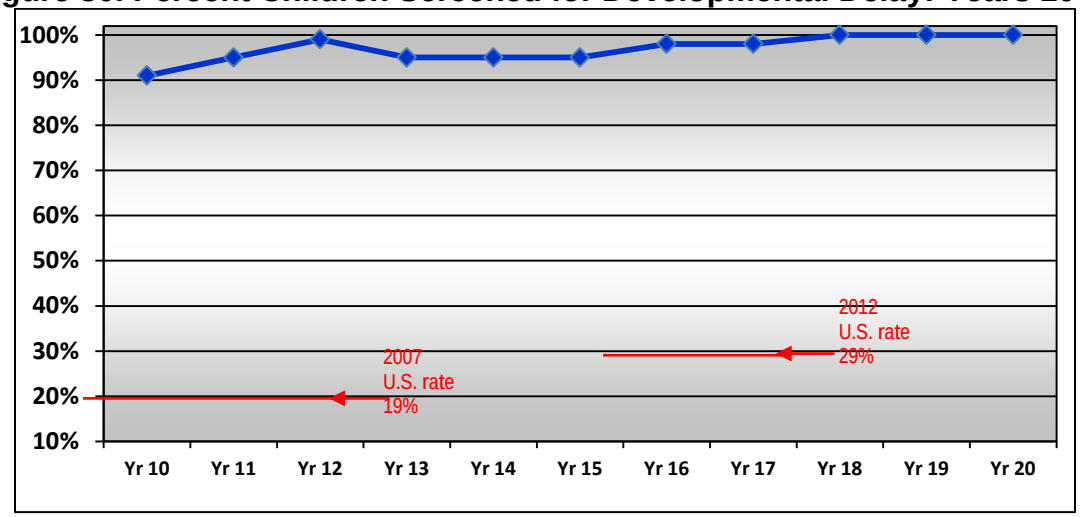
Year 20: In the area of screening for developmental delay, of the 127 target children who were active during Year 20, 92 were due for an ASQ screening during the fiscal year. Of these, ***100% (n=92/92) received a timely ASQ.*** Of the remaining children, 15 children were not due for a screening during the fiscal year and 20 children left the program before the screening was due. The HFM rate for developmental screening of participating children far exceeds the comparable national rate of 29%, which increased from 19% in 2007 to 29% in 2012.[49]

HFM has had consistently high rates of developmental screening. The hiring of an Early Intervention Consultant (EIC) in Year 4 significantly enhanced HFM's ability over the years to identify potential delays, make appropriate referrals for services, and monitor children who are suspected of having a delay. Specific data on screening rates was available from Year 10 to the present. As seen in **Figure 30. Percent Children Screened for Developmental Delay: Years 10-20**, the HFM program rates were all greater than 90%. Year 10 was the lowest at 91%. Rates for Years 11-20 were all between 95% and 100% of all target children screened for developmental delay, with an average of 97%. These rates are significantly higher than the national developmental screening rates of 19% in 2007 and 29% in 2012.

[48] Child Trends Data Bank, 2013. Screening and Risk for Developmental Delay, July 2013. Available at http://www.childtrends.org/wp-content/uploads/2013/07/111_Developmental-Risk-and-Screening.pdf

[49] Child Trends Data Bank, 2013. Screening and Risk for Developmental Delay, July 2013. Available at https://www.childtrends.org/indicators/screening-and-risk-for-developmental-delay/

Figure 30. Percent Children Screened for Developmental Delay: Years 10-20



Identify Potential Delays and Refer for Early Intervention Services

The prevalence of any developmental disability in U.S. children increased over the first decade of HFM program operation and has remained about at 14% since then. In 1996, the prevalence was 12.8% of children ages 3-17 years were identified with a developmental disability, as compared to 15% of children in 2008. Researchers attribute this change to increased identification of autism, ADHD and other developmental delays, while the prevalence of physical disabilities, such as hearing and vision loss have decreased. Most recent data indicates that in 2015, approximately 15%[50] of U.S. children had developmental delays that would qualify them for Part C early intervention services.[51] Child Trends reports that the prevalence of children ages five to 17 years reported to have at least one limitation (i.e., vision; hearing; motor; learning disability; ADD/ADHD; intellectual and developmental delay; and functional limitations) has remained fairly consistent from 1998-2013, ranging between 17% and 20%. Research also revealed differences by gender and race/ethnicity. Males had twice the prevalence of any Developmental Disability (DD) than females and more specifically had higher prevalence of ADHD, autism, learning disabilities, stuttering or stammering and other DDs. Hispanic children had lower prevalence of several disorders compared to non-Hispanic white and non-Hispanic black children, including ADHD and learning disabilities. Child Trends reports that in 2013, 23% of boys as compared to 15% of girls were reported to have at last one physical or developmental limitation. Children were more likely to have a limitation if they had public health insurance, or if their families were living below the poverty line or receiving public assistance (TANF). Many of these risk factors for developmental delay are present in the HFM participant population.

Note: It is important to note that at the start of the previous fiscal year (FY'15), HFM redefined its primary goal for child development. The current goal is met by the percent of target children who are meeting developmental milestones and children who are receiving

[50] CDC. 2015. Key Findings: Trends in the Prevalence of Developmental Disabilities in U.S. Children, 1997-2008. Available at https://www.cdc.gov/ncbddd/developmentaldisabilities/about.html

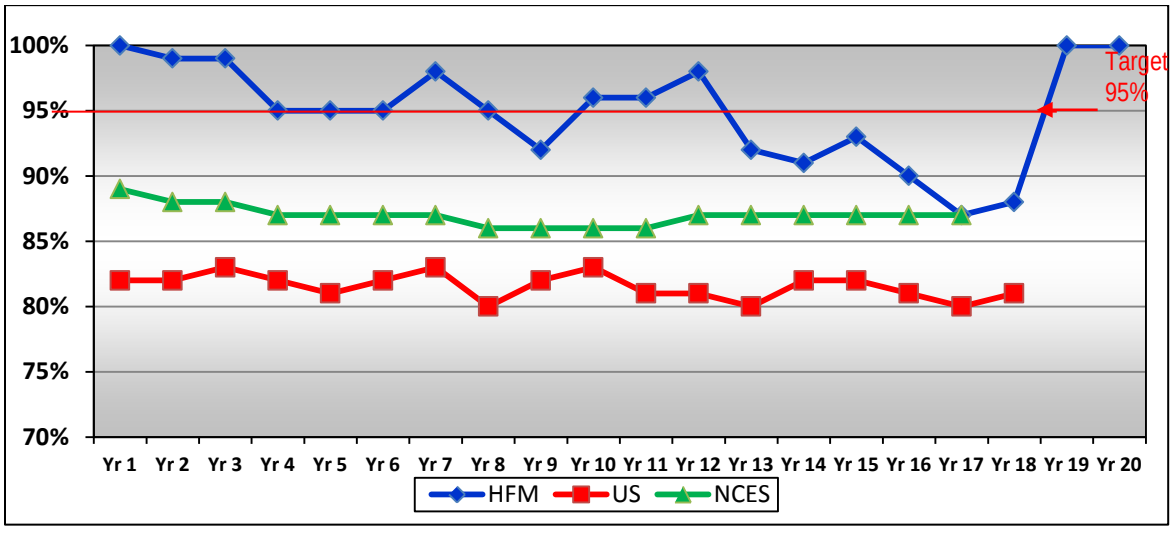
[51] Rosenberg, S.A., Zhang. D., Robinson, C.C, *Prevalence of Developmental Delays and participation in Early Intervention Services for Young Children*. Pediatrics: Official Journal of the American Academy of Pediatrics, May 26, 2008. Available at http://illinoisaap.org/wp-content/uploads/5-Prevalence-of-Developmental-Delays-Rosenberg-2008-Peds.pdf

appropriate services. This change should be taken into consideration when reviewing HFM results.

Year 20: In total, 14 children were followed by the Early Intervention Consultant (EIC) during Year 20. Of these, 6 were closed by the end of the fiscal year, either because they improved significantly and no longer qualified for services (n=4), or because they were receiving services from another program (PEP; Head Start). The remaining 8 children continued to receive early intervention services: 2 with Child Find, 5 with MCITP, and 1 is continuing to be monitored by the HFM Early Intervention Consultant. For Year 20, 100% (n=128/128) of children demonstrated normal child functioning and were meeting developmental milestones or were receiving appropriate services.

As seen in **Figure 31. Children Meeting Developmental Milestones/Appropriate Services: Years 1-20**, the HFM program has achieved significantly higher percentages of children being on target developmentally for most years of operation than comparative statistics for the national population. However, HFM's percentages have trended toward a decrease since Year 1 (100%) and reached the lowest percentage in Year 17 (87%). For Years 1-10, the average percentage was 96%, while for Years 11-20, the average percentage decreased slightly to 94%. As indicated in the figure, when HFM modified its goal to include children receiving appropriate services, the percentages of children meeting milestones rose to 100% again. The hiring an Early Intervention Consultant (EIC) in Year 4 had an impact on increasing surveillance for delays, providing support and training to the FSWs around developmental delay, and identifying children with potential delays. The role of the EIC, coupled with an increase in speech/language delays associated with HFM's Hispanic, Spanish-speaking participant population, have contributed to increased percentages of children identified, monitored and referred to Early Intervention Services. Additionally, HFM results for this objective indicate the positive impact of the program's developmental activities on mitigating the role of environmental factors in developmental delay within a high-risk population.

Figure 31. Children Meeting Developmental Milestones/Appropriate Services: Years 1-20



HFM: Percentage of children meeting developmental milestones. Years 19-20 also includes children receiving appropriate services
Child Trends: Percentage of children ages 5-17 years with no reported physical or developmental limitation.
NCES: Number of children ages 3-21 years served under the Individuals with Disabilities Act, Part B

Goal IV. Promote Positive Parenting and Parent-Child Interaction

Parents will have adequate knowledge of child development

The HFM program began administering The Healthy Families Parenting Inventory (HFPI) in 2007 (Year 12). Therefore there is no comparable data for the first decade of HFM (Years 1-10). Previously, the Knowledge of Infant Development Inventory (KIDI) was used to assess parenting knowledge. The Healthy Families Parenting Inventory (HFPI) is a more comprehensive instrument that focuses on behavior, attitudes and perceptions related to parenting within nine domains: Social Support, Problem Solving, Depression, Personal Care, Mobilizing Resources, Role Satisfaction, Parent-Child Interaction, Home Environment, and Parenting Efficacy.

Percentages were calculated for each subscale at baseline and at 12-month follow-up. As seen in **Table 16. HFPI Subscales-Percentage of Mothers' Score At-Risk: Years 12-20**, the percentage of mothers at risk in most domains decreased by 12-months. However, mother's risk increased from enrollment to 12-months for two domains: Depression and Role Satisfaction. It is not surprising that these two psychosocial domains would increase in the year following the baby's birth and as mothers may develop post-partum depression and as they adjust to their new role as parents.

Table 16. HFPI Subscales-Percentage of Mothers' Score At-Risk: Years 12-20*

	Years 12-20		Year 20	
Subscale	**Baseline (n=283)**	**12- Months (n=159)**	**Baseline (n=102)**	**12- Months (n=59)**
Social Support	24%	20%	26%	20%
Problem Solving	17%	11%	13%	12%
Depression	29%	39%	19%	28%
Personal Care	17%	16%	23%	19%
Mobilizing Resources	22%	7%	22%	9%
Role Satisfaction	25%	31%	26%	25%
Parent-Child Behavior	21%	16%	15%	10%
Home Environment	21%	4%	15%	5%
Parenting Efficacy	15%	9%	12%	17%

**Note: HFM began using the HFPI in Year 12.*

Mothers' mean scores were calculated for each domain subscale and results are summarized in **Table 17. Mother's HFPI Subscale Mean Scores.** *GLM Repeated Measures Analysis* was used to compare mean scores of mothers on each subscale at baseline to 12-months and 24-months follow-up. Using this method, the same group of mothers is compared across timepoints. As a more rigorous measure of changes in parenting skills, GLM analysis found a statistically significant improvement in the first year

of program participation in five subscales: *Problem Solving, Personal Care, Mobilizing Resources, Parent-Child Interaction, and Home Environment.*

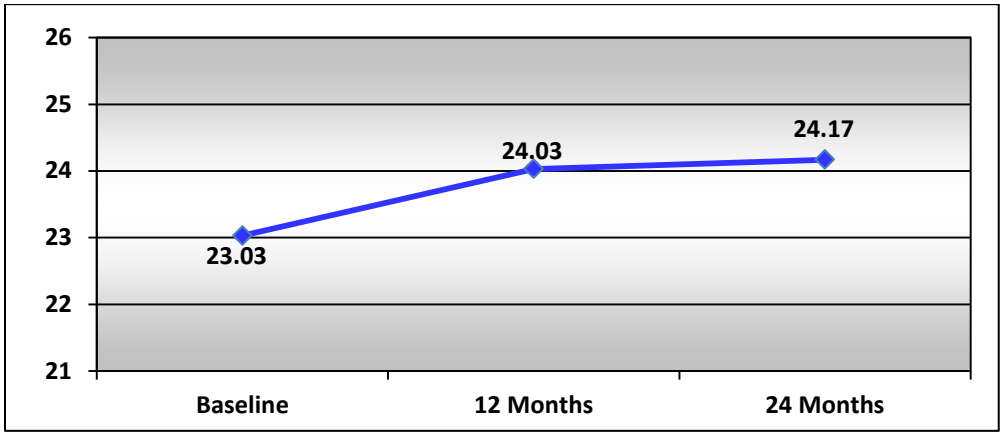
Table 17. Mother's HFPI Subscale Mean Scores
Baseline to 12-Months & 24-Months: Years 12-20

HFPI Subscale (n=95)	Baseline	12-Months	24-Months	F Value	Significance[1]	Effect Size[2]
Social Support	19.51	20.11	20.09	1.232	n.s.	.013
Problem Solving	23.03	24.03	24.17	5.588	p=.020	.056
Depression	35.94	35.51	36.64	.505	n.s.	.005
Personal Care	19.12	19.81	19.94	4.589	p=.035	.047
Mobilizing Resources	21.96	25.18	25.98	59.026	p=.000	.383
Role Satisfaction	23.35	22.68	23.90	.301	n.s.	.004
Parent-Child Behavior	43.11	45.10	44.73	4.076	p=.047	.047
Home Environment	37.40	43.40	43.25	45.499	p=.000	.351
Parenting Efficacy	25.70	26.95	26.60	2.722	n.s.	.033

[1]p value <.05; [2]Partial Eta Squared

Results for each of the HFPI subscales that showed significant changes over time were charted in the figures below. The *Problem Solving* subscale measures the parent's ability to cope with unexpected situations, deal with setbacks, and find solutions when faced with problems. Although the mean score at baseline was already above the risk cutoff, GLM Repeated Measures analysis indicated there was significant improvement in the mothers' scores, see **Figure 32. Mothers' Mean Score Improvement: Problem Solving**. Using partial eta squared, an effect size of .056 was calculated and indicated that 6% of the variance in *Problem Solving* mean scores can be accounted for by time in the program.

Figure 32. Mothers' Mean Score Improvement: Problem Solving (N=95)
Risk Cut-off =<19

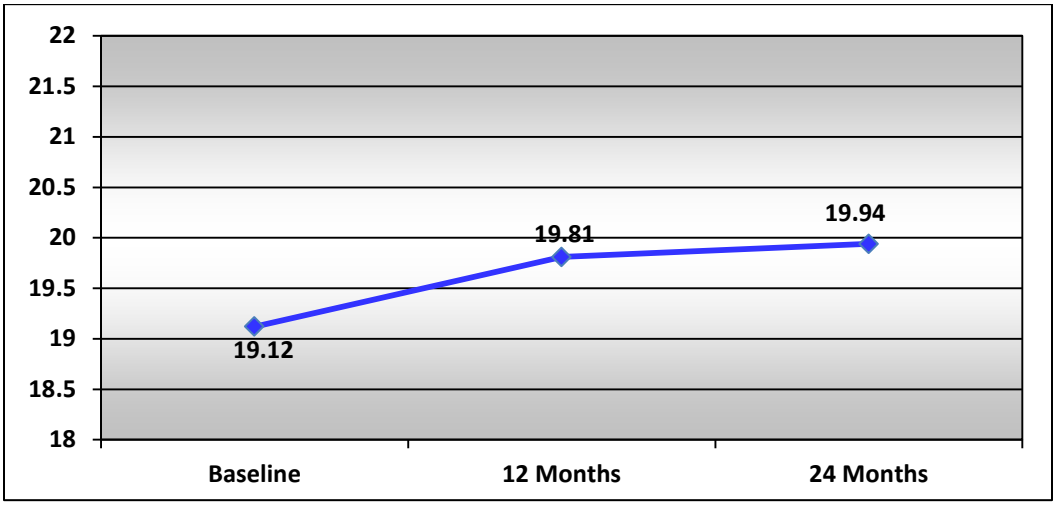


The *Personal Care* Subscale targets the individual parent level regarding whether they are taking care of themselves and, therefore, are well enough to take care of their baby. GLM Repeated Measures results indicate that a significant increase in mean scores was attained from baseline to 24 months of program participation, thus significantly reducing risk. As seen in **Figure 33. Mothers' Mean Score Improvement-Personal Care,** mean scores

increased from baseline (x=19.12) to the 12-month follow-up (x=19.81) and to 24-month follow-up (x=19.94). Using partial eta squared, an effect size of .047 was calculated and indicated that 5% of the variance in *Personal Care* mean scores can be accounted for by time in the program.

Figure 33. Mothers' Mean Score Improvement-Personal Care (N=95)

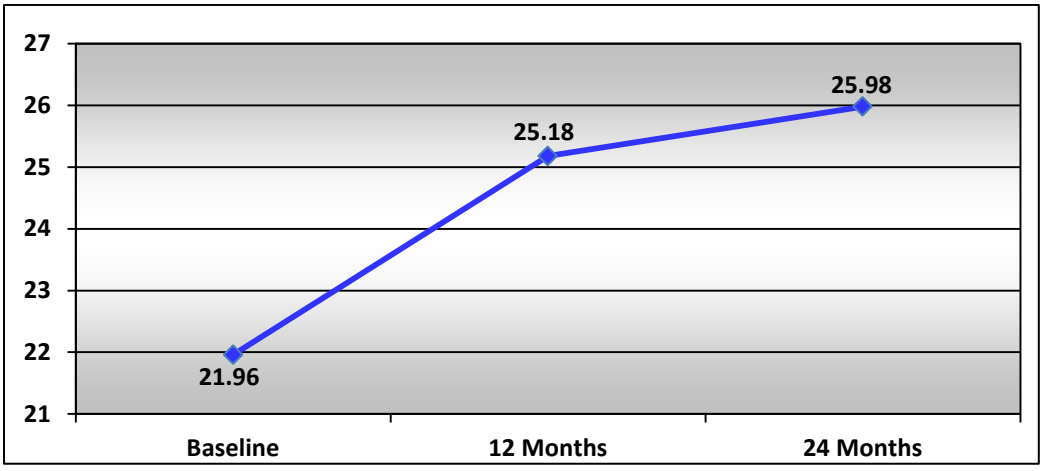
Risk Cut-off =<16



The *Mobilizing Resources* Subscale measures participants' knowledge of available resources in the community, as well as their comfort level in seeking help if needed. GLM Repeated Measures results indicate that a significant increase in mean scores was attained after 12 months and 24 months of program participation, thus significantly reducing risk. As seen in **Figure 34. Mothers' Mean Score Improvement-Mobilizing Resources**, mean scores increased from baseline (x=22.29) to the 12-month follow-up (x=25.24). Using partial eta squared, an effect size of .383 was calculated and indicated that 38% of the variance in *Mobilizing Resources* mean scores can be accounted for by time in the program.

Figure 34. Mothers' Mean Score Improvement-Mobilizing Resources (n=96)

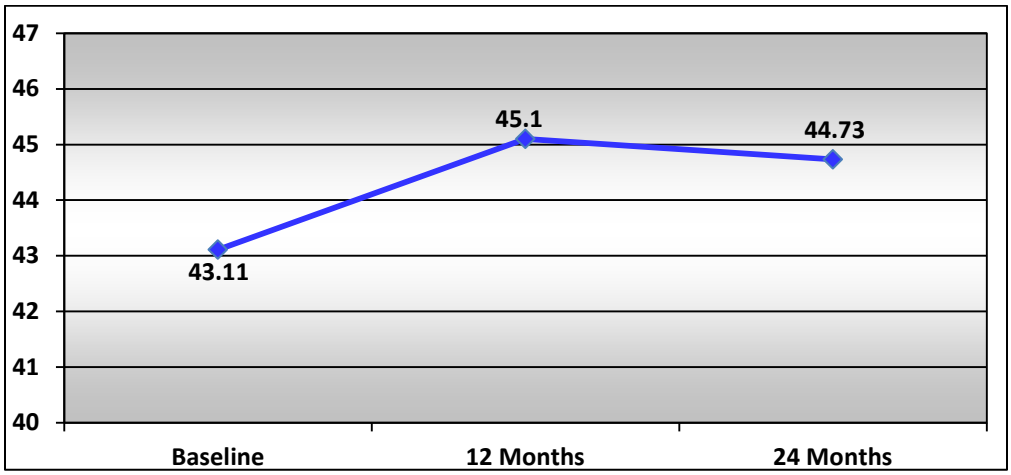
Risk Cut-off =<18



The *Parent-Child Behavior* subscale measures the quality of the parent-child relationship in the context of parental engagement, responsiveness to the child's needs, and the ability to provide positive reinforcement appropriately. Significant improvements were found in the mothers' mean scores from baseline (x=43.11) to 12 months (x=45.10) and 24 months (x=44.73). As seen in **Figure 35. Mothers' Mean Score Improvement-Parent-Child Behavior**, the most significant change occurred from baseline to 12-months of program participation, indicating that the HFM program is effective in improving Parent-Child Behavior within one year of enrollment-a key objective for all Healthy Families programs. Using partial eta squared, an effect size of .047 was calculated and indicated that 5% of the variance in *Parent-Child Behavior* mean scores can be accounted for by time in the program.

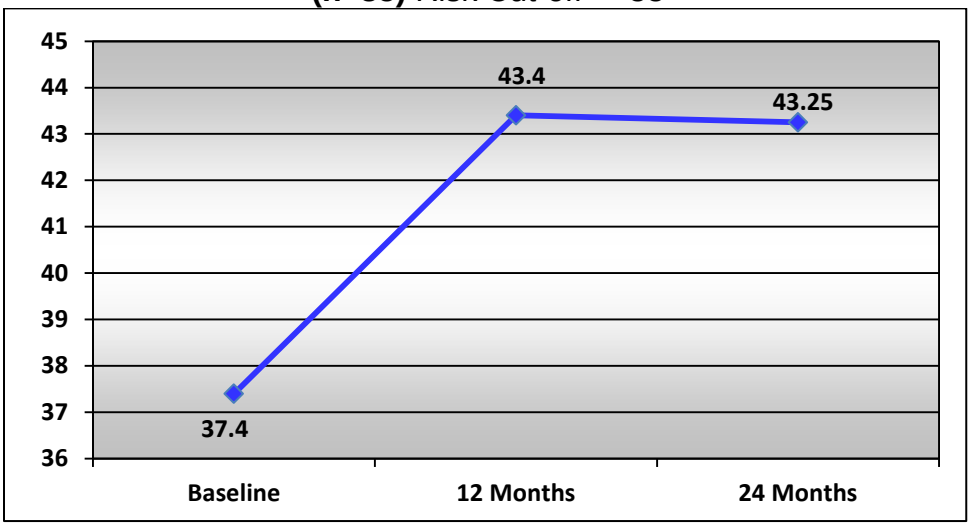
Figure 35. Mothers' Mean Score Improvement-Parent-Child Behavior (n=83)

Risk Cut-off =<40



The *Home Environment* subscale measures the safety, organization, availability and quality of stimulating materials and activities in the home. While the mean score at baseline was also above the risk cutoff, there was significant improvement in the mother's mean scores from baseline (x=37.40) to the 12-month follow-up (x=43.40) and 24-month (x=43.25), see **Figure 36. Mothers' Mean Score Improvement-Home Environment**. Similar to the mean score improvement in Parent-Child Behavior, the most significant change occurred between baseline and 12-months, indicating that the HFM program is effective in improving the home environment for families within one year of enrollment. Using partial eta squared, an effect size of .351 was calculated and indicated that 35% of the variance in *Home Environment* mean scores can be accounted for by time in the program. This is a particularly important finding as the HFM program places emphasis on teaching parents child development activities through the use of the ASQ and the Growing Great Kids (GGK) curriculum.

Figure 36. Mothers' Mean Score Improvement-Home Environment (n=85) Risk Cut-off =<33



Parents' Knowledge of Home Safety

The home is the most common place for young children to be injured. It is important that parents know how to make their home as safe as possible, that they understand safety risks and prevention, and that they provide supervision as much as possible. FSWs work with parents in the home to assess and develop their knowledge of home safety, and assist them in creating a safe home for their children. Parents' knowledge of safety in the home is measured through the use of the Safety Checklist. Through interview and observation, the FSW assesses a variety of safety factors, such as knowledge of emergency phone numbers, installation of safety devices, use of automobile safety restraints, monitoring of lead, radon, and CO levels, and the presence of firearms in the home.

Year 20: At baseline, 94% (n=111) had knowledge that would make their homes almost completely safe. At the 12-month follow-up, 100% of parents had sufficient knowledge of home safety. To investigate achievement of the HFM objective regarding parent knowledge of home safety, GLM repeated measures analyses were conducted on Safety Checklist scores for Year 20 participants from Baseline to 12-months. There were 61 participants for whom data was available for both timepoints. Results indicate a significant improvement in safety knowledge ($F=22.61$; $df(1,60)$; $p=.000$) from Baseline ($x=15.57$) to 12-months ($x=17.23$). Using partial eta squared, an effect size of .274 was calculated and indicated that 27% of the variance can be attributed to program effects.

As seen in **Table 18. Prevalence of Home Safety Risk**, ratings for home safety risk were much higher in the first decade (Years 1-10) of the HFM program at both baseline and 12-month follow-up. In Years 11-20, the prevalence of high risk scores decreased at baseline and there were no families that scored at risk at the 12-month follow-up.

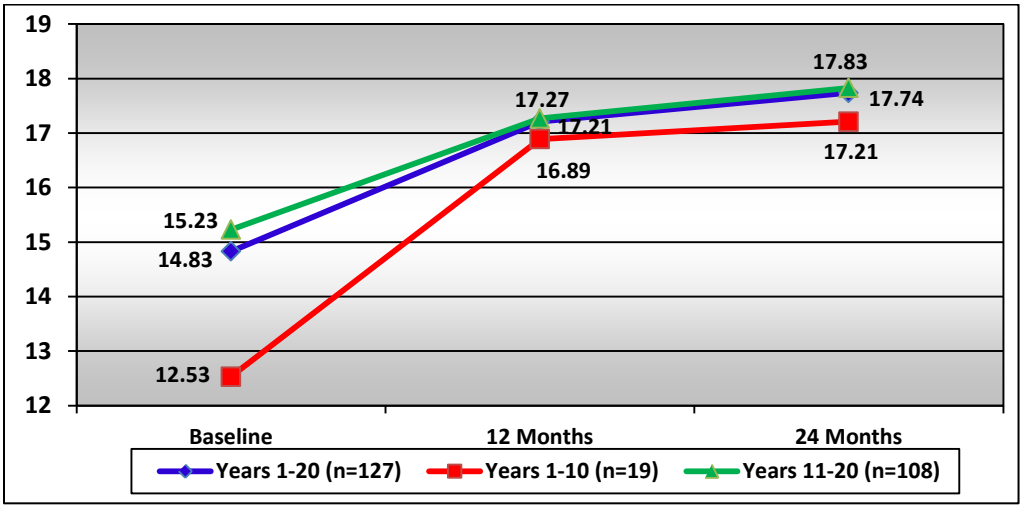
Table 18. Prevalence of Home Safety Risk

	Years 1-10	Year 11-20	Year 20	Years 1-20
Home Safety Risk-Baseline	**(n=347)**	**(n=341)**	**(n=111)**	**(n=690)**
Yes (unsafe/moderately unsafe)	39%	4%	6%	22%
No (almost or completely safe)	61%	96%	94%	78%
Home Safety Risk at 12-Months	**(n=197)**	**(n=172)**	**(n=65)**	**(n=370)**
Yes (unsafe/moderately unsafe)	66%	-	-	36%
No (almost or completely safe)	34%	100%	100%	64%

For longitudinal analyses, mother's mean scores on the Safety Checklist were analyzed and graphed for three groups of participants: the total HFM population active from Years 1-20; the mothers active during Years 1-10 only; and the mothers active for Years 11-20 only. GLM repeated measures analyses were conducted on Home Safety Knowledge scores for three timepoints: Baseline, 12-months, and 24-months.

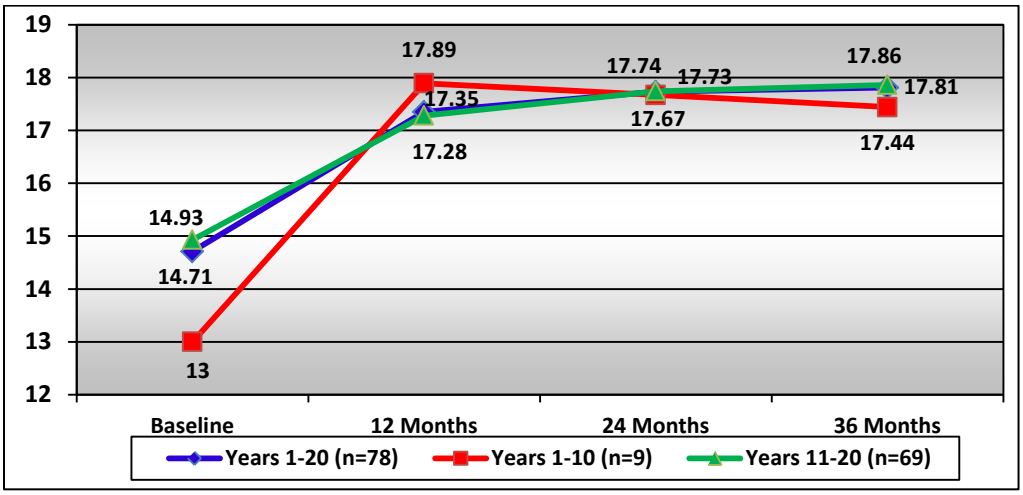
As illustrated in **Figure 37. Mother's Mean Score Improvement-Knowledge of Safety,** each group had a significant increase in knowledge of home safety from baseline to 12-months and 24-months. Also represented in the figure below is the finding that mothers who were active in Years 1-10 had the lowest mean scores for home safety knowledge at baseline (x=12.53), but by the 12-month follow-up had increased scores more closely aligned with those of mothers in Years 11-20.

Figure 37. Mother's Mean Score Improvement-Knowledge of Safety Baseline to 24 Months



Examination of mean scores up to 36 months indicates that mothers who have the lower scores for knowledge of home safety can improve their home safety within one year of participation and score slightly higher than mothers who had higher knowledge scores at baseline. Longer participation in the program does not appear to provide additional benefit for home safety as scores level off for the remaining timepoints.(see **Figure 38**)

Figure 38. Mother's Mean Scores-Knowledge of Safety Baseline to 36 Months



The impact of the HFM program on the significant increases in safety knowledge scores is evident in the statistical results table below. As seen in **Table 19. Parent Knowledge of Home Safety-GLM Results**, the *p* values for each group are very significant (<.05), and the effect sizes, as measured by the partial eta squared, indicate that participation in the HFM program can account for between 47% to 76% of the change that occurred over time in participants' knowledge of home safety.

Table 19. Parent Knowledge of Home Safety-GLM Results

Time Period	F value	df	Significance	Effect Size
Baseline to 24 Months				
Years 1-10	21.290	(1)18	.000	.765
Years 11-20	96.357	(1)107	.000	.474
Years 1-20 Total	134.471	(1)126	.000	.516
Baseline to 36 Months				
Years 1-10	15.343	(1)8	.000	.657
Years 11-20	76.895	(1)68	.000	.531
Years 1-20 Total	96.469	(1)77	.000	.556

[1]p value <.05; [2]Partial Eta Squared

Psychosocial Factors

The birth of a child can be stressful in its new demands and responsibilities as well as due to hormonal changes and lack of sleep. Mild depressive symptoms including occasional sadness, crying, irritability, and trouble concentrating, are common and transient. However, depression occurs when these symptoms, including depressed mood and loss of interest in activities, are severe and last for more than two weeks. Other symptoms can include changes in appetite, feelings of worthlessness or guilt, and suicidal thoughts. The US Department of Health and Human Services, Health Resources and Services Administration (HRSA) in their Women's Health USA 2012 report that in 2009, 11.9 percent of recent mothers in a 29-state area reported postpartum depressive symptoms since the birth of their child in the previous 2–9 months. Interestingly, these postpartum depressive symptoms varied significantly by education level. Mothers with higher levels of education

(16+ years) had a lower percentage of postpartum depressive symptoms (6.9%) than mothers with less than 12 years of education, 22.2% of whom had depressive symptoms.[52]

Risk for Maternal Depression

The Center for Epidemiological Studies–Depression (CES-D) measures depressive symptomology in mothers using somatic and psychological symptoms, such as changes in appetite or sleep habits, feelings of sadness, and lack of motivation. For the total sample of mothers in Years 1-20, one-third (33%) were at risk for depression. The percentage of mothers at risk was higher in the first decade (41%; n=254) as compared to the second decade of the program (29%; n=339). See **Table 20. Percentage Mothers at Risk for Depression: Baseline & 12 Months.** HFM's CES-D results suggest higher baseline prevalence rates of depressive symptomology for HFM mothers than those reported by the CDC (2012) for post-partum women (8% to 19%) non-pregnant women (11%)[53]. Results highlight the importance of the HFM program in ongoing screening for depression and linking participants to appropriate mental health professionals.

Table 20. Percentage Mothers at Risk for Depression: Baseline & 12 Months Years 1-20

	Years 1-10	Year 11-20	Year 20	Years 1-20
Depression Risk - Baseline	**(n=254)**	**(n=339)**	**(n=122)**	**(n=603)**
Yes	41%	29%	24%	33%
No	59%	71%	76%	66%
Depression Risk at 12-Months	**(n=113)**	**(n=180)**	**(n=74)**	**(n=294)**
Yes	29%	19%	19%	23%
No	71%	81%	81%	77%

Year 20: At baseline, about one-quarter of mothers scored at-risk for depression. GLM repeated measures analyses were conducted on CES-D scores for Year 20 participants from Baseline to 12-months. There were 73 participants for whom data was available for both timepoints. Results indicate a non-significant decrease in depressive symptomology ($F=1.784$); $df(1,72)$; $p=.186$) from Baseline ($x=10.52$) to 12-months ($x=9.16$). Using partial eta squared, an effect size of .024 was calculated and indicated that 2% of the variance can be attributed to program effects. However, when mean scores are compared from baseline to 12-months and 24-months, there was a significant decrease in risk for depression ($F=4.341$); $df(1,46)$; $p=.043$) from Baseline ($x=11.34$) to 24-months ($x=7.87$). This means that mothers who are at risk for depression receive greater benefit if they stay in the program longer; approximately 24 months, in order to reduce depressive symptomology.

For longitudinal analyses, mother's mean scores on the CES-D were analyzed and graphed for three groups of participants: the total HFM population active from Years 1-20; the mothers active during Years 1-10 only; and the mothers active for Years 11-20 only.

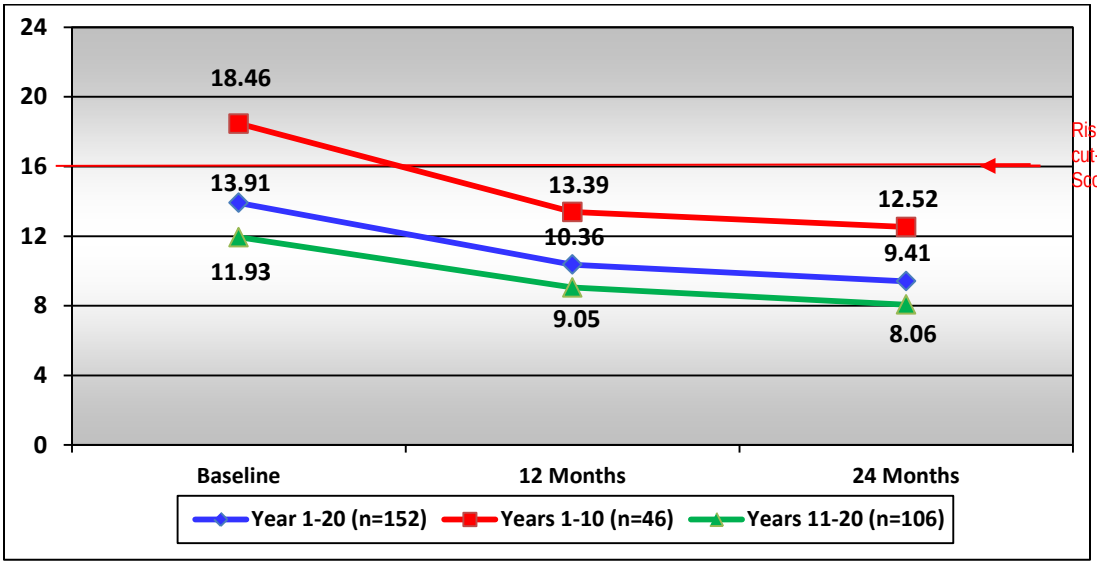
[52] Women's Health USA 2012, January 2013. Available at *http://www.mchb.hrsa.gov/whusa12/more/downloads/pdf/whusa12.pdf*

[53] Centers for Disease Control (CDC): Depression Among Women of Reproductive Age. 2012. Available at http://www.cdc.gov/reproductivehealth/depression/

GLM repeated measures analyses were conducted on CES-D scores for three timepoints: Baseline, 12-months, and 24-months.

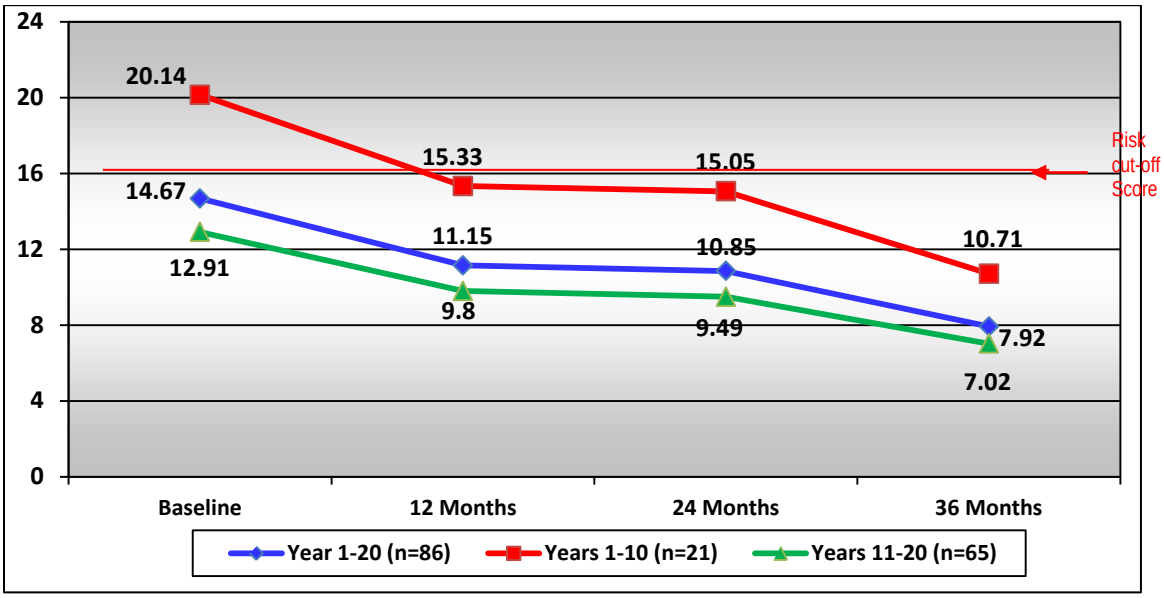
As illustrated in **Figure 39. Mothers' Mean Scores-Risk for Depression,** each group had a significant decrease in risk for depression from baseline to 12-months and 24-months, indicating that the longer mothers remain in the program, the more likely they are to reduce their risk for depression. Also represented in the figure below is the finding that mothers who were active in Years 1-10 had the highest mean scores for depression risk, with the only mean score above the risk cut-off at baseline (x=18.46). Mothers active in Years 11-20 had the lowest mean scores, including a baseline mean score (x=11.93). The differences in mean scores between the two decades could indicate a trend for the target population to have a lowered risk for depression. However, it could also indicate differences in staff administration of the CES-D, staff training in depressive symptomology, and staff perception/cultural values associated with maternal depression.

Figure 39. Mothers' Mean Scores-Risk for Depression
Baseline to 24-Months



Examination of mean scores up to 36 months (see **Figure 40**) indicates that mothers at high risk at baseline and who stay in the program longer benefit significantly from the continued participation. For these mothers, increased duration of enrollment was associated with greater reductions in maternal risk for depression.

Figure 40. Mothers' Mean Scores: Risk for Depression: Baseline to 36-months



The statistically significant results are supported by the effect size estimates (partial eta squared) which were higher for participants with scores from baseline to 36 months. Effect sizes for mothers, represented in **Table 21. Risk for Maternal Depression-GLM Results** below, ranged from .29 to .35, indicating that 29% to 35% of the variance in results is attributable to HFM program effects.

Table 21. Risk for Maternal Depression-GLM Results

Time Period	F value	df	Significance[1]	Effect Size[2]
Baseline to 24 Months				
Years 1-10	12.912	(1)45	.001	.223
Years 11-20	9.802	(1)105	.002	.085
Years 1-20 Total	20.337	(1)151	.000	.119
Baseline to 36 Months				
Years 1-10	10.875	(1)20	.004	.352
Years 11-20	25.939	(1)64	.000	.288
Years 1-20 Total	36.265	(1)85	.000	.299

[1]p value <.05; [2]Partial Eta Squared

Goal V. Promote Family Self-Sufficiency

Family self-sufficiency is a "composite variable" encompassing factors such as marital status, employment, education and housing status that serve as indicators of a participant's autonomy and ability to live without public aid or support. These factors were examined at entry and again at the close of each program year. Mothers who are married or living with their partner are considered to have more support. Participants who work either full or part-time or who are enrolled in school are viewed as demonstrating positive self-sufficiency. In addition, participants who have improved or stable housing are also viewed as

demonstrating positive self-sufficiency. Conversely, participants who are neither working nor enrolled in school are viewed as having decreased or negative self-sufficiency. Participants who do not have improved or stable housing are also viewed as having decreased or negative self-sufficiency.

Marital Status

Marital status was compared at enrollment and at the last follow-up for all active participants.

Year 20: Following the trend in recent years, most mothers (48%) were living together with a partner at the time of enrollment, while 43% were single. A small percentage of mothers were married (9%) or divorced (<1%). At the most recent follow-up, a greater percentage of mothers were living together (52%), while 35% were single. The percentage of mothers who were married increased slightly from baseline to 11%, while 2% were separated or divorced.

For longitudinal analysis, there was limited follow-up data available for Years 1-10, but 85% of participants enrolled in Years 11-20 had a follow-up data point. As seen in **Table 22. Longitudinal Marital Status: by Decade & Total Years 1-20**, there was a trend for decreases in percentages of single marital status at baseline, and corresponding increases in percentages for living together and married categories. A very small percentage of mothers (2%-3%) were separated or divorced at baseline, and only a few (3%) divorced while in the program. These results indicate mothers are increasingly in partnerships that provide more support and stability than they would have if they were single. These trends may also reflect changes in attitudes in the U.S. regarding unmarried couples living together and having children outside of marriage.

Table 22. Longitudinal Marital Status: by Decade & Total Years 1-20

	Years 1-10		Years 11-20		Years 1-20	
	Baseline (n=545)	**Follow-up** (n=24)	**Baseline** (n=417)	**Follow-up** (n=353)	**Baseline** (n=981)	**Follow-up** (n=395)
Single/Never Married	59%	33%	42%	35%	52%	35%
Living Together	27%	42%	44%	45%	35%	44%
Married	11%	25%	12%	18%	12%	18%
Separated/Divorced	3%	-	2%	3%	2%	3%

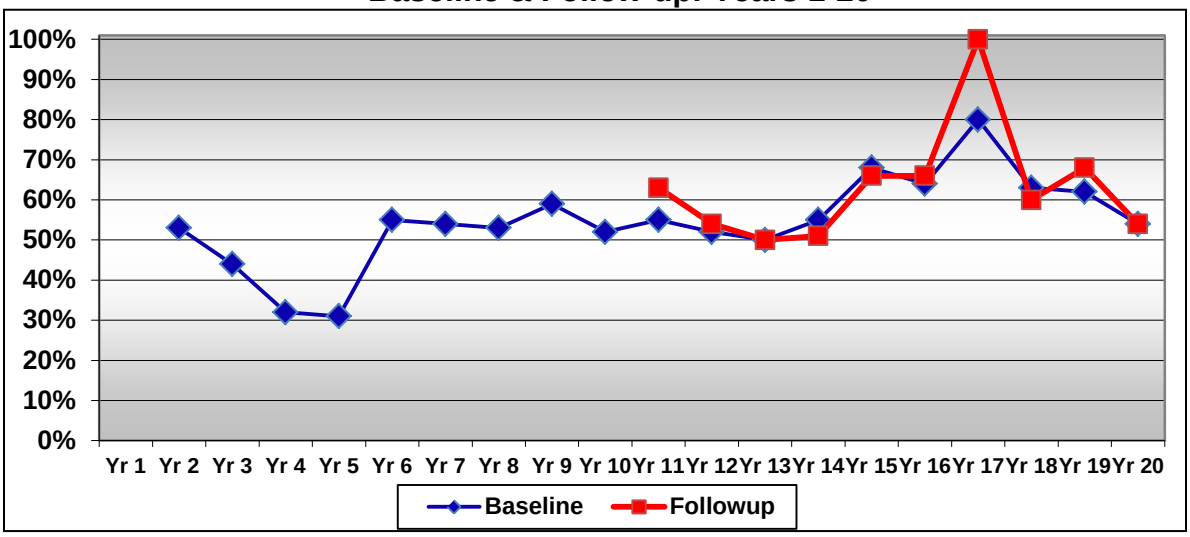
Mother's Level of Education

Mother's highest level of education was compared at enrollment and at the last follow-up for all active participants.

Year 20: Most mothers (58%) had a high school degree or higher at enrollment. Of these, 13% had post high school training, 9% had some college, and 7% had a college degree. However, a significant percentage had less than a 7th grade education (17%) and 25% had completed less than 12th grade. Percentages were approximately the same percentage at follow-up, but there were slight increases in the percentages of mothers who completed some college (11%) and mothers who achieved a college degree (9%).

For longitudinal analysis, there was very limited follow-up data available for Years 1-10 so it is not included in the chart, but the aggregate data is reported below. For participants who enrolled in Years 11-20, 65% (n=423) had a follow-up education data point. As seen in **Figure 41. Percentage Mothers with High School Degree or Greater**, percentages for mothers who had attained a high school degree or higher trended toward increases both at baseline and follow-up. For participants who enrolled in Years 1-10, the average percentage of mothers with a high school degree or higher was 47%. This average percentage increased to 58% for Years 11-20. Mothers who enrolled in Year 17 achieved 100% with a high school degree or higher. Overall for Years 1-20, an average of 51% (n=966) of mothers had at least a high school degree at baseline, and an average of 58% (n=393) had completed high school at follow-up. In addition to the increased percentage of HFM mothers who received a high school diploma while in the program, the percentage of mothers who achieved a college or graduate degree at baseline (7%) more than doubled to 15% at follow-up. Overall, 60% of mothers had stable or improved education. These results reflect the HFM program's emphasis on educational attainment, as well as the supports provided by the program that facilitate mothers remaining in school.

Figure 41. Percentage Mothers with High School Degree or Greater Baseline & Follow-up: Years 1-20



Mother's Employment

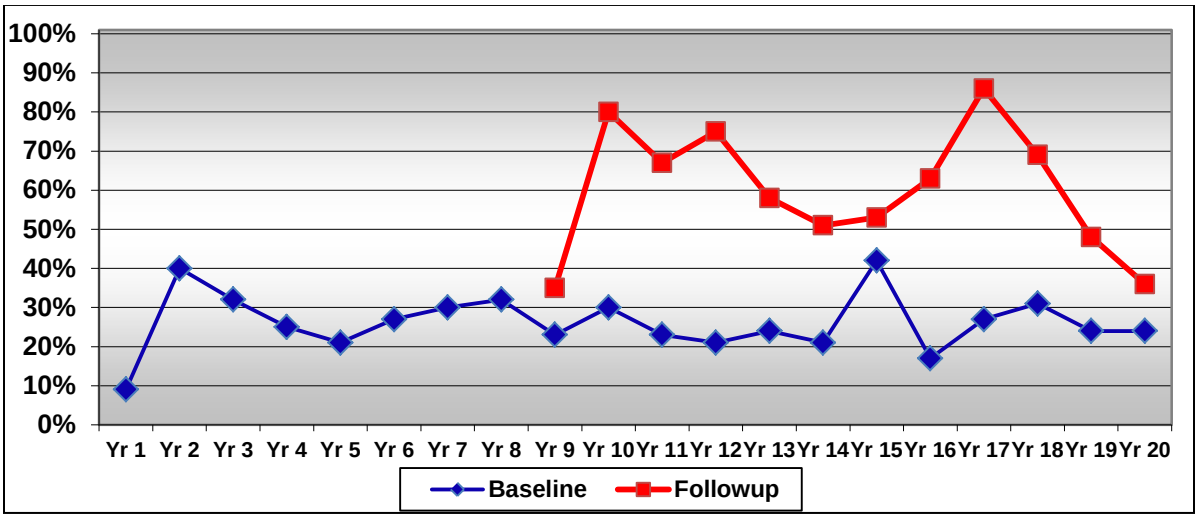
The HFM program has had consistent and significant success in supporting mothers in gaining employment after the birth of their baby. For this reporting, mother's employment status was compared at enrollment and at the last follow-up for all active participants.

Year 20: At enrollment (n=125), 28% of mothers were employed either full or part-time. The majority of mothers were unemployed and not looking for employment (64%). An additional 5% were unemployed because they were in school full time and one mother was on medical leave/disability. At follow-up (n=129), the percentage of mother employed either full or part-time had almost doubled at 50%. Of the remaining mothers, 36% were unemployed and not looking for employment, but an additional 10% of unemployed mothers were actively seeking employment and 3% were in school full time.

There was very limited follow-up data available for Years 1-10 so it is not included in the chart below. For participants who enrolled in Years 11-20, 65% (n=423) had a follow-up data point. As seen in **Figure 42. Mother's Employment Status-Baseline and Follow-up: Years 1-20,** percentages for employment at baseline varied over the twenty years, ranging from 9%-42%, an average of 27% for Years 1-10; and an average of 25% for Years 11-20. All follow-up percentages for mother's employment increased from baseline to follow-up by at least 11% (Year 15) to as high as a 59% increase in Year 17. There was an average increase in employment status from unemployed to employed (full time/part-time) of 19% overall.

The percentage of mothers working either full or part-time increased from 26% (n=975) at enrollment to 36% (n=538) at follow-up. There were corresponding decreases in the percentage of mothers unemployed and not looking for employment from 64% at baseline to 30% at follow-up. Overall, 50% of mothers had stable or improved employment status at follow-up. These results indicate that the HFM program has been extraordinarily successful at promoting mother's economic self-sufficiency.

Figure 42. Mother's Employment Status-Baseline and Follow-up: Years 1-20



When education and employment status are examined together for being stable or improved, 78% (272/349) of mothers who enrolled in Years 11-20 had stable or improved education/employment.

- Stable or improved education and employment n=126
- Stable or improved employment only n=61
- Stable or improved education only n=85

Housing

Housing instability is defined as including persons who are literally homeless (i.e., living on streets; shelter), imminently losing their housing (i.e., eviction; hospital discharge), or unstably housed and at-risk of losing housing (i.e., temporary housing; guest in other's

home).[54] [55]Mother's housing status was compared at enrollment and at the last follow-up for all active participants.

Year 20: At enrollment (n=127), most mothers lived with their families (43%), half of whom paid rent. Another 32% of mothers lived with friends and paid rent, while 22% either owned or rented their own house or apartment. The remaining mothers had unstable housing, including living as a guest in other's home (2%) or living in a shelter or group home (1%). At follow-up (n=127), the percentage of mothers who owned or rented their own house or apartment increased to 32%, and the percentage of mothers with unstable housing decreased from 3% to 2%. Of the mothers who lived with family, the percentage that paid rent increased from 24% to 26%. Overall, at 12-month follow-up, 98% of families had stable or improved housing.

There was very limited follow-up data available for Years 1-10, but 85% of participants enrolled in Years 11-20 had a follow-up data point. As seen in **Table 23. Longitudinal Housing Status: by Decade & Total Years 1-20**, there were increases in percentages of mothers who owned/rented their own apartment or home for each decade and corresponding decreases in percentages of mothers who live with family or friends. Of particular note are the decreased percentages of mothers living in unstable housing such as shelters, group homes, foster family homes, Section 8 housing, or living as guests in someone's home.

At baseline the majority of mothers lived with their families (51%), to whom they may or may not have paid rent. Of the remaining mothers, about one-quarter (24%) rented or owned a home/apartment, and 17% lived with friends and 8% had unstable housing. At follow-up, the percentage of mothers who lived with family decreased from 51% to 44%, and the percentage of mothers who owned or rented a house or apartment increased from 24% to 30%. Most significantly, there was a significant decrease in the percentage of mothers who lived in unstable housing from 8% to 4%. Overall, 98% of families who enrolled in Years 11-20 had stable or improved housing status at follow-up.

Table 23. Longitudinal Housing Status: by Decade & Total Years 1-20

	Years 1-10		**Years 11-20**		**Years 1-20**	
	Baseline (n=447)	**Follow-up** (n=24)	**Baseline** (n=412)	**Follow-up** (n=350)	**Baseline** (n=877)	**Follow-up** (n=392)
Owns/Rents	26%	29%	22%	31%	24%	30%
Lives with family	54%	54%	47%	44%	51%	44%
Lives with friends	11%	8%	27%	22%	17%	22%
Shelter/Group Home/ Guest in other's home	9%	8%	3%	2%	6%	3%
Other/Section 8/Foster Family	4%	-	1%	1%	2%	1%

[54] National Health Care for the Homeless Council 2015. *What is the Official Definition of Homelessness.* Available at https://www.nhchc.org/faq/official-definition-homelessness/

[55] HUD Exchange. *Chronic Homelessness*. (2016). Available at https://www.hudexchange.info/homelessness-assistance/resources-for-chronic-homelessness/

Results demonstrating improved housing status while in the HFM program , combined with the improvements in other indicators of self-sufficiency, including increases in percentages of supportive marital/partner status, increased levels of educational achievement, and significant increases in the percentages of mothers employed full or part-time, indicate that the HFM program has been extremely successful at empowering mothers with the skills and linkages to resources for increased self-sufficiency.

Several summary tables of results are provided below. Outcome Results for Years 1-20 by decade are summarized in Table 24. Summary Table of Outcomes by Decade below. Annual Outcome Results are summarized in Table 25. Summary of Goals, Objectives and Program Outcomes-Healthy Families Montgomery: Years 1-20.

Table 24. Summary Table of Outcomes by Decade

Status at Last Follow-up	**Years 1-10 N=546**	**Years 11-20 N=423**
I. Promote Preventive Health		
Child Health Care Provider	98%	99%
Medicaid/CHIP Enrollment	99%	99%
Child Current Immunizations	94%	96%
Trimester of Prenatal Care		
First	57%	54%
Second	38%	42%
Third	4%	3%
No PNC	<1%	1%
No Addt'l Births <24 mos.	97%	99%
Post-Partum Care	90%	97%
Healthy Birthweight	92%	94%
II. Reduce Incidence of Child Maltreatment		
No Indicated Reports of CAN	99%	99.8%
III. Optimize Child Development		
Children Screened for Delay	-	97%
Child Development	96%	94%
IV. Promote Positive Parenting		
Parenting Knowledge	-	96%
Parent-Child Interaction	-	84%
Home Safety Knowledge	34%	100%
Maternal Depression Risk	29%	19%
V. Promote Family Self-Sufficiency		
Improved Education Status	-	60%
Improved Employment Status	-	50%
Improved/Stable Housing	-	98%

Table 25. Summary of Goals, Objectives and Outcomes
Healthy Families Montgomery: Years 1-20

Goals and Target Objectives	Yr 1 N=38	Yr 2 N=71	Yr 3 N=73	Yr 4 N=145	Yr 5 N=159	Yr 6 N=196	Yr 7 N=191	Yr 8 N=146	Yr 9 N=162	Yr 10 N=170	Yr 11 N=179	Yr 12 N=144	Yr 13 N=131	Yr 14 N=141	Yr 15 N=135	Yr 16 N=137	Yr 17 N=109	Yr 18 N=123	Yr 19 N=122	Yr 20 N=131
Goal I: Promote Preventive Health																				
95% Children have health care provider	97%	97%	99%	100%	99%	98%	97%	99%	95%	99%	99%	99%	99%	99%	98%	99%	99%	100%	100%	100%
95% Eligible families enrolled in MA	100%	99%	99%	99%.	97%	99%	97%	100%	98%	98%	99%	99%	99%	99%	99%	99%	99%	100%	100%	99%
90% Children immunized on schedule	92%	99%	97%	100%	100%	94%	91%	84%	83%	95%	92%	94%	97%	94%	95%	98%	99%	98%	98%	98%
90% Mothers will not have an additional birth within two yrs. of target child's birth.	All-100%	99% Teens-99%	99% Teens-97%	94% Teens-100%	100% Teens-98%	98% Teens - 98%	96%	97%	96%	92%	94% Teens-100%	99% Teens 100%	99% Teens 100%	99% Teens 99%	100% Teens 100%	100% Teens 100%	97%	100%	100%	100%
85% Mothers complete post-partum care.	85%	89%	97%	96%	95%	88%	81%	98%	94%	80%	98%	91%	96%	96%	100%	97%	92%	98%	100%	98%
90% Mothers will deliver newborns of healthy birth weight (>2500 gr/5.5 lbs.)[2]	All–82% Excl. preterm 97%	All–74% Excl. preterm 96%	All–85% Excl. preterm 97%	All–85% Excl. preterm 95%	All–86% Excl. preterm 97%	All–89% Excl. preterm 97%	89%	96%	93%	97%	96%	91%	91%	90%	96%	99%	98%	92%	92%	95%
Goal II: Reduce Incidence of Child Maltreatment																				
95% No indicated CWS reports[1]	95%	100%	99%	100%	98%	99%	99.6%	100%	100%	99%	100%	100%	100%	100%	100%	99%	99%	100%	100%	100%
Goal III: Optimize Child Development																				
95% of Children demonstrate normal child functioning or receiving appropriate services.[3]	100%	99%	99%	95%	95%	95%	98%	95%	92%	96%	97%	98%	92%	91%	93%	88%	87%	88%	100%	100%
Goal V: Positive Parenting																				
85% of parents have adequate knowledge of child development.	78%	90%	97%	95%	96%	96%	97%	85%*	83%	74%	74%	99%[4]	94%	95%	98%	98%	95%	96%	95%	95%
95% of parents have adequate knowledge of child safety.	79%	100%	100%	93%	97%	92%	96%	100%	100%	86%	86%	100%	98%	100%	96%	97%	97%	97%	97%	100%
Parents demonstrate positive parent-child interaction	77%	100%	100%	100%	99%	96%	95%	97%	N/A	N/A	N/A	100%	76%	78%	83%	86%	89%	95%	95%	90%
Goal IV: Improved Self-Sufficiency																				
99% of families have stable or improved housing; 65% have positive educ/employ status	Hous 100% Ed/Em 68%	Hous 100% Ed/Em 73%	Hous 99% Ed/Em 86%	Hous 95% Ed/Em 88%	Hous 96% Ed/Em 90%	Hous 97%	Hous 100%	Hous 99% Ed/Emp 63%	Hous 99% Ed/Emp 53%	Hous 98% Ed/Emp 56%	Hous 96% Ed/Emp 49%	Hous 96% Ed/Emp 85%	Hous 96% Ed/Em 81%	Hous 96% Ed/Em 86%	Hous 98% Ed/Em 88%	Hous 99% Ed/Em 88%	Hous 99% Ed/Emp 88%	Hous 98% Ed/Em 92%	Hous 97% Ed/Em 89%	Hous 98% Ed/Em 89%

[1]Each year that the percentage <100% represents one case of founded neglect for that year. [2]This goal was changed in Year 5 to include only mothers enrolled in 1st or 2nd trimester. However, beginning in Year 12, most mothers enrolled in the 3rd trimester or postnatally, so percentages reflect 1st & 2nd trimester of prenatal care. *HFM changes to long version of KIDI. [4]HFM changes to parenting measure- HFPI. Year 13-Re-normed HFPI. Parent Knowledge percentage reflects Home Environment subscale; Parent-Child Interaction percentage reflects Parent-Child Behavior subscale. [3]This goal was changed in Year 19 to reflect children meeting developmental milestones and children who are receiving appropriate services.

Table 26. Summary of Goals, Objectives, Outcomes and Comparative Statistics
Healthy Families Montgomery: Years 1-20

Goals and Objectives	HFM TARGET	HFM Year 20	HFM Years 1-10	HFM Years 11-20	Montgomery County	State of Maryland	National
Goal I: Promote Preventive Health Care Children will have a health care provider	95%	100%	98%	99%	96% [14]	95% [11]	96% [2]
Eligible families will be enrolled in MA	95%	100%	99%	99%		92% [11]	91% [3]
Children immunized on schedule*	90%	98%	94%	96%		77% [4]	73%[4]
Mothers will not have an additional birth within two years of the target child's birth. (Teens <20 Yrs)	90%	100%	97%	99%		Teens 85% [16]	Teens-82% [5]
Babies Born with Healthy Birthweight	90%	93%*	92%	94%	93% [14]	92% [8]	92% [8]
Mothers will complete post-partum care.	85%	100%	90%	97%		90.2 [7]	90.7 All Mothers 63% Medicaid 80% Private Ins [6]
Goal II: Reduce Incidence of Child Maltreatment Enrolled families will not have substantiated CWS reports	95%	100%	99%	99.8%	Rate of 3.8 per thousand [14]	Rate of 12.9 per thousand [9]	Rate of 9.2 per thousand [9]
Goal III: *Optimize Child Development* Children will demonstrate normal child functioning or receiving appropriate services	95%	100%	96%	94%	92% [13]	87% [12]	85% [10]

* Represents complete series of immunizations (4:3:1:3:3:1 series) in order to be comparable to HFM reporting.

Data Sources

[2] U.S. Data from Children's Defense Fund. Source U.S. Census Bureau, Current Population Survey and National Center for Health Statistics 2015. Available at https://www.cdc.gov/nchs/data/hus/hus15.pdf

[3] Urban Institute and Robert Wood Johnson Foundation, Children's Coverage Climb Continues: Uninsurance and Medicaid and CHIP Eligibility and Participation under the ACA, May 2015. Tabulations of 2013 and 2014 American Community Survey (ACS) data from the Integrated Public Use Microdata Series (IPUMS). 2008-2010 data from Kenney et al. 2012; 2011 data from Kenney et al. 2013; 2012 data from Kenney et al. 2015; original 2013 data from Kenney and Anderson 2015. Available at http://www.urban.org/sites/default/files/publication/80536/2000787-Childrens-Coverage-Climb-Continues-Uninsurance-and-Medicaid-CHIP-Eligibility-and-Participation-Under-the-ACA.pdf

[4] Centers for Disease Control and Prevention (CDC-P). 2015 National Immunization Survey: Child ages 19-35 months-National and State data. Comparative percentages are based on the child receiving the 4:3:1:3:3:1 vaccination coverage. Data available at: https://www.cdc.gov/vaccines/imz-managers/coverage/nis/child/; https://www.cdc.gov/mmwr/volumes/65/wr/mm6539a4.htm#T3_down

[5] Centers for Disease Control and Prevention: Morbidity and Mortality Weekly Report. Vital Signs: Repeat Births Among Teens – United States, 2007-2010 (April 5, 2013). Available at www.cdc.gov/mmwr/preview/mmwrhtml/mm6213a4.htm?s_cid=mm6213a4_w

[6] National Center on Quality Assurance (NCQA).The State of Health Care Quality 2013. Improving Quality and Patient Experience. Available at: http://www.ncqa.org/Portals/0/Newsroom/SOHC/2013/SOHC-web%20version%20report.pdf

[7]United Health Foundation. America's Health Rankings: 2016 Health of Women and Children Report. Available at http://www.americashealthrankings.org/explore/2016-health-of-women-and-children-report/measure/postpartum_visit/state/ALL

[8] National-Centers for Disease Control and Prevention, National Vital Statistics Report-Births: Final Data for 2014. National data (December 23, 2015). Available at https://www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_12_tables.pdf#i09

[9] https://www.childtrends.org/indicators/child-maltreatment/ http://datacenter.kidscount.org/data/tables/6221-children-who-are-confirmed-by-child-protective-services-as-victims-of-maltreatment?loc=1&loct=2#detailed/2/22/false/869,36,868,867/any/12943,12942; http://forumfyi.org/files/Results_Book_2008.pdf

[10] https://www.cdc.gov/ncbddd/developmentaldisabilities/about.html https://www.childtrends.org/indicators/screening-and-risk-for-developmental-delay/

[11] http://kff.org/other/state-indicator/children-0-18/?currentTimeframe=0

[12] http://archives.marylandpublicschools.org/MSDE/divisions/earlyinterv/docs/2015MSDEParentSurvey.pdf

[13] https://www.montgomerycountymd.gov/HHS-Program/Resources/Files/CYF%20Docs/ECAC/DemographicReport12-14.pdf

[14] http://www.healthymontgomery.org/index.php?module=indicators&controller=index&action=view&indicatorId=365&localeId=1259; https://app.resultsscorecard.com/Scorecard/Embed/20101

[15] http://www.collaborationcouncil.org/2015%20Annual%20Report.pdf

[16] http://datacenter.kidscount.org/data/tables/5-teen-births-to-women-who-were-already-mothers?loc=1&loct=2#detailed/2/2-52/false/869,36,868,867,133/any/253,254

IV. SUMMARY AND RECOMMENDATIONS

Background and History

The long-term negative impact of child maltreatment has been well researched over the past twenty years. In an updated report, *New Directions in Child Abuse and Neglect Research (2013)*, the Institute of Medicine and the National Research Council summarizes the research describing the impact on victims, families, and society.[56] Children who have experienced abuse and neglect are at increased risk for poor health and mental health outcomes, including obesity, depression, suicide, substance abuse, post-traumatic stress disorder, attention difficulties, and delinquency.[57] Findings in biology and neuropsychology have highlighted the impact of abuse and neglect on early brain functioning and development.[58] However, the long-term impact on child victims is mediated by the severity, frequency and timing of the abuse, as well as the protective factors that exist for the child and family. Findings such as these have led to the development of evidence-based prevention strategies and programs, such *as Healthy Families Montgomery*, that are multifaceted and implemented in a community setting.

In addition to the impact of child maltreatment on health and mental health outcomes, direct and indirect costs associated with abuse and neglect are significant for both victims and society. In 2001, the total estimated cost of child abuse and neglect was $94 billion per year.[59] In 2012, CDC researchers estimated the total lifetime cost of child maltreatment (physical abuse, sexual abuse, psychological abuse and neglect) was approximately $124 billion. In a sensitivity analysis, the total burden was estimated to be as large as $585 billion. Given the substantial economic burden of child maltreatment, the benefits of prevention would likely outweigh the costs for effective programs. In one analysis (Heckman, 2016), results showed that investing in high quality comprehensive early childhood programs can deliver a 13% return on investment.[60]

Research has shown that home visiting is an effective method of preventing child maltreatment, health and mental health issues, and delinquency, with considerable savings for states and localities.[61] The Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV, 2009) funded by Congress conducted a review of nineteen home visiting models and their outcomes. Researchers (2016) concluded that the *Healthy Families America* model had the greatest breadth of favorable total findings, with positive impacts identified in each of the eight domains such as child development, school readiness, and positive parenting practices.[62]

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[56] Institute of Medicine and the National Research Council 2013. New Directions in Child Abuse and Neglect Research. http://www.nationalacademies.org/hmd/Reports/2013/New-Directions-in-Child-Abuse-and-Neglect-Research.aspx

[57] (Felitti, et al, 1998;),

[58] (Bernstein et al, 1986; U.S. DHHS, 2003; Zuckerman, 1993; Shonkoff, 2000).

[59] Fromm, 2001

[60] Garcia, J. L., Heckman, J.J. & Pradas, M. J. "The Life-cycle Benefits of an Influential Early childhood Program." (2016):n. page. Web

[61] http://www.cbpp.org/research/effective-evidence-based-home-visiting-programs-in-every-state-at-risk-if-congress-does-not

[62] Available at http://homvee.acf.hhs.gov/HomVEE_Executive_Summary_2016_B508.pdf

For the past twenty years, *Healthy Families Montgomery* has addressed the impact that family, community, and culture have on child development and risk for child maltreatment. HFM has long targeted the risk/protective factors associated with child maltreatment and provided comprehensive, multi-level prevention services to high-risk families using a cost-effective home visiting strategy. With a focus on promoting positive parenting, optimal child health and development, long-term health and family self-sufficiency, home visitors provide expectant and new parents with guidance, information, and support using a culturally responsive and competent approach that reflects the most current best practice research.

Healthy Families Montgomery (HFM)

The *Healthy Families Montgomery Program* was launched in 1996 with funding from the Freddie Mac Foundation. Initially operating as a pilot program, HFM conducted a rigorous process and outcome evaluation. After two years of implementation, evaluation results were so compelling that the Maryland State legislature approved funding for 15 replication sites across the state. Additional sustainable funding was received from local city and county governments in 1998 and continues to this day. **In June 2016, HFM marked its twentieth year of service to families at-risk for child abuse and neglect in Montgomery County, Maryland.**

When the HFM program was founded in 1996, Montgomery County was experiencing a dramatic shift in demographics. Due to a tremendous wave of immigration, the County became home to an increasingly poor and more diverse population. Recent Census data indicates that by 2012, the County's minority population accounted for 52% of the state total. Additionally, of children aged 5 years and older, 39% speak a language other than English at home, and 40% report not speaking English very well.[63] The poverty rate for children under age 5 years is 38%. Over the past twenty years, the demographic trends of families served by *Healthy Families Montgomery* have reflected those of the County's. In 2000, 56% of HFM program families were Hispanic; rising to 60% by 2006; and to 92% by 2016.

HFM Quality and Fidelity

As with all Healthy Families programs, HFM was required to complete the initial *Healthy Families America* affiliation process by successfully implementing each of twelve critical elements. To ensure HFM continues to implement evidence-based effective practices and adhere to quality standards, the *Healthy Families America* accreditation process was completed within the first three years of operation and every four years thereafter. The HFM program has been accredited since November 1999, when it received the first national credential of all the Healthy Family America sites in the State of Maryland. Most recently, HFM successfully completed the updated, more rigorous accreditation process, received their credential in January 2017, and are now accredited through March 2021.

Program Participation

HFM screening, assessment and enrollment procedures have remained consistent for the past twenty years, but implementation of these procedures has been refined to meet updated best practices. The HFM program has had a

[63] Family Services, Inc. Discovery Station Early Head Start Community Assessment: Program Year 2015-2016.

longstanding partnership with the Montgomery County Department of Health and Human Services (DHHS). As the major provider of reproductive health and social services to income-eligible families in the County, DHHS conducts universal screenings of all prenatal, perinatal and postnatal female clients. Positive screens are reviewed by the HFM Family Resource Specialist (FRS), who completes an in-depth assessment interview using the Parent Survey with families in the order of their due date. The assessment measures risk in ten domains: self-esteem, depression and substance abuse, perceived expectations regarding childrearing, and bonding and attachment. Families with scores 25 or higher are eligible for the HFM program. Since the program is voluntary, if eligible families decline home visitation services or if there is no available space in HFM for new families, the FRS uses in-depth knowledge of community resources to connect families to needed linkages immediately.

Since program inception, over 15,760 positive screens for risk of child maltreatment have been referred to HFM and over 2,680 in-depth assessments have been completed. The program capacity has expanded and contracted over the past two decades due to funding variations. Capacity was lowest in Year 1 with 50 spaces, and highest in Year 5 with 160 spaces. Capacity has been consistent at 120-130 spaces since Year 11. However, the program capacity has never been sufficient to meet the identified need in the community. In Years 1-10, only 65% of positive assessments were able to be enrolled. This percentage decreased in Years 11-20 when only 50% of positive assessments could be enrolled. These findings indicate that the screening and assessment processes are effective in identifying families at-risk for child maltreatment, but staffing and program capacity limitations make it impossible to assess and enroll all families in need. This reflects the ongoing gap in services for the at-risk population in Montgomery County.

The HFM program does an excellent job of engaging and retaining families. Over the past twenty years, the program averaged an attrition rate of 27%, well below the national rate of 60%. Families who do enroll in the HFM program remain enrolled for an average of two years. If families leave the program, it is most often due to either a move from the service area, a conflict with work or school schedules, or refusing services as unnecessary or due to a change in home visitor. Many leave the program through graduation, indicating they have met their goals. A more in-depth analysis of retention and attrition revealed that older mothers who were living with a partner or married, who spoke English, and who had a consistent home visitor were more likely to remain in the program. Younger single mothers, with less than a high school diploma, and who spoke only Spanish had a shorter mean length of enrollment.

HFM Participant Characteristics

The characteristics that define the program population act as mediating influences on the program effects. These demographics illuminate the risk, strength and resiliency factors with which families enter the program and assist in interpreting outcome evaluation results. Population demographics, such as level of education and marital status, and risk factors identified by the Parent Survey or depression measure, can contribute to a participant's level of risk for child maltreatment and add to the strains on already stressed families. A summary of

the HFM population demographics for each decade of operation is provided in **Table 27.**

Table 27. Population Demographics

Status at Enrollment	Years 1-10 N=546	Years 11-20 N=423
Mother's Age (years)		
14-19	38%	18%
20-25	39%	42%
26-45	23%	40%
Mean Age	**23 yrs.**	**25 yrs.**
Marital Status		
Single	59%	42%
Married	11%	12%
Living Together	27%	44%
Separated/Divorced	3%	2%
Race		
Black	23%	10%
White-Non-Hispanic	8%	1%
White-Hispanic	65%	88%
Other	4%	2%
Primary Language		
English	33%	13%
Spanish	62%	83%
Other	5%	4%
Education Level		
HS Degree or Higher	47%	58%
Employment Level		
Employed at least PT	26%	25%
Housing Status		
Stable Housing	91%	96%
Income Source		
Employment	10%	3%
Public Aid	14%	19%
Employment & Public Aid	66%	76%
Other	10%	2%
Trimester of Enrollment		
Third	60%	50%
Postnatal	23%	49%
Medical Insurance		
Medicaid (Regular)	11%	3%
Medicaid (Emergency)	71%	93%
No Insurance	8%	3%
FSC Assessment Risk		
High/Severe Range	41%	33%

As seen in the table, there is a trend toward older participants enrolling, which is reflected in the increase in the mean age. In the first decade, most mothers were single, and small percentages were married or living together. These proportions changed in the second decade, as the percentage of single mothers decreased and the percentage of mothers living with their partner increased.

Over the past twenty years, the overwhelming majority of families in the HFM program have been Hispanic and Spanish speaking. However, the percentage has increased significantly so that by Year 20, almost all mothers reported Hispanic ethnicity and Spanish as their primary language.

The percentage of mothers having a high school degree or higher has increased over time. Further analysis indicated significant differences by ethnicity, as Black, White, and Asian/ Pacific mothers were significantly more likely to have a high school degree compared with Hispanic mothers.

Only about one-quarter of mothers were employed either full or part-time at enrollment. Despite this, most mothers had stable housing, either owning or renting homes/apartments, or living with friends or family. The income source for most mothers was a combination of both employment and public aid.

Most mothers enroll in HFM in the third trimester or postnatally with emergency Medicaid health insurance. Due to program and partner agency efforts, the percentages of mothers who enroll prenatally and have Medicaid insurance have increased over time.

Overall, the most recent demographic data (2016) reveals a population of increasingly older mothers, with a mean age of 26 years. Most mothers are either single (43%) or living with their partner (48%). Most are Hispanic (94%) and speak Spanish as their primary language. Almost half of mothers over the age of 18 years have less than a high school degree (42%) and are unemployed (72%) at the time of enrollment, factors that greatly increase their risk and affect their ability to support their children. One-third of mothers (32%) scored in the High/ Severe risk range on

the Parent Survey, a decrease from Years 1-10. However, the same five risk factors have been consistently high over the past twenty years. These include, in rank order: social isolation/depression; mother abused as a child; multiple stressors; poor bonding with the child; and unrealistic expectations.

HFM Participant Outcomes

Healthy Families Montgomery has tracked achievement of its goals and measured program outcomes each year since program inception. Over the past twenty years, the program has consistently demonstrated success at meeting or exceeding its targets for key outcomes. Outcome results presented below are organized by program goals and include data broken out by decade. Specific outcome results for Year 20 are also provided.

Table 28 below provides a summary of outcomes achieved by the HFM program, broken out by decade.

Table 28. Summary Chart of Outcomes

Status at Last Follow-up	Yrs. 1-10 N=546	Yrs. 11-20 N=423
I. Promote Preventive Health		
Child Health Care Provider	98%	99%
Medicaid/CHIP Enrollment	99%	99%
Child Current Immunizations	94%	96%
Trimester of Prenatal Care		
First	57%	54%
Second	38%	42%
Third	4%	3%
No PNC	<1%	1%
No Addt'l Births <24 mos.	97%	99%
Post-Partum Care	90%	97%
Healthy Birthweight	92%	94%
II. Reduce Incidence of Child Maltreatment		
No Indicated Reports of CAN	99%	99.8%
III. Optimize Child Development		
Children Screened for Delay	-	97%
Child Development	96%	94%
IV. Promote Positive Parenting		
Parenting Knowledge	-	96%
Parent-Child Interaction	-	84%
Home Safety Knowledge	34%	100%
Maternal Depression Risk	29%	19%
V. Promote Family Self-Sufficiency		
Improved Education Status	-	60%
Improved Employment Status	-	50%
Improved/Stable Housing	-	98%

I. Preventive Health Care

HFM continues to exceed its target objectives related to promoting preventive health care with families. In Year 20, there were 123 target children older than two months of age. Of these, 100% were linked with medical providers and enrolled in Medical Assistance (MA). Likewise, all mothers eligible for MA were enrolled and (100%; n=131) were successfully linked with a medical provider. Over the past twenty years, HFM percentages for access to health care provider and enrollment in Medicaid/MCHIP have consistently been over 95% and averaged 99%. HFM percentages exceed comparable national rates over the past twenty years, which have ranged from 50% to 91%, and averaged 90% for access to health care provider and 75% for enrollment in Medicaid/ CHIP.

Also during Year 20, 98% (n=109/111) of all target children over four months of age were current with their immunizations. Over the past twenty years, HFM has consistently exceeded comparative statistics for the U.S. and the State of Maryland, despite shortages across the country between 2001 and 2005 that lowered average percentages for both the HFM program and national/state immunization programs. HFM's average for Years 1-20 still exceeded its target with 95% of children current with immunizations, and was significantly higher than comparable averages for U.S. (73%) and Maryland (77%) averages for the same time period.

Additionally, during Year 20, 100% (n=127) of all mothers did not have a repeat birth within a 24-month period. This includes 22 mothers who were teens when they enrolled (ages 16-19 years old). HFM's

success rate in this area has consistently exceeded its target of 90% and both Maryland State (84%) and National statistics (82%) for teen repeat births.[64]
Of the active mothers who were due for their post-partum medical visit during Year 20, 98% (n=41/42) received post-partum care, affording them the opportunity to monitor their health and discuss family planning options with their doctors. HFM's success with this objective has increased significantly over the past twenty years. In Years 1-10, the average percentage was 90% completion of post-partum visit, while in Years 11-20, the average was 97% completion. All HFM percentages exceed the national Medicaid rate of 63%.

Of the 52 births during Year 20, 98% (n=51/52) were born at a healthy birthweight (>2500 grams or 5.5 lbs.). Over the pasty twenty years, HFM's success at this objective has been impacted by the number of premature births and sets of twins. For example, in Year 2 there were 15 premature births and 5 sets of twins. The average percentage of children born with a healthy birthweight for Years 1-10 was 87%, while in Years 11-20 it was 94% of children had a healthy birthweight. Additionally, HFM percentages for healthy birthweight from Year 8 to Year 20 met or exceeded the 2015 national and Maryland rates of 92%.

II. Child Maltreatment

For Year 20, data from Montgomery County Child Welfare Services (CWS) for the period between July 2015 and June 2016 indicates that of the 131 active families, 100% had no indicated report of child maltreatment. Over the past twenty years, HFM program met its target in Year 1 and has consistently exceeded it every year since, with many years achieving 100%. The average percentage for both decades was 99.1%, while the total average for Years 1-20 was 99.5%. This is particularly noteworthy when HFM results are compared to national and state trends among the general population. The HFM program has had remarkable success in preventing child abuse and neglect within a targeted population of families identified to be a very high risk for child abuse and neglect.

III. Child Development

In order to monitor the social, emotional, cognitive, language and motor development of each participating child, the HFM program administers the Ages and Stages Questionnaire (ASQ) at regular intervals throughout a family's participation. HFM focuses on two major activities within this goal: 1) ongoing and timely screening of all children, and 2) referrals to local child development programs for children identified with a potential delay. Year 20: Of the 127 target children, 92 were due for an ASQ screening during the fiscal year. Of these, 100% (n=92/92) received a timely ASQ. Over the life of the HFM program, specific data on screening rates was available from Year 10 to the present. For Years 10-20, the HFM program rates were all greater than 90%. When including only Years 11-20, rates increased to between 95% and 100% of all target children screened for developmental delay, with an average percentage of 97%. These rates are significantly higher than the national developmental screening rates of 19% in 2007 and 29% in 2012.

[64] Centers for Disease Control and Prevention: Morbidity and Mortality Weekly Report. *Vital Signs: Repeat Births Among Teens – United States, 2007-2010 (April 5, 2013)*. Available at www.cdc.gov/mmwr/preview/mmwrhtml/mm6213a4.htm?s_cid=mm6213a4_w

HFM redefined its primary goal for child development in 2015. The current goal is met by the percent of target children who are meeting developmental milestones and children who are receiving appropriate services. For Year 20, 100% (n=128/128) of children demonstrated normal child functioning and were meeting developmental milestones or receiving appropriate services. Over the past twenty years, the HFM program has achieved significantly higher percentages of children being on target developmentally for most years of operation, particularly when compared with the national rate. For Years 1-10, the average percentage was 96%, while for Years 11-20 the average percentage was 94%. The lowest percentage occurred in Year 17, with 87% of children meeting developmental milestones. The hiring an Early Intervention Consultant (EIC) in Year 4 had an impact on increasing surveillance for delays, providing support and training to the FSWs around developmental delay, and identifying children with potential delays. The role of the EIC, coupled with an increase in speech/language delays associated with the primarily Spanish speaking participant population, have contributed to increased percentages of children identified, monitored and referred to Early Intervention Services. HFM results for this objective indicate the positive impact of the program's developmental activities on mitigating the role of environmental factors in developmental delay within a high-risk population.

IV. Positive Parenting

Positive parenting includes the areas of parenting knowledge, parent-child interaction, and home safety, as well as mother's psychosocial status. The HFM program began administering The Healthy Families Parenting Inventory (HFPI) in 2007 (Year 12) to identify areas of parental risk and resiliency. There is no comparable data for the first decade of HFM (Years 1-11). Percentages were calculated for each subscale at baseline and at 12-month follow-up. The percentage of mothers at risk decreased from baseline to 12-month follow-up for seven of the nine HFPI subscales. In contrast, mother's risk increased from enrollment to 12-months for two domains: Depression and Role Satisfaction. It is not surprising that risk in these two psychosocial domains would increase in the year following the baby's birth as mothers may develop post-partum depression and as they adjust to their new role as parents. *GLM Repeated Measures Analysis* was used to compare mean scores of mothers on each subscale at baseline to 12-months and 24-months follow-up. Using this method, the same group of mothers is compared across time points. As a more rigorous measure of changes in parenting skills, GLM analysis found a statistically significant improvement after one year of program participation in five subscales: Problem Solving, Personal Care, Mobilizing Resources, Parent-Child Interaction, and Home Environment. Each of these domains is specifically targeted by HFM and is a major focus of home visitors in their work with families. Results indicate that the HFM program has increased parent's ability to cope with unexpected situations, deal with setbacks, and find solutions when faced with problems; increased parent ability to take care of themselves and therefore, take care of their baby; improved participants' knowledge of available resources in the community, as well as their comfort level in seeking help if needed. Further, HFM results indicate improvement in the quality of the parent-child relationship, including parental engagement, responsiveness to the child's needs, and the ability to provide positive

reinforcement appropriately, as well as safety, organization, availability and quality of stimulating materials and activities in the home.

Measurement of parents' knowledge of safety in the home focuses on a variety of factors, such as knowledge of emergency phone numbers, installation of safety devices, and use of automobile safety restraints. Year 20: At baseline, 94% (n=104/111) of mothers had adequate knowledge of home safety. At the 12-month follow-up, 100% of parents had sufficient knowledge of home safety. GLM Repeated Measures analysis was conducted on mean scores of parent knowledge of safety. Results indicate a significant improvement in safety knowledge from baseline mean score (x=15.57) to 12-month follow-up mean score (x=17.23). Using partial eta squared, an effect size of .274 was calculated and indicated that 27% of the variance can be attributed to program effects. For longitudinal analysis, GLM repeated measures procedure was conducted on mean scores for three timepoints: Baseline, 12-months, and 24-months, for both decades and for the total Years 1-20 sample. Results indicate significant increases in knowledge of home safety from baseline to 12-months and 24-months for each decade and the overall sample. Interestingly, mothers who were active in Years 1-10 had the lowest mean scores for home safety knowledge at baseline, but by the 12-month follow-up had increased their mean scores so that they were more closely aligned with those of mothers in Years 11-20. Results indicate the success of the HFM program in increasing parents' knowledge of home safety after one year of participation.

Mothers' risk for depression was measured using the Center for Epidemiologic Studies - Depression (CES-D) scale, which assesses somatic and psychological symptoms, such as changes in appetite or sleep habits, feelings of sadness, and lack of motivation. Year 20: At baseline, about one-quarter of mothers scored at-risk for depression. GLM repeated measures analyses were conducted on CES-D scores from baseline to 12-month follow-up. Results indicated a non-significant decrease in depressive symptomology. However, when mean scores are compared from baseline to 24-months, there was a significant decrease in risk for depression from Baseline mean score (x=11.34) to 24-month follow-up mean score (x=7.87). For the total sample of mothers Years 1-20, one-third (33%) were at risk for depression at enrollment. The percentage of mothers at risk was higher in the first decade (41%; n=254) as compared to the second decade of the program (29%; n=339). Results of GLM analyses by decade and for the overall sample paralleled Year 20 findings, and indicated a significant decrease in mothers' mean scores for depression risk from baseline to 24-months. Mean scores continued to decline up to the 36-month follow-up. These findings suggests that mothers who are at risk for depression receive greater benefit if they stay in the program longer; a minimum of 24 months, but up to 36-months in order to reduce depressive symptomology.

V. Self-Sufficiency

Improvements in mothers' self-sufficiency were measured primarily through marital status, education, employment, and housing status that serve as indicators of a participant's autonomy and ability to live without public aid or support. These factors were examined at entry and again at the close of each program year, however, there

was limited follow-up data for participants active during Years 1-10.

Marital Status: Following the trend in recent years, most mothers (48%) active in Year 20 were living together at the time of enrollment, while 43% were single. At follow-up, a greater percentage of mothers were living together (52%), while fewer (35%) were single. The percentage of mothers who were married increased slightly from 9% at baseline to 11% at follow-up. Longitudinal data for marital status reflects the same trend, with decreases in percentages of single marital status at baseline, and corresponding increases in percentages for living together and married categories over time and from baseline to follow-up. A very small percentage of mothers (2%-3%) were separated or divorced at any time point. These results indicate mothers are increasingly living in partnerships that provide more support and stability than they would have if they were single.

Education Level: Another recent trend has been an increase in the percentage of mothers with a high school degree at enrollment. In Year 20: Most mothers (58%) had a high school degree or higher at enrollment. Of these, 13% had post high school training, 9% had some college, and 7% had a college degree. However, a significant percentage had less than a 7th grade education (17%) and 25% had completed less than 12th grade. Percentages were approximately the same at follow-up, but there were slight increases in the percentages of mothers who completed some college (11%) and mothers who achieved a college degree (9%). Longitudinal data indicates that percentages for mothers who had attained a high school degree or higher trended toward increases both at baseline and follow-up. For participants who enrolled in Years 1-10, the average percentage of mothers with a high school degree or higher was 47%. This percentage increased to 58% for Years 11-20. In addition to the increased percentage of HFM mothers who received a high school diploma while in the program, the percentage of mothers who achieved a college or graduate degree at baseline (7%) more than doubled to 15% at follow-up. These results reflect the HFM program's emphasis on educational attainment, as well as the supports provided by the program that facilitate mothers remaining in school.

Employment Status: The HFM program has had consistent and significant success in supporting mothers in gaining employment after the birth of their baby. Year 20: At enrollment (n=125), 28% of mothers were employed either full or part-time. The majority of mothers were unemployed and not looking for employment (64%). An additional 5% were unemployed because they were in school full time and one mother was on medical leave/disability. At follow-up (n=129), the percentage of mothers employed either full or part-time had almost doubled at 50%. Longitudinal data reflect a similar trend. Overall, the percentage of mothers working either full or part-time increased from 26% (n=975) at enrollment to 36% (n=538) at follow-up. There were corresponding decreases in the percentage of mothers unemployed and not looking for employment from 64% at baseline to 30% at follow-up. These results indicate that the HFM program has been extraordinarily successful at promoting mother's economic self-sufficiency.

Housing Status: Housing instability is defined as including persons who are literally homeless (i.e., living on streets; shelter), imminently losing their housing (i.e., eviction; hospital discharge), or

unstably housed and at-risk of losing housing. Year 20: At enrollment (n=127), most mothers lived with their families (43%). Another 32% of mothers lived with friends, while 22% either owned or rented their own house or apartment. The remaining 3% of mothers had unstable housing (living as a guest in other's home; a shelter or group home). At follow-up (n=127), the percentage of mothers who owned or rented their own house or apartment increased from 22% to 32%, and the percentage of mothers with unstable housing decreased from 3% to 2%. Longitudinal data follow a similar trend. Overall, the majority of mothers lived with their families (51%) at enrollment, to whom they may or may not have paid rent. About one-quarter (24%) rented or owned a home/apartment, and 17% lived with friends, while 8% had unstable housing. At follow-up, the percentage of mothers who lived with family decreased from 51% to 44%, and the percentage of mothers who owned or rented a house or apartment increased from 24% to 30%. Most significantly, there was a decrease in the percentage of mothers who lived in unstable housing from 8% to 4%.

Results demonstrating improved housing status while in the HFM program, combined with improvements in other indicators of self-sufficiency, including increases in percentages of supportive marital status, increased levels of educational achievement, and significant increases in the percentages of mothers employed full or part-time, indicate that the HFM program has been extremely successful at empowering mothers with the skills and linkages to resources for increased self-sufficiency.

Staff and Participant Satisfaction are assessed annually by the HFM program. HFM participants have consistently reported high levels of satisfaction with the program. All respondents have reported that both their Family Support Worker (FSW) and the HFM program were either "Excellent" or "Good", and all (100%) agreed that they would recommend the program to a friend or relative. When asked what they like best about the HFM program, most participants focused on how the program has helped them to become better parents by teaching them about child development and providing the education to care for their children. Many also commented on the helpful support and advice they get from their FSW. They appreciated opportunities to socialize with and learn from other families. Several mothers simply said they liked "everything" about the program. Comments indicate that participants are so positive about the program that they would like to see longer visits, additional activities, and visits for their children beyond 3 or 5 years old.

Results of staff surveys have been very consistent over the past twenty years, indicating that most staff enjoy their work, find it worthwhile, and believe they are having a positive impact on families. All agree that they are satisfied with their position and feel appreciated by management for the work they do. However, a consistent theme for staff over the years is concern that they are not appropriately compensated for the work they do. Interestingly, almost all staff did not think the work they do is hard. When asked what areas of the program are particularly strong, comments focused on several key areas: the dedication and preparedness of staff, the strength-based approach of the program, and the respect for cultural diversity and the ability to connect with families. Respondents commented on the dedication and strength of staff to connect with families and

empower them to be their child's best advocate. They also cited the strength-based program and a curriculum that provides services in a structured way.

Impact

It is evident from 1996 prevalence data regarding rising child maltreatment rates that the HFM program and its partners have had a tremendous positive impact on the health and well-being of families in Montgomery County and the State of Maryland. The rate of founded cases of child abuse and neglect for families who participated in the HFM program has been less than 1% (ranging from 0.0%-0.9%) for the past twenty years. Additionally, when HFM began, community needs assessment results indicated low rates of screening for child developmental delay, a lack of parenting resources and supports, poor access to health care for low-income families, a high teen birth rate, and low educational and employment levels among at-risk families. Over the past twenty years, HFM has worked with local, state and national partners to address these issues, resulting in increased identification and services for child developmental delay, an increase in the number and range of parenting resources and supports, significant improvements in parenting knowledge and parent-child interaction, decreased teen birth rate, access to health care for all children and most mothers, and increased education and employment levels of participating mothers. These accomplishments were achieved despite a rapidly changing demographic within Montgomery County and the State of Maryland, and the high level of risk of participating families.

HFM played a leadership role in the state by operationalizing its vision for healthy families. With relatively few resources and within a short period of time, HFM achieved all of its primary objectives and demonstrated significant improvements on major standardized measures of health, child maltreatment, parenting skills, risk for maternal depression, and family self-sufficiency. The program's early successes led to statewide replication and infrastructure for early childhood home visiting. Through its advocacy efforts, HFM increased awareness in the community of the serious public health issue posed by child abuse and neglect and forged long lasting partnership to address the issue.

HFM continued to provide leadership by repeatedly incorporating the most current research and practice on risk and protective factors, research on the impact of child maltreatment on the child's developing brain and the deleterious effects of abuse and neglect on lifelong health and well-being. The program has translated this research into practice through extensive training, intensive supervision, and maintaining its accreditation.

HFM's successes can demonstrate to legislators the cost benefits of prevention.

Recommendations

- Leverage program successes to secure funding for expansion of services to meet the outstanding need for prevention services in the community, resulting in significant savings in public health and welfare costs.

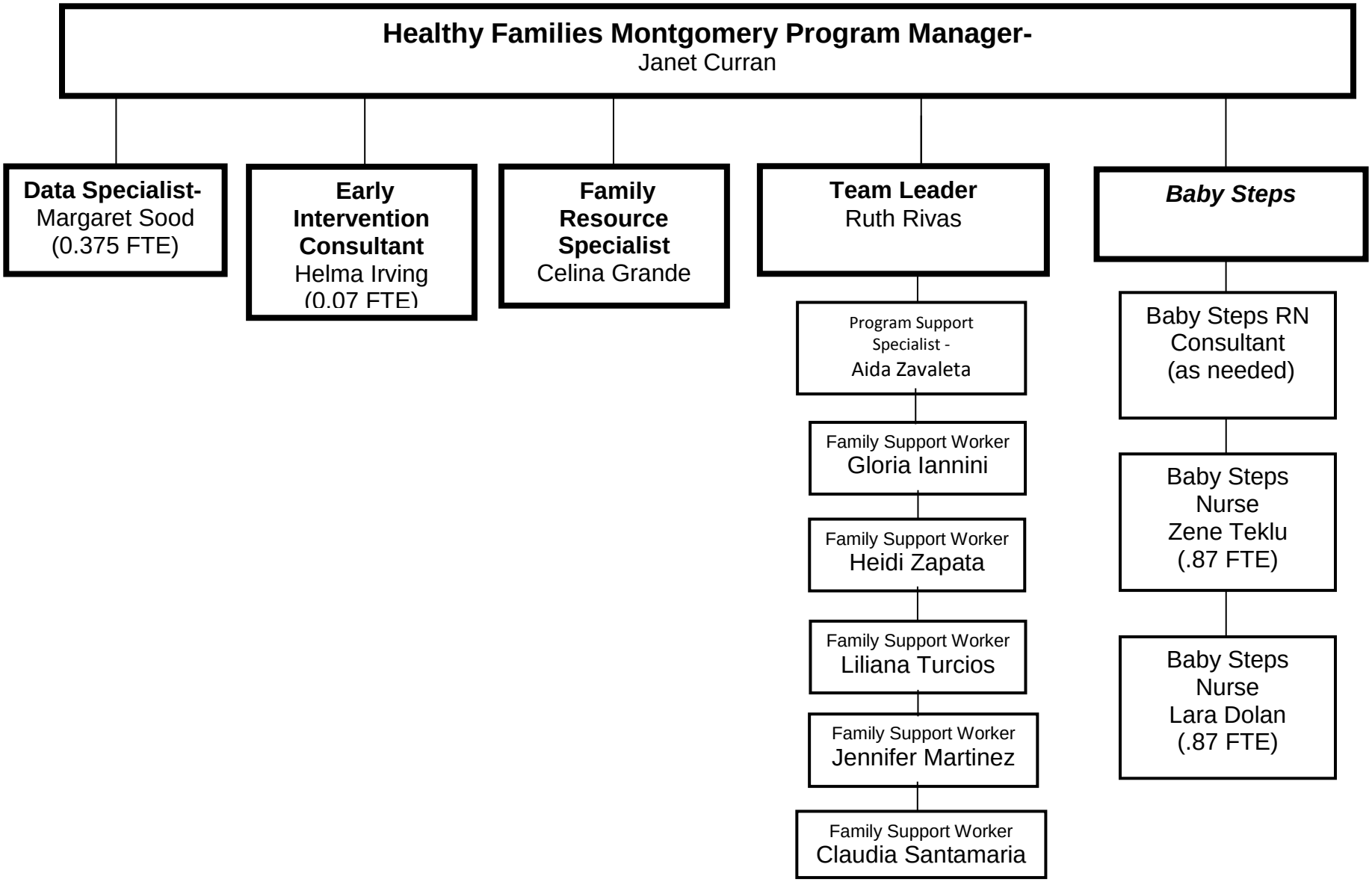
- Continue to provide leadership within the county and across the state that bolsters the quality, fidelity, staff training, program evaluation, and achievement of outcomes. Advocate for policies and practices that support these goals.

- Continue to collaborate with other early childhood home visiting programs to implement and meet the MIECHV benchmark measures.

- Continue to expand partnerships that help meet evolving needs of diverse families.

- Continue to develop and implement strategies that address the recommendations from the recent accreditation review.

APPENDIX A. HFM ORGANIZATIONAL CHART



APPENDIX B. HFM FUNDING SOURCES & EXPENDITURES

Healthy Families Montgomery Funding Sources
July 2015– June 2016

Private Foundations

William S. Abell Foundation
Morris and Gwendolyn Cafritz Foundation
Clark-Winchcole Foundation
William J. and Dorothy K. O'Neill Foundation

Public Funding

City of Rockville
Montgomery County Collaboration Council for Children, Youth and Families (Local Management Board)
Montgomery County Department of Health and Human Services

Individual Donors and Other

Individual Donors

In-Kind Donations

Barnes and Noble, RIO Washingtonian Center
Christ Child Society
First Books – Montgomery County
Friendship Star Quilters
Weichert Realty – Gaithersburg/North Potomac
Woodworkers for Charity

Program Expenditures
July 2015– June 2016

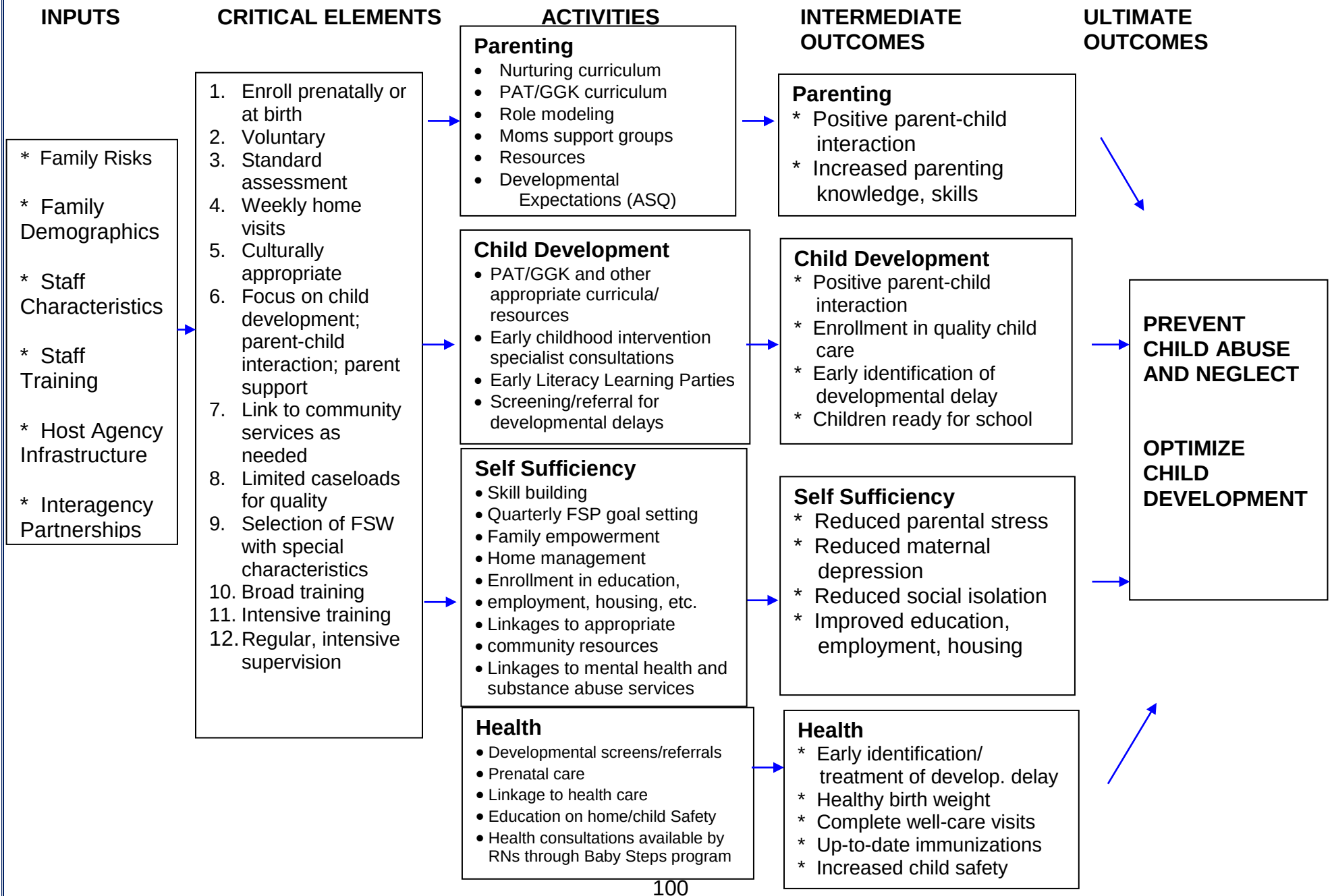
Program Funding	
Montgomery County DHHS	$547,998
Montgomery County Collaboration Council	170,267
City of Rockville	15,000
William S. Abell Foundation	13,739
Morris and Gwendolyn Cafritz Foundation	10,152
Clark-Winchcole Foundation	10,000
William J. and Dorothy K. O'Neill Foundation	11,982
Foundation support and training fees	20,543
Total Funding	**$799,681**
Program Expenses	
Personnel salaries	$424,003
Personnel fringe benefits	126,098
Building occupancy	60,130
Professional services and evaluation	13,320
Transportation, local travel	13,644
Telephone	7,983
Training/conferences	23,940
Program activities/supplies/equipment	29,800
Subtotal Expenses	**$698,918**
General and administration	$96,913
Total Expenses	**$795,831**
Excess/Deficit	$ 3,850

APPENDIX C. HEALTHY FAMILIES MONTGOMERY ADVISORY BOARD

July 2015– June 2016

Member	Organization/Title
Barbara Andrews (*Ex-Officio Member*)	MC DHHS Early Childhood Services
Beth Arcarese	Saint Rose of Lima
Robin Chernoff, MD	Retired Pediatrician, Montgomery County Collaboration Council Board Member
Janet Curran (*Ex-Officio Member*)	FSI/HFM Program Manager
Ruth Hayn	League of Women Voters
April Kaplan (*Ex-Officio Member*)	Montgomery County Collaboration Council
Joan Liversidge	Community Member
Carol May	Community Member
Meredith Myers (*Ex-Officio Member*)	FSI/ECFT Director
Rebecca Smith, RN (Ex-Officio Member)	Nurse Administrator Silver Spring Health Center
Margaret Sood (*Ex-Officio Member*)	HFM Data Specialist

APPENDIX D. HEALTHY FAMILIES MONTGOMERY LOGIC MODEL



APPENDIX E. PARENTAL CONSENT FOR PARTICIPATION

HEALTHY FAMILIES MONTGOMERY
Family Services, Inc.
610 E. Diamond Avenue, Suite 100
Gaithersburg, MD 20877-5323
(301) 840-2000

PARENTAL CONSENT FOR PARTICIPATION

I, _____,

residing at _____,

hereby consent to participate in Healthy Families Montgomery, a program of Family Services, Inc.

I understand that the services provided by Healthy Families Montgomery are free of charge.

I understand that in order to assess, plan and provide services for my family, it may be necessary to share information with other persons. Healthy Families Montgomery is bound by the rules of confidentiality.

I understand that my participation is voluntary, and that I have the right to withdraw from services at any time. This consent will be in effect until 30 days after discharge from the program.

_____ _____
Parent's Signature Date Witness' Signature Date

_____ _____
Printed Name of Parent Printed Name of Witness

_____
Relationship to Target Child

_____ _____
Parent's Signature Date Witness' Signature Date

_____ _____
Printed Name of Parent Printed Name of Witness

_____
Relationship to Target Child

Consent Withdrawn

_____ _____
Signature Date

HEALTHY FAMILIES MONTGOMERY
Family Services, Inc.
610 E. Diamond Avenue, Suite 100
Gaithersburg, MD 20877-5323
(301) 840-2000

Consentimiento para Participación

Yo, _____, residiendo en _____

Por este medio doy el consentimiento para participar en el programa de Healthy Families, un programa de Family Services, Inc.

Yo entiendo que los servicios que ofrece Healthy Families Montgomery son sin cargo alguno.

Yo entiendo que para asesorar, planear y proveer servicios para mí y mi familia, puede ser necesario intercambiar información con otras personas / agencias. El programa de Healthy Families Montgomery está regido por las reglas de confidencialidad.

Yo doy mi aprobación para que las siguientes agencias intercambien información.

Yo entiendo que mi participación es voluntaria y que tengo el derecho de terminar los servicios en cualquier momento. Este consentimiento estará vigente hasta 30 días después de concluir los servicios.

_____ _____
Firma de la madre / tutora Fecha Firma del testigo(a) Fecha

_____ _____
Nombre de imprenta de la madre Nombre de Imprenta del testigo

_____
Parentesco con el niño(a)

_____ _____
Firma del Padre / tutor Fecha Firma del testigo(a) Fecha

_____ _____
Nombre de imprenta del padre / tutor Fecha Nombre de Imprenta del testigo

_____
Parentesco con el niño(a)

Consentimiento Revocado

_____
Firma Fecha

APPENDIX F. PARENTAL CONSENT FOR PARTICIPATION OF A MINOR

HEALTHY FAMILIES MONTGOMERY
Family Services, Inc.
610 E. Diamond Avenue, Suite 100
Gaithersburg, MD 20877-5323
(301) 840-2000

PARENTAL CONSENT FOR PARTICIPATION OF A MINOR

I, _____,
(Parent or Guardian of the Minor Mother of the Baby)
residing at _____,

hereby consent for _____
(Minor Mother of the Baby)

to participate in Healthy Families Montgomery, a program of Family Services, Inc.

I understand that the services provided by Healthy Families Montgomery are free of charge.

I understand that in order to assess, plan and provide services for my family, it may be necessary to share information with other persons. Healthy Families Montgomery is bound by the rules of confidentiality.

I understand that my participation is voluntary, and that I have the right to withdraw from services at any time. This consent will be in effect until 30 days after discharge from the program.

_____ _____
Parent's/Guardian's Signature Date Witness' Signature Date

_____ _____
Printed Name of Parent/Guardian Printed Name of Witness

_____
Relationship to Target Child

Consent Withdrawn

_____ _____
Signature Date

HEALTHY FAMILIES MONTGOMERY
Family Services, Inc.
610 E. Diamond Avenue, Suite 100
Gaithersburg, MD 20877-5323
(301) 840-2000

Consentimiento de los padres para la participación de una menor de edad

Yo, _____,
residiendo en_____,
por este medio doy el consentimiento para que _____
(la menor, madre del bebé)
participe en Healthy Families Montgomery, un programa de Family Services, Inc.

Yo entiendo que los servicios que ofrece Healthy Families Montgomery son sin cargo alguno.

Yo entiendo que para asesorar, planear y proveer servicios para mí y mi familia, puede ser necesario intercambiar información con otras personas / agencias. El programa de Healthy Families Montgomery está regido por reglas de confidencialidad.

Yo doy mi aprobación para que las siguientes agencias intercambien información.

Yo entiendo que mi participación es voluntaria y que tengo el derecho de terminar los servicios en cualquier momento. Este consentimiento estará vigente hasta 30 días después de concluir los servicios.

_____ _____
Firma de la madre / tutora Parentesco con el niño(a)

_____ _____
Nombre de imprenta Fecha

_____ _____
Firma del padre / tutor Parentesco con el niño(a)

_____ _____
Nombre de imprenta Fecha

_____ _____
Firma del testigo(a) Fecha

_____
Nombre de imprenta

Consentimiento Revocado

_____ _____
Firma Fecha

APPENDIX G. PARENTAL CONSENT TO PARTICIPATE IN PROGRAM EVALUATION

HEALTHY FAMILIES MONTGOMERY
Family Services, Inc.
610 E. Diamond Avenue, Suite 100
Gaithersburg, MD 20877-5323
(301) 840-2000

Parental Consent to Participate in Program Evaluation

This consent form is for families who participate in the Healthy Families Montgomery (HFM) program. We are currently participating in an evaluation project that will allow us to have a better understanding of how our services make a difference in the families we serve over a period of time. It also assists us in finding ways to better meet families' needs. Your participation in this project is very important. Your Family Support Worker will assist you in completing several questionnaires/surveys for this purpose.

Please be aware of the following:

- Your participation is voluntary, and if you decide not to participate, this will not prevent you from receiving HFM services.
- Your name and your child's name will be omitted in all data sent to the evaluator.
- All information gathered from the questionnaires/surveys is used only with the purpose to evaluate how the program makes a difference in the lives of the participants.
- All information is kept confidential at all times.
- We would like you to answer all questions, but if there is any question that you do not want to answer for any reason, just leave it blank.
- This consent is good for six years; however, consent can be withdrawn at any time.

If you have any questions about the questionnaires/surveys or the evaluation project, please call the HFM office at 301.840.2000 or Donna Klagholz at 703.759.9204. Thank you.

Donna D. Klagholz, Ph.D.
Program Evaluator

_____ _____
Participant's Signature Date Print Name

_____ _____
Witness' Signature Date Print Name

_____ _____
Parent or Guardian of Participant Date Print Name

HEALTHY FAMILIES MONTGOMERY
Family Services, Inc.
610 E. Diamond Avenue, Suite 100
Gaithersburg, MD 20877-5323
(301) 840-2000

Consentimiento para Participar en el Proyecto de Evaluación

Este consentimiento es para las familias que participan en el programa de Healthy Families Montgomery (HFM). Al presente, estamos participando en un proyecto de evaluación que nos permitirá entender con más claridad cómo a través del tiempo, nuestros servicios hacen una diferencia en las familias que servimos. También nos ayudará a encontrar mejores formas de servir a las familias de acuerdo a sus necesidades. Su participación en este proyecto es muy importante. Su Trabajadora de Apoyo Familiar (FSW) le ayudará a completar varios cuestionarios / encuestas para este propósito.

Por favor tome nota de lo siguiente:

- Su participación es voluntaria y si usted decide no participar, esto no evitará que usted continúe recibiendo servicios de HFM.
- Su nombre y el de su hijo(a) se omitirán en cualquier dato que se envíe al evaluador.
- Toda información obtenida de los cuestionarios / encuestas se usará solamente con el propósito de evaluar como el programa de HFM hace la diferencia en la vida de los participantes.
- Toda la información obtenida es confidencial.
- Nos gustaría que respondiera a todas las preguntas, pero si por alguna razón no desea contestar alguna pregunta, puede dejarla en blanco.
- Este consentimiento es válido por seis (6) años; sin embargo, usted puede anular este consentimiento en cualquier momento.

Si tiene alguna pregunta acerca de los cuestionarios / encuestas o de este proyecto, por favor llame a la oficina de HFM (301.840.2000) ó a Donna Klagholz (703.759.9204). Gracias por su colaboración.

Donna D. Klagholz, Ph.D.
Evaluador de Programas

_____ _____
Firma del Participante Fecha Nombre de Imprenta

_____ _____
Firma del Testigo(a) Fecha Nombre de Imprenta

_____ _____
Padre o Tutor Legal del participante Fecha Nombre de Imprenta

APPENDIX H. HFM DESCRIPTION OF EVALUATION MEASURES

Ages & Stages Questionnaire (ASQ)
Authors: Jane Squires, Ph.D., LaWanda Potter, M.S., and Diane Bricker, Ph.D.
Description: The ASQ is a child-monitoring system consisting of 11 questionnaires designed to identify infants and young children who demonstrate potential developmental problems. The questionnaires were developed to use when the child is 4, 8, 12, 16, 20, 24, 30, 36, and 48 months of age, with optional forms available at 6 and 18 months. Each questionnaire features 30 developmental items in five areas: (1) communication, (2) gross motor, (3) fine motor, (4) problem solving, and (5) personal-social. Each item, focusing on performance of a specific behavior, is marked "yes", "sometimes", or "not yet". Children are identified as needing further testing and possible referral for early intervention services when scores fall below designated cutoff points. The reliability of the ASQ is strong with a two-week test-retest coefficient of .94 and an interobserver reliability value of .94. The validity of the ASQ is supported by a concurrent validity coefficient of .84.

Ages & Stages Questionnaire: Social-Emotional (ASQ:SE)
Author: Jane Squires, Ph.D., Diane Bricker, Ph.D., and Elizabeth Twombly, M.S.
Description: The ASQ:SE is a screening tool that identifies infants and young children whose social and emotional development may require further evaluation. Designed to be used in conjunction with the ASQ that was originally released in 1995, the ASQ:SE provides additional information that targets the social and emotional behavior of children ages 3 to 66 months. The ASQ:SE is a series of eight questionnaires for use at 6, 12, 18, 24, 30, 36, 48, and 60 month age intervals that focus on eight behavioral areas: *Self-regulation, Compliance, Communication, Adaptive functioning, Autonomy, Affect,* and *Interaction with people.* The ASQ:SE was normed using 3,014 completed questionnaires from 1,041 pre-school aged children and their families. This normative group closely approximates the 2000 United States census data for income, level of education, and ethnicity. The ASQ is completed by parents/caregivers in approximately 10-15 minutes. As the readability levels of the questionnaires range from 5th to 6th grade, an interview format may be used for parents with limited literacy, or who do not read English or Spanish. Each questionnaire should be administered within a 3-month (for 6 through 30 month intervals) or 4-month (for the 36 through 60 month intervals) "window" of time surrounding each age interval.

Center for Epidemiologic Studies – Depression (CES-D)
Author: The Center for Epidemiologic Studies, National Institute of Mental Health
Description: The CES-D is used to measure maternal depression. This 20-item self-reporting instrument focuses on depression symptomology rather than diagnosing clinical depression. It consists of four separate factors: depressive affect, somatic symptoms, positive affect, and interpersonal relations. The evidence that shows a causal link between symptoms of depression and children's well-being provides the rationale for including this construct in the Parent Interview. It has been used in many rural and urban populations and cross-cultural studies of depression. The reliability of the CES-D is supported by a correlation with the NIMH Depressed Mood subscale of the General Well-Being Scale with a correlation coefficient of .71, a high test-retest correlation, and a sensitivity of .89 and specificity of .70 when related to psychiatric instruments such as the Diagnostic Interview Scale (DIS). Demonstrated associations with related constructs support its construct validity and CES-D has been shown to have good discriminant validity.

Healthy Families Parenting Inventory (HFPI)

Authors: Craig W. LeCroy, Judy Krysik, Kerry Milligan

Description: The HFPI is designed to measure major dimensions of healthy parenting for parents of newborns and young children. The HFPI is an easy to administer, 63-item instrument that measures important aspects of behavior, attitudes, and perceptions related to parenting. The instrument has nine distinct subscales that are organized as follows: social support (items 1 through 5), problem-solving (items 6 through 11), depression (items 12 through 20), personal care (items 21 through 25), mobilizing resources (items 26 through 31), role satisfaction (items 32 through 37), parent/child interaction (items 38 through 47), home environment (items 48 through 57), and parenting efficacy (items 58 through 63). The HFPI was developed specifically for use in evaluating home visitation programs for populations of at-risk children from birth to five years of age. These programs are designed to prevent child abuse and neglect, improve parent/child interaction, and improve child development. The HFPI can be used to identify critical areas of need, target concerns, build on strengths, and to develop an individualized case plan. The HFPI subscales have alpha coefficients ranging from .76 to .86, indicating excellent internal consistency. All nine subscales have good construct validity, correlating poorly with measures with which they should not correlate, and low to moderately with other subscales on the instrument.

APPENDIX I. HFM EVALUATION ADMINISTRATION SCHEDULE

HFPI*	Baseline	12 months	24 months	36 months	48 months	60 months
	Prior to 3 months enrollment	One month before & up to one month after the TC's first birthday	One month before & up to one month after the TC's second birthday	One month before & up to one month after the TC's third birthday	One month before & up to one month after the TC's fourth birthday	One month before & up to one month after the TC's fifth birthday

Safety	Baseline	Postnatal administration or Baseline	12 months	24 months	36 months	48 months	60 months
	Prior to 3 months enrollment	30 to 60 days after TC's birth	One month before & up to one month after the TC's first birthday	One month before & up to one month after the TC's second birthday	One month before & up to one month after the TC's third birthday	One month before & up to one month after the TC's fourth birthday	One month before & up to one month after the TC's fifth birthday

CES-D	Prenatal Baseline	Postnatal administration or Baseline	12 months	24 months	36 months	48 months	60 months
	Prior to 3 months enrollment	45 to 60 days after TC's birth	One month before & up to one month after the TC's first birthday	One month before & up to one month after the TC's second birthday	One month before & up to one month after the TC's third birthday	One month before & up to one month after the TC's fourth birthday	One month before & up to one month after the TC's fifth birthday

**During Year 12, the HFPI was administered at a six-month interval to pilot pre/post comparison.*

APPENDIX J. HFA CRITICAL ELEMENTS OF SUCCESSFUL HOME VISITATION PROGRAMS

1. Initiate services at birth or prenatally.

2. Use a standardized assessment tool to systematically identify families who are most in need of services. The Parent Survey or other HFA approved tool is used to assess the presence of various factors associated with increased risk for child maltreatment or other adverse childhood experiences.

3. Offer services voluntarily and use positive, persistent outreach efforts to build family trust.

4. Offer services intensely and over the long term, with well-defined criteria for increasing or decreasing intensity of service.

5. Services are culturally sensitive such that staff understands, acknowledges, and respects cultural differences among families; staff and materials used reflect to the greatest extent possible the cultural, language, geographic, racial and ethnic diversity of the population served.

6. Services focus on supporting the parent(s) as well as the child by cultivating the growth of nurturing, responsive parent-child relationships and promoting healthy childhood growth and development.

7. At a minimum, all families are linked to a medical provider to assure optimal health and development. Depending on the family's needs, they may also be linked to additional services related to: finances, food, housing assistance, school readiness, child care, job training, family support, substance abuse treatment, mental health treatment, and domestic violence resources.

8. Services are provided by staff with limited caseloads to assure that home visitors have an adequate amount of time to spend with each family to meet their unique and varying needs and to plan for future activities.

9. Service providers are selected because of their personal characteristics, their willingness to work in or their experience working with culturally diverse communities, and their skills to do the job.

10. Service providers receive intensive training specific to their role to understand the essential components of family assessment, home visiting and supervision.

11. Service providers have a framework, based on education or experience, for handling the variety of experiences they may encounter when working with at-risk families. All service providers receive basic training in areas such as cultural competency, reporting child abuse, determining the safety of the home, managing crisis situations, responding to mental health, substance abuse, and/or domestic violence issues, drug-exposed infants, and services in their community.

12. Service providers receive ongoing, effective supervision so they are able to develop realistic and effective plans to empower families.

GOVERNANCE AND ADMINISTRATION

The program is governed and administered in accordance with principles of effective management and of ethical practice. Please note GA is not a Critical Element.

APPENDIX K. HFM SERVICE LEVEL SYSTEM DESCRIPTIONS

ACTIVE LEVELS		
Level	Definition	Number of Home Visits Due
1-P1	Up to 7 months prenatal.	2 per month (biweekly)
1-P2	7 months prenatal to birth.	4 per month (weekly)
1-SS	Special Services- The family is in crisis and needs additional services for a temporary period of time.	More than 1 per week or longer home visits.
1	Begins once the baby is born and is residing in the home.	4 per month
2	When criteria for promotion are met.	2 per month
3	When criteria for promotion are met.	1 per month
4	When criteria for promotion are met.	1 per quarter
XA	Creative Outreach - Families on creative outreach. (FSW has been unable to locate or have regular contact with family for three weeks. Families usually stay in creative outreach status for 3 months unless they refuse services). This level is also utilized when engaged families are unable to accept visits due to a temporary change in their work or school schedule, or are temporarily out of the service area.	No visits required; attempted visits will be made, if appropriate

APPENDIX L. HEALTHY FAMILIES MONTGOMERY STAFF TENURE DATES

1996 – 2016

NAME	TITLE	% TIME	START DATE	EXIT DATE
Brenda Barnes-Tucker	Program Coordinator	100	1/96	6/96
Rita Pridgen	FSW	100	02/11/96	09/28/01
Janet Curran	QA Team Leader Program Manager	100 100	03/06/96 01/01/06	
Maria Paganini	DHHS/FSW	50	04/01/96	05/29/98
Katrina Delaney	DHHS/FSW	50	04/02/96	07/31/96
Janet Ceasar	Program Director	100	07/05/96	12/15/00
Amy Hernandez	DHHS/FSW	50	12/09/96	02/27/98
Peggy Matthews-Nilsen	Supervisor	50	04/16/97	10/16/97
Luz Escobar	FSW III Team Leader	100 100	05/06/97 06/01/06	04/15/2016
Lucia Torres	FSW III	100	05/06/97	07/15/02
LeShaun Williams	FSW	100	05/06/97	03/31/98
Liz Craig	Supervisor	100	10/28/97	07/02/99
Marlene Weiss	DHHS/FSW	100	04/01/98	02/01/99
Rhonda Banks	FSW	100	06/29/98	07/14/00
Gloria Iannini	FSW III FSWIII	100 100	01/21/99 8/27/07	06/30/04
Tanya Brown	FSW	100	05/15/99	09/21/01
Noelle Cochran	FSW	100	09/13/99	08/09/00
Mayra Luna	FSW	100	09/13/99	02/23/01
Georgia Rios	FSW	100	09/13/99	07/17/00
Jessica Robertson	Administrative Assistant	100	09/13/99	04/07/03
Estela Villa-Galeano	FSW	100	09/13/99	10/06/00
Cheryl Grant	Supervisor	100	10/04/99	07/07/00
Jennifer Simpson	Early Intervention Specialist	50	11/22/99	11/20/00
Jodi Glick	Supervisor	100	12/01/99	05/20/00
David Rocha	Dads Coordinator	100	12/16/99	07/14/00
Elizabeth O'Connell	Nurse	100	03/01/00	11/20/00
Marta Aragon	FSW I	100	04/16/00	07/31/02
Ashley Poindexter	FSW I	100	10/30/00	09/04/03
Adah Clarke	FSW III	100	10/30/00	06/04/07
Peggy Easley	Program Director	100	11/06/00	07/26/02
Hilda Filomeno	FSW II	100	01/16/01	09/15/03
Stacie Banks Hall	Supervisor	100	02/16/01	05/15/01
Cynthia Samples	Supervisor	100	02/26/01	06/30/04
Carmen Aparicio	FSW III	100	06/01/01	08/04/06
Victor Quiroz	Dads Coordinator	100	06/01/01	02/28/02
America Caballero	Lead Coordinator Early Intervention EIS/Team Leader	100 50 75	07/23/01 06/01/08 01/09/09	12/07/2012
Maritza Buitrago	FRS II	100	08/06/01	06/10/05
Patricia Paredes	Nurse	50	09/04/01	11/15/04

NAME	TITLE	% TIME	START DATE	EXIT DATE
Helma Irving	Early Intervention	50	09/10/01	07/31/02
Leigh-Ann Nauser	FSW I	100	12/03/01	06/30/04
Melodye Berry	FSW I	100	12/03/01	01/01/03
Silvia Hurtarte	FSW I	100	09/03/02	02/00/04
Celina Grande	FRS II	100	10/01/02	
Ana Caba	FSW I	100	10/07/02	08/31/04
Crystal Carr	Program Director	100	11/04/02	12/31/05
Diana Hawley	Early Intervention Specialist	50	02/11/03	11/00/03
Aleta (Pedreira) Winters	Program Assistant	100	06/02/03	04/27/07
Meredith Jossi	FSW I	100	12/15/03	08/15/05
Helma Irving	Early Intervention	50	02/00/04	02/01/08
Bridget Kish	FSW I	100	02/02/04	04/15/04
Megan Broadbent	FSW I	100	02/23/04	08/15/04
Maria Pilar Sepulveda	FSW I	100	04/21/04	07/14/2012
Adriana Parra	FSW I	100	07/12/04	08/12/04
Latteefa Salaam	FSW I	100	07/12/04	08/13/04
Mery Aguirre	FSWI	100	07/26/04	01/26/07
Latika Wilson	Data Entry Specialist	100	07/26/04	09/15/05
Gloria Gonzalez	FSW I	100	08/16/04	05/08/2015
Aida Zavaleta	FSW I	100	08/16/04	
Nancy Patino	FSW I	100	09/27/04	02/15/05
Elaine Zagami	FSW Team Leader	100	11/03/04	05/26/06
Samantha LaBelle	FSW I	100	03/28/05	04/06/06
Asia Conley	FSW I	100	04/25/05	08/16/05
Ruth Rivas	FRS I	100	06/13/05	01/25/08
Marian Bolton	FSW II	100	08/11/05	02/15/07
Amita Binger	Early Intervention	50	10/03/05	05/31/06
Meredith Myers	Director, ECS	25	04/23/06	
Lourdes L. Castro	FSW I	100	06/12/06	12/07/2011
Zelma Sciaudone	FSW II	100	01/02/07	10/01/09
Sandra Peltier	FSW I	100	02/08/07	07/05/07
Joylyn Bishop	FSW I	100	04/02/07	09/09/08
Sue Chen	FSW III	50	09/13/07	09/30/10
Supreet Kaur	Program Assistant	50	10/08/07	11/15/2013
Liana Vega-Hernandez	Team Leader	100	04/07/08	01/09/09
Erin Yoon	Data Specialist	On call	04/07/08	01/01/09
Ana Del Negro	FSW I	100	11/30/2009	06/15/2010
Heidi Zapata	FSW I	100	11/30/2009	
Sandra Buitrago	FSW	100	01/23/2012	09/10/2012
Helma Irving	Early Intervention	As needed	12/07/2012	
Cinthia Guzman	FSW	100	04/1/2013	3/11/2014
Jamuna Sundrum	FSW	100	04/01/2013	4/30/2014
Margaret Sood	Data Specialist	38%	11/15/2013	
Shelly Tamayo	FSW	100	04/14/2014	08/14/2015
Liliana Turcios	FSW	100	04/13/2015	

NAME	TITLE	% TIME	START DATE	EXIT DATE
Jennifer Martinez	FSW	100	09/14/2015	
Claudia Santamaria	FSW	100	01/11/2016	
Ruth Rivas	Team Leader	100	06/06/2016	

APPENDIX M. HEALTHY FAMILIES MONTGOMERY STAFF TRAININGS

Year 20

DATE	TOPIC	# HFM STAFF ATTENDED
Professional Development		
7/16/2015	Advanced Ethics	1
8/27/2015	Boundaries Training	1
9/23/2015	Parent Survey Rating Scale Update	1
11/01/2015	Qualified Bilingual Staff Training Program 24-Hour	1
12/02/2015	MANDT Crisis training	1
12/08/2015	Get On Board with FSI	1
1/25/2016	Confidentiality & HIPAA	1
2/03/2016	HFA Trainer: Supervisor Training Outlines	1
2/15/2016	Crisis Training	1
3/08/2016	HFA Advanced Supervision	2
3/17/2016	Secondary Traumatic Stress	8
3/17/2016	Secondary Traumatic Stress at the Program Level	1
3/17/2016	Why Don't People Do What's Good for Them	1
6/10/2016	Integrated Strategies for Supervisors	1
6/10/2016	The ACE Study	7
6/17/2016	Home Visiting Safety	7
Multiple Dates	Integrated Strategies for Home Visiting	4
Multiple Dates	Family Goal Plan Process	4
Multiple Dates	Orientation to Administrative Information	2
Multiple Dates	Orientation to Healthy Families Montgomery	3
Multiple Dates	Orientation to Family Services, Inc.	3
Multiple Dates	Orientation to Issues of Confidentiality	3
Multiple Dates	Program Processes	2
Multiple Dates	Orientation to Program's Relationship with Community Resources	2
Multiple Dates	Orientation to Issues of Boundaries	3
Multiple Dates	Orientation to Home Visiting Safety	3
Multiple Dates	HFM Chart Documentation	3
Multiple Dates	Program Evaluation including Screening for Depression	2
Multiple Dates	FSW Stop Gap training	2
Multiple Dates	Sexual Harassment/Discrimination Prevention	7
Multiple Dates	Optimizing Your Effectiveness	4
Multiple Dates	Corporate Compliance & Ethics	7
Multiple Dates	HIPAA	5
Topics Related to Culture		
9/16/2015	Cultural Diversity for Paraprofessionals	1
10/30/2015	Role of Culture in Parenting	1

2/19/2016	Gangs in the Community	7
3/17/2016	Giving a Fish a Bath: Adolescent Mind	1
Multiple Dates	Cultural Diversity	7
Multiple Dates	Cultural Sensitivity/Awareness in Home Visiting	2
Parenting		
8/20/2015	Building Parent-Child Relationships/Reduce Stress	1
2/17/2016	CHEEERS Training	1
3/17/2016	Impact of Toxic Stress on Parenting	3
6/23/2016	Responding to Relationships	1
Multiple Dates	Coaching on Positive Parenting Strategies	3
Family Mental Health and Well Being		
9/18/2015	Responding to Relationships	1
10/23/2015	Substance Abuse Screening	7
10/23/2015	Effects of Trauma: From Flood to Flow	1
3/17/2016	Infant Mental Health	5
4/26/2016	Screening for Intimate Partner Violence and Domestic Violence	9
6/22/2016	Preventing Child Abuse	1
Multiple Dates	Addressing Domestic Violence	2
Multiple Dates	Annual Child Abuse & Neglect/Indicators/Reporting Requirement Training	10
Multiple Dates	Promoting Mental Health	5
Multiple Dates	Recognizing Perinatal Depression	3
Family and Child Health Care		
8/28/2015	Abusive Head Trauma	4
3/17/2016	Substance Use & Pregnancy	2
3/17/2016	Having Difficult Conversations – Family Planning	1
3/17/2016	Reducing Risks of Child Injury and Death	1
5/13/2016	Grow and Glow Breastfeeding training	4
Multiple Dates	Infection Control: The Basics	4
Multiple Dates	CPR, AED & Basic First Aid	2
Multiple Dates	Keeping Babies Healthy & Safe	3
Multiple Dates	Prenatal Training	2
Multiple Dates	Recognizing Substance Abuse	2
Multiple Dates	Striving for a Smoke-Free Environment	2
Multiple Dates	Infection Prevention, Part 1	4
Multiple Dates	Preparing Moms for Birth and Beyond	4
Child Development		
3/17/2016	Concerns When Referring to MCITP	1
Multiple Dates	GGK Formal Curriculum training	3
Multiple Dates	Curriculum/Materials Overview	3
Multiple Dates	Fostering Infant & Child Development	3
Multiple Dates	ASQ & ASQ-SE	2

APPENDIX N. HFM STAFF SATISFACTION SURVEY

Version-June 2014

Healthy Families Montgomery Staff Satisfaction Survey

Please take a few minutes to share your thoughts your program. Your responses to the questions below are important and will help us improve the program and plan future activities. Your answers are kept confidential, so do not put your name on the survey. Thank you for all of your contributions to HFM and Baby Steps!

1. In what capacity do you work with HFM?

   - ☐ Administrative/Management/Supervisory
   - ☐ Family Support Worker (FSW)/Family Assessment Worker (FAW)
   - ☐ Other (Please Specify)

2. Please respond to the following statements by checking the appropriate box:

	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
I understand the HFA Critical Elements.					
I understand the goals and objectives of HFM.					
I receive an adequate amount of supervision to help me get my job done in a quality manner.					
HFM is designed to optimize child development through comprehensive support to families.					
The program management is responsive to the needs of staff.					
HFM is strength-based and family centered.					
I have participated in training that adequately prepared me for my position.					
I have participated in training in the past six months.					
The agency and program management represent the community.					
The staff is culturally representative of the families served.					
The program uses materials that are culturally appropriate.					
The program uses bilingual materials as appropriate.					
I feel comfortable working with culturally diverse families.					
HFM helps prepare children to be ready for school.					

3. Please respond to the following statements by checking the appropriate box:

	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
I enjoy my work.					
I find my work worthwhile.					
I find the work that I do is hard.					
I find my work boring.					
The work I do uses my skills.					
I am satisfied with my position.					
I am appropriately compensated for my position.					
I feel appreciated by HFM management for the work I do for the program.					
Ii believe I have made a positive impact on the children and families I work with.					

4. Which areas of the program are particularly strong?

_____
_____
_____

5. Which areas of the program need improvement?

_____
_____
_____

6. How stressful is your job? (Check one)

☐ Always stressful ☐ Usually ☐Sometimes ☐ Rarely ☐ Never

7. Which of the following benefits have you received as a result of your participation in work related trainings?

☐ None ☐ Promotion ☐Wage Increase ☐ Bonus

☐ Certification ☐ Other (please specify) _____

Thank you for sharing your thoughts and suggestions today.

APPENDIX O. HFM PARTICIPANT SATISFACTION SURVEY

Healthy Families Montgomery
Participant Satisfaction Survey

Today's Date:_____

Please share the following information:

Your age: ☐12-15 ☐16-20 ☐21-30 ☐31 or older

How often does your Family Support Worker visit you? ☐Once a week ☐Twice a month ☐Once a month ☐Don't remember

Did you receive your first home visit before your baby was 3 months old? YES NO

How old was your baby at the time of your most recent home visit? _____

When was your last home visit? ☐Within the past week ☐Within the past 2 weeks ☐Within the past month ☐A month ago ☐Several months ago ☐I left the program

If your last visit was more than 1 month ago, is there a reason if wasn't more often? YES NO
If YES, please explain: _____
_____

Please answer the following questions by circling either Yes or No.

1. My Family Support Worker visited me as agreed upon.
   YES **NO**

2. My Family Support Worker gives me information on how to care for my baby.
   YES **NO**

3. My Family Support Worker is helping me learn about my child's development.
   YES **NO**

4. My Family Support Worker helps me with my needs and the needs of my baby and family.
   YES **NO**

5. My Family Support Worker is respectful of my baby, my family and me.
   YES **NO**

6. My Family Support Worker accepts and respects my culture.
   YES **NO**

7. My Family Support Worker gives me information that I can understand.
YES **NO**

8. My Family Support Worker communicates with me in a way that I understand.
YES **NO**

9. My Family Support Worker helps me to be more independent by helping me make my own decisions.
YES **NO**

10. My Family Support Worker has helped me to become a better parent.
YES **NO**

11. Healthy Families has made a positive impact in the life of my baby.
YES **NO**

Please give us your opinion on the following questions.

What do you like most about Healthy Families?
_____
_____
_____

What do you not like about Healthy Families?
_____
_____
_____

How do you think we could improve our program?
_____
_____
_____

How would you rate your Family Support Worker?

☐**EXCELLENT** ☐**GOOD** ☐**AVERAGE** ☐**POOR**

How would you rate Healthy Families?

☐**EXCELLENT** ☐**GOOD** ☐**AVERAGE** ☐**POOR**

I would recommend Healthy Families to a friend or relative.

☐**Strongly Agree** ☐**Agree** ☐**No Opinion** ☐Disa**gree** ☐**Strongly Disagree_____**

If you would not recommend Healthy Families, please let us know why. _____

Thank you for taking the time to participate in our survey.

HEALTHY FAMILIES MONTGOMERY
Encuesta de satisfacción de los participantes

Fecha de hoy: _____

Por favor comparta con nosotros la siguiente información:

Su edad: ☐12-15 ☐16-20 ☐21-30 ☐Arriba de 30

¿Qué tan frecuente la visita su trabajadora de apoyo familiar?

☐Una vez por semana ☐Dos veces al mes ☐Una vez al mes ☐No me acuerdo

¿La primera visita que recibió fue antes que su bebé cumpliera 3 meses? **SI** **NO**

¿Qué edad tenía su bebé en la visita más reciente? _____

¿Cuándo fue su última visita? ☐ Hace una semana ☐Hace dos semanas ☐Hace un mes

☐Más de un mes ☐Hace varios meses ☐Me Salí del programa

Si la última visita fue hace más de un mes, ¿por qué razón no fue más reciente? **SI** **NO**
Si la respuesta es si, por favor díganos la razón:

_____

_____

Por favor conteste SI o NO a las siguientes declaraciones.

1. Mi trabajadora de apoyo familiar me visita como acordamos.
SI **NO**

2. Mi trabajadora de apoyo familiar me informa de cómo cuidar de mi bebé.
SI **NO**

3. Mi trabajadora de apoyo familiar me enseña acerca del desarrollo de mi bebé.
SI **NO**

4. Mi trabajadora de apoyo familiar me ayuda con mis necesidades, las de mi bebé y de mi familia.
SI **NO**

5. Mi trabajadora de apoyo familia respeta a mi bebé, a mi familia y a mí.
SI **NO**

6. Mi trabajadora de apoyo familiar acepta y respeta mi cultura.
SI **NO**

7. Mi trabajadora de apoyo familiar muestra interés en aprender acerca de mi cultura.
SI **NO**

8. Mi trabajadora de apoyo familiar me da información fácil de comprender.
SI **NO**

9. Mi trabajadora de apoyo familiar se comunica conmigo con un lenguaje que yo le pueda entender.
SI **NO**

10. Mi trabajadora de apoyo familiar me ayuda a ser independiente dejándome tomar mis propias decisiones. **SI** **NO**

11. Mi trabajadora de apoyo familiar me ha ayudado a ser un mejor padre de familia.
SI **NO**

12. El programa de Healthy Families ha hecho un impacto positivo en la vida de mi bebé.
SI **NO**

Por favor denos su opinión en las siguientes preguntas.

¿Qué le ha gustado más del programa de Healthy Families?

_____
_____
_____

¿Qué es lo que no le ha gustado del programa de Healthy Families?

_____
_____
_____

¿Cómo cree que podemos mejorar el programa?

¿Cómo calificaría a su trabajadora de apoyo familiar?

□Excelente **□Muy Buena** **□Buena** **□No muy Buena**

¿Cómo calificaría al programa de Healthy Families?

□Excelente **□Muy bueno** **□Bueno** **□No muy bueno**

Yo recomendaría este programa a un familiar o un amigo.

□Muy en acuerdo **□De acuerdo** **□No opino** **□ Endes acuerdo** **□ Muy en desacuerdo**

Si no recomendaría a Healthy Families, por favor díganos el por qué.

_____

Muchísimas gracias por participar en esta encuesta.

APPENDIX P. PROGRAM GOALS AND OBJECTIVES

Derived from the Healthy Families America program model, the HFM goals and objectives have remained fairly consistent over the past twelve years, focusing on parenting, child health and development, family self-sufficiency, and the reduction of child maltreatment. A change was made in Year 19 to one of the child development objectives in order to reflect the program's success at linking children to appropriate developmental intervention services. The percentage for Objective III.1 is now calculated using both children on target developmentally as well as those receiving appropriate services.

I. Promote Preventive Health Care

1. 95% of participating children who are at least 2 months old will have a primary health care provider.
2. 95% of eligible children will be enrolled in MA (includes non-target children)
3. 90% of participating children will receive all immunizations on schedule and completed by the age of two.
4. 90% of mothers will not have an additional birth within two years of target child's birth.
5. 85% of enrolled mothers will complete post-partum care.
6. 90% of mothers enrolled within the first two trimesters will deliver newborns weighing 2500 grams (5.5 lbs.) or more.
7. 95% of mothers will have a health care provider.

II. Reduce Incidence of Child Maltreatment

1. 95% of families, who have never had a previous Child Welfare Services (CWS) history, will not have an indicated CWS report while enrolled in the program.

III. Optimize Child Development

1. 95% of children will demonstrate normal child functioning through ASQ developmental screening or receiving appropriate services.
2. 100% of children actively enrolled will be screened for developmental delays in accordance with an ASQ schedule.
3. 100% of children who screen at risk for developmental delays will be informed of the Montgomery County Infant and Toddlers Program (MCITP) for assessment/services (referrals only made with parent's consent).

IV. Promote Positive Parenting

1. 85% of participants will score at or above normal range for knowledge of child development after one year and annually thereafter as measured on the HFPI (Parenting Efficacy Subscale).
2. 95% of participants will score at or above program-determined level for knowledge of child safety after one year and annually thereafter as measured on the Safety Checklist (version 5).

V. Promote Family Self-Sufficiency

1. 65% of families will have improved self-sufficiency within 12 months of enrollment as measured by improved education or employment status.
2. 99% of families will have improved self-sufficiency within 12 months of enrollment as measured by improved or stable housing.