Over 100 Years of Service

Family Services, Inc.

PART OF THE SHEPPARD PRATT HEALTH SYSTEM

Healthy Families Montgomery

Program Year 21
July 2016 – June 2017

Healthy Families Maryland™
Montgomery County

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

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EXECUTIVE SUMMARY

Healthy Families Montgomery (HFM) has concluded its twenty-first year of comprehensive home visiting services to high-risk families in Montgomery County, Maryland. The services are designed to reduce family risk factors and enhance protective factors in order to prevent child abuse and neglect and promote optimal child development. The program continues to exceed its target objectives. This report describes the HFM program implementation during Year 21 (July 1, 2016 – June 30, 2017) and the outcomes achieved by the end of the fiscal year (FY17).

Over the past twenty-one years, HFM has demonstrated its ability to maintain high quality standards and consistently achieve positive maternal and child health outcomes despite funding and other logistical challenges. HFM's longstanding success has been recognized in their outstanding scores by Healthy Families America (HFA) accreditation experts.

The HFM program submitted a lengthy Accreditation Self-study report in summer 2016, which provided the necessary evidence of program policies, procedures and practices used to meet each of the HFA standards. The program underwent the accreditation review process and site visit by a team of specially trained peers in September 18-20, 2016. Strengths noted in the Site Visit 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 and these were adopted. The program received a new credential in January 2017 and is accredited by HFA through March 2021.

The HFM program serves first-time parents who are identified to be at risk for child abuse and neglect based on a standardized screening and assessment process. Families receiving prenatal care at the county's three health centers are screened. Those families meeting the criteria for HFM services are referred for further assessment. Assessments identified as positive for risk of child maltreatment are considered for enrollment in the HFM program.

HFM received 500 screens from the collaborating county health clinics in FY17. Due to limited resources, only 25% of positive screens were further assessed by the program. Due to limited capacity, only about 7% of all individuals with positive screens ultimately receive the intensive home-based services offered by HFM. This reflects the ongoing gap in services for the at-risk population in Montgomery County. For those families who are at-risk but not enrolled, HFM provides referrals to other services as appropriate.

The pattern that emerges from the Year 21 profile of risk factors includes childhood abuse, mental health issues, multiple stressors in their lives, poor bonding and attachment with their child, and unrealistic expectations of their child. These factors represent an increased potential for child maltreatment, particularly neglect. The prevalence of social isolation and depression are also closely associated with potential for neglect. There is a high incidence of mothers that experienced moderate to severe abuse as a child and who have unrealistic expectations of their child, which places them at much higher risk for harsh discipline with their child and may lead to physical abuse. The identification

of these at-risk mothers provides the Healthy Families Montgomery program the opportunity to help these new mothers and their babies break the cycle of abuse.

In Year 21, the program served 117 families and 116 children. Demographic data reveals a relatively new trend toward younger mothers; the mean age at entry is 25.8 years (down from a high of 27.2 in Year 19). Most mothers are Hispanic and speak Spanish as their primary language (87%). More than one-third (46%) of mothers over the age of 18 had less than a HS diploma and most (73%) were unemployed, factors that greatly increase their risk and affect their ability to support their children.

The HFM program is structured around five primary goals: (I) promote preventive health care, (II) reduce the incidence of child maltreatment, (III) optimize child development, (IV) promote positive parenting, and (V) promote family self-sufficiency.

Goal I: HFM continues to exceed its target objectives in preventative health care. 100% of all target children were linked with medical providers, and 99% were enrolled in Medical Assistance (MA). Likewise, 99% of all mothers were successfully linked with a medical provider. 98% of all target children over four months of age were current with their 12 and 24 month immunizations. This is especially impressive when compared to the Centers for Disease Control 2014 findings on immunization rates for the nation (75%), and the State of Maryland rate of 78%. 100% of mothers who were due for their post-partum medical visit received timely care, affording them the opportunity to monitor their health and discuss family planning options with their doctors. This percentage also exceeds the national Medicaid rate of 63%. Additionally, 98% of mothers did not have a repeat birth within a 24-month period. HFM's success rate in this area has consistently exceeded both national statistics (82%) and Maryland State (84%) for repeat births. During Year 21, 33 target babies were born to active participants in the program. Of those who were enrolled prenatally, 95% were born at a healthy birthweight. Percentages for Year 21 babies exceeded both national (92%) and Maryland (91%) rates.

Goal II: There were no indicated cases of child maltreatment in HFM families in Year 21. This is an indicator of the positive impact that prevention can have on reducing the incidence of child maltreatment in high-risk families.

Goal III: Optimal child development includes the social, emotional, cognitive, language and motor development of participating children. The HFM program administers the Ages and Stages Questionnaire (ASQ) and the ASQ Social Emotional (ASQ-SE) at regular intervals throughout a family's participation. 99% of all target children who were due for screening in Year 21 received a timely ASQ, and 95% received a timely ASQ-SE. The HFM rate for developmental screening of participating children far exceeds the comparable national rate of 29%. All children (21) who have been identified with developmental delays or concerns were followed by the Early Intervention Consultant (EIC). Many received county services, including Child Find, MCITP and PEP.

Goal IV: Positive parenting includes issues of home safety, parent-child interaction, and parenting knowledge, as well as mother's psychosocial status. 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. Statistical analysis of scores indicates that mothers' knowledge of safety in the home increased significantly after 12 months of program participation, with 100% of parents demonstrating adequate safety knowledge after one year of program participation.

HFM measures parent-child interaction and parenting knowledge using the Healthy Families Parenting Inventory (HFPI). Results have consistently revealed statistically significant improvement from enrollment to one year in several subscales: 1) *Mobilizing Resources*, including knowledge of available

resources in the community and comfort level in seeking help, increased after 12 months and the percentage of mothers at risk decreased from 22% at enrollment to 9% at 12-months; 2) *Parent-Child Interaction*, which 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, also increased after 12 months of participation and the percentage of mothers at risk decreased from 17% at enrollment to 13% at 12-months; 3) *Home Environment*, which examines home safety, organization, availability and quality of stimulating materials/activities in the home, increased after 12 months and the percentage of mothers at risk decreased from 17% at enrollment to 9% at 12-months.

Maternal depression can have a negative impact on positive parenting. Mothers' risk for depression was measured using the Center for Epidemiologic Studies-Depression (CES-D) scale. Parents' risk for depression is a potent factor in reducing risk for child maltreatment. The percent of mothers at risk went from 19% at risk for depression at enrollment to 22% at 12-months to 12% at 24-months. As a result of the HFM screening and assessment process, which includes depression as a risk indicator, HFM mothers have higher rates of depressive symptomology than those reported by the Centers for Disease Control (CDC) in 2012 for post-partum women (8% to 19%) and non-pregnant women (11%). Results highlight the importance of the HFM program in ongoing screening for depression and linking participants to appropriate mental health professionals.

Goal V: Improvements in mothers' self-sufficiency were measured primarily through marital status, education, employment, and housing status. Most mothers (67%) were married or reported that they lived with their partners. At enrollment, 46% of mothers over the age of 18 had less than a HS diploma and most were unemployed (73%), factors that greatly increase their risk and affect their ability to support their children. By the end of Year 21, marital status and educational achievement had improved slightly. However, there was a significant increase in mothers' employment status, from 27% at enrollment to 56% at the end of the reporting period. 97% of participants had stable housing at the time of enrollment. Follow-up data on housing status indicates that 97% either maintained stable housing or improved their housing status by the end of the reporting period.

HFM employed 13 individuals in FY17, at the level of 11.65 full time employees. The HFM program has an excellent history of hiring and retaining good staff. High levels of staff retention reflect a stable program that values its staff and provides opportunities for feedback and growth. Staff retention can also been linked to family retention, which is a key component of program success.

Staff and Participant Satisfaction are assessed annually by the HFM program. Participants continue to report high levels of satisfaction with the program. All respondents reported that both their Family Support Worker (FSW) and the HFM program were either "Excellent" or "Good", and all agreed that they would recommend the program to a friend or relative. When asked what they like best about the HFM program, most 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. Results of staff surveys found that most staff enjoy their work, find it worthwhile, and believe they are having a positive impact on families. 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.

I. HEALTHY FAMILIES MONTGOMERY

A Program of Family Services, Inc.

Healthy Families Montgomery is a program of Family Services, Inc. (FSI), a private nonprofit serving Montgomery County, Maryland and environs since 1908. The mission of FSI is to promote the resilience, recovery and independence of individuals and families across the life span through integrated mental and physical health, social service and education programs, and thereby strengthening communities. FSI currently offers over 30 programs serving over 25,000 individuals annually in Montgomery and Prince George's County, Maryland. FSI's staff of over 400 individuals represent 50 countries and speak 42 different languages. As part of the Sheppard Pratt Health System, FSI has extensive experience developing and implementing in-home and community-based services for children, adolescents, and adults who have limited access to critical resources.

Partners

HFM's partnerships with child development, behavioral health, education and general medical health organizations have continued to enrich the services it provides to its clients. Currently, the program is supported by several partnerships that have helped HFM meet its goals and objectives.

In addition to the collaborative programs and services that are available within Family Services, Inc., HFM has established numerous formal and informal partnerships with community agencies outside of FSI. Some of these include:

- Montgomery County Department of Health and Human Services (Health, Child Welfare, Early Childhood and Family Support Services)
- Montgomery County Collaboration Council for Children, Youth and Families
- Aspire Counseling
- Judy Centers
- Montgomery County Infants and Toddlers Program/Child Find/PEP
- Healthy Families Maryland Site Network
- Rockville Caregivers Association
- Gaithersburg Coalition of Providers
- Shady Grove Adventist Hospital
- Holy Cross Hospital
- Teen and Young Adult Health Connection (TAYA)
- Lourie Center for Children's Social and Emotional Wellness

Funders

The HFM program is supported through a diversified array of public and private funding streams, as well as through private donations. Program funding and expenses have either increased or remained approximately the same. During Year 21, the bulk of program funding was provided by local public sources, such as the Montgomery County Department of Health and Human Services, Montgomery County Collaboration Council for Children, Youth and Families (Local Management Board), and the City of Rockville. About 8% of the total revenue was provided by private sources such as the Morris and Gwendolyn Cafritz Foundation, the Clark Winchole Foundation, and the William S. Abell Foundation. The HFM program also received donations from individuals and in-kind donations from

Christ Child Society (infant layettes), Friendship Star Quilters (Tummy Time quilts), and Woodworkers for Charity (wooden toys). See ***Appendix A: HFM Funding Sources & Expenditures***.

Advisory Board

Since the program's inception, an advisory board has been in place to support HFM in efforts of advocacy, community awareness, strategic planning, and coordination of program services within the community. During Year 21, the HFM Advisory Board was comprised of 10 local private and public stakeholders who serve a 2-year term and meet regularly. The Board is comprised of individuals representing diverse ethnic and professional sectors, including medical, educational, political, and religious, that bring a range of expertise and cultural perspectives. Members provide input and supports to ensure the quality, relevance, and success of program services in the community. See ***Appendix B: HFM Advisory Board*.**

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 C: HFA Critical Elements of Successful Home Visitation Programs***). As with all Healthy Families programs, HFM is required to complete the Healthy Families America accreditation process every four years in order to be considered an affiliated 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. Accreditation ensures that programs implement evidence-based effective practices and adhere to quality standards on a regular basis over time.

The HFM program has been accredited since November 1999 (Year 4), when it received the first national credential of all the Healthy Family America sites in the State of Maryland. HFM received re-accreditation in 2003, 2008, 2013 and 2017, each time receiving consistently strong ratings in multiple program areas. *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 the extensive self-study report in summer 2016, which provided the necessary evidence of program policies, procedures and practices used to meet each of standards. During 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 further improve 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

Evaluation

The HFM program has published an external evaluation by Donna D. Klagholz, Ph.D. & Associates, LLC, annually since its inception, culminating in the ***Healthy Families Montgomery Twenty Year Longitudinal Study 1996 – 2016***, published in April, 2017. The collection of reports provides a wealth of historical data which documents the program's evolution, enhancing the quality of the outcomes. Due primarily to budget restrictions and acquired staff experience, this analysis and reporting is now being done in-house, beginning with Year 21.

This document utilizes both qualitative and quantitative data and methods, and provides an update of the program's implementation and an evaluation of the program's impact on participants. HFM has also developed internal monitoring mechanisms that enable management to evaluate program operations and fidelity, staff training, quality assurance of data integrity, service utilization and participant dosage. The Data Specialist and Program Manager ensure the consistency and quality of data. 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.

Participant Consent and Confidentiality

Throughout the program's implementation, HFM and its consultants have developed and implemented mechanisms for participant protection, including consent and confidentiality procedures. The consent forms are written at an appropriate reading level for the target population and also available in Spanish. of For participants under the age of 18 years, consent forms are given to parents.

Data Management

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 this database provides the bulk of the data used for this report. It 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).

III. PROGRAM PROCESS

The HFM program 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 for the participants and for 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.

Target 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. All HFM families screened and assessed were identified at one of three Montgomery County Health Centers (Germantown, Silver Spring or Dedicated Administrative Care Coordination Team/Rockville). 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.

Screening and Assessment

Screening

The HFM program has a longstanding partnership with the Montgomery County Department of Health and Human Services. County Health Center staff conduct universal screenings of all new first-time 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. All screens are forwarded to HFM on a monthly basis for review by the Family Resource Specialist (FRS), who then completes assessments on families based on their eligibility and their due date.

500 screens were received by HFM in FY17; all came from the 3 Montgomery County Health Centers. 99% (496) were prenatal. ***Figure 1. Screen Outcome Summary, FY17*** below shows the breakdown and dispositions of all screens received. 86% (429) of the screens were positive for risk of child maltreatment. Positive screens are referred for further assessment and possible enrollment. Due to limited resources, only a portion are assessed by HFM's Family Resource Specialist (FRS) using the HFA Parent Survey Tool. Of the screens received in FY17, 106 have been assessed thus far. This represents 25% of all positive screens, or 21% of all screens. Note that FY17 screens will continue to be assessed in FY18 as the mothers' due dates approach.

FIGURE 1. SCREEN OUTCOME SUMMARY, FY17

There were 500 individuals screened in FY17.

Out of 500 screens, 429 (86%) were positive
71 (14%) were negative

Out of 429 positive screens,
106* (25%) were assessed
323 (75%) were not assessed

Out of 323 positive screens that were not assessed,
160 (50%) not assessed (or not yet) due to lack of resources
90 (28%) could not be located
23 (7%) client declined
50 (15%) other reasons

* number of FY17 screens which are assessed will continue to grow as due dates for these individuals approach.

Assessment

From the total pool of positive screens received, 122 families were assessed during FY17. These are not necessarily FY17 screens, the screen dates range from 1/28/16 – 4/6/17. Screens from the rest of FY17 will continue to be processed in FY18 as their due dates approach.

Table 1. Assessment Outcome Summary, FY17 shows the breakdown: of the 122 families assessed in FY17, 67% (82) were positive and considered eligible for services. Due to limited capacity, 48 have been offered services thus far, representing 58% of positive assessments or 39% of all assessments. 33 accepted and have been enrolled in HFM, representing 69% of those offered or 27% of all assessments.

TABLE 1. ASSESSMENT OUTCOME SUMMARY, FY17

Post Assessment Disposition	Total	% of All Assessments	% of All Assessments	% of Positive Assessments	% of those offered
Positive, offered services, participant accepted	33*	27%	67% (n=82) positive	58% (n=48) of positive were offered services	69% (n=33) of those offered accepted & enrolled
Positive, offered services, participant refused	15	12%			
Positive, not offered services	34*	28%			
Negative, minimal services or referrals given	40	33%	33% (n=40) negative		
Negative, no services or referrals given	0	0%			
Total number of assessments	**122**	**100%**			

* number of FY17 assessments which may be offered services may continue to grow as due-dates for these individuals approach.

Eligibility Timeframe

Eligibility for HFM is determined by Parent Survey assessment, and normally occurs prenatally or within the first two weeks after the birth of the baby. The HFA goal is for 95% to be prior to two weeks after baby's birth. ***Table 2. Eligibility Timeframe*** shows that 98% of assessments occur within this time period.

TABLE 2. ELIGIBILITY TIMEFRAME

Time of Parent Survey	Number of surveys (assessments)	% of total
Prenatal	119	98%
Within 2 weeks after birth	1	
More than 2 weeks after birth	2	2%
Total	**122**	**100%**

Service Acceptance

Acceptance rate is a measure of those accepting services when offered. HFM measures the acceptance rate of families offered services every year. HFA methodology defines the calculation of acceptance rate for a specified period of time as:

$$\frac{\text{Count of families who completed a first home visit}}{\text{Count of families who were offered services after being determined eligible}}$$

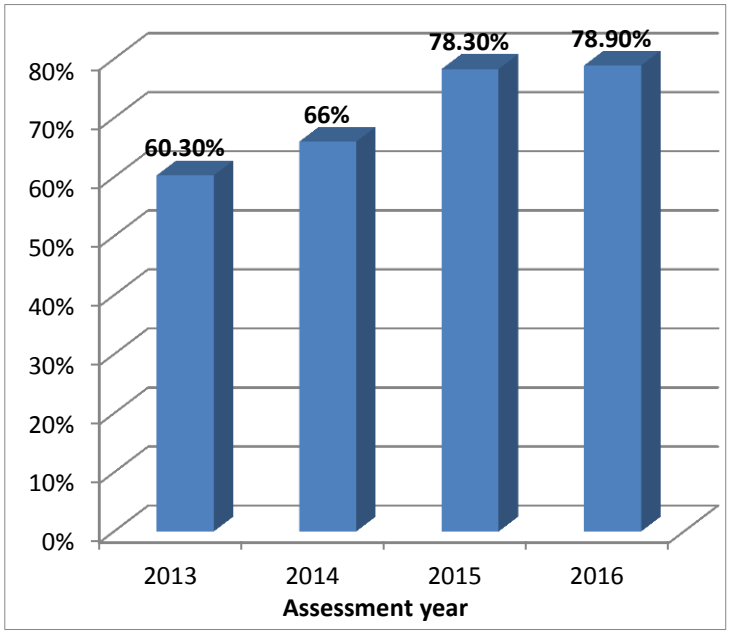
Because the outcomes for some assessments from FY17 are unknown (some accept services in FY18), HFM uses calendar year of assessments for calculation and comparison of acceptance rates. Of all positive assessments (78) in the period January 1, 2016 – December 31, 2016, 73% (57/78) had been offered services as of October 2017. 78.9% (45/57) of these families accepted services and received at least a first home visit. The acceptance rate for all assessments in calendar year 2016 is 78.9%. (This rate continues to change as more assessments from this time period are still in the pipeline.) The progression is detailed in ***Table 3. Assessment Outcome Summary, CY16.***

TABLE 3. ASSESSMENT OUTCOME SUMMARY, CY16

Post Assessment Disposition	Total	% of All Assessments	% of All Assessments	% of Positive Assessments	% of those offered
Positive, offered services, participant accepted	45	37%	64% (n=78) positive	73% (n=57) of positive were offered services	78.9% (n=45) of those offered accepted & enrolled
Positive, offered services, participant refused	12	10%			
Positive, not offered services	21	17%			
pending	1				
Negative, minimal services or referrals given	43	35%	35% (n=43) negative		
Negative, no services or referrals given	0	0%			
Total number of assessments	**122**	**100%**			

Acceptance rate has been increasing each year. Data for the past four calendar years is presented in ***Figure 2. Acceptance Rates*** below.

FIGURE 2. ACCEPTANCE RATES



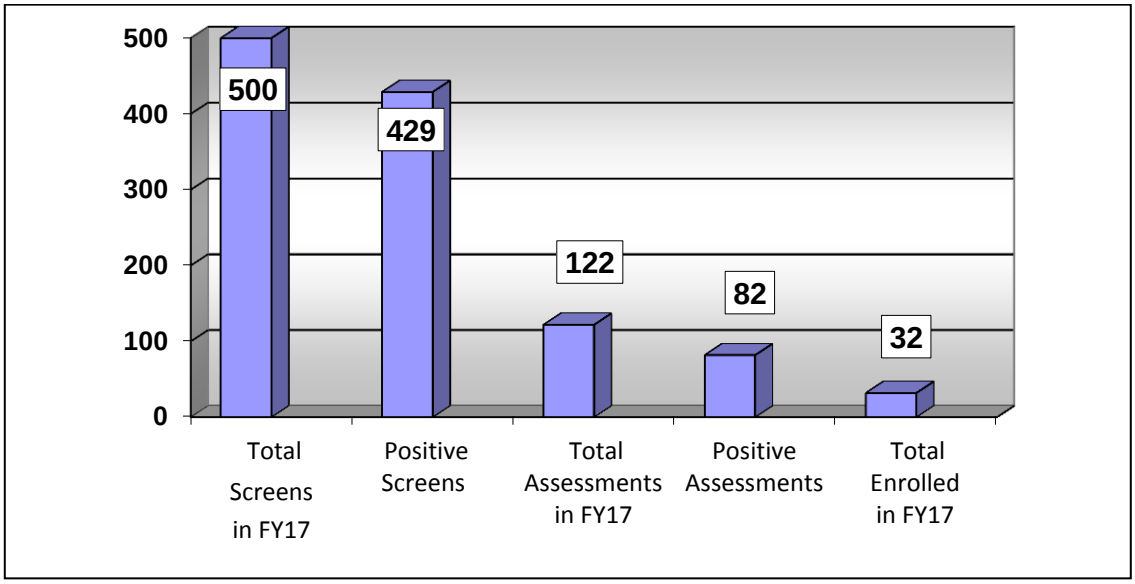
12 families refused the offer of HFM services. 5 indicated they did not have time to participate in the program, as it involves a weekly commitment. Three indicated they did not feel they needed the service. Three never had a first home visit to complete the enrollment process.

21 families whose assessment was positive were not offered services. Due to limited HFM resources there is often not an opening at the most appropriate time (close to the birth of the child). 12 could not be located in order for services to be offered, or were planning to move out of the service area.

Summary

A total of 500 screens were received in FY17. 429 (86%) of these were positive. A total of 122 mothers were assessed in FY17, from a pool of screens ranging 1/28/16 – 4/6/17. 82 (67%) of these were positive. A total of 32 participants were enrolled in FY17, from a pool of assessments ranging from 5/4/16 – 4/7/17. Ultimately, only approximately 7% of positive screens result in enrollment due to limited capacity. ***Figure 3. Summary of Screens, Assessments, Enrollments*** below shows a graphical representation of the progression from screens to enrollments.

FIGURE 3. SUMMARY OF SCREENS, ASSESSMENTS, ENROLLMENTS



Home Visiting

Home visits are the core of the HFM program and can be a balancing act of focusing on the parent, child, and parent-child interaction. 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. Visits are scheduled based on the level of services for each family.

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. If a family's attendance in the program becomes inconsistent, or a family is temporarily unavailable for home visits, the Family Support Worker engages in creative outreach activities in order to support re-engagement. 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.

HFM uses the Growing Great Kids (GGK) curriculum due to its emphasis on attachment and bonding, as well as its alignment with the HFM program model. All direct service and supervision staff are trained in the GGK curriculum. 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 with a strong emphasis on social and emotional development and nurturing self-regulation. The skill-driven curriculum provides home visitors with an approach that is research informed, strength-based and solution-focused. The various modules provide a step-by-step guide that encourages interactive questions in order to actively engage parents with the information and skills being presented.

Family Goal Plans (FGPs) are completed with each family on an ongoing basis throughout their tenure 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 reviewed on an ongoing basis, and when achieved, new goals are formulated.

Service Levels

Through the HFA Leveling System (see ***Appendix E: HFM Service Level Descriptions***), 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.

First Home Visit

HFA research, as well as significant anecdotal evidence, points clearly to a site's ability to achieve improved outcomes the earlier services are initiated. This is owing to multiple variables including:

- The particular vulnerability of the infant during the prenatal and newborn period, and an opportunity to help shape better health, nutrition and lifestyle practices that can impact the infant during this particularly sensitive period
- The patterns of the parent-infant relationship, including parental responsiveness and interpretation of infant behavior begin during this period as well, and strategies employed by Family Support Workers can promote healthier bonding and attachment
- And especially for families with limited exposure to healthy, trusting relationships during their life, the ability to form a trusting relationship with the FSW requires time

Therefore, the earlier the alliance between FSW and parent is formed, the greater the likelihood of increased family retention. For this reason, the HFM goal is to ensure that, whenever possible, the first home visit occurs prenatally or within the first three months after the birth of the baby. For the 32 families enrolling in FY17, ***Table 4. First Home Visit Summary, FY17*** shows that 100% of families were within the desired timeframe; 18 had their first home visit prenatally, and 14 were within three months of the birth of the baby.

TABLE 4. FIRST HOME VISIT SUMMARY, FY17

Healthy Families Montgomery County ('MD005')

Best Practice Standard 1-3.B

PIMS08A: First Home Visit Summary

Includes participants accepting services between 7/1/2016 and 6/30/2017

Group filter not applied

As configured in Site Definitions, the first home visit is tabulated from the Monthly Contact Log

Please refer to "PIMS08C: First Home Visit by Individual" for individual level data corresponding to this summary report
Pending enrollment counts unterminated participants with a completed Intake record, but no first home visit.
Passive refusal counts terminated participants with a completed Intake record, but no first home visit.

Time of First Home Visit	*Number*	*% of All First Home Visits*
Prenatally	18	56.3%
Within the first three months of birth of baby	14	43.8%
After the first three months of birth of baby	0	0.0%
Pending enrollment	0	0.0%
Passive refusal	0	0.0%
Total participants accepting services	**32**	**100.0%**

Given the specified latest service acceptance date of 7/1/2016 and the data cutoff date of 10/13/2017, this allows for a window of at least 469 days after service acceptance before a visit is categorized as 'First home visit not yet received.' Valid first home visits recorded after the Cutoff Date are counted as received.

Intensive Services for New Families

The first 6 months of involvement with a family, after a baby has been born, is critical for many reasons including: parent-infant relationship development, newborn care and safety, and adjustment to parenthood. For these reasons, HFM ensures that new families receive intensive services for at least 6 months after the birth of the baby or within six months of enrollment, and this period is extended when families have been on creative outreach. Families are initially scheduled to receive at least 4 home visits per month To evaluate those with intensive services for at least 6 months, we must look at those starting service 1/1/2016 – 1/1/2017 (those who enrolled in the second half of FY17 have not yet received services for 6 months). ***Table 5. Intensive Services for New Families Report, CY2016*** shows that of 48 families who initiated services during this timeframe, 14 terminated service prior to 6 months. 34 remained in the program for at least 6 months and all received intensive services for at least 6 months.

Table 5. Intensive Services for New Families Report, CY2016

Healthy Families Montgomery County ('MD005') — Best Practice Standard 4-1.B

PIMS14C: Summary of Intensive Services for New Families

Includes participants with target child born between 1/1/2010 and 12/31/2016

Participants with Service Start Date Between 1/1/16 and 12/31/16 (n = 48)

For unterminated participants, the Cutoff Date is used as the end date for the most recent service level

Cutoff Date: 10/31/2017

Group filter not applied

Site Summary	
N/A - Terminated before six months	14
Yes - Served six months intensive	17
Yes - Served six months intensive but not immediately after birth	17
Total	48

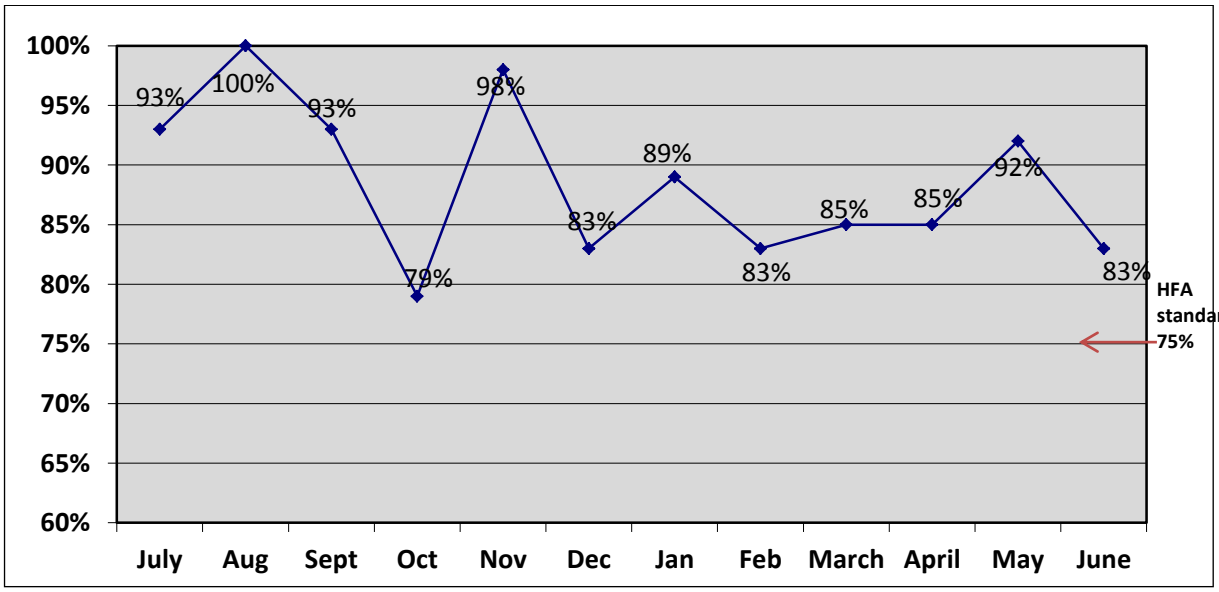
Starting Intensive Service After Birth	
# Months Late	n
two weeks to three months	12
up to two weeks	5
Total	17

* Those identified as “served six months intensive but not immediately after birth” were enrolled postnatally, but still received intensive services for at least 6 months after enrollment.

Home Visiting Compliance

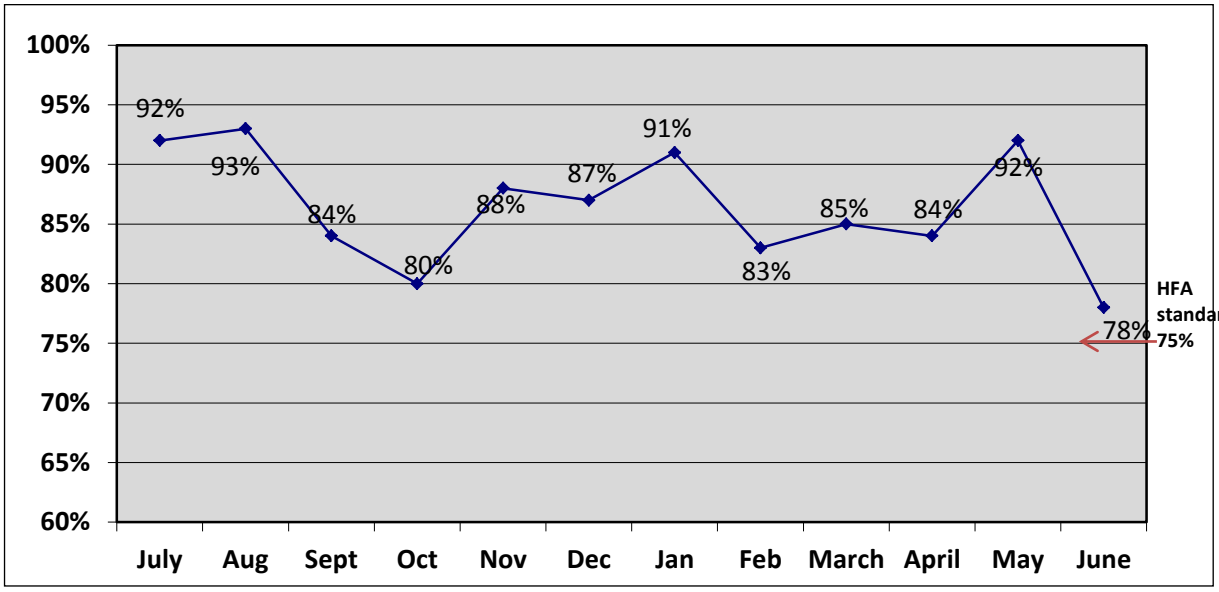
The HFM program monitors the number of expected home visits (HV) that are completed each month according to each FSW’s caseload. The expected number of home visits per family is determined by service level. As seen in ***Figure 4. Home Visit Completion Month, FY17***, most of the HV compliance percentages were very high and exceed Healthy Families America standards, which indicate a completion rate of 75% is acceptable for intensive home visiting. The HFM program averaged a completion rate of 89% for FY17.

Figure 4. Home Visit Completion Month, FY17



HFA also measures the number of families receiving at least 75% of expected visits. The HFA standards indicate that at least 75% of families should receive at least 75% of expected visits. This is a measure of the number of families being served, rather than an measure of site-wide expected vs. completed visits. This compliance measure is demonstrated in ***Figure 5. Home Visiting Compliance by Month, FY17***. Every month exceeds the 75% goal set by HFA.

FIGURE 5. HOME VISITING COMPLIANCE BY MONTH, FY17



Creative Outreach

Participant families are placed on creative outreach status when they become unavailable for home visits. The family must have received at least one home visit prior to this disengagement. Creative Outreach activities continue for a minimum of three months, unless the family reengages, refuses services, moves out of the service area, the parent has lost custody of the target child, the pregnancy has been terminated, the target child or primary caregiver is deceased, there are significant staff safety issues, or if the family has transferred to another program. Outreach efforts include phone calls, text messages, attempts at unscheduled home visits, written correspondence tailored to the family's interest (e.g., ASQs, invitation to group activities, community resource information). FSWs are responsible for a minimum of one attempt per week to contact the family.

Creative outreach continues for at least three months, only concluding services prior to three months when families have reengaged in services, refused services or moved from the area.

20 participants were on creative outreach at some point during FY17. 12 returned to normal service level after being on creative outreach for a range of 20 – 228 days. Of the 8 terminated services while on outreach, 3 disengaged voluntarily due to scheduling conflicts with their jobs or for personal reasons. 5 were terminated by HFM; 2 of these had never truly engaged with the program, having 5 or less home visits, 3 could no longer be reached. Each of these was on creative outreach for over 90 days.

TABLE 6. PARTICIPANTS ON CREATIVE OUTREACH

20 participants were on creative outreach at one or more times during FY17	
12 returned to service	
8 terminated while on creative outreach	Days on CO
3 participants actively terminated services; two due to scheduling conflicts with their jobs, one for personal reasons	27 – 70 days
3 were terminated because HFM was unable to contact the participant	92 – 178 days
2 were terminated after at least 3 months of consistently trying to reengage the participant	92 days each

Standardized Assessments

A brief description of the standardized measures and the schedule of assessment are provided in ***Appendix F: HFM Description of Evaluation Measures*** and ***Appendix G: HFM Evaluation Administration Schedule***. In addition, ***Table 7. HFM Instrument Administration Matrix*** 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 7. 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

Case Closure

Transition planning

Healthy Families Montgomery (HFM) ensures that families planning to discontinue or close from services have a well-thought-out transition plan. Transition plans are developed when a family is ending services with a planned service closure (i.e., when family is known to be graduating soon from the program or when the family shares they will be moving from the service area to another location and there is sufficient time to plan). The family, the home visitor, and the supervisor are involved. Other collaborative service partners are identified and notified (when consents are in place to do so), resources and/or services needed or desired by the family are identified and steps are outlined to obtain any identified resources or services. Prior to closure, HFM follows-up with identified resources to determine availability and assist with successful case closing transition.

Retention

HFM measures retention rate annually. Retention rate is the percent of families who remain in the site over specified periods of time (6 months, 12 months, 24 months, 36 months, etc.) after receiving a first home visit. Families who moved out of the service area are not included. For each time period (volume year) selected, retention is calculated for each applicable interval. Retention can only be calculated for a volume year that is old enough for the interval, e.g. to calculate the number of families retained for 24 months after their first home visit, we must use a volume year that ends at least 24 months ago.

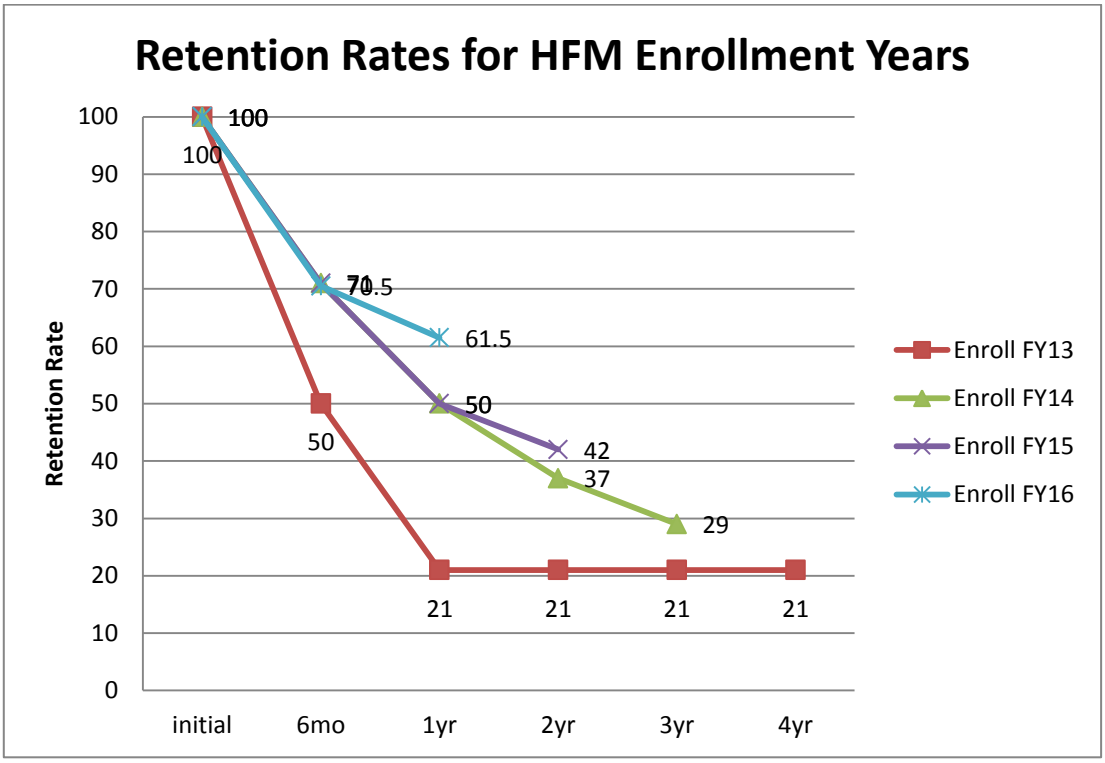
Table 8. Retention rates for years FY12 – FY16 shows the rate at various intervals for volume years FY12 through FY16. The 12 month retention rate for families enrolled in FY16 is 61.5%, meaning that of the 44 families who enrolled in FY16 (and didn't leave due to moving out of the area), 27 (61.5%) stayed with the program for 12 months or more.

TABLE 8. RETENTION RATES FOR YEARS FY12 – FY16

Retention period	Enrolled in FY12	Enrolled in FY13	Enrolled in FY14	Enrolled in FY15	Enrolled in FY16
6 months	79.5%	50%	71%	71%	70.5%
1 year	74.5%	21%	50%	50%	61.5%
2 year	64%	21%	37%	42%	
3 year	51%	21%	29%		
4 year	31%	21%			

Retention rates have increased steadily over the enrollment years analyzed. 12 month retention (families remaining in the program for at least 12 months) has increased from 21% in the FY13 volume year to 61% in the FY16 volume year. 24 month retention has increased from 21% to 42%. This trend is demonstrated in ***Figure 6. Retention Rates for HFM Enrollment Years FY13 – FY16***.

FIGURE 6. RETENTION RATES FOR HFM ENROLLMENT YEARS FY13 – FY16



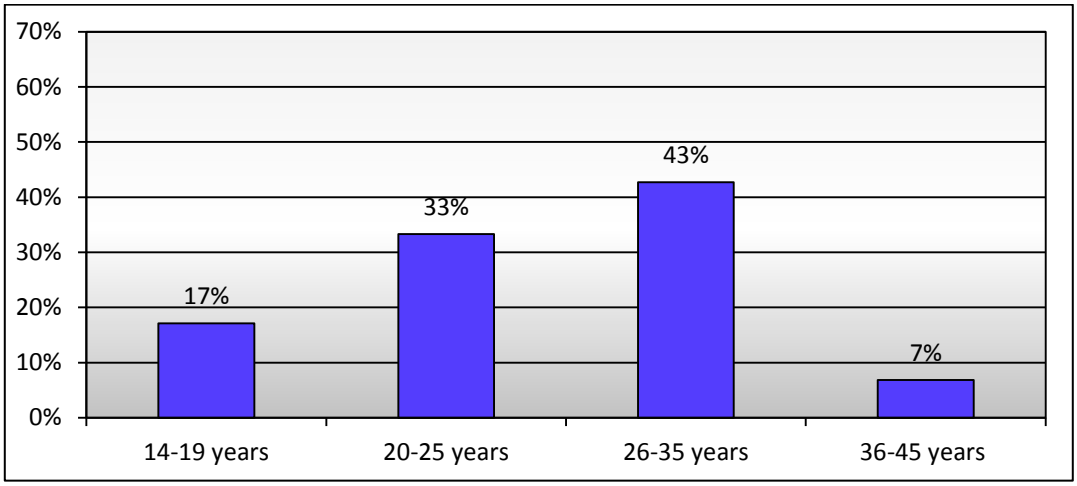
Demographics and Risk

117 families (116 children) were served by HFM in FY17. 85 families were already enrolled prior to the start of the year, 32 were enrolled during the year. 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. Both standard 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.

Age

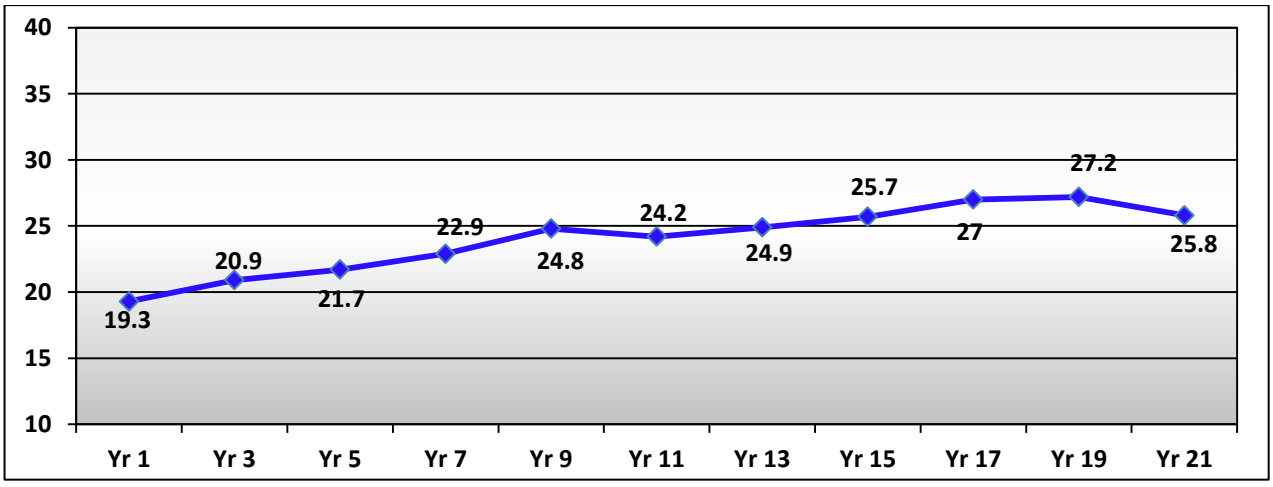
Mother's age is an important factor in determining risk for poor parenting. Teen and young mothers face particular challenges in terms of completing educational goals, achieving self-sufficiency, single parenting, and a lack of emotional maturity necessary for parenting. As ***Table 9. Mother's Age Groups at Program Entry*** shows, the 117 mothers served in FY17 range in age from 14-45 years at program entry, with the majority between 26-35 years. The program is showing a trend towards enrolling younger mothers; the portion of teens has risen over the past two years from 10% to 17%.

TABLE 9. MOTHER'S AGE GROUPS AT PROGRAM ENTRY



The median age at program entry of those served in FY17 is 25.8 years. Data collected across all program years on mother's age at enrollment is shown in ***Figure 7. Mean Ages of Program Enrollees: Years 1-21.*** As more teen mothers are enrolled, the previous upward trend toward increasingly older participants entering the program has now turned towards a cohort of slightly younger participants.

FIGURE 7. MEAN AGES OF PROGRAM ENROLLEES: YEARS 1-21

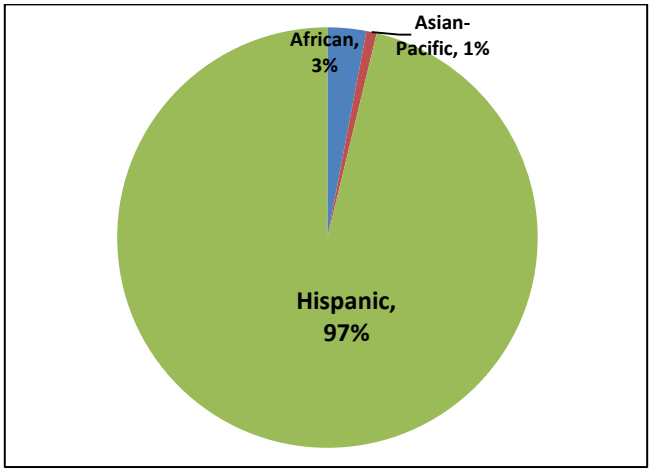


Ethnicity

Ethnicity and cultural factors are potent mediators of parenting knowledge, values, and behavior. 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.

As in previous years, the overwhelming majority of families in the HFM program were Hispanic (97%), as shown in ***Figure 8. Mothers' Ethnicity***. This is an increase from 92% two years ago. The remaining mothers were African (3%) and Asian-Pacific Islander (1%).

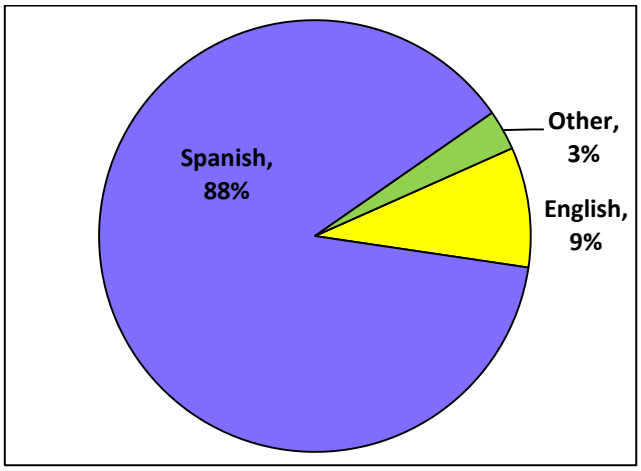
FIGURE 8. MOTHERS' ETHNICITY



Language

Reflecting the race/ethnicity findings described above, the majority of participants speak Spanish (see ***Figure 9. Mothers' Primary Language***). 88% cited Spanish as their primary language, while 5% spoke English and 3% 'Other'. Those who cited 'Other' listed French or French-Madagasy as their primary language. Of the mothers who report Spanish or another language as their primary language, many speak some English, but many 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 classes in order to address these communication issues.

FIGURE 9. MOTHERS' PRIMARY LANGUAGE



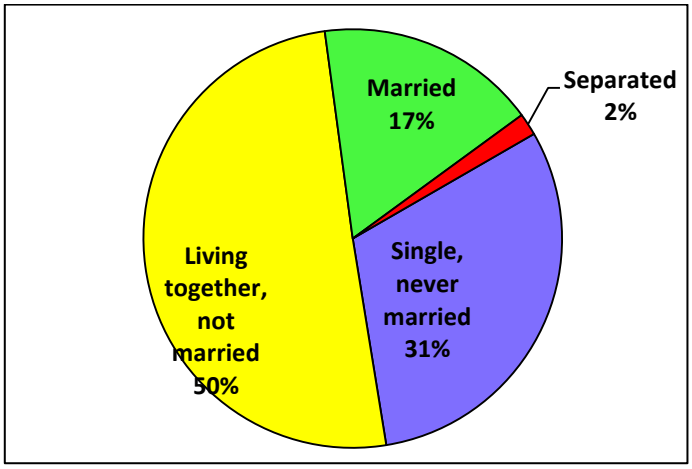
Marital Status

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 10. Mothers' Marital Status*** below, most participants were living with their partner (50%) but not married. Nearly one-third were single. Some mothers were married (17%), and

two are separated. Overall, 86% of mothers are not married, which research has indicated is significantly associated with economic risk and instability and places them and their babies at greater risk.

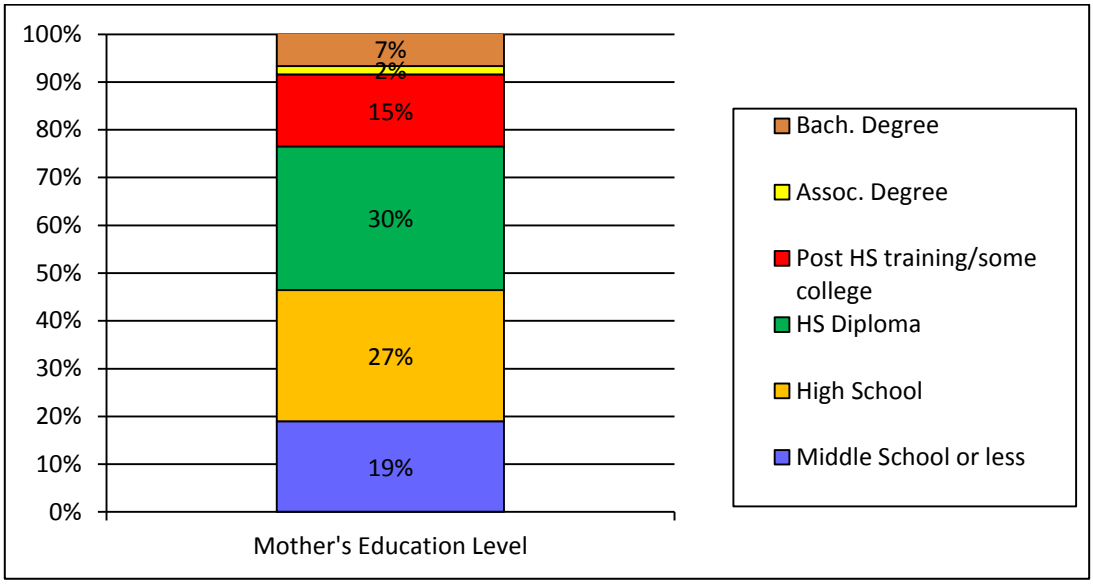
FIGURE 10. MOTHERS' MARITAL STATUS



Education

Mother's level of education is strongly associated with 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. In examining the highest level of education achieved at enrollment, over half (54%) of active participants had obtained at least their high school diploma at the time of entry, GED or higher. As seen in ***Figure 11. Mothers' Education Status at Program Entry***, 27% held only a high school diploma, 24% had some post high school training or college, and 12% held an Associates or Bachelor's Degree. However, 46% had no high school diploma; 19% with only middle school or less. This high percentage of mothers with less than a high school degree is likely attributable to the number of newly immigrated mothers from Latin America and the lack of education offered 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 high school equivalency and language classes.

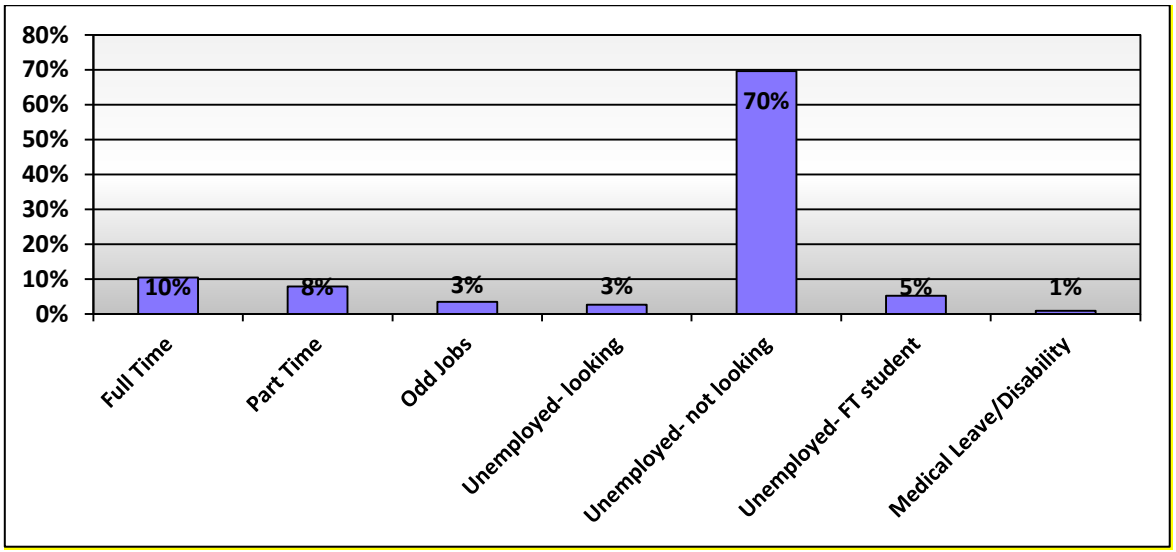
FIGURE 11. MOTHERS' EDUCATION STATUS AT PROGRAM ENTRY



Employment

Mothers' employment status is indicative of economic stability and self-sufficiency. However, mothers often become unemployed around the birth of their baby, or go on maternity leave. The HFM program fosters financial stability by offering assistance with employment-related issues, connecting families to community resources and opportunities, and providing encouragement. As seen in ***Figure 12. Mothers' Employment Status at Enrollment***, the majority of mothers (78%) were unemployed at enrollment; most (66%) were not looking for employment, 3% were looking for work. It is not surprising that such a large percentage of mothers were not employed since they were either perinatal or within 3 months postnatal. However, the 5% who were full time students is a significant increase from 1% two years ago, reflecting the increased number of teens enrolled in the program.

FIGURE 12. MOTHERS' EMPLOYMENT STATUS AT ENROLLMENT

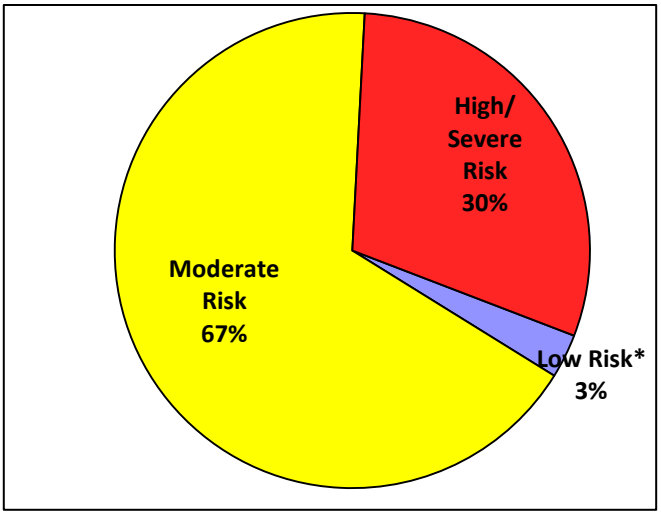


Risk Factors

In addition to examining demographic data, the HFM program assesses participants' initial measured 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 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 a parent who scores 25 or greater are offered services if the program has availability. Mothers who are enrolled with FSC <25 were found eligible based on the father's FSC score.

While eligibility criteria pre-selects a participant population that is at moderate risk or greater for child abuse and neglect, many families present a constellation of factors that place them at severe risk. As seen in ***Figure 13. FSC/Parent Survey Risk Scores***, 30% of mothers scored in the High/Severe Risk range, while most mothers (67%) scored in moderate risk range.

FIGURE 13. FSC/PARENT SURVEY RISK SCORES



** Eligibility based on FOB score or medical risk*

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 possible scores for each factor, 0 (low risk), 5 (moderate risk), or 10 (severe risk), were averaged across participants and the mean score for each calculated. Results for active participants in Year 21 for the five most significant risk factors based on mean score are displayed in ***Table 10. Risk Factors with Highest Mean Score*** in rank order. This constellation of severe risk factors places these mothers and their children at very high risk for child maltreatment.

Table 10. Risk Factors with Highest Mean Score

Parent Survey Risk Factor	Mean Score
• Social isolation/Depression	7.7
• Being Abused as a Child	6.9
• Multiple Stressors	5.2
• Poor Bonding	5.1
• Unrealistic expectations	4.3

The mean scores for all ten factors on the Parent Survey are shown below in ***Table 11. Parent Survey Item Mean Scores by Subscale***. These scores assist the HFM program in targeting their interventions to address the overall risk of the participants and to guide the FSW's individual work with the family.

Table 11. Parent Survey Item Mean Scores by Subscale

Subscales	Mean Score*
1. Abused as child	6.9
2. Mental Health/Substance Abuse	3.5
3. Previous or Current CWS Involvement	0
4. Self-esteem/Social Isolation/Depression	7.7
5. Multiple Stressors	5.2
6. Violence Potential	0.5
7. Unrealistic Expectations	4.3
8. Harsh Punishment	0.5
9. Difficult Child	0
10. Poor Bonding/Attachment	5.1

**Range is 0-10 for each subscale with 10=highest risk*

The pattern that emerges from the Year 21 profile of risk factors, including childhood abuse, mental health issues, multiple stressors in their lives, poor bonding and attachment with their child, and unrealistic expectations of their child is one that reflects an increased potential for child maltreatment, particularly neglect. The prevalence of social isolation and depression are more closely associated with potential for neglect. However, the high incidence of mothers that experienced moderate to severe abuse as a child and who have unrealistic expectations of their child places them at much higher risk for harsh discipline with their child and may lead to physical abuse. The identification of these at-risk mothers provides the Healthy Families Montgomery program the opportunity to break the cycle of abuse with these new mothers and their babies.

IV. OUTCOMES

Healthy Families Montgomery has tracked achievement of its goals and measured program outcomes each year since program inception. See ***Appendix H: Program Goals and Objectives*** for a detailed list of program goals and objectives.

Goal I: Promote Preventive Health Care

Medical Providers

HFM ensures that all participating target children over the age of 2 months are linked to a medical/health care provider in order to ensure optimal health and development. During FY17, there were 116 children served by HFM and all *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, 100*% of eligible children (target children and siblings) enrolled were in Medical Assistance (MA).* These results, combined, increase the likelihood that children will receive timely immunizations and well-child checkups.

HFM also works to ensure that all adult participants are connected to health care providers. Among enrolled mothers, *99% (116/117) had health care providers.*

Immunizations

Key to a child's receipt of the recommended immunizations is educating parents about the recommended schedule, the reasons for immunization, and the resources available in the community. FSWs orient families to the process of immunization and track the child's receipt of vaccines. They educate parents about the immunization schedule and the importance of immunizing their children. The first immunization information is usually collected at birth. FSWs continually review progress of the child's immunization administration with parents. FSWs encourage parents to maintain immunization records for their children.

HFM follows the Vaccine Requirements for Children Enrolled in Preschool Programs and in Schools for Maryland schedule for immunization. The schedule is contained in ***Appendix I: Maryland Vaccine Schedule.*** Immunizations are tracked, and compliance with recommended schedules is measured. The key tracking measures are for those immunizations required by one and two years of age. Children are considered to have up-to-date immunizations at one year of age if they have received all scheduled immunizations through six months of age, and they are considered to be up-to-date at two years of age when they have received all scheduled immunizations through 18 months of age.

In FY17 there were 33 children who had reached age one and 17 children who had reached age two by the end of the period. Among one year olds, *32 of 33 (97%) and all two year olds (17/17) had at least the required immunizations for that time period.*

Additional Births

It is recommended that mothers wait a period of at least 24 months between pregnancies for health reasons. 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.

By the end of FY17, 116 mothers had at least one child. In FY17, 6 of these mothers had a subsequent birth (second child or later). 2 of these were less than 24 months after the birth of the prior child. Both of these mothers were 34 years old at the time of the second birth. *98% (114/116) of mothers did not have a repeat birth within two years of the target child's birth, exceeding HFM's target of 90%.*

Post-Partum Care

The American College of Obstetricians and Gynecologists (ACOG) recommends that mothers receive a postpartum care visit 4-6 weeks after delivery.[1] Nationally, 90.7% of women report completing their postpartum visit. 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.[2]

HFM Family Support Workers work with new mothers to understand the importance of timely postpartum care. Postpartum care is expected within 2 months of birth. Mothers who gave birth during the 3-month period ending 2 months prior to the end of each quarter are expected to have a postpartum medical care visit by the end of the quarter. In Year 21, *100% of mothers completed their postpartum check-up, exceeding the HFM goal of 85%.* This is 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*)[3].

Healthy Birth weight

Babies born with low birth weight (less than 2500 grams or 5.5 lbs) 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 birth weight also incurs enormous economic costs, including higher medical expenditures, special education and social service expenses, and decreased productivity in adulthood. Very low birth weight 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 birth weight 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.[4]

The HFM indicator for healthy birth weight targets mothers who enrolled in the first or second trimester when there is the greatest likelihood of impacting the risk factors associated with low birth weight. *In FY17, no mothers were enrolled prior to the third trimester.* 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. In FY17, *95% (19/20) of all mothers who enrolled prenatally had babies at a healthy birth weight (2500+ grams or 5.5 lbs.).*

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[1] 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

[2] 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

[3] 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*

[4]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/

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. The state of Maryland has also adopted "alternative response", 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.

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.

FY17: Data from Montgomery County Child Welfare Services for the period between July 2016 and June 2017 indicates that of active families during this time, *100% (n=117) of families had no indicated Child Welfare Services (CWS) report.* The HFM target for this objective is that 95% of families will not have a confirmed report of child maltreatment.

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.[5] 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.

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.[6] These compelling statistics clearly indicate the importance of early screening and referral for early intervention services.

HFM uses the Ages and Stages Questionnaire (ASQ) and the ASQ:SE-2 (Ages and Stages Questionnaire – Social Emotional) at designated intervals throughout a child's participation in the program to monitor social, emotional, cognitive, language and motor development, as well as social and emotional development. These tools and their schedules are described ***Appendix F: HFM Description of Evaluation Measures*** and ***Appendix G: HFM Evaluation Administration Schedule.*** These screenings allow HFM staff and parents to monitor children's progress, provide appropriate stimulation at each stage, and identify potential delays. If indicated, staff provide resources and/or referrals. ASQ administration may be suspended while a child is receiving developmental assessment through early intervention services. Concerns about delays are discussed in supervision and if indicated, the HFM Early Intervention Consultant (EIC) is consulted for guidance is assisting the FSW and the parent in encouraging the child's development. The EIC may refer to early intervention services immediately, or may accompany the FSW on a visit in order to provide further observation and assistance. If concerns about a delay persist, then a referral is made to the Montgomery County Infants and Toddlers Program (MCITP), or Child Find, depending on the age of the child.

Of the 116 children served in FY17, 97 were due for ASQ screening (age at least 5 months). ***Table 12. ASQ Screening in FY17*** shows that 96/97 (99%) received a timely ASQ screening during the year. Of the remaining children, 9 were not yet five months old, and 8 were on creative outreach or terminated prior to the next screening due. 3 children did not receive screening due to already confirmed delays, these children are receiving services from the Montgomery County Infants and Toddlers program. 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.[7]

[5] 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/

[6] 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

[7] 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/

Table 12. ASQ Screening in FY17

116	Target children served FY17	
	97 children due for ASQ (5+ months age)	
	96 children received ASQ in FY17	99%
	The remaining 20 did not receive ASQ in FY17:	
	9	Target child less than 5 months old
	6	Were on creative outreach when they terminated
	3	ASQ not administered due to confirmed delays
	2	Terminated prior to next due ASQ

Of the 116 children served, 87 were due for ASQ-SE screening (age at least 7 months). ***Table 13. ASQ-SE Screening in FY17*** shows that 95% (83/87) received a timely ASQ-SE screening during the year. Of all those who did not, 24 were not yet seven months. 5 were on creative outreach, or terminated prior to the next screening due. 3 children did not receive screening due to already confirmed delays, these children are receiving services from the Montgomery County Infants and Toddlers program.

Table 13. ASQ-SE Screening in FY17

116	Target children served FY17	
	87 children due for ASQ-SE (7+ months age)	
	83 children received ASQ-SE in FY17	95%
	The remaining 33 did not receive ASQ in FY17:	
	24	Target child less than 7 months old
	3	Were on creative outreach when they terminated
	3	ASQ not administered due to confirmed delays
	2	Terminated prior to next due ASQ
	1	Delayed administration

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%[8] of U.S. children had developmental delays that would qualify them for Part C early intervention services.[9] Child Trends

[8] 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

[9] 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

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 least 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.

In total, 21 children were followed by the HFM Early Intervention Consultant (EIC) during FY17. By the end of the fiscal year, 12 children had ended services due to improvements. 9 children were still receiving services: 2 with Child Find/PEP, 5 with MCITP and 2 children continued to be monitored by the HFM Early Intervention Consultant.

For FY17, 100% of children demonstrated normal child functioning and were meeting developmental milestones or were receiving appropriate services.

Goal IV. Promote Positive Parenting and Parent-Child Interaction

The HFM program administers The Healthy Families Parenting Inventory (HFPI), a 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 14. HFPI Subscales-Percentage of Mothers Score At-Risk***, the percentage of mothers at risk in several domains decreased by 12 months. Mothers' risk was unchanged in three domains: Social Support, Role Satisfaction and Parenting Efficacy. Mothers' risk increased from enrollment to 12-months for more two domains: Problem Solving and Depression. It is not surprising that 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. By 24 months, risks had decreased from baseline in all but one subscale; Social Support risk had increased from 21% to 27%.

TABLE 14. HFPI SUBSCALES-PERCENTAGE OF MOTHERS SCORE AT-RISK

Subscale	Percent at Risk				
	Baseline (n=104)	12- month (n=77)	Change from Baseline	24-month (n=45)	Change from Baseline
Social Support	21%	21%	—	27%	↑
Problem Solving	15%	31%	↑	7%	↓
Depression	19%	28%	↑	18%	↓
Personal Care	20%	18%	↓	19%	↓
Mobilizing Resources	22%	9%	↓	2%	↓

Role Satisfaction	31%	31%	–	20%	↓
Parent-Child Behavior	17%	13%	↓	16%	↓
Home Environment	17%	9%	↓	7%	↓
Parenting Efficacy	17%	17%	–	13%	↓

Parents' Knowledge of Child Development

For all families served in FY17 who have received a 12-month HFPI assessment, *83% demonstrated adequate knowledge of child development based on the Parenting Efficacy subscale at 12 months*. For all families who received their 12-month assessment during FY17, 75% demonstrated adequate knowledge of child development.

Parent's Having Positive Parent-Child Interaction

For all families served in FY17 who have received a 12-month HFPI assessment, *87% demonstrated positive parent-child interaction based on the Parent-Child Behavior subscale at 12 months*. For all families who received their 12-month assessment during FY17, 79% demonstrated positive parent-child interaction.

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 carbon monoxide levels, and the presence of firearms in the home.

For all families served in FY17, 94% (n=110) demonstrated knowledge that would make their homes completely or almost completely safe upon enrollment. *At the 12-month follow-up, 100% (n=76) of parents had sufficient knowledge of home safety.* This indicates that mothers who have the lower scores for knowledge of home safety can improve their home safety within one year of participation.

Maternal Depression Screening

HFM conducts depression screening with all enrolled mothers to assess for risk of perinatal depression. FSWs are trained in the use of the **Center for Epidemiologic Studies – Depression (CES-D)** instrument. 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. Screening is provided at least once prior to the child's birth if the family is enrolled prenatally, again in the post-partum period, and at least annually thereafter. Families can be screened prenatally at the time of assessment, even if they are not enrolled until after the child's birth. Based on the CES-D score, participants who are considered to be at risk for depression are referred to the community mental health resources for a follow up mental health assessment. Community mental health resources include: Aspire Counseling, Family Services, Inc. and Mobile Med.

Prenatal: Of the 21 mothers who were served prenatally during FY17, 100% received prenatal CES-D screenings. This is achieved in HFM because the FRS conducts prenatal CES-D at the time of assessment. Any time a screen indicates the possibility of prenatal depression, the FRS provides information about available counseling services.

Postnatal: 32 mothers were enrolled during FY17. 1 terminated services prior to birth. 97% (30/31) of the remaining mothers had a postnatal CES-D screen within 3 months of the birth of the baby.

Depression screening is done annually throughout a mother's enrollment. ***Table 15. Percentage Mothers at Risk for Depression*** shows percentages of mothers displaying risk of depression over various timepoints. The sample is all mothers served at any time during FY17, the timepoints are any time during their service. 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%)[10]. Results highlight the importance of the HFM program in ongoing screening for depression and linking participants to appropriate mental health professionals.

The timepoint demonstrating the greatest period of risk of depression is prenatal (34%). All mothers are screened at baseline, and the percentage of those at risk is 18%. This increases to 22% at 12 months after the birth of the baby, and 26% at 24 months. After that point it steadily declines; only 13% of mothers show risk at 48 months, and for the 8 mothers screened at 60 months, 0 screen positive for depressive symptomology.

TABLE 15. PERCENTAGE MOTHERS AT RISK FOR DEPRESSION

Timepoint	Number of screens	Number at risk for depression	Percentage
Prenatal	44	15	34%
Baseline (after birth of baby)	110	21	19%
12-month	83	18	22%
24 month	48	12	26%
36 month	28	6	21%
48 month	16	2	13%
60 month	8	0	0%

Goal V. Promote Family Self-Sufficiency

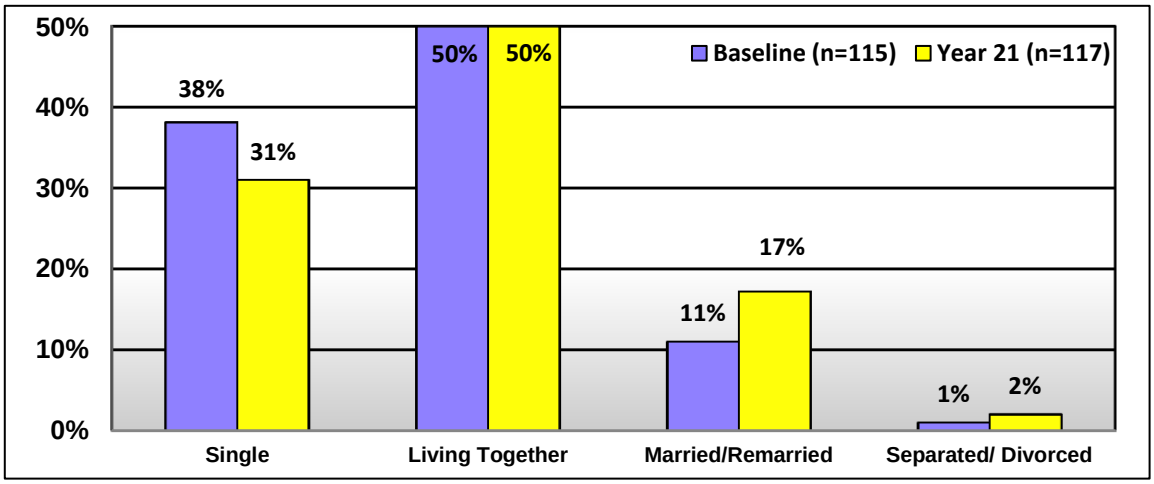
Family self-sufficiency is a "composite variable" encompassing factors such as marital status, employment, education and housing status that serve as indicators of a participant's autonomy and ability to live without public aid or support. These factors were examined at entry and again at the close of 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.

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

Marital Status

Following the trend in recent years, half of mothers (50%) were living together with a partner at the time of enrollment, while 38% were single, 11% were married. At the most recent follow-up (end of FY17), still 50% of mothers were living together with a partnet, while only 31% were single. The percentage of mothers who were married increased from baseline to 17%, while 2% were separated or divorced. These results indicate mothers are increasingly in partnerships that provide more support and stability than they would have if they were single.

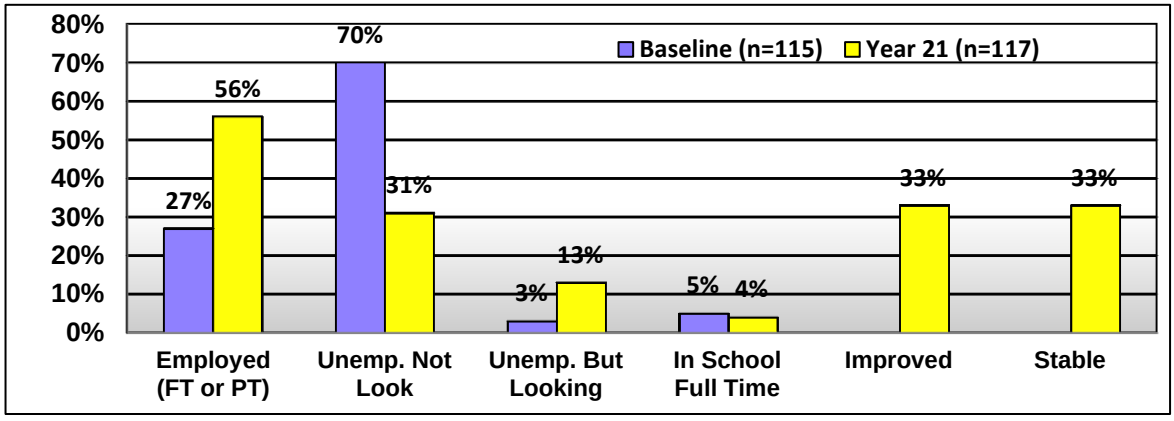
FIGURE 14. MARITAL STATUS FOLLOW-UP



Mother's Employment

At enrollment, 27% of mothers were employed either full or part-time. The majority of mothers were unemployed and not looking for employment (70%). An additional 5% were unemployed because they were in school full time. At follow-up, the percentage of mothers employed either full or part-time had more than doubled to 56%. Of the remaining mothers, 31% were unemployed and not looking for employment, but unemployed mothers actively seeking employment rose from 3% to 13%, with 4% were in school full time. Overall, 66% 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 15. EMPLOYMENT STATUS FOLLOW-UP

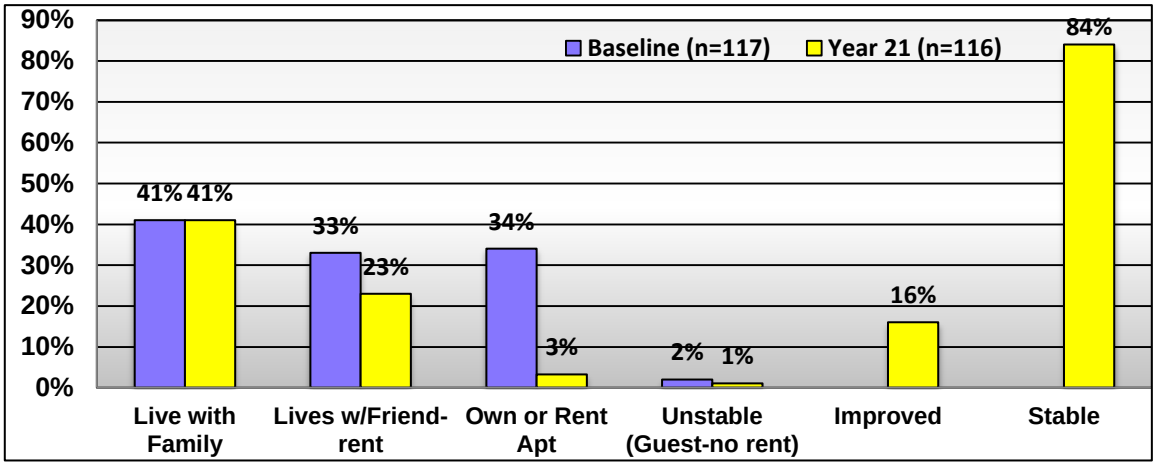


Housing

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).[11] [12]Mother's housing status was compared at enrollment and at the last follow-up for all active participants.

At enrollment, most mothers lived with their families (41%), more than half of whom paid rent. Another 33% of mothers lived with friends and paid rent, while 34% either owned or rented their own house or apartment. The remaining mothers had unstable housing, they were living as a guest in other's home (2%). At follow-up, the percentage of mothers who owned or rented their own house or apartment increased to 34%, and the percentage of mothers with unstable housing decreased from 2% to 1%. Overall, 99% of families had stable or improved housing.

FIGURE 16. HOUSING STATUS FOLLOW-UP



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.

Summary of Goal Achievement

Healthy Families Montgomery has tracked achievement of its goals and measured program outcomes each year since program inception. Over the past twenty-one years, HFM has consistently demonstrated success at meeting or exceeding its targets for key outcomes. Outcome results presented in ***Table 16: HFM Goals and Outcomes: Year 21 (FY17)*** below are organized by program goals. Data for previous program years can be found in the ***Healthy Families Montgomery Twenty Year Longitudinal Study 1996 – 2016***, published in April, 2017.

[11] 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/

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

Table 16: HFM Goals and Outcomes: Year 21 (FY17)

Indicator	Goal	1Q	2Q	3Q	4Q	FY17
Goal I: Promote Preventive Health Care						
Children with a healthcare provider (for children who are at least two months old)	95%	100% 83/83	100% 94/94	100% 90/90	100% 97/97	100%
Eligible children enrolled in MA, including non-target children	95%	100% 96/96	97% 97/100	100% 103/103	100% 108/108	99%
Children with current immunizations	90%	97% 88/91	97% 91/94	95% 92/97	99% 96/97	97%
Teen mothers who have no additional birth within 2 years	90%	100% 93/93	100% 95/95	100% 98/98	100% 97/97	100%
Mothers who have completed postpartum care	85%	100% 8/8	100% 8/8	100% 9/9	100% 9/9	100%
Currently active mothers with a healthcare provider	95%	99% 84/85	99% 94/95	100% 98/98	100% 97/97	99%
Mothers enrolled < third trimester, child will have healthy birthweight	95%	No mother enrolled prior to third trimester in FY17				
Goal II: Reduce Incidence of Child Maltreatment						
Enrolled families will not have substantiated CWS reports	95%	100% [1*] 104/104	100% [1*] 104/104	100% [2*] 100/100	100% [2*] 100/100	100%
Goal III. Optimize Child Development Reported semi-annually						
Children will demonstrate normal child functioning or receive appropriate services	95%		100%		100%	100%
Goal IV. Promote Positive Parenting and Parent-Child Interaction Reported semi-annually						
Parents will have adequate knowledge of child development at 12 months	85%		86%		83%	83%
Parents having positive Parent-Child Interaction at 12 months	85%		94%		87%	87%
Parents' Knowledge of Child Safety	95%		100%		100%	100%
Goal V. Promote Family Self-Sufficiency Reported semi-annually						
Mother's Level of Education	65%		63%		55%	
Mother's Employment	65%		54%		39%	
Housing	99%		99%		98%	

[1*] HFM receives aggregated reports from Child Welfare Services semiannually. Results are for second half of FY16.
[2*] HFM receives aggregated reports from Child Welfare Services semiannually. Results are for first half of FY17

Comparative local, state and national statistics are presented in ***Table 17. Summary of Goals, Objectives, Outcomes and Comparative Statistics*** where possible and are used to measure HFM's impact on community indicators.

TABLE 17. SUMMARY OF GOALS, OBJECTIVES, OUTCOMES AND COMPARATIVE STATISTICS

Healthy Families Montgomery: Year 21 (FY17)

Goals and Objectives	HFM TARGET	HFM Year 21	Montgomery County	State of Maryland	National
Goal I: Promote Preventive Health Care Children will have a health care provider	95%	100%	96% [14]	95% [11]	96% [2]
Eligible families will be enrolled in MA	95%	99%		92% [11]	91% [3]
Children immunized on schedule*	90%	97%		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%		Teens 85% [16]	Teens 82% [5]
Babies Born with Healthy Birthweight**	90%	95%	93% [14]	92% [8]	92% [8]
Mothers will complete post-partum care.	85%	100%		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%	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%	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.
** 32 babies born HFM in FY17, 30 had birthweight >2500g, all enrolled third trimester

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

Participant Satisfaction

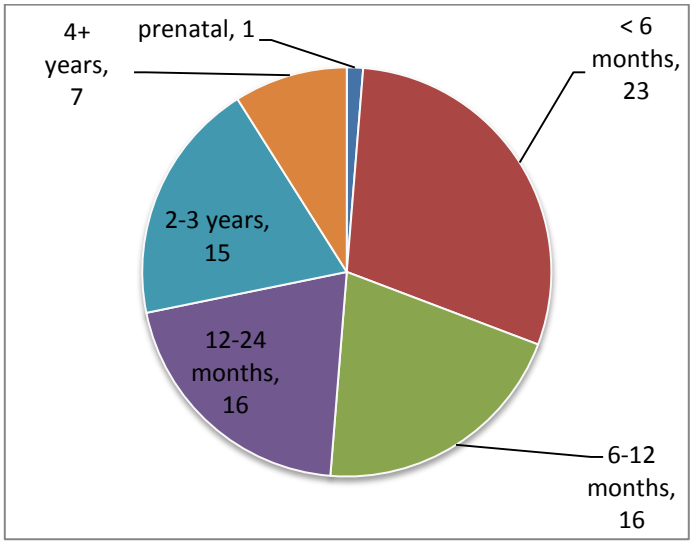
> "The tips, the advice, the resource, everything is very helpful to build a really healthy family. Makes us feel safe, secure, and more confident."

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 J: HFM Participant Satisfaction Survey***).

As in past years, surveys in English and Spanish were distributed to all active participants during home visits. In Year 21, 80 participants returned the survey. The majority of respondents were between 21 and 30 years old (59), while 26%) were over 31 years of age; and 15% were age 20 or under. Because respondents represent the entire spectrum of service levels, the majority of respondents (53%) were receiving home visits on a weekly basis, while 27% were on a biweekly schedule and 19% were visited monthly.

At the time of the survey, most of the children were less than one year old, indicating that most of the respondents are new to the program within the past year. The breakdown of the children's ages is shown in ***Figure 17. Age of Children at Time of Survey Response.***

FIGURE 17. AGE OF CHILDREN AT TIME OF SURVEY RESPONSE



Participants were asked how effective they thought the program was in various areas by circling "Yes" or "No." ***Table 18. 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 18. PARTICIPANT PERCEPTION OF PROGRAM EFFECTIVENESS

1. My Family Support Worker visited me as agreed upon.	100%
2. I feel safe when I am receiving services from Healthy Families Montgomery.	100%
3. If I have a concern, I know I can call the supervisor or program manager, and I have information on how to use the grievance process.	96%

4. My Family Support Worker gives me information on how to care for my baby.	100%
5. My Family Support Worker is helping me learn about my child's development.	100%
6. My Family Support helps me with my needs and the needs of my baby and family.	100%
7. My Family Support Worker is respectful of my baby, my family and me.	100%
8. My Family Support Worker accepts and respects my culture.	100%
9. My Family Support Worker shows an interest in learning about my culture.	100%
10. My Family Support Worker gives me information that I can understand.	100%
11. My Family Support Worker communicates with me in a way that I understand.	100%
12. My Family Support Worker helps me to be more independent by helping me make my own decisions.	100%
13. My Family Support Worker has helped me to become a better parent.	100%
14. Healthy Families has made a positive impact in the life of my baby.	100%

"What I like about HFM is learning about my baby, the development and what I can to do to help."

When asked what they liked best about the program, participants responded with 76 positive comments about the program. Fifty-three percent of mothers provided comments in reference to how much they, and subsequently their children, have benefitted from learning about child development and understanding the stages of their own child. Twenty-eight percent focused on the support and information they received that helped them better understand their child. Twelve mothers simply repeated that they liked "everything" about the program. Most comments in all categories mentioned the care and support they receive from their FSWs.

Table 19. Best Aspects of HFM Program

	# Comments	Percent
1. Parenting/Child Development	40	53%
2. Information/Support/Advice	21	28%
3. Everything	12	16%

Thirty participants responded to a question that asked what they did not like about the program. Most of mothers (83%) responded that there was nothing that they did not like and liked everything. Two of the remaining respondents felt the visits should be longer.

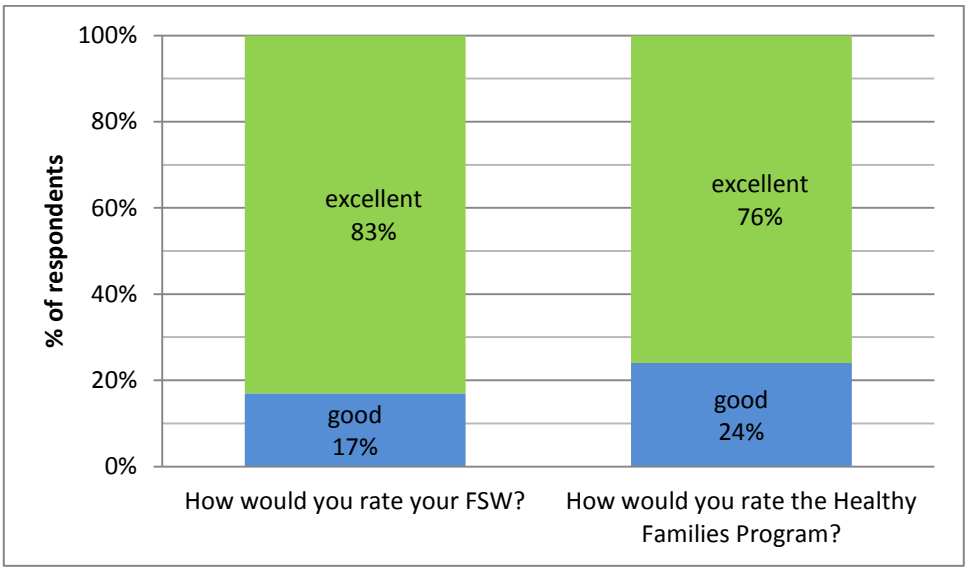
Participants were asked if they had any recommendations for improvement of the HFM program. Of the 39 mothers who responded to the question, 23 (59%) re-iterated that the program was excellent and that there was nothing to change. Of the remaining mothers who offered suggestions for improvement, most expressed a desire for the program to reach more families. Others asked for more activities, more or longer home visits, and more opportunities for participants to socialize and network with other families. One mother suggested that the program should provide "a space where we can bring our child to have an education before starting school," while another suggested offering transportation.

Table 20. Recommendations for Improvement

Comment	# Respondents
1. No improvement necessary	23
2. Reach more families	5
3. Additional education/resources/activities	4
4. More group activities/socialization/network	2
5. More or longer home visits	3
6. Preschool	1
7. Transportation	1

Families were also asked to rate their FSW and the HFM program. All of the respondents reported that both their FSW and the HFM program were either "Excellent" or "Good," as shown in ***Figure 18. Participant Ratings of FSWs and HFM.*** No participants rated the program or their FSW as "Average" or "Poor".

Figure 18. Participant Ratings of FSWs and HFM



All of those who responded to the question agreed that they would recommend the program to a friend or relative, with 90% responding "Strongly Agree."

> "The FSW's support is wonderful and respectful and always helps with my needs."

In summary, HFM participants continue to report high levels of satisfaction with the program. Comments focused on how the program has helped them be better parents by teaching them about child development and providing them with the education to care for their children. Parents value the guidance and support they receive from their FSWs and rely on staff when they need information and referrals. They also appreciate opportunities to socialize with and learn from other families. Day care and transportation, however, are two areas that are difficult for many parents. Finally, participants are so positive about the program that they would like to see longer visits, additional activities, and visits for their children beyond 5 years old.

Success Stories

HFM has many stories of successful outcomes for families completing the program. Following are stories from three of the families who graduated in FY17.

This young mother was left in the care of grandparents in Guatemala at age 10 while her parents moved to California to work. Her parents had additional children in the US, but she did not join them until later. She ran away from home (twice) to join her boyfriend in Maryland who had also immigrated to the US. She became pregnant and was referred to HFM by a Montgomery County health center. Initially, she was reluctant to participate in the program, but did make time to meet with her family support worker (FSW) regularly.

With her FSW, she discussed her strong resentment towards her own mother, and her negative feelings about life and socialization. At first, she rejected her home visitor's recommendations for therapy and returning to high school. While the FSW continued to work at forging a stronger bond with the young mother, they worked together to identify goals for her. She received validation, praise for her strengths and celebration of her successes. After various suggestions for reducing her self-imposed isolation (and therefore the child's isolation), the couple found a church community to become involved in. As a direct result of her HFM involvement, she began to feel competent in her knowledge of child development, and decided to contribute to her church by taking care of children in the church's day care center. She then began making connections with others and started going on trips and to church events. With the support of her FSW, she continued to increase her independence by learning to take the bus to get to church on her own. Her child also had opportunities to socialize with other children, which increased his social-emotional development.

With encouragement and support from her FSW, she attended the Family Discovery Center (FDC) to learn English and meet other parents. She became close friends with another HFM mother, and also appreciated the opportunity for her child to play with other children. He continues to thrive. After attending classes at FDC for a year and improving her English skills, she also began to attend some of the HFM participant groups.

She has set and achieved many more goals: she got her driver's license, the couple got married, and reestablished a relationship with her parents. She got a job, and feels very happy to be able to contribute to the household income. At the time of graduation, she was pregnant with the couple's second child, and they were renting a two bedroom apartment on their own.

Another mother is from Columbia, where she received a university degree in finance and public affairs. She joined a program to work as a nanny in the US and learn English. While living in the US, she met and married her husband, a man from Chili who teaches Spanish at a private school. The family enrolled in HFM when mom was close to delivery of the couple's first child. At that time, the couple lived on their own in a comfortable apartment. Dad worked full time and mom was home alone. The only family Mom has in the US is a sister who lives in another state. Mom did not have a network of friends and knew little of child development. Their new FSW taught them how local systems work so they could access the services they needed. She also guided mom in learning about her baby. Mom's mother (MGM) came from Colombia to help with the baby. Many things that MGM told her daughter about babies were outdated and in conflict with what mom was learning from her FSW. FSW was able to persuade MGM to accept the more current information about bonding, attachment and brain development.

After MGM returned to Colombia, the FSW addressed mom's isolation by suggestinig that mom go out in neighborhood. She began to meet new people, one of whom was a professional woman with twins. Once they fostered a friendship, the new friend asked mom if she would like to be the caregiver to her children when she was at work. Mom accepted the offer and consequently was able to earn some extra money for the household. Mom struggled at times to balance the needs of the older twins with the needs of her own infant; her FSW was able to provide helpful guidance and coaching.

She became depressed that she was "just a nanny" and her professional training was not being utilized. Her FSW screened her for depression and referred her for treatment. Mom attended therapy sessions and took medication that was helpful. Once mom started feeling better, she realized that she had been depressed for some time.

During the course of HFM services Dad was present in the home for many of the home visits, but was not participatory. In spite of being invited to participate, he didn't think he needed what she had to offer. However, as their child became more mobile, discipline became a source of conflict between the parents. Upon observing Dad's impulsive reaction to his child's behavior, she asked him if he was open to learning about different approaches. She taught him other ways to manage his child's behavior. When he began to see results, he was very open to participating in home visits.

Concerned about how the parents' conflicts might be affecting the child, the FSW asked dad to reflect on his own childhood. Dad's childhood included abandonment and parental alcoholism. The reflective process included asking dad to think about what kind of future he would like for his own child. During goal setting discussions, mom decided that she wanted to look for a professional job, become a US citizen (her husband already is a US citizen), and she and her husband wanted to purchase a house. The FSW guided them through the process of the housing lottery and the path to citizenship. Eventually mom achieved her goal of citizenship and the family won the housing lottery, enabling them to purchase a home. Mom accepted a managerial position at a well-known bank.

The family participated in the graduation celebration in April of 2017. When the graduating families were invited to speak about their experiences with HFM, Dad decided to share his admiration of their FSW and his appreciation for all of the benefits of participation in Healthy Families Montgomery.

When this mother was a child, her parents immigrated to the US from Honduras and left her in the care of an older sister, who was abusive to her. Eventually she and her younger brother were reunited with their parents in the US. She completed high school, was working and attending college when she became pregnant with her first child. While pregnant, mom enrolled in the Healthy Families Montgomery (HFM) program. At the time of enrollment, mom was living with her parents who were very upset about the pregnancy, and as a result her self-esteem was quite low. Her Family Support Worker (FSW) began to build a trusting relationship. Early on, she screened the young mother-to-be for depression, and referred her for therapy. She attended several therapy sessions which were very helpful. Her son was born about 6 weeks after enrollment in HFM. When her child was about four months old, mother and baby moved in with her partner and his parents. Soon after, her father left his wife. Mother and child moved back to living with her mother (Maternal grandmother – MGM) and her brother. As MGM became very depressed, mom assumed the role of head of household, managing the family's day-to-day needs, including the financial responsibilities.

She was very protective of her child, she wanted him to be cared for only by family members. She arranged to work only when a family member or her son's father would be able to care for him. She was not able to continue in college. Throughout the course of home visits, the FSW used the Parents As Teachers curriculum to guide her in learning how to parent and address her personal challenges.

Her relationship with her partner had its ups and downs. The couple eventually had a second child, a daughter when their son was three. When the relationship with her children's father did not work out, her FSW also used the Building Your Bounce resources to help mom to decide to include her partner in the relationship with his children. Mom has maintained a close and loving attachment to her children.

Throughout services, mom and her FSW worked on goals formed following mutual discussion and planning. These included: to live independently, get a full time job, obtain steady financial support from the children's father, and to return to college. At the conclusion of services with HFM, mom had moved to her own housing, was working full time, and was receiving regular financial support from the children's father. Together, mom and her FSW designed a Family Goal Plan that addressed easing mom's stress. One of the concerns resolved by the transition planning process was to identify another mentor that mom could depend on after the family was no longer involved with HFM. FSW suggested that mom become a mentor to another woman who was struggling with many of the same issues that mom had had over the years. The two women are now serving as supports to each other. Mom's children are thriving, her son was on target to start kindergarten and eventually mom hopes to return to college.

IV. TRENDS

Acceptance Analysis

HFM periodically analyzes families who accept services compared to those who refuse services when offered. This comprehensive analysis includes formal data collection and informal discussions with staff. In addition, HFM addresses ways in which it might increase its acceptance rate based on this analysis. The most recent analyses were done in August 2016 and October 2017.

August 2016

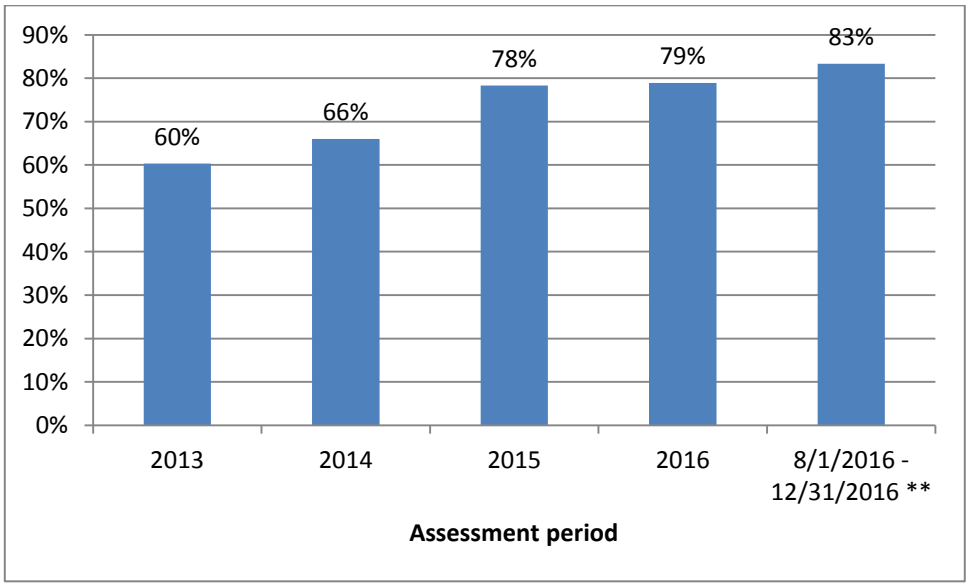
A detailed acceptance analysis was done in August 2016 as part of the site's preparation for re-accreditation. HFM uses calendar year of assessments for calculation and comparison of acceptance rates; the analysis was based on assessments done between January 1, 2015 – December 31, 2015. The result was a set of recommendations aimed at increasing site acceptance rates. That plan included:

- Mothers who feel they do not need services or are not ready to commit account for the biggest portion of refusals (62%). Prior to the offer of services, the Family Resource Specialist (FRS) emphasizes to the parent the benefits of participation in HFM.
- For families who stated they do not have the time to participate, the FRS explores the specifics of the family's schedule and problem solves alternatives.
- When a family member refuses to allow a home visitor into the home, the FRS may suggest that the mother explain the reasons she would like to participate to the family member and give the family member time to think it over. The FRS can offer to talk with the family member. The FRS will follow-up at a later date, if appropriate.
- FRS will continue to inform all who are offered services about the benefits of participation as well as the flexibility of the program.
- The program would continue to be welcoming to all mothers regardless of their ethnicity. Staff are hired for their skills in relating to families from a variety of ethnicities.

- For mothers who have little support due to the absence of a partner, the FRS explains how the Family Support Worker can provide support and link to community resources.
- For mothers who are working the FRS informs the mother that the FSW offers flexibility of days/time for home visiting.
- HFM continues to offer services to families who will benefit the most from home visiting services based on parent survey scores.

It should be noted that this plan was created and implemented in August 2016, when most assessments for that year had already been completed. It is encouraging to observe that the acceptance rate for those offered services between 8/1/2016 – 12/31/2016 is **83.3%** (18 offered, 15 accepted), indicating that periodic analysis and subsequent staff discussions may be impactful to program results.

FIGURE 19. HFM ACCEPTANCE RATES, 2013 - 2016



** Acceptance improvement plan implemented in August 2016.

October 2017

A complete acceptance analysis for assessments was done at this time for the period January 1, 2016 - December 31, 2016.

Of 122 assessments during this period, 57 families were offered services. 45 of these families accepted services and received at least a first home visit. (This rate is constantly changing as more assessments from this time period are still in the pipeline.) Acceptance rate has been increasing each year, as seen in ***Figure 19. HFM Acceptance Rates, 2013 - 2016*** above. At the time of the most recent analysis, the acceptance rate for all assessments in calendar year 2016 is 78.9%. The improvement resulting after the August 2016 analysis is also shown for comparison.

Various factors relevant to the population being considered are analyzed in order to understand which groups may be most likely to accept offers of service, and to improve acceptance rates if possible.

As a result of the analysis, a plan for increasing acceptance rates has been compiled.

- Acceptance rates for those assessed during the second trimester have increased dramatically over the previous year (60% -> 90%). Still, HFM completes most of its Parent Surveys (assessments) in the 3rd trimester (77%). HFM has begun working with the Montgomery County DHHS centers to change the process for screening. HFM staff will be on site at one center to assist with screening, and allow for parent surveys to be scheduled or conducted at that time. This should result in obtaining more assessments in second trimester.

- Although the benefits of enrollment are discussed with all who are offered services, investigate better ways to connect with those in the lowest education levels, for whom refusal rate is highest.

- Since mothers who feel they do not have time for services account for the biggest number of refusals, utilize this information and plan accordingly when discussing the benefits of participation in HFM with a parent prior to offering services.

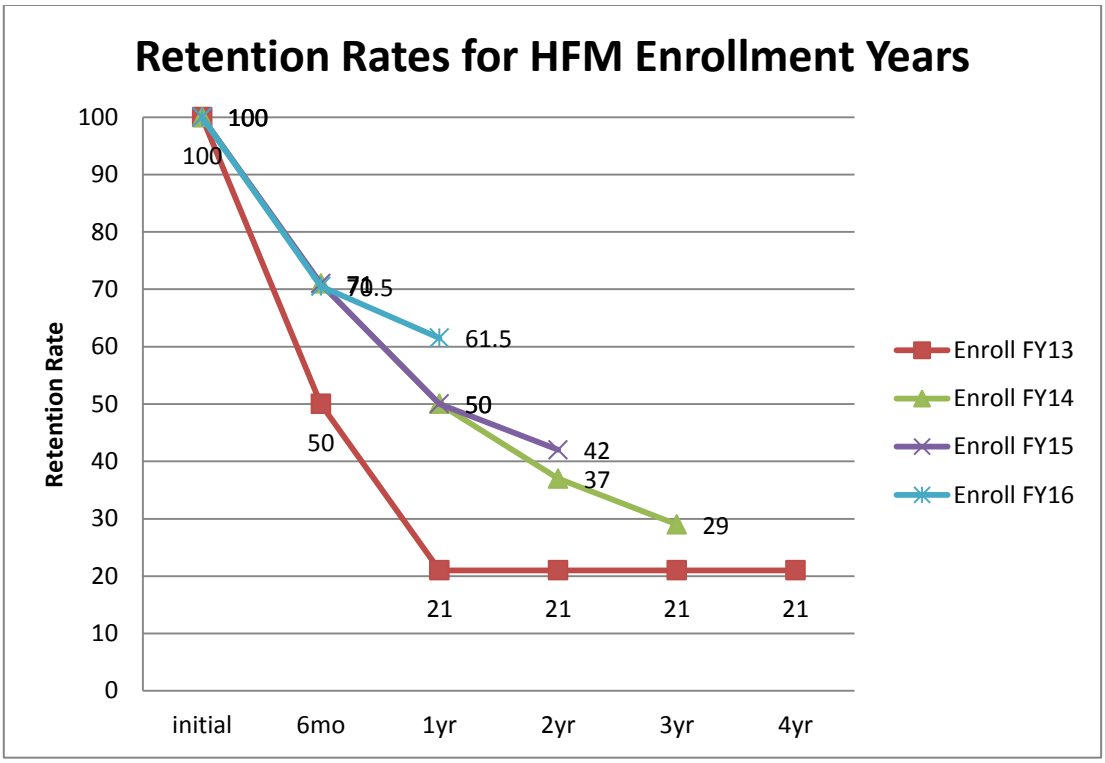
- Consider further investigation into an ideal window around birth of child for offering services when participant is more likely to accept. HFM currently does not track verbal "date offered services" to compare to due date (EDC) or service start date. Recommend doing this in the future. It could be that if services are offered too early prior to EDC, mother-to-be might not be focused enough/ready to plan; too close or after EDC they may be overwhelmed and unlikely to take on a new commitment.

Retention Analysis

HFM periodically analyzes families no longer receiving services compared to those remaining in services. This comprehensive analysis includes formal data collection and informal discussions with staff. In addition, HFM addresses ways in which it might increase its retention rate based on this analysis.

Retention Analysis, August 2017

HFA Retention Rates measure families who stayed in services (enrolled) compared to those who dropped out (terminated) of services. HFA methodology requires that sites measure the percent of families who remain in the site over specified periods of time (6 months, 12 months, 24 months, 36 months, etc.) after receiving a first home visit. Retention analysis is a detailed study and reporting of site patterns and trends.



Retention rates have increased steadily over the enrollment years analyzed. 12 month retention (families remaining in the program for at least 12 months) has increased from 21% in the FY13 cohort to 61% in the FY16 cohort. 24 month retention has increased from 21% to 42%.

Various factors were examined, comparing those who left the program vs. those who stayed.

- Demographic factors: age, ethnicity, marital status, income level, zip code, education level
- Programmatic factors: assigned staff, service level at closure, total days in program
- Social factors: average assessment score

Primary reasons for those leaving (other than moved out of area) for those enrolled 7/1/2013 – 6/30/2016, leaving between 7/1/2013 – 6/30/2017 (N=95):

Scheduling conflicts with job or school	31
Participant never engaged	16
Refused change in FSW	9
Participant voluntary withdraw	8
Lost contact with participant	6

Observations from data:

Retention rates are highest among Hispanic mothers, those cohabitating with partner, those in the lowest income category and those with no diploma. Total assessment score doesn't vary greatly between those who remained vs. those who left.

Staff discussion on retention, 8/25/17:

- Prenatal vs. Postnatal enrollment – most prenatal enrollments are too close to birth, not enough time to help them as much as clients need/staff want. Staff feel they have greater success developing relationships and engaging families if they start prenatally, best if more than a month.

- Job – families who may be very much appreciating and benefitting from services must still prioritize making money over the program.

- Immigration issues in current political climate are impacting families – not seeking prenatal care early enough, skeptical of FRS, not seeking resources.

- Culture – observation that Asian cultures are polite and appear welcoming but aren't open to help.

- Discussions on specific cases which have terminated – some are coded "refused services" when actually they had met program goals, just not the end of the 5 year program they signed up for. Reclassify these as "met program goals". When the child has started school or Head Start, mom has gone back to work full time, services are no longer beneficial.

- Some parents don't engage/commit, despite intense effort from FSW and supervisor. They need services but are ambivalent. Current team practice is effective but sometimes it's obvious it won't work out.

- It was beneficial to educate staff on the nuances of termination reasons and the importance of understanding each case for future references and lessons learned. Staff have benefitted from such discussions, and agreed to a plan to add to agenda quarterly.

- Although data was not investigated comparing those enrolled prenatally vs. after birth, staff noted anecdotally that they believe they can form a better bond with families when enrollment is prenatal.

Plan for Increasing Retention Rates

Based on the analysis and discussion with staff, the following recommendations are made to potentially increase retention rates.

- Investigate feasibility of training for "Great Beginnings Start Before Birth" curriculum.

- Examine and more closely monitor termination reason, and document it more carefully.

- Add staff discussion of retention to agenda quarterly.

V. STAFF

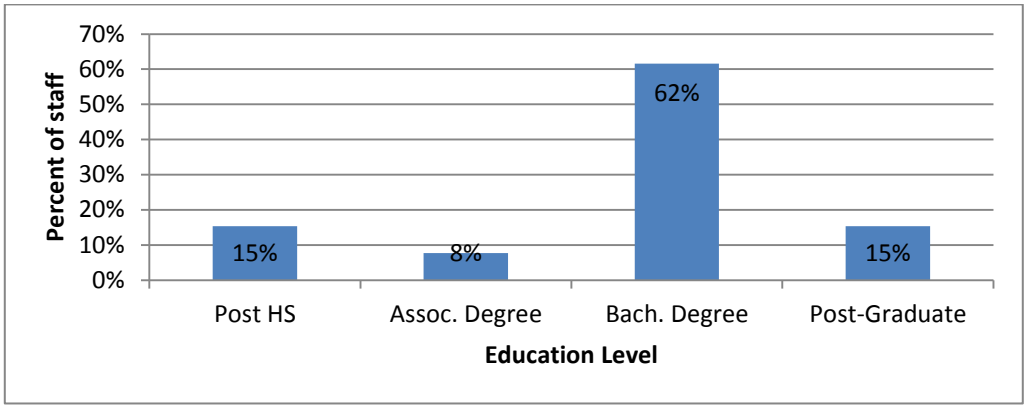
Program Staffing

During Year 21, the HFM program employed 13 individuals in 13 positions (11.65 FTEs). Staff positions included one Program Manager, one Team Leader, one Family Resource Specialist, one Program Support Specialist, 5 Family Support Workers, one part-time Data Specialist, and a part-time Early Intervention Consultant. The program also had two Baby Steps nurses who are available to the HFM program on an as-needed basis. The structure is represented in ***Appendix K: HFM Organizational Chart.***

In order to ensure cultural and linguistic competence, the HFM program hires staff that reflect the ethnic and cultural composition of the target population. All staff were female and all direct service staff are bilingual in English and Spanish, and one speaks Portuguese as well.

The collective educational level of the staff remains high (see Staff Training section below also). As seen in ***Figure 20. Staff Education Levels***, all (100%) staff members have graduated high school and at a minimum have attended post-high school training or some college. The majority of staff have attained a post-secondary degree, either an Associate's, Bachelor's or a Graduate Degree. HFM staff education levels exceed Best Practice Standards requirement of at least a high school degree, and the HFA national percentage of 74% having some college or higher.

FIGURE 20. STAFF EDUCATION LEVELS



The HFM program has an excellent history of retaining good staff. High levels of staff retention reflect a stable program that values its staff and provides opportunities for feedback and growth. Staff retention is also linked to family retention. When a Family Support Worker resigns, families are sometimes reluctant to engage with a new Family Support Worker. One new team member, the team leader/supervisor, joined just prior to the beginning of FY17. Only one staff member left the program during FY17 – one Family Support Worker left the program in June 2016 to relocate out of the state. The Program Manager has been employed by HFM for 21 years, since the program began in 1996. The FRS has been with the program for 15 years. The average length of staff tenure is 9 years.

TABLE 21. PROFILE OF STAFF CHARACTERISTICS

Bilingual English/Spanish*	100% (8/8) direct service staff
Education Level Post HS/Some College Associate Degree Bachelor Degree Post-Graduate	 15% 8% 62% 15%
Mean Age at Hire Range	38 23 – 52
Mean Length of Tenure Range	9 years 1 – 21 years

*One bilingual FSW also speaks Portuguese

Staff Development

HFM provides rigorous, continuous and varied training as part of its commitment to supporting staff and ensuring that employees feel competent and prepared for their work with families. 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 / limit setting and confidentiality. Additionally, wrap-around trainings on varied topics are offered on an ongoing basis.

As part of the HFA accreditation process, certain trainings have been identified as required at various timeframes. For example, some trainings, such as those mentioned above, are required prior to FSWs completing any home visits with families. Other trainings are required within three, 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.

Over 80 unique trainings covering numerous topics were provided. The extensive number and type of trainings offered demonstrate the program's dedication to expanding the knowledge and skill set of its staff. The trainings 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. Most of the trainings were within the area of Professional Development, while Family Mental Health/Well-Being trainings were also significantly attended. This pattern is 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.

Caseload

Caseload ***size*** is the number of active families an FSW is working with, caseload ***weight*** is a measure of the intensity of the home visiting schedule. Each service level is assigned a weighted numerical value so FSWs and the Team Leader can closely monitor when their caseload has availability, or conversely is at capacity. Consistent with best practice standards, an FSW carries no more than a weighted caseload of 30 and no more than 25 families (no more than 15 families when all are on Level 1). Caseload size is monitored by the Team Leader and Family Support Worker during supervision through completion of the monthly Caseload List per FSW.

Level P (2 points):	Prenatal: weekly or every other week home visits
Level 1 (2 points):	Weekly home visits
Level 1SS (3 points):	Weekly or more frequent home visits
Level 2 (1 point):	Two visits per month
Level 3 (.5 point):	Monthly home visits
Level 4 (.25 points):	Quarterly home visits
Level XA (.5-2 points):	Creative Outreach (attempted weekly contact)

The site's policy regarding established caseload ***size*** is no more than twelve families at the most intensive level (offered weekly visits) per full time home visitor. Maximum caseload ***size*** is no more than twenty-four at any combination of service levels per full-time home visitor and a maximum case ***weight*** of 30 points.

When making caseload assignments, the supervisor will take into consideration the experience and skill level of the home visitor, nature and difficulty of the problems encountered with families, work and time required to serve each family, number of families per service provider which involve more

intensive intervention, travel and other non-direct service time required to fulfill the service providers' responsibilities, and the extent of other resources available in the community to meet family needs.

Table 22. Annual Weighted Caseload Report, FY17 demonstrates the weighted caseloads of all FSWs throughout FY17. The maximum weighted caseload was 24.5, and the mean across all FSWs was 20.4.

TABLE 22. ANNUAL WEIGHTED CASELOAD REPORT, FY17

FSW	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	April	May	June
HFM49	17.9	18.0	15.0	15.0	15.0	15.8	16.8	19.1	19.7	19.3	20.3	21.3
HFM67	22.4	21.9	20.8	21.9	23.0	23.0	22.1	20.8	22.0	22.4	20.8	22.5
HFM7	19.3	18.7	19.4	20.0	18.8	17.4	17.5	19.4	20.4	20.1	18.5	20.5
HFM73	24.5	24.5	21.8	20.7	20.2	20.6	22.4	22.5	21.6	20.6	21.0	10.4
HFM74	24.2	24.0	23.9	20.0	21.9	23.0	21.5	22.2	23.7	24.0	24.0	24.0
HFM75	18.0	16.8	17.5	18.3	20.0	20.0	18.6	18.0	19.4	22.0	22.0	23.9
Site Total	126.3	123.9	118.4	115.9	118.9	119.8	118.9	122.0	126.8	128.4	126.6	122.6

Staff Satisfaction

HFM evaluates and reports on personnel satisfaction annually. In July 2017, eight 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 L: HFM Staff Satisfaction Survey Form***). All respondents identified their position within the agency. Six respondents identified themselves as either an FSW or FRS, while two were identified as a manager/team leader.

"HFM has a well trained and dedicated staff who take pride in their work."

The questionnaire consisted of 23 statements accompanied by a 5-point scale, in which to indicate level of agreement for each item. As seen in ***Table 23. Staff Satisfaction Survey***, most staff members agree or strongly agree with the positive statements about the program.

TABLE 23. STAFF SATISFACTION SURVEY

	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree	No Answer/ NA
I understand the goals and objectives of HFM.	7	1				
HFM is a strength-based and family centered program.	8					
HFM trainings have adequately prepared me for my position.	8					

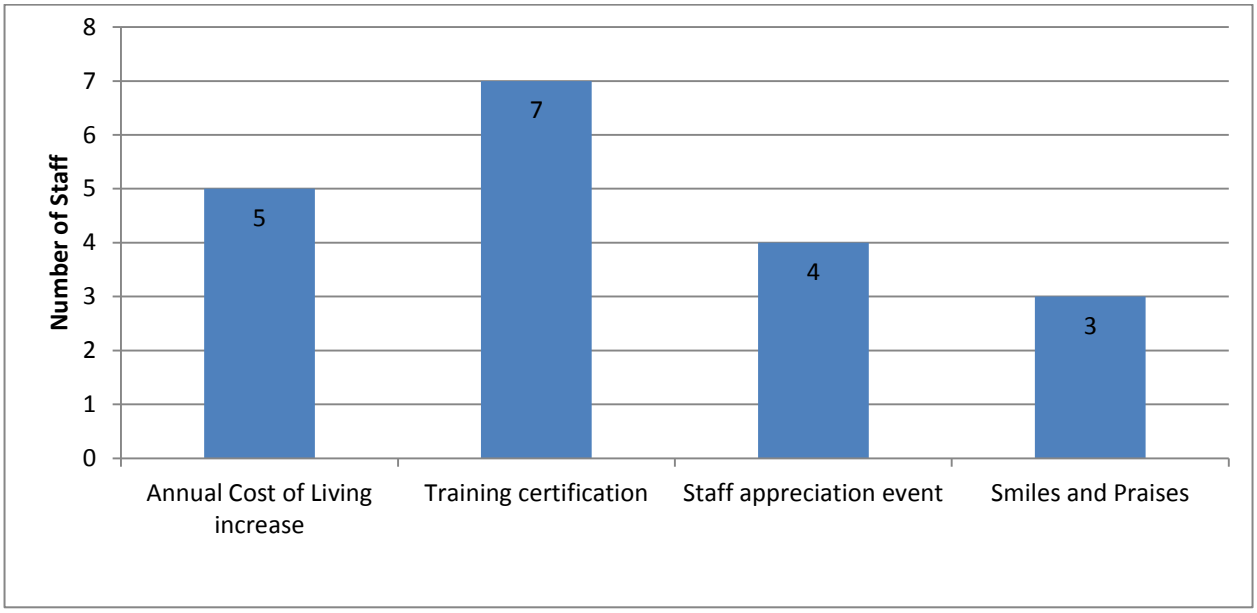
	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree	No Answer/ NA
My supervisor is responsive and supportive of my needs.	8					
The program uses materials that are culturally and linguistically appropriate.	8					
The program uses bilingual materials as appropriate.	7	1				
I feel comfortable working with the culturally diverse families served by HFM.	6	1				1
I enjoy being part of the HFM team.	8					
My work is worthwhile and has a positive impact on children and families.	8					
The work I do uses my skills, knowledge and experience.	8					
I generally feel safe in the communities I visit.	2	5				1
HFM management shows appreciation for the work I do for the program.	6	2				
I am adequately compensated for my position.	2	3	2		1	

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, consistent with previous years, several staff members are “Not Sure” or “Disagree” that they are appropriately compensated for the work they do. Interestingly, almost all staff did not think the work they do is hard.

Staff members were asked to indicate how often they feel stressed at work. Most staff (6/8 = 75%) *sometimes* feel stress associated with their work, while two respondents (2/8=25%) *rarely* feel stressed.

Staff members were asked what employment incentives they have received during the past year. Although only five staff members indicated they received a wage increase, all staff received a cost of living wage increase in Year 21.

TABLE 24. STAFF REPORT OF INCENTIVES RECEIVED



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 focused on several key areas. Staff appreciate the strong dedicated team with support from leadership/supervisor. They also cited the strength-based program and a curriculum that provides services in a structured way. When asked which areas of the program need improvement, areas identified as targets for improvement included having space for family group gatherings and salary.

"HFM is a great program and I truly enjoy working with our HFM team."

SUMMARY AND RECOMMENDATIONS

For the past twenty-one 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.

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 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.

Healthy Families Montgomery has tracked achievement of its goals and measured program outcomes each year since program inception. The program has consistently demonstrated success at meeting or exceeding its targets for key outcomes.

It is evident 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% for the past twenty-one years. This year it was 0%.

Over the past twenty years, HFM has worked with local, state and national partners to address increased rates of screening for child developmental delay, parenting resources and supports, awareness of and access to health care for low-income families. The results include 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, 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 has demonstrated significant improvements on major standardized measures of health, child maltreatment, parenting skills, risk for maternal depression, and family self-sufficiency. HFM's successes can demonstrate to legislators the cost benefits of prevention.

Recommendations

- 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 improve the partnership with Montgomery County DHHS to best serve the evolving needs of diverse, at-risk families.

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

- Upgrade policies, procedures and practices as required by the newly updated *HFA Best Practice Standards, Effective January 1, 2018 – December 31, 2021.*

APPENDIX A. HFM FUNDING SOURCES & EXPENDITURES

Healthy Families Montgomery Funding Sources
July 2016– June 2017

Private Foundations

William S. Abell Foundation
Morris and Gwendolyn Cafritz Foundation
Clark-Winchcole 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

Christ Child Society
Friendship Star Quilters
Woodworkers for Charity

Healthy Families Montgomery Program Expenditures
July 2016– June 2017

Program Funding	
Montgomery County DHHS	$554,689
Montgomery County Collaboration Council	170,267
City of Rockville	18,000
William S. Abell Foundation	11,261
Morris and Gwendolyn Cafritz Foundation	32,403
Clark-Winchcole Foundation	18,153
Other support and training fees	16,378
Total Funding	**$821,170**
Program Expenses	
Personnel salaries	$450,060
Personnel fringe benefits	133,848
Building occupancy	59,126
Professional services and evaluation	18,603
Transportation, local travel	15,986
Telephone	5,481
Training/conferences	14,830
Program activities/supplies/equipment	18,412
Subtotal Expenses	**$716,346**
General and administration	$94,548
Total Expenses	**$810,894**
Excess/Deficit	$ 10,276

APPENDIX B. HFM ADVISORY BOARD

July 2016– June 2017

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 Director
Joan Liversidge	Community Member
Carol May	Community Member
Meredith Myers (Ex-Officio Member)	FSI/EC-FT Division Director
Rebecca Smith, RN (Ex-Officio Member)	Nurse Administrator Silver Spring Health Center
Margaret Sood (Ex-Officio Member)	HFM Data Specialist
Shari Waddy	FSI/Family Discovery Center Program Director

APPENDIX C. 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.

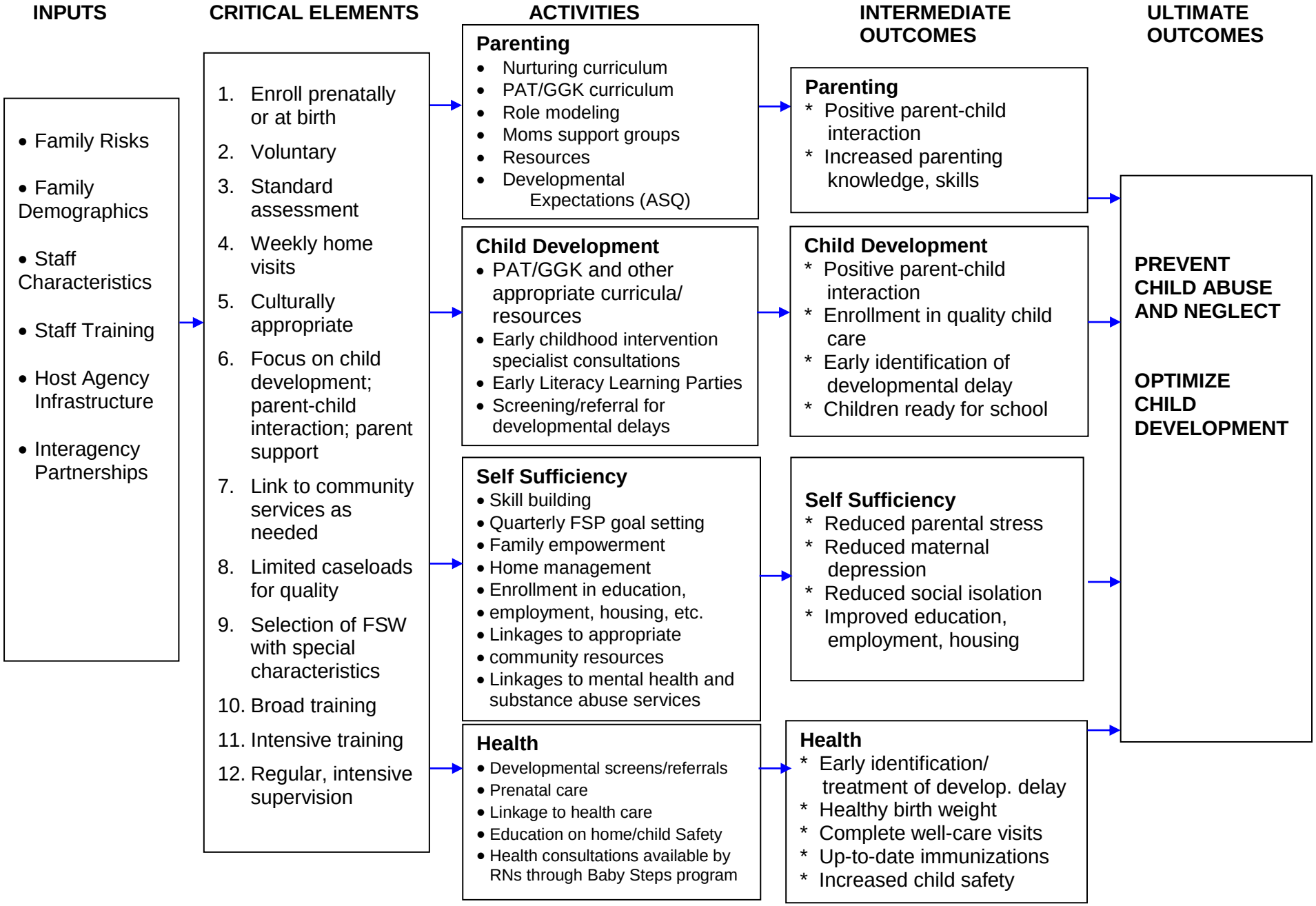
11. Service providers have a framework, based on education or experience, for handling the variety of experiences they may encounter when working with at-risk families. All service providers receive basic training in areas such as cultural competency, reporting child abuse, determining the safety of 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 D. HEALTHY FAMILIES MONTGOMERY LOGIC MODEL



APPENDIX E. HFM SERVICE LEVEL 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 F. 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 G. 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

APPENDIX H. 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.

APPENDIX I. MARYLAND VACCINE SCHEDULE

Maryland Department of Health and Mental Hygiene

2016 Recommended Childhood Immunization Schedule

Vaccine ▼ / Age ►	Birth	2 months	4 months	6 months	12 months	15 months	18 months	2-3 years	4-6 years
Hepatitis B[1]	Hep B	Hep B		Hep B					
Rotavirus[2]		RV	RV	RV					
Diphtheria, tetanus, & acellular pertussis[3]		DTaP	DTaP	DTaP		DTaP			DTaP
Haemophilus Influenzae type b[4]		Hib	Hib	Hib		Hib			Hib
Pneumococcal[5]		PCV13	PCV13	PCV13	PCV13			PPSV23	
Inactivated Poliovirus[6]		IPV	IPV	IPV					IPV
Influenza[7]				INFLUENZA (YEARLY)					
Measles, Mumps, Rubella[8]					MMR				MMR
Varicella[9]					Var				Var
Hepatitis A[10]					HepA		HepA	HepA	
Meningococcal[11]		Meningococcal							

Please see reverse side for footnotes

Certain High-Risk Groups & Catch-Up Vaccination

Certain High-Risk Groups

This schedule includes recommendations in effect as of January 01, 2016. The use of a combination vaccine generally is preferred over separate injections of its equivalent component vaccines. Clinically significant adverse events that follow vaccination should be reported to the Vaccine Adverse Event Reporting System (VAERS) online (http://www.vaers.hhs.gov) or by telephone (800-822-7967)

Approved by MedChi - The Maryland State Medical Society

www.dhmh.maryland.gov | Center for Immunization | dhmh.IZinfo@maryland.gov

APPENDIX J. HFM PARTICIPANT SATISFACTION SURVEY

Family Services, Inc.
HEALTHY FAMILIES MONTGOMERY
Participant Satisfaction Survey

Today's Date:_____

Please share the following information:

Your age: ☐ 12-15 ☐ 16-20 ☐ 21-30 ☐ 31 and above

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. I feel safe when I am receiving services from Healthy Families Montgomery.
   YES NO
3. If I have a concern, I know I can call the supervisor or program manager, and I have information on how to use the Grievance Process.
   YES NO
4. My Family Support Worker gives me information on how to care for my baby.
   YES NO
5. My Family Support Worker is helping me learn about my child's development.
   YES NO
6. My Family Support Worker helps me with my needs and the needs of my baby and family.
   YES NO
7. My Family Support Worker is respectful of my baby, my family and me.
   YES NO
8. My Family Support Worker accepts and respects my culture.
   YES NO
9. My Family Support Worker shows an interest in learning about my culture.
   YES NO

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

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

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

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

14. 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 ☐ Disagree ☐ 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 ☐Mayor 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 de 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 ultima visita fue hace más de un mes, ¿Existe una razón por la que no fue mas 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. Me siento segura cuando estoy recibiendo los servicios de Healthy Families Montgomery
SI **NO**

3. Si tengo una preocupación, se que puedo llamar a la supervisora o a la directora del programa, además tengo la información de los pasos a seguir en caso de una queja.
SI **NO**

4. Mi trabajadora de apoyo familiar me informa de como cuidar de mi bebé.
SI **NO**

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

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

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

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

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

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

11. Mi trabajadora de apoyo familiar se comunica conmigo en un lenguaje que yo le puedo entender.
SI **NO**

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

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

14. 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 de acuerdo** ☐**De acuerdo** ☐**No opino** ☐ **En desacuerdo** ☐ **Muy en desacuerdo**

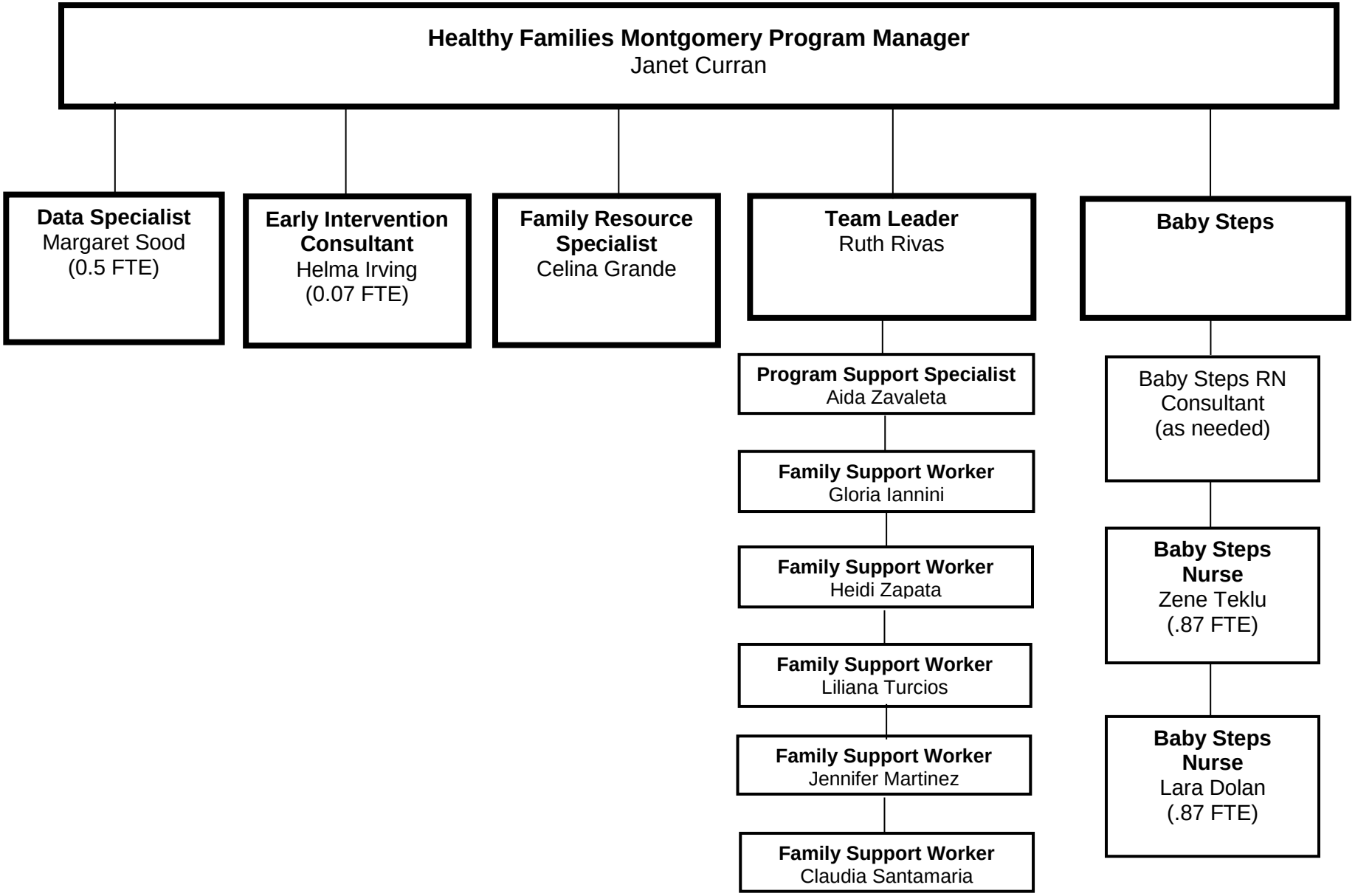
Si no recomendaría a Healthy Families, por favor díganos el por qué.

_____

_____

Muchísimas gracias por participar en esta encuesta.

APPENDIX K. HFM ORGANIZATIONAL CHART



APPENDIX L. HFM STAFF SATISFACTION SURVEY FORM

June 2017

Healthy Families Montgomery
Staff Satisfaction Survey

Please take a few minutes to share your thoughts about the Healthy Families Montgomery (HFM) 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!

1. What is your job with HFM?

- ☐ Family Support Worker (FSW) or Family Resource Specialist (FRS)
- ☐ Manager/Team Leader
- ☐ Other

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

	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
I understand the goals and objectives of HFM.					
HFM is a strength-based and family centered program.					
HFM trainings have adequately prepared me for my position.					
My supervisor is responsive and supportive of my needs.					
The program uses materials that are culturally and linguistically appropriate.					
The program uses bilingual materials as appropriate.					
I feel comfortable working with the culturally diverse families served by HFM.					
I enjoy being part of the HFM team.					
My work is worthwhile and has a positive impact on children and families.					
The work I do uses my skills, knowledge and experience.					
I generally feel safe in the communities I visit.					
HFM management shows appreciation for the work I do for the program.					
I am adequately compensated for my position.					
I understand the goals and objectives of HFM.					

3. How often do you feel stressed at work? (Check one)

❒ Never ❒ Rarely ❒ Sometimes ❒ Often ❒ Every day

4. Have you received/taken part in any of these employment incentives during the past year? (Check all that apply)

❒ Annual Cost of Living increase ❒ Promotion ❒ Training certification
❒ Staff appreciation event ❒ Smiles and Praises ❒ Other (list) _____

5. Which areas of the program are particularly strong?

_____
_____
_____

6. Which areas of the program need improvement?

_____
_____
_____

7. Additional Commenta and Suggestions:

_____
_____
_____

Thank you for sharing your thoughts and suggestions today.