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Healthy Families Montgomery

Program Year 22
July 2017 – June 2018

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-second 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. This report describes the HFM program implementation during Program Year 22 (July 1, 2017 – June 30, 2018) and the outcomes achieved by the end of the fiscal year (FY18).

Over the past twenty-two 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.

Following a lengthy and thorough review process, the HFM program received a new credential in January 2017 and is accredited by HFA through March 2021. Since that time, the HFA Best Practice Standards have been updated, effective June 1, 2018. HFM is constantly reviewing and updating processes to conform to the new standards. This document is intended to facilitate Self-Study and Accreditation, and to more clearly communicate to its stakeholders the metrics they require.

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. Positive screens are referred for further assessment. Assessments identified as positive for risk of child maltreatment are considered for enrollment in the HFM program when there are caseload openings.

HFM received 562 screens, primarily from the collaborating county health clinics in FY18. HFM was able to conduct 181 assessments from the pool of positive screens. Due to limited caseload capacity, 61 new families were enrolled. Families may remain in the program for up to 3 years, and a total of 143 families were served by the HFM home visiting program in the year. Due to limited capacity, only about 12% of 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 22 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 who 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 22, the program served 143 families and 139 children. Demographic data reveals a relatively new trend toward younger mothers; the mean age at entry is 25 years, 21% were teens. Most mothers are Hispanic and speak Spanish as their primary language (87%). More than one-

third (39%) of mothers 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 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%. Of mothers who were due for their post-partum medical visit, 86% received timely care, affording them the opportunity to monitor their health and discuss family planning options with their doctors. This percentage 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 22, 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 22 babies exceeded both national (92%) and Maryland (91%) rates.

Goal II: There were no indicated cases of child maltreatment in HFM families in Year 22. This is an indicator of the positive impact that prevention services 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 22 received a timely ASQ, and 100% received a timely ASQ-SE. The HFM rate for developmental screening of participating children far exceeds the comparable national rate of 29%. All children who have been identified with developmental delays or concerns were followed by the team leaders. Many received county services, including Child Find, Infants & Toddlers (MCITP) and the Preschool Education Program (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 99% of parents demonstrating adequate safety knowledge after one year of program participation, from 96% at the time of enrollment.

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. The percentage of mothers at risk decreased from 21% 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 19% at enrollment to 12% 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 with the percentage of mothers at risk decreasing from 15% at enrollment to 6% 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 for depression prenatally was 32%; at 12-months it was 16%. 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. 58% of mothers were married or living together with their partners at the time of enrollment; this has increased to 62% in recent follow-ups. Employment status is stable or improved for 90% of mothers, with 50% working part-time or full-time (up from 25% at enrollment). Those who are currently living independently, whether alone or with a partner, has risen from 23% to 36%, with 92% having stable or improved housing status. Education levels remained stable, with 39% of mothers having less than a high school diploma.

HFM employed a staff of 13 individuals in FY18, at the level of 12.5 full time equivalents. 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 be 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 a better parent 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./ Sheppard Pratt Health Systems

Established in 1908, Family Services, Inc. (FSI) is a private nonprofit serving approximately 13,000 individuals in Montgomery and Prince George's Counties each year. As part of the Sheppard Pratt Health System (SPHS), FSI is engaged in providing in-home and community-based services for at-risk children, adolescents and adults who have limited access to critical resources. The mission is to promote the resilience, recovery and independence of individuals and families across the lifespan through integrated mental and physical health, social service and education programs, thereby strengthening communities. FSI's staff of 400 is very diverse representing 50 birth-origin countries and speaking 42 different languages.

Healthy Families Montgomery (HFM) has served the community since 1996, and was the first fully accredited site in Maryland. HFM is a bilingual home visiting service for first time parents facing multiple stressors, with the goal of preventing child abuse. Home-based services begin before the baby is born, and continue until the child is three years old. Emphasis is placed on health care, child development, parenting education and support, and family self-sufficiency. Families benefit from the ongoing professional relationship with a specially trained, caring Family Support Worker (FSW) who guides them in building a strong parent-child bond. The FSW also teaches parents how to recognize developmental progress and encourage the child's developmental next steps.

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 SPHS, HFM has established numerous formal and informal partnerships with other community programs and organizations. 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
- Discovery Station Early Head Start
- Family Discovery Center

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 22, 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-Winchcole 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 22, 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 3), 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 CHEERS parent-child observation tool *(Cues, Holding, Expression, Empathy, 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 a new credential in January 2017 and is now accredited through March 2021.

II. METHODS

Evaluation

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 Director 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 Director 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. 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 1999, 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).

Data provided in this evaluation may vary from reports provided periodically throughout the year, as the database is continually updated with the most recent information available at any given time. Information provided here is current as of August 31, 2018.

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. Most HFM families screened and assessed were identified at one of three Montgomery County Health Centers (Germantown, Silver Spring or Rockville/Dedicated Administrative Care Coordination Team). 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 Specialists (FRS), who then complete assessments on families based on their eligibility and their due date.

During FY18, 562 screens were received by HFM. 97% came from the 3 Montgomery County Health Centers; the remainder were referred from Mary's Center, the SMILE program, or local high schools. Almost all women were referred prenatally (99%). ***Figure 1. Screen Outcome Summary, FY18*** below shows the breakdown and dispositions of all screens received. 89% (502) 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 Specialists using the HFA Parent Survey tool. Of the screens received in FY18, 179 have been assessed thus far. This represents 36% of all positive screens, or 32% of all screens. This is a significant increase over the previous year, when only 25% of positive screens could be assessed. HFM added a second FRS this year, allowing the program to address a broader portion of the referrals. Note that FY18 screens will continue to be assessed in FY19 as the mothers' due dates approach. (#BPS 1-1.C)

FIGURE 1. SCREEN OUTCOME SUMMARY, FY18

HFM received 562 screens in FY18.

Out of 562 screens, 502 (89%) were positive
60 (11%) were negative

Out of 502 positive screens received in FY18,
179* (36%) were assessed
323* (64%) were not assessed (#BPS1-2.D)

Out of 323 positive screens that were not assessed,
81 could not be located
72* still pregnant
28 client declined
12 no longer pregnant when contacted
8 inappropriate referrals
9 other (referred to EHS, language, inappropriate ref)
113 lack of resources or past due date before FRS able to contact

* as of 8/31/2018. The number of FY18 screens which are assessed will continue to grow as due dates for these individuals approach.

Assessment

From the total pool of positive screens received, 181 families were assessed during FY18. These are not necessarily FY18 screens, the screen dates range from 1/5/17 – 6/7/18. Screens from the rest of FY18 will continue to be processed in FY18 as their due dates approach.

Figure 2. Assessment Outcome Summary, FY18 shows the breakdown: of the 181 families assessed in FY18, 75% (136) were positive and considered eligible for services. Due to limited capacity, 99 have been offered services thus far, representing 73% of positive assessments. 60 accepted and have been enrolled in HFM, representing 61% of those offered services.

181 assessments, 36% of all positive screens, is a significant increase over the previous year, when only 25% of positive screens could be assessed. HFM added a second FRS this year, allowing the program to address a broader portion of the referrals.

FIGURE 2. ASSESSMENT OUTCOME SUMMARY, FY18

There were 181 individuals assessed in FY18.

Out of 181 assessments, 136 (75%) were positive
45 (25%) were negative, referrals were given

Out of 136 positive assessments,
99 (73%) were offered services
60 (61%) accepted services, enrolled
39 (39%) refused services

25* are still pending, due date not yet passed
12 were not offered services due to full caseload

* as of 8/31/2018, may be offered services as due dates for these individuals approach and caseload capacity allows.

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:

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

Currently available data for all individuals assessed in FY18, as seen in ***Figure 2. Assessment Outcome Summary, FY18*** above, indicate an acceptance rate of 61% (99 offered services, 60 accepted and enrolled.) Because there are still outstanding assessments for this cohort, we can look at data for all individuals assessed in calendar year 2017 (CY17) for a more complete picture. As shown in ***Figure 3. Acceptance Rate, CY17,*** below, the acceptance rate for this group is 64% (88 offered services, 56 accepted and enrolled.) (#BPS 1-4.A)

FIGURE 3. ACCEPTANCE RATE, CY17

There were 131 individuals assessed by HFM in CY17.

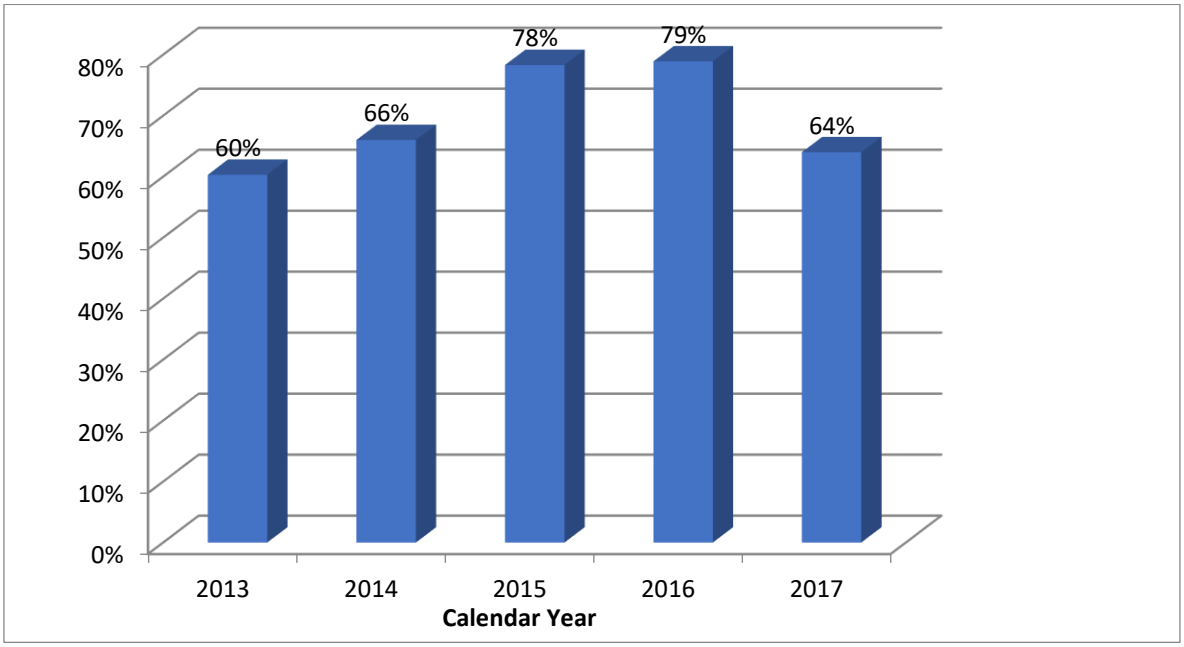
Out of 131 assessments, 99 (76%) positive
32 (24%) negative, given referrals for other community resources

Out of 99 positive assessments,
88 (89%) were offered services
56 (64%) accepted services, enrolled
32 (36%) refused services

11 (11%) were not offered services

Data for the past five calendar years is presented in ***Figure 4. Acceptance Rates*** below.

FIGURE 4. ACCEPTANCE RATES



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% of assessments to be prior to two weeks after baby's birth. ***Table 1. Eligibility Timeframe*** shows that 99% of assessments occurred within this time period. (#BPS 1-2.C)

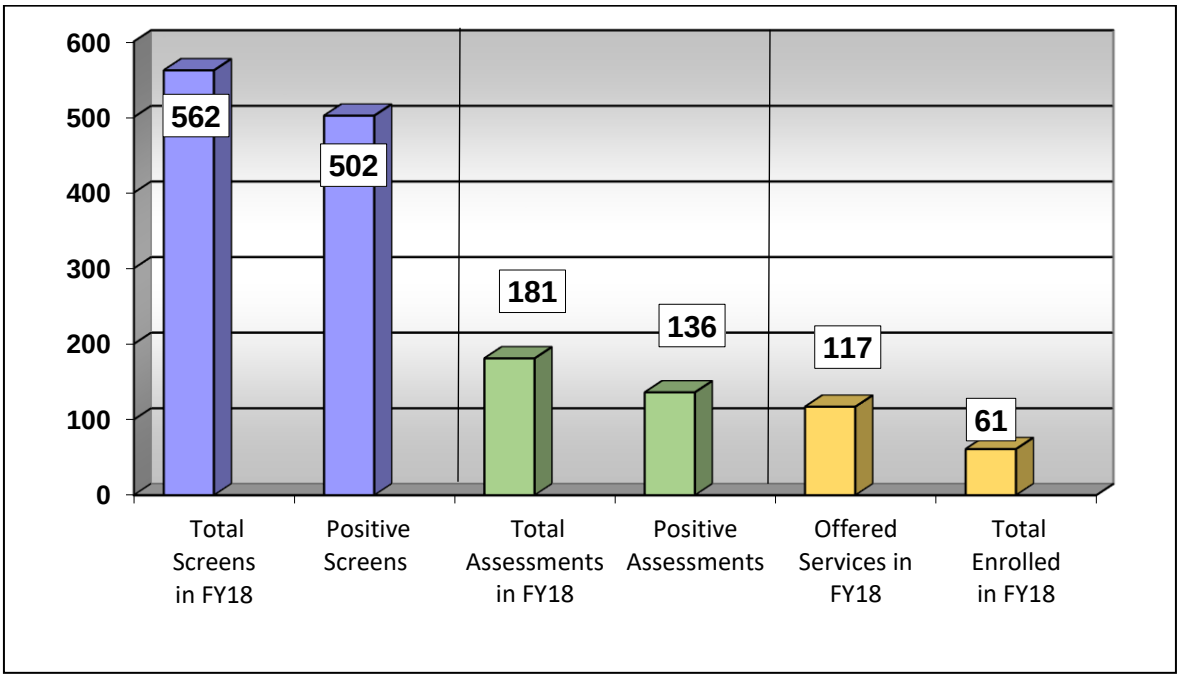
TABLE 1. ELIGIBILITY TIMEFRAME

Time of Parent Survey	Number of surveys (assessments)	% of total
Prenatal	178	99%
Within 2 weeks after birth	2	
More than 2 weeks after birth	1	<1%
Total	**181**	**100%**

Summary

A total of 562 screens were received in FY18. 89% (502) of these were positive. A total of 181 mothers were assessed in FY18, from a pool of screens ranging 1/5/17 – 6/7/18. 75% (136) of these were positive. A total of 61 new participants were enrolled in FY18, from a pool of assessments ranging from April 2017 – May 2018. Ultimately, only approximately 12% of positive screens result in enrollment due to limited capacity. ***Figure 5. Summary of Screens, Assessments, Enrollments*** below shows a graphical representation of the progression from screens to enrollments.

FIGURE 5. SUMMARY OF SCREENS, ASSESSMENTS, ENROLLMENTS



Home Visiting

Home visits are the core of the HFM program and are 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.

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.

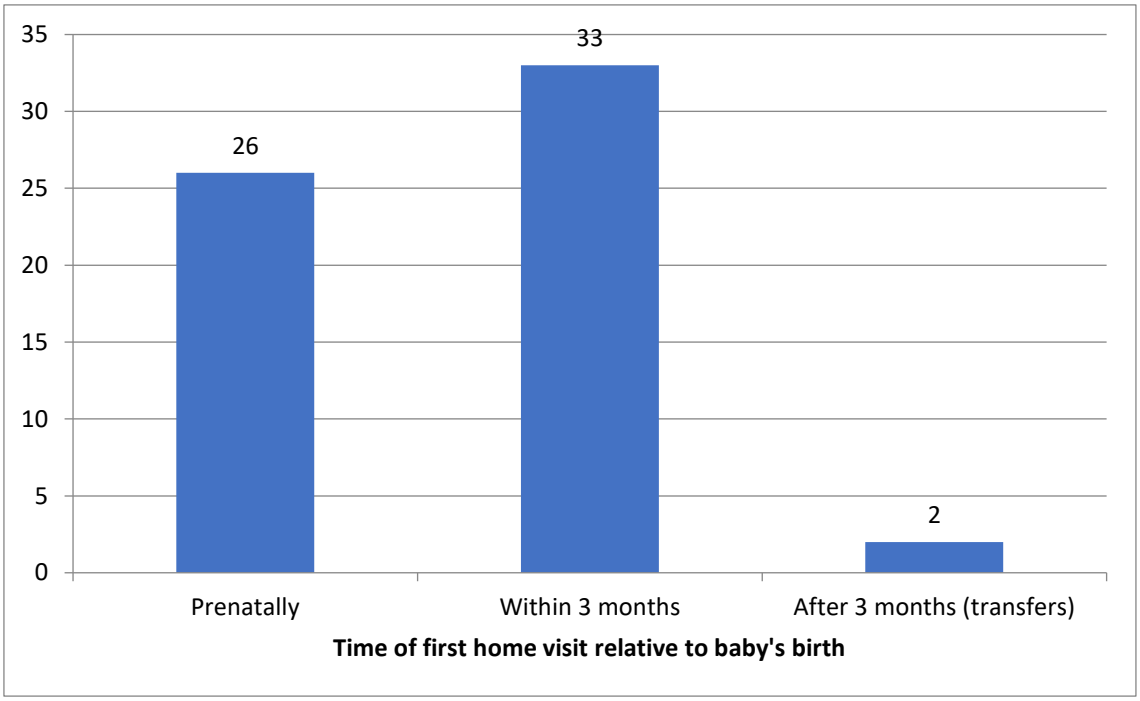
First Home Visit

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. ***Table 2. First Home Visit Timeframe, FY18*** shows that all 59 non-transfer enrollments had their first home visit before or within 3 months after baby's birth. There were 2 transfers from other Healthy Families sites, the children were 6 and 7 months old at the time of enrollment. (#BPS 1-3.B)

TABLE 2. FIRST HOME VISIT TIMEFRAME, FY18



Intensive Services for New Families

The first 6 months of involvement with a family 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, 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 6 months of intensive services for families served in FY18, we must look at those starting service 1/1/2017 – 12/31/2017 (those who enrolled in the second half of FY18 have not yet received services for 6 months). ***Table 3. Intensive Services for New Families, CY17*** shows that of 36 families who

initiated services during this timeframe, 10 terminated service prior to 6 months. 26 remained in the program for at least 6 months and received intensive services for at least 6 months. (#BPS 4-1.B)

TABLE 3. INTENSIVE SERVICES FOR NEW FAMILIES, CY17

Terminated before 6 months of service	10
Enrolled prenatally, received 6 months of intensive services after birth of baby	7
Enrolled postnatally, received 6 months of intensive services after enrollment	19
Total enrollments during period	36

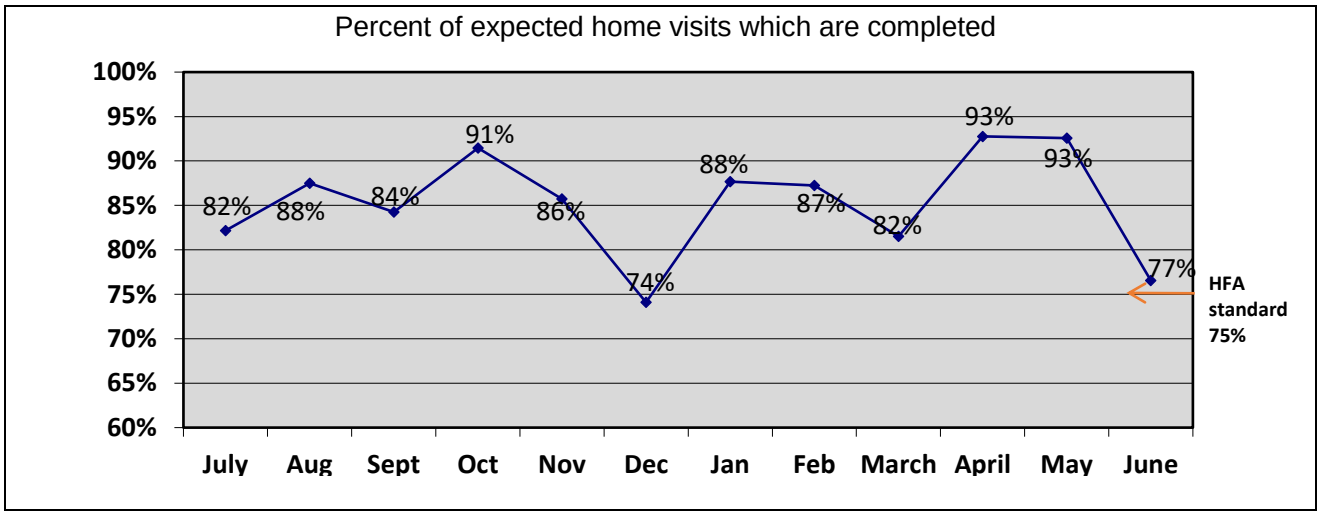
Service Levels

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. When 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. When 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 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. Families who are out of the service area temporarily are assigned to Level TO. When an FSW is unavailable, a family may be temporarily reassigned to a new FSW, and is placed on Level TR. HFM monitors the number of home visits expected and completed based on the FSW's caseload on a monthly basis and consistently exceeds national standards for intensive home visiting compliance.

Home Visiting Completion

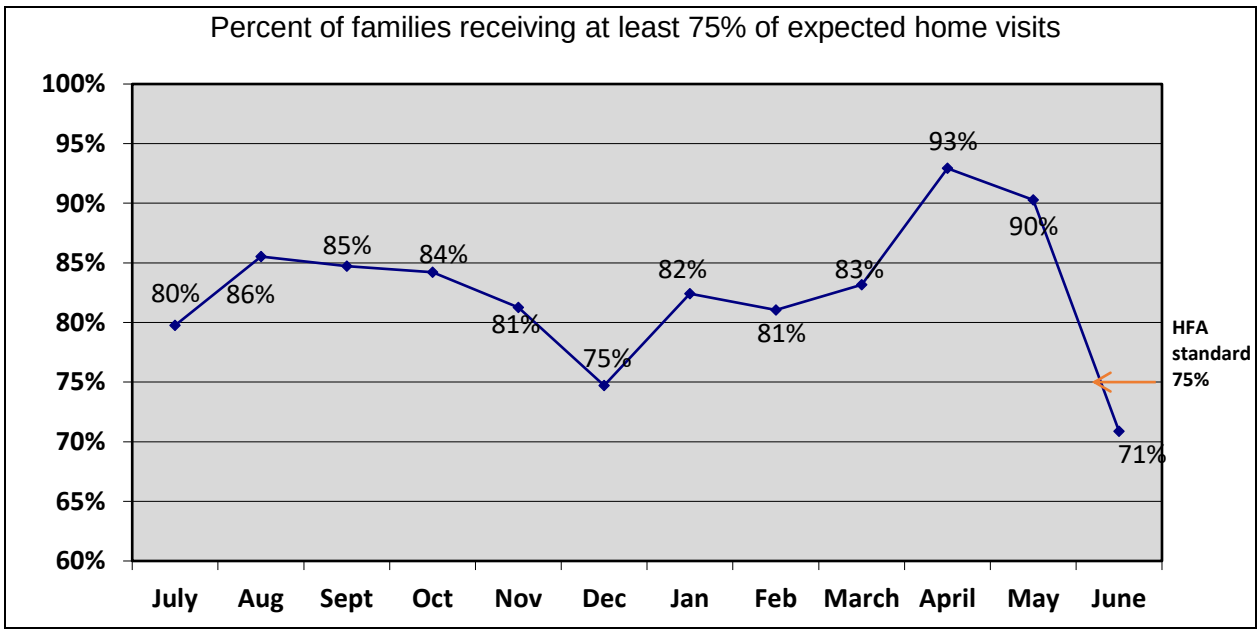
The HFM program monitors home visit completion, which compares the number of expected home visits (HV) each month according to each FSW's caseload to the number that are completed. The expected number of home visits per family is determined by service level. As seen in ***Figure 6. Home Visit Completion by Month, FY18***, completion rates for all but one month 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 85% for FY18.

FIGURE 6. HOME VISIT COMPLETION BY MONTH, FY18



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 a measure of site-wide expected vs. completed visits. This compliance measure, percent of families receiving at least 75% of expected home visits, is demonstrated in ***Figure 7. Home Visiting Compliance by Month, FY18***. Every month except June 2018 meets or exceeds the 75% goal set by HFA.

FIGURE 7. HOME VISITING COMPLIANCE BY MONTH, FY18



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 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.

26 participants were on creative outreach at some point during FY18. 12 returned to normal service level after being on creative outreach for a range of 24 – 89 days. 13 eventually terminated services, 1 was still on creative outreach. ***Table 4. Participants on Creative Outreach*** shows a breakdown of all participants who were on creative outreach at any time during FY18.

Of the 13 who terminated services while on outreach, 3 graduated from the program, 2 moved out of the area. 7 disengaged voluntarily due to scheduling conflicts with their jobs or for personal reasons. 1 was terminated by HFM because the family could no longer be reached after 92 days. Healthy Families America standards mandate that families are not terminated by HFM until they have been on creative outreach for over 90 days. (#BPS 3-3.B)

TABLE 4. PARTICIPANTS ON CREATIVE OUTREACH

26 participants were on creative outreach at one or more times during FY18:	# Days on Creative Outreach:
1 still on creative outreach	
12 returned to service	24 - 89 days
3 graduated after completing all program requirements	44 - 119 days
2 moved out of the service area	21 - 90 days
7 actively terminated services while on creative outreach, primarily due to scheduling conflicts with their jobs	23 – 83 days
1 was terminated because HFM was no longer unable to contact the participant	92 days

Standardized Assessments

Standardized assessments are conducted by FSWs during home visits. 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 5. 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-3 and ASQ:SE-2. 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 5. HFM INSTRUMENT ADMINISTRATION MATRIX

Measure	Domain	# Items/ Admin Time	Source	Data Points
Ages & Stages Questionnaire (ASQ-3)	Child Development	30 items/ 30 min	Parent & child	Baseline (baby 4 months old) then every four months
Ages & Stages: Social Emotional (ASQ: SE-2)	Child Social Emotional Development	30 items/ 30 min	Parent & child	Baseline (baby 6 months old) then every six months
Center for Epidemiologic Studies (CES-D)	Mental Health/ Maternal Depression	20 items/ 15 min	Parent	Baseline (prenatally and/or postnatally 2-3 months) then annually
Home Safety Measure Version 5	Home Safety	9 items/ 5 min	Parent	Baseline (enrollment) then annually
Healthy Families Parenting Inventory (HFPI)	Parenting skills and behavior (9 subscales)	63 items/ 20-30 min	Parent	Prenatally, Baseline (baby's birth) then annually
Relationship Assessment Tool	Intimate Partner Violence	10 items	Parent	At time of Parent Survey and annually after enrollment
Two-Item Conjoint Screen (TICS)	Alcohol and other drug problems	2 items	Parent	At time of Parent Survey and annually after enrollment

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 FSW, 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.

Table 6. Retention rates for years FY13 – FY17 shows the rate at various intervals for volume years FY13 through FY17. The 12-month retention rate for families enrolled in FY17 is 76%, a significant increase over 61.5% for FY16. This means that of the 29 families who enrolled in FY17 (and didn't leave due to moving out of the area), 22 (76%) stayed with the program for 12 months or more.

TABLE 6. RETENTION RATES FOR YEARS FY13 – FY17

Retention period	Enrolled in FY13* (n=14)	Enrolled in FY14* (n=38)	Enrolled in FY15* (n=38)	Enrolled in FY16* (n=44)	Enrolled in FY17* (n=29)
6 months	50%	71%	71%	70.5%	83%
1 year	21%	50%	50%	61.5%	76%
2 years	21%	37%	42%	48%	
3 years	21%	29%	** 24%		

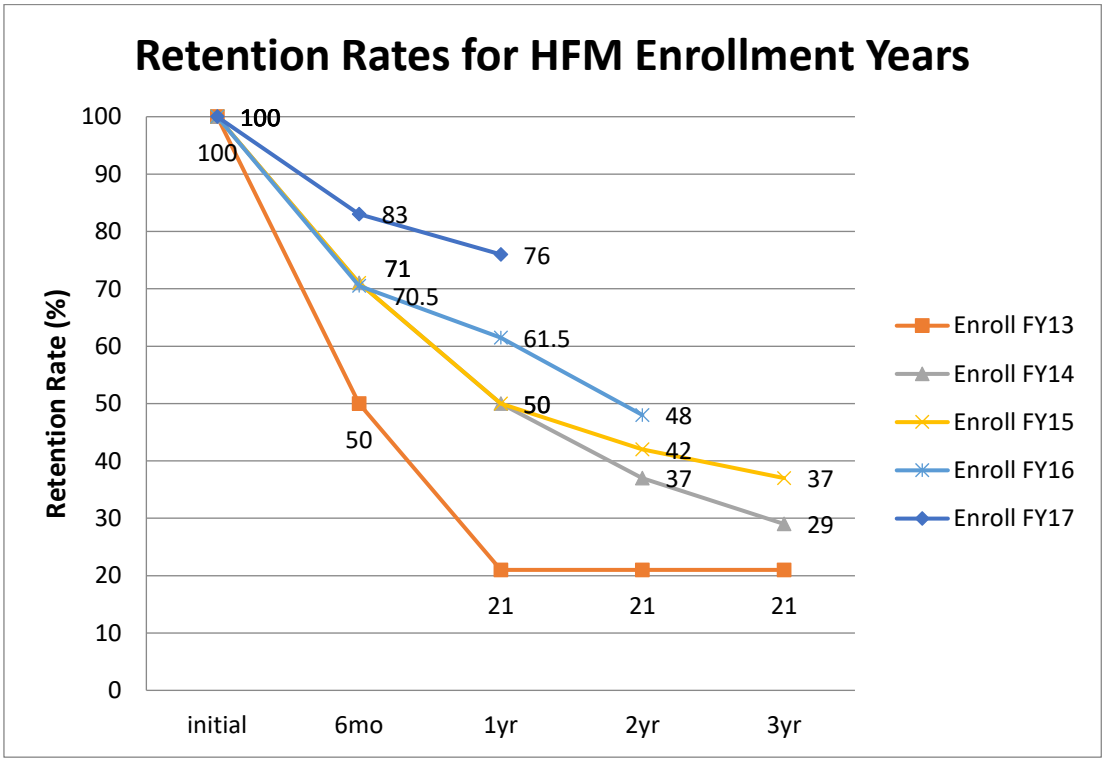
* Number enrolled during timeframe, excluding those who terminated services because they moved out of the service area.

** While FY15 3-year retention rate appears lower than would be expected, 4 participants graduated at 35 months after meeting all program goals. Adjusting for this, the rate is 37%.

Highlighted cells include participants served in FY18

As demonstrated above, 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 76% in the FY17 volume year. 24-month retention has increased from 21% to 48%. This trend is demonstrated in ***Figure 8. Retention Rates for HFM Enrollment Years FY13 – FY17.***

FIGURE 8. RETENTION RATES FOR HFM ENROLLMENT YEARS FY13 – FY17



Demographics and Risk

143 families (138 children) were served by HFM in FY18. Of these, 82 families enrolled prior to the start of the year, and 61 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. (#BPS 5-1)

Age

Mother's age is an important factor in determining initial parenting abilities. 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 ***Figure 9. Mother's Age Groups at Program Entry*** shows, the 143 mothers served in FY18 range in age from 15-41 years at program entry, with the majority between 20-25 years. The program is showing a trend towards enrolling younger mothers; the portion of teens has risen over the past three years from 10% to 21%.

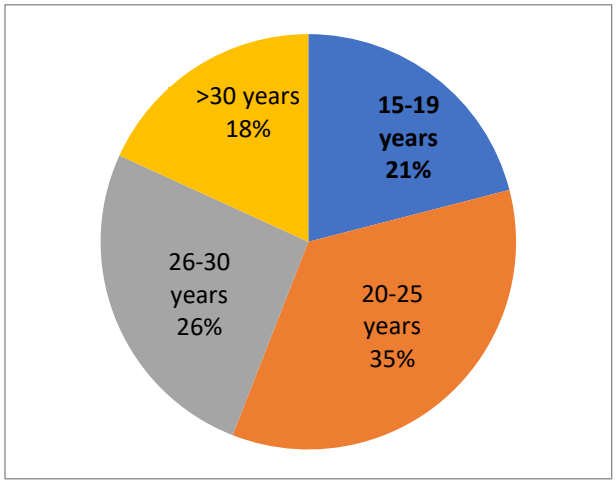
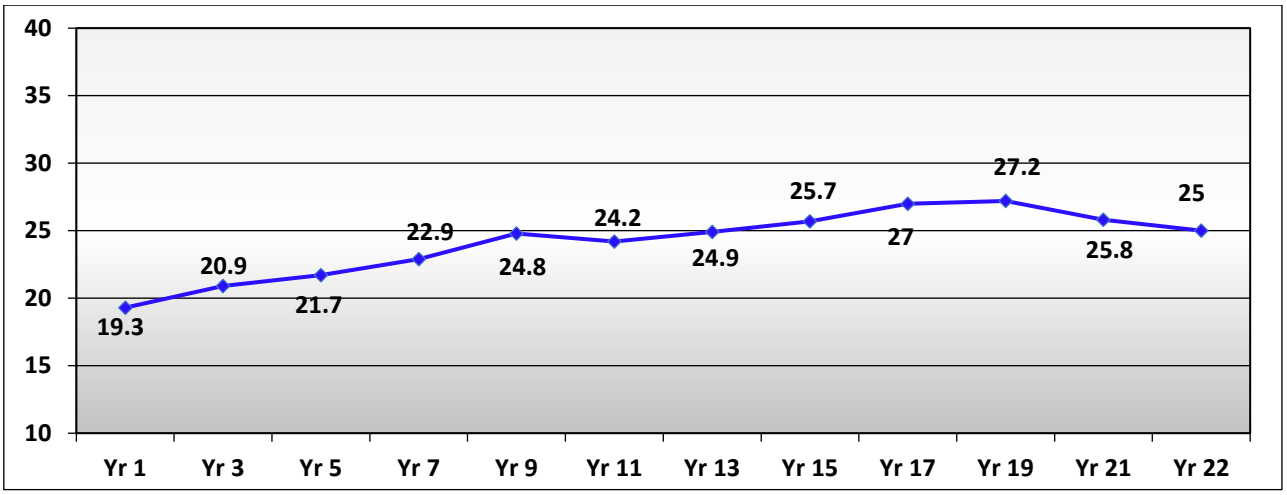


FIGURE 9. MOTHER'S AGE GROUPS AT PROGRAM ENTRY

The mean age at program entry of those served in FY18 is 25 years, slightly lower than the previous year. Data collected across all program years on mother's age at enrollment is shown in ***Figure 10. Mean Ages of Program Enrollees, Years 1-22.*** As more teen mothers are enrolled, the previous upward trend toward increasingly older participants entering the program has now turned towards a cohort of younger participants. This trend is expected to continue, as the mean age of those enrolled in this program year alone is 23.

FIGURE 10. MEAN AGES OF PROGRAM ENROLLEES, YEARS 1-22



Ethnicity

Ethnicity and cultural factors are potent mediators of parenting knowledge, values, and behavior. 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 (95%), as shown in ***Figure 11. Mothers' Ethnicity***. This is an increase from 92% three years ago. The remaining mothers were African, Asian-Pacific Islander and Caucasian.

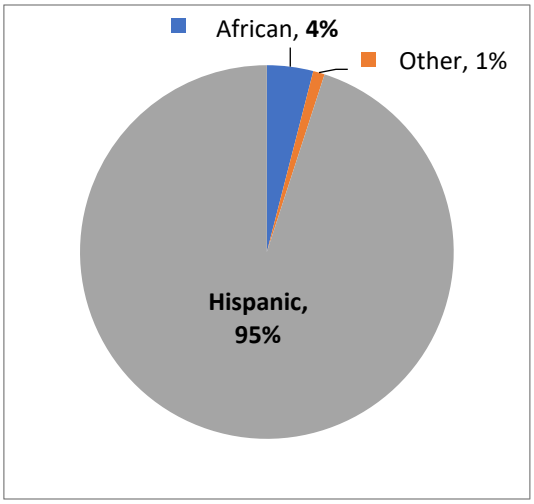


FIGURE 11. MOTHERS' ETHNICITY

Language

Reflecting the cultural findings described above, the majority of participants speak Spanish (see ***Figure 12. Mothers' Primary Language***). 85% cited Spanish as their primary language, while 12% spoke English and 3% 'Other', including French, Malagasy and Portuguese. Of the mothers who report Spanish or another language as their primary language, 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.

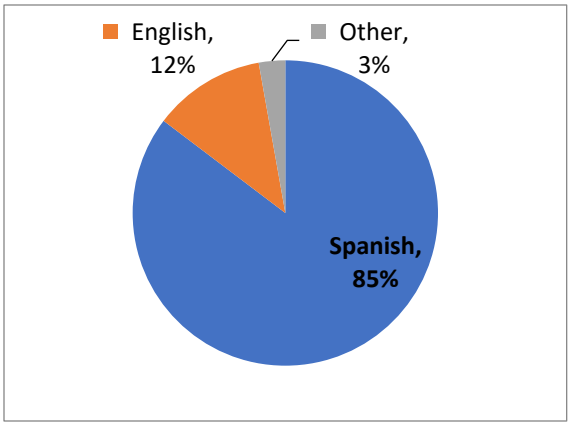


FIGURE 12. MOTHERS' PRIMARY LANGUAGE

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 13. Mothers' Marital Status***, most participants were living with their partner (48%) but not married. Over one-third were single. Some mothers were married (10%), and three are separated or divorced. Overall, 88% 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.

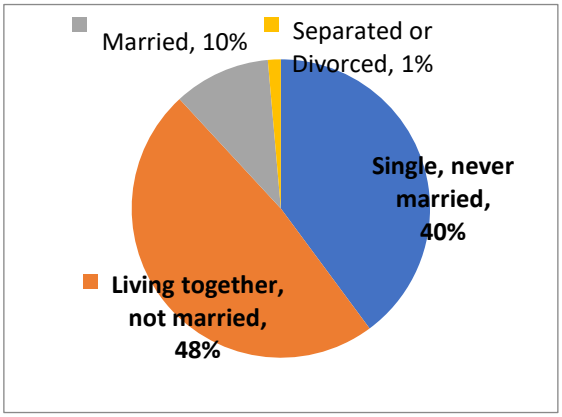
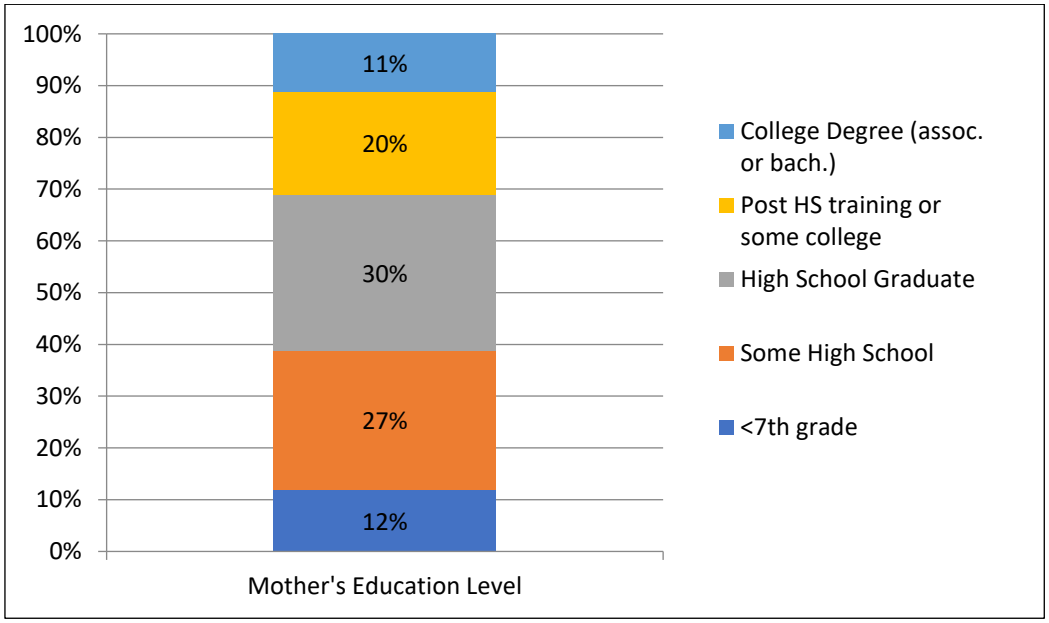


FIGURE 13. MOTHERS' MARITAL STATUS

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 diploma and increased scores on measures of parenting knowledge. In examining the highest level of education achieved at enrollment, over half (61%) of active participants had obtained at least their high school diploma or GED at the time of entry. As seen in ***Figure 14. Mothers' Education Status at Program Entry***, 30% held only a high school diploma, 20% had some post high school training or college, and 11% held an Associates or Bachelor's Degree. However, 39% had no high school diploma; 12% with less than 7th grade education. 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. FSWs provide links to resources for ESOL and GED classes.

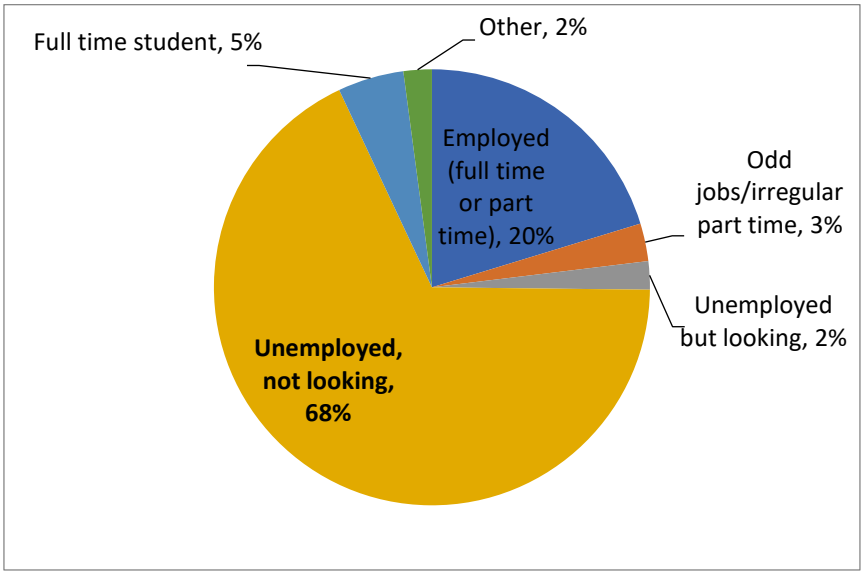
FIGURE 14. MOTHERS' EDUCATION STATUS AT PROGRAM ENTRY



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 15. Mothers' Employment Status at Enrollment,*** the majority of mothers (73%) were unemployed or had only odd-job arrangements at enrollment; most (68%) were not looking for employment. 20% were employed, either full-time or part-time, and 5% were in school full time. 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% three years ago, reflecting the increased number of teens enrolled in the program.

FIGURE 15. MOTHERS' EMPLOYMENT STATUS AT ENROLLMENT

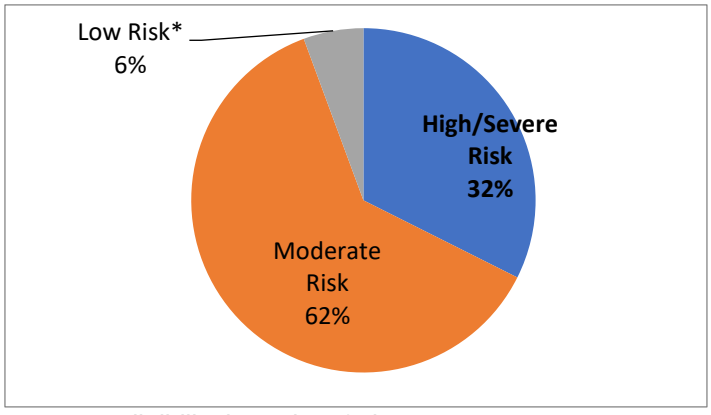


Risk Factors

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 or greater risk for child abuse and neglect, many families present a constellation of factors that place them at severe risk. As seen in ***Figure 16. Parent Survey Risk Scores***, 32% of mothers scored in the High/Severe Risk range, while most mothers (62%) scored in moderate risk range.

FIGURE 16. PARENT SURVEY RISK SCORES



** Eligibility based on father score*

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 22 for the six most significant risk factors based on mean score are displayed in ***Table 7. 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 7. RISK FACTORS WITH HIGHEST MEAN SCORE

Parent Survey Risk Factor	Mean Score*
Social isolation/Depression	7.1
Being Abused as a Child	7.1
Multiple Stressors	5.1
Poor Bonding	5.0
Unrealistic expectations	4.4
Mental Health/Substance Abuse	4.1

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

The mean score for "Violence Potential" was 0.5, and for "Harsh Punishment" it was 0.9. The remaining factors, Previous/Current CWS Involvement and Difficult Child, did not apply to any of the participants in this cohort. The complete picture for each participant assists 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.

The pattern that emerges from the Year 22 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 FY18, there were 138 children served by HFM and *100% 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, *98% 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. (#BPS 7-1.B)

HFM also works to ensure that all adult participants are connected to health care providers. *99% (142/143) of all enrolled mothers 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 FY18 there were 24 children who reached age one and 32 children who had reached age two during the year. *100% of all one and two-year olds had at least the required immunizations for that time period.* (#BPS 7-2.B, 7-2.C)

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, when 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.

There were 138 mothers with at least one child. 7 of these mothers had a subsequent birth (second child or later) during the year. 3 of these were less than 24 months after the birth of the prior child. *98% (135/138) 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. In FY18, 42 mothers were due for postpartum checkups*; 86% (36/42) mothers are known to have received timely postpartum care.* 3 did not, and 3 are unknown as they were on creative outreach and subsequently terminated.

Completion rate of 86% is 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 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 FY18, 21 mothers were enrolled prenatally. Only one was enrolled in the second trimester; the baby was of healthy birth weight (2750 grams). *100% of mothers enrolled in the prior to the third trimester had a baby at a healthy birth weight (2500+ grams).* All the rest were enrolled in the third trimester. 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 FY18, *100% (21/21) 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/

Drug and Alcohol Screening

In May 2016, HFM began screening for alcohol and other drug issues using the Two-Item Conjoint Screen (TICS), developed by Richard L. Brown, MD, MPH. All potential participants are initially screened at the time of assessment (Parent Survey) to aid in identifying risk factors and challenging issues facing families, and annually thereafter. 76 participants were screened in FY17, and 111 participants were screened in FY18. Any time potential problems are flagged, referrals to resources are provided. 9 participants initially screened positive. 5 of these have subsequently been rescreened, only one of which still indicated potential for alcohol and other drug problems. (#BPS 6-1)

Intimate Partner Violence

In January 2017, HFM began screening for intimate partner violence (IPV) using the Relationship Assessment Tool (RAT), developed by Dr. Paige Hall and colleagues. The tool contains a series of 10 statements asking how safe a woman feels, physically and mentally, in her relationship. Baseline screening is done by FSWs within 3 months of enrollment, and annually thereafter. Since that time, 94 screens have been administered to 86 unique mothers. To date, 4 women have scored 20 or higher, which is considered positive for IPV. The issues are addressed by FSWs, referrals are made as appropriate, and a safety plan is developed. (#BPS 6-1)

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 Montgomery County Child Welfare Services semiannually.

Data from Montgomery County Child Welfare Services for the period between July 2017 and June 2018 indicates that of active families during this time, *100% 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, intervention services can be provided quickly, 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.

[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/

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. 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-3) 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. When the results of an ASQ-3 or ASQ:SE-2 indicate a concern, the FSW and supervisor discuss how best to proceed. For some children, it may be simply a matter of not having had the opportunity to develop a particular domain. In this case, parents are given guidance about how best to stimulate the child. Otherwise, a referral is made to Montgomery County Infants and Toddlers Program (MCITP) or Child Find, depending on the age of the child.

HFA standards indicate that, using the ASQ-3 instrument, at least 90% of children served (excluding those when developmentally inappropriate) are screened a minimum of twice per year for children under the age of three. Of the 138 children served in FY18, 99 were due for ASQ screening during their enrollment this year (children > 5 months who were enrolled as of time of next due screening). 3 of these were not screened due to previously confirmed delays; these children are currently receiving services from the Montgomery County Infants and Toddlers program. *Excluding these, 99% (95/96) received a timely ASQ screening during the year.* The HFM rate for developmental screening of participating children far exceeds the comparable national rate of 30%.[7](#BPS 6-5.B)

HFA standards also indicate that at least 90% of children served (excluding those when developmentally inappropriate) are screened annually using the ASQ-SE:2 for Social Emotional development. Out of 138 children served in FY18, 86 were due for ASQ-SE:2 screening during their enrollment this year (children > 7 months who were enrolled as of next due screening). 4 of these were not screened due to previously confirmed delays; these children are currently receiving services from the Montgomery County Infants and Toddlers program. *Excluding these, 100% (82/82) received a timely ASQ-SE screening during the year.*

Identify Potential Delays and Refer for Early Intervention Services

According to the CDC, during 2016 the prevalence of children aged 3–17 years who had ever been diagnosed with a developmental disability, intellectual disability, Autism spectrum disorder, or other

[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] Hirai AH, Kogan MD, Kandasamy V, Reuland C, Bethell C. Prevalence and variation of developmental screening and surveillance in early childhood. JAMA Pediatr. Published online July 9, 2018. https://jamanetwork.com/journals/jamapediatrics/article-abstract/2686728.

developmental delay was 15.5%.[8] In 2015, approximately 15%[9] of U.S. children had developmental delays that would qualify them for Part C early intervention services.[10] Child Trends reports that the prevalence of children ages 5 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 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.

HFM tracked 20 children with suspected or confirmed delays and provided follow up as needed. Children are often identified as a result of ASQ-3 or ASQ:SE-2 screening. FSWs may contact the appropriate service providers, but often encourage parents to become involved and learn to advocate for their children by making the call themselves. This is an important step in parental development. Children are evaluated by the providers and may receive services from Child Find/PEP or MCITP. In FY18, *99% 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. Participants are deemed to be at risk based on their score in each of these subscales.

Percentages for those deemed at-risk were calculated for each subscale at baseline (participants' first HFPI screen) and at 12-month follow-up. As seen in ***Table 8. HFPI Subscales-Percentage of Mothers Score At-Risk***, the percentage of mothers at risk in most domains decreased by the time they had been in the program for 12 months. Mothers' risk increased from enrollment to 12-months only for Depression. It is not surprising that this domain would increase in the year following the baby's birth, as mothers may develop post-partum depression and face increased responsibility. By 24 months, the category of Mobilizing Resources showed a dramatic decrease (17%) in mother's risks. This is encouraging, as this is one of the key skills FSWs focus on. Risks were higher than at baseline in 5 subscales: Role Satisfaction, Social Support, Parent-Child Behavior, Parenting Efficacy, and Depression. FSWs use the individual scores to work on decreasing parents' risks.

[8] CDC, November 2017, Estimated Prevalence of Children with Diagnosed Developmental Disabilities in the United States 2014-2016. Zablotsky, Black, Blumberg. Available at https://www.cdc.gov/nchs/products/databriefs/db291.htm

[9] 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

[10] 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

TABLE 8. HFPI SUBSCALES-PERCENTAGE OF MOTHERS SCORE AT-RISK

Subscale	Percent at Risk				
	Baseline (n=123)	12- month (n=77)	Change from Baseline	24-month (n=50)	Change from Baseline
Role Satisfaction	25%	17%	↓	30%	↑
Mobilizing Resources	21%	9%	↓	4%	↓
Social Support	21%	19%	↓	30%	↑
Parent-Child Behavior	19%	12%	↓	22%	↑
Personal Care	18%	14%	↓	16%	↓
Problem Solving	16%	13%	↓	16%	-
Parenting Efficacy	16%	16%	↓	18%	↑
Home Environment	15%	6%	↓	10%	↓
Depression	15%	17%	↑	24%	↑

Parents' Knowledge of Child Development

For all families served in FY18 who have received a 12-month HFPI assessment, *84% demonstrated adequate knowledge of child development based on the Parenting Efficacy subscale at 12 months*.

Parent's Having Positive Parent-Child Interaction

For all families served in FY18 who have received a 12-month HFPI assessment, *88% demonstrated positive parent-child interaction based on the Parent-Child Behavior subscale at 12 months*.

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 Home 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.

Of the families served in FY18, available scores indicate that 96% (116/121) demonstrated knowledge that would make their homes completely or almost completely safe upon enrollment. *At the 12-month follow-up, 99% (80/81) 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 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. Mothers are screened prenatally at the time of assessment, even if they are not yet enrolled. 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 screening: Of the 26 mothers who were served prenatally during FY18, 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. (#BPS 7-4.B)

Postnatal screening: HFM also screens all mothers for depression within 3 months after the baby's birth. 61 mothers were enrolled during FY18. 9 were still pregnant or the baby was less than 3 months at the most recent home visit. Out of the remaining 52 mothers, 98% (51/52) had a postnatal CES-D screen within 3 months of the birth of the baby. (#BPS 7-4.C)

Depression screening is done annually throughout a mother's enrollment. ***Table 9. 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 FY18, the timepoints are any time during their service. Results highlight the importance of the HFM program in ongoing screening for depression and linking participants to appropriate mental health professionals.

Among all participants served in FY18, the greatest period of risk of depression is prenatal (32%). All mothers are screened again after baby's birth, and the percentage of those at risk is 15%. This increases slightly at 12 months after the birth of the baby, and to 27% at 24 months. After that point it steadily declines.

TABLE 9. PERCENTAGE MOTHERS AT RISK FOR DEPRESSION

Timepoint	Number of screens	Number at risk for depression*	Percentage
Prenatal	95	30	32%
Baseline (after birth of baby)	133	20	15%
12-month	81	13	16%
24 month	55	15	27%
36 month	29	6	21%
* Based on CES-D screening			

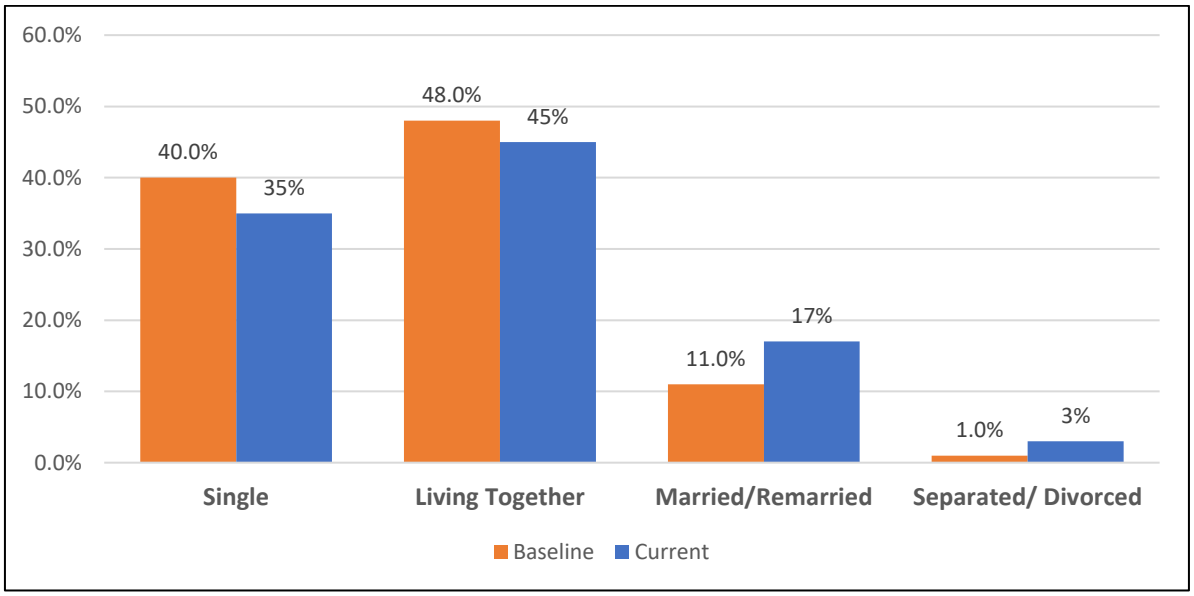
Goal V. Promote Family Self-Sufficiency

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

Marital Status

Following the trend in recent years, 59% were living together with a partner or married at the time of enrollment, 40% were single. At the most recent follow-up (end of FY18), 62% of mothers were living together with a partner or married, while only 35% were single. The percentage of mothers who were married increased from 11% at baseline to 17%, while 3% 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.

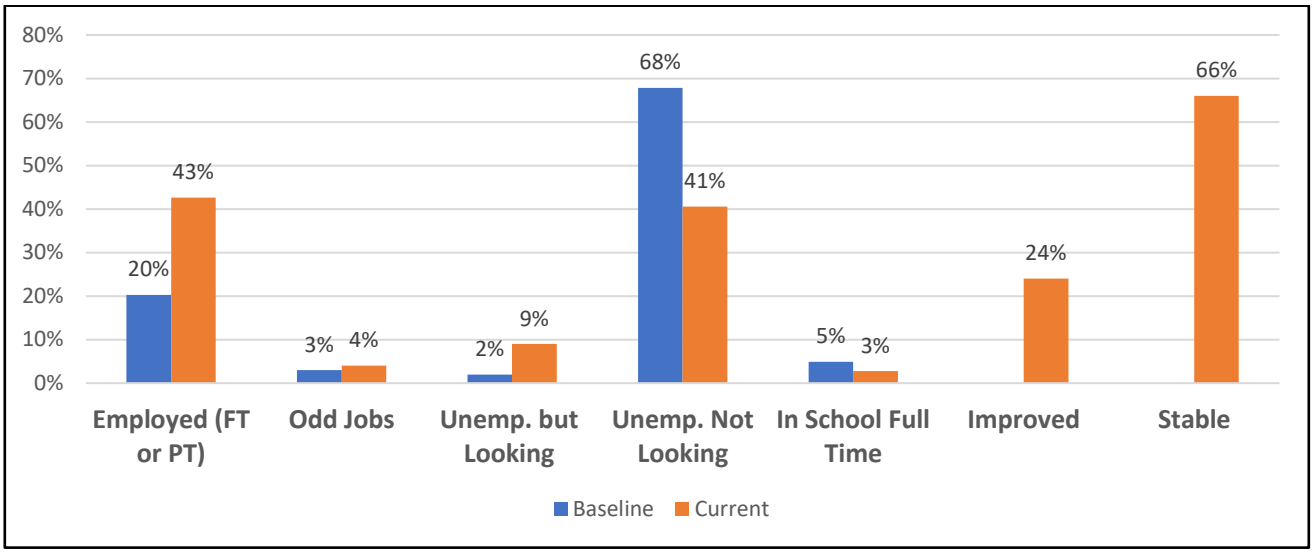
FIGURE 17. MARITAL STATUS FOLLOW-UP



Mother's Employment

At enrollment, 20% of mothers were employed either full or part-time. The majority of mothers were unemployed and not looking for employment (68%). An additional 5% were not employed 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 43%. Of the remaining mothers, 41% were unemployed and not looking for employment, but unemployed mothers actively seeking employment rose from 2% to 9%. 3% were in school full time at follow-up. Overall, 90% 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 18. EMPLOYMENT STATUS FOLLOW-UP

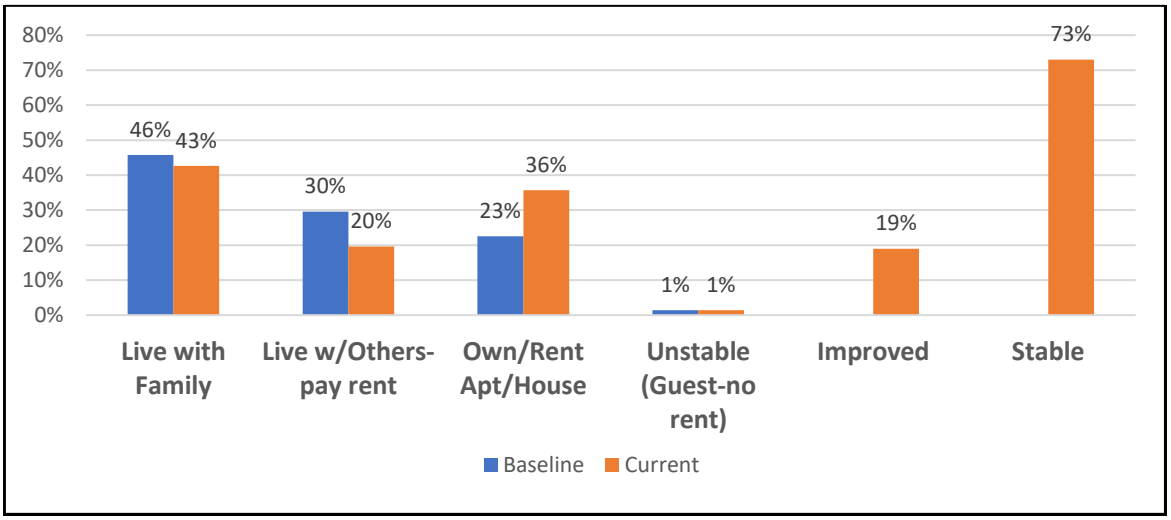


Housing

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 another'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 family members (46%), most of whom paid rent. Another 30% of mothers lived with friends and paid rent, while 23% either owned or rented their own house or apartment. The remaining mothers had unstable housing, they were living as a guest in another's home (1%). At follow-up, the percentage of mothers who owned or rented their own house or apartment increased to 36%. Overall, 92% of families had stable or improved housing.

FIGURE 19. HOUSING STATUS FOLLOW-UP



[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/

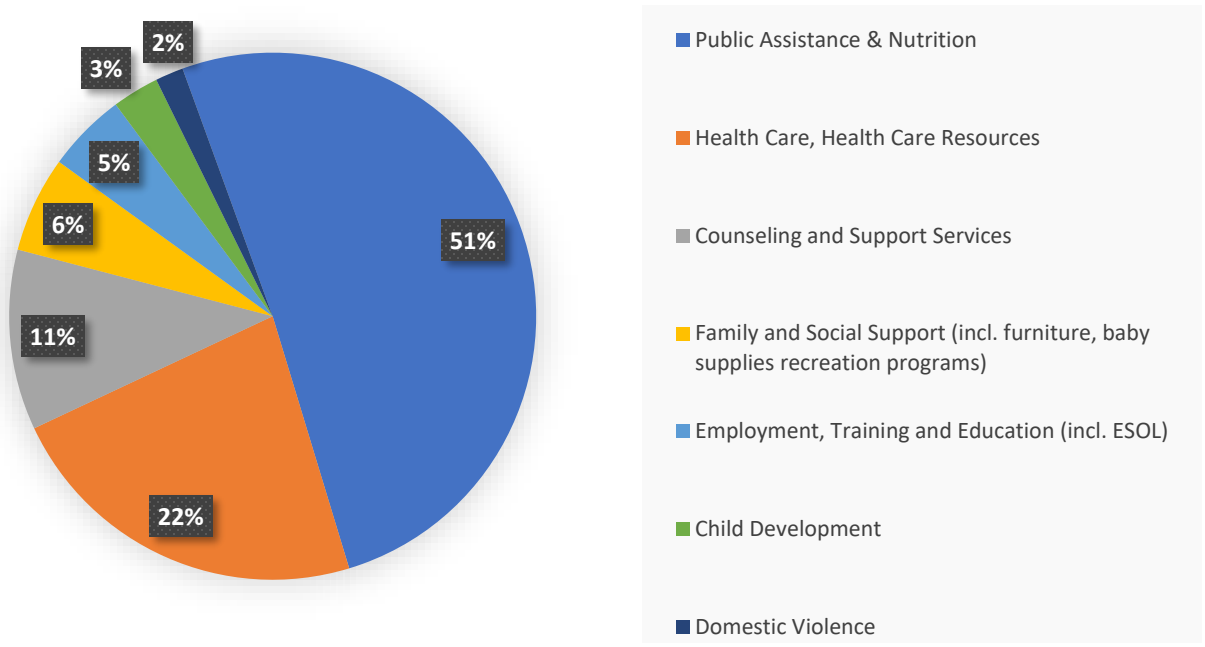
[12] HUD Exchange. *Chronic Homelessness*. (2016). Available at https://www.hudexchange.info/homelessness-assistance/resources-for-chronic-homelessness/

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.

Referrals

Family Support Workers provide families with referrals, resources and linkages to health care and community resources. 696 referrals were made in FY18, categorized as shown in ***Figure 20. Referrals for Community Resources.***

FIGURE 20. REFERRALS FOR COMMUNITY RESOURCES



Referral Service Type	Count
Public Assistance & Nutrition	354
Health Care, Health Care Resources	158
Counseling and Support Services	77
Family and Social Support, e.g. furniture, baby supplies, recreation programs	41
Employment, Training and Education, e.g. ESOL	34
Child Development	20
Domestic Violence	12
Total	**696**

Some referrals are purely informational. For those involving arrangements or intervention by the FSW, the FSWs follow-up on whether services were received, reasons which may be interfering with receiving services, or other appropriate services needed. 319 of the referrals involved arrangements or intervention by the FSW, 82% (262) resulted in services successfully received by

the client. When services have not been accessed, FSWs work with the families and community resources to meet the families' needs. (#BPS 7-3.B,C,D)

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 10: HFM Goals and Outcomes, Year 22 (FY18)*** 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.

TABLE 10: HFM GOALS AND OUTCOMES, YEAR 22 (FY18)

Indicator	Goal	1Q	2Q	3Q	4Q	FY18
Goal I: Promote Preventive Health Care						
Children with a healthcare provider (for children who are at least two months old)	95%	100%	100%	100%	100%	100%
Eligible children enrolled in MA, including non-target children	95%	98%	98%	97%	99%	98%
Children with current immunizations	90%	99%	100%	99%	100%	100% *
Mothers who have no additional birth within 2 years	90%	100%	99%	100%	99%	98%
Mothers who have completed postpartum care	85%	75%	73%	100%	93%	86%
Currently active mothers with a healthcare provider	95%	100%	100%	100%	99%	100%
Mothers enrolled < third trimester, child will have healthy birthweight	95%	100%	100%	100%	100%	100%
* As of the end of FY18, all children were up to date with 1-year and 2-year immunizations						
Goal II: Reduce Incidence of Child Maltreatment						
Enrolled families will not have substantiated CWS reports	95%	100% [1*] 102/102		100% [2*] 120/120		100%
[1*] HFM receives aggregated reports from Child Welfare Services semiannually. Results are for second half of FY17. [2*] HFM receives aggregated reports from Child Welfare Services semiannually. Results are for first half of FY18						
Goal III. Optimize Child Development						
Children will demonstrate normal child functioning or receive appropriate services	95%	98%	100%	99%	100%	99%
Goal IV. Promote Positive Parenting and Parent-Child Interaction Reported semi-annually						
Parents will have adequate knowledge of child development at 12 months	85%		93%		89%	84%

Indicator	Goal	1Q	2Q	3Q	4Q	FY18
Parents having positive Parent-Child Interaction at 12 months	85%		89%		88%	88%
Parents' Knowledge of Child Safety	95%		100%		98%	99%
Goal V. Promote Family Self-Sufficiency Reported semi-annually						
Mother's Employment	65%		89%		44%	44%
Stable Housing	99%		99%		99%	99%

Comparative local, state and national statistics are presented in ***Table 11. Summary of Goals, Objectives, Outcomes and Comparative Statistics*** where possible and are used to measure HFM's impact on community indicators.

TABLE 11. SUMMARY OF GOALS, OBJECTIVES, OUTCOMES AND COMPARATIVE STATISTICS

Goals and Objectives	HFM TARGET	HFM Year 22	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%	98%		92% [11]	91% [3]
Children immunized on schedule*	90%	100%		77% [4]	73% [4]
Mothers will not have an additional birth within two years of the target child's birth.	90%	98%		Teens 85% [16]	Teens 82% [5]
Babies Born with Healthy Birthweight**	90%	100%	93% [14]	92% [8]	92% [8]
Mothers will complete post-partum care.	85%	86%		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.

**21 babies born into HFM in FY18, 100% had birthweight >2500g, 1 enrolled < third trimester

Data Sources for ***Table 11. Summary of Goals, Objectives, Outcomes and Comparative Statistics:***

[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]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 anonymously gather 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 22, 78 participants returned the survey. Those who returned the survey range from less than 6 months in the program (18%) to over a year (68%). Responses to the quantitative questions on the survey are shown in ***Table 12. Participant Perception of Program***. These results demonstrate, according to the families served, that HFM FSWs are meeting the objectives of the program: discuss parenting, child health, goal setting, connections to community resources, increasing parenting confidence. Cultural sensitivity is not only addressed but met through language, materials and respect. As a result of seeing that only 94% report knowing about the HFM Grievance Process (which is explained and signed at enrollment, FSWs are now discussing this with participants periodically throughout the year.

Table 12. Participant Perception of Program

How often does your home visitor talk with you about parenting your baby and your baby's health and development?	Most visits – 100%
How often does your home visitor bring an activity for you to do with your child?	Most visits – 90%
Does your home visitor come when she says she will, or call to reschedule?	Most visits – 93%
Have you and your home visitor talked about goals that you and your family wanted to work toward?	Yes – 100%
Has your home visitor offered to connect you with other agencies or programs that you are interested in?	Yes – 100%
Are you more confident that you can do a good job of raising your child because you are a part of Healthy Families Montgomery?	Yes – 100% (Yes, definitely – 95%)
Does your home visitor speak clearly to you in a language you understand?	Yes – 100%
Does your home visitor provide materials (videos, handouts, fliers, and brochures) that represent your race, language, and ethnicity (i.e. that look like you and your family)?	Yes – 100% (Yes, definitely – 92%)
Does your home visitor give you opportunities to share information about your culture?	Yes – 100% (Yes, definitely – 99%)
Does your home visitor respect and understand your culture and beliefs?	Yes, definitely – 100%
Does your home visitor respect and understand your parenting style and the choices you make for your children?	Yes, definitely – 100%
Do you feel safe when receiving services from Healthy Families Montgomery?	Yes – 100%
I know that the program has a Grievance Process that I can use if I have a concern.	Yes – 94%
Are the materials and information presented in a way that allows you to determine what is best for your child?	Yes, definitely – 100%
If you have attended any group gatherings, have you been satisfied with the group?	Yes – 96% (Yes, definitely – 91%)

Participants indicated that the following areas of their lives have improved since their partnership with HFM: 99% feel they have an improved ability to read child's cues, and 90% have a better understanding of child development and parenting. Over 75% also report more patience with their children's behavior, more confidence in problem solving, and a stronger support system. Over half indicate improved relationships with partners and family, appreciation for their children, and increased temper control. Every participant said they would recommend Healthy Families Montgomery to family and friends.

When asked what would make HFM a better program, 50% of the respondents took the opportunity to compliment the program instead: "the program is perfect as it is", "everything is good as is", "thank you", "I like the support the program provides for moms", "you've helped me a lot", "what you do is good and you have what is necessary to teach".

> "All of the activities are interesting. Please maintain this wonderful program for mothers. Thanks!"

> "I think this program is a complete package!"

Of the remaining mothers who offered suggestions for improvement, most expressed a desire for more or longer home visits, more opportunities for participants to socialize and network with other families. Four mothers requested transportation for group events. While the program is sometimes able to assist with metro access, a comprehensive transportation program is not a feasible option at this time.

In summary, HFM participants continue to report high levels of satisfaction with the program, year after year. Parents report that they 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. Finally, participants are so positive about the program that they would like to see longer visits, additional activities, and visits for their children beyond 3 years old.

19 families graduated from the program in FY18. Many provided feedback and thanks at that time. Following are some of their comments:

"Thanks for your time, dedication and advice related to parenting our son. Thousands of blessings and keep being a good FSW that with your experience and love makes it easier to understand each child's development."

"We have been very blessed to be part of the program. We thank you all, each and every one of the HFM team. The services that have been provided really helped us to grow as a real healthy family. Thank you for everything.; for the groups, we always enjoy good times with the team. We will never thank you all enough. May God bless you all."

"I am very grateful for the program. I wish more people had the opportunity to participate in the program to be able to spread the information and importance of education and well-being of the families."

"I want to truly thank you for everything the program has done for me and for my daughter through your workers. Thanks for everything you taught me. It's an excellent program. Your workers are even better. God bless the Family Support Workers always."

"My FSW is an amazing person. I don't like having to leave the program. I will miss my Family Support Worker a lot, but I am very grateful for being with us all this time. It was very helpful for me and my family. Thanks for all your help."

"Thanks for the support provided to my family. The education and knowledge we received from the workers are very good. God bless you and continue giving you the wisdom to share all you know with parents for them to learn good parenting skills, because our kids are the future of this country."

"It is such a great pleasure working with Family Services, Inc. My family wishes Family Services, Inc. all the best and a very special thank you to the Family Support Worker with whom we have been working. Thank you to all the Healthy Families Montgomery team."

"Just very grateful with each and every one of you for your patience, dedication and love with me and my daughter, and for teaching and listening to us during the time that you have been visiting us. With my humble words I wish you many blessings and continue doing what you do best: supporting us."

Success Stories

HFM has many stories of successful outcomes for families completing the program. Following are stories from families who graduated in FY18.

Naomi and Joseph are immigrants from the Middle East who enrolled in Healthy Families Montgomery before the birth of their baby. Joseph is the sole provider for the family since Naomi is a stay-at-home mom. Their son, Adam is 4 ½ years old. Joseph has been very involved with HFM, attending many home visits and group activities. Around Adam's second birthday the Family Support Worker (FSW) noticed some signs that could indicate a possible autism diagnosis. After discussions regarding concerns and observations, the FSW informed the parents about the resources available at the Montgomery County Infants and Toddlers Program (MCITP). Naomi made the call herself and Adam was assessed.

Adam had low scores in cognitive and language development and began receiving once a week therapy at home. Naomi is making every effort to make sure Adam learns and understands as much as possible. Following the FSW's suggestion, Naomi has made pictures of daily routines, foods, and other activities, and placed them on a wall for Adam to point at when he needs something. Naomi also taught him numbers up to 10 using flash cards. Adam is recognizing colors when Naomi reads the Brown Bear Book. Adam has made some good progress: singing children songs, putting together 5 pieces puzzle, recognizing shapes and making brief eye contact with Mom, Dad and the FSW.

Naomi is grateful for the support offered by the program. She said that without the FSW's support she wouldn't have been able to recognize Adam's delay and have access to resources. Additionally, the FSW encouraged Naomi to address her concerns about Adam's development with the pediatrician which led to a referral for a developmental pediatrician and a neurologist. FSW also provided information about First Time Home Buyer workshops and the couple was pre-approved to buy a house. Naomi wants to stay in Montgomery County to continue receiving services even though this is going to be a challenge due to the high cost of housing. The parents use community resources as needed and are very committed to the program.

Julie and Daniel lived in one room of an apartment that belonged to his mother when they began participating with HFM. He did not have a good relationship with his mother because she was not good to him. Julie, Daniel and their daughter Bella moved to a place of their own as soon as they were able, Julie handled the family's finances very well. When their child turned one year, she got a job and with the help of her Family Support Worker, found child care for her daughter. The couple was able to buy a car, which contributed to their independence. When the Family Support

Worker took another position at HFM, the family was assigned a new FSW who helped mom make connections with another HFM family. Throughout participation in HFM, Daniel attended home visits whenever he was able. The child's development was monitored regularly, and she was always on target. When the FSW noticed that Julie had labeled her child as shy, she helped mom to understand how labeling her child was not only inaccurate, but it could also affect the child's self-esteem. At graduation, Julie expressed her appreciation for "everything the program has done for me and for my daughter. Thanks for everything you taught me. It's an excellent program, your workers are even better."

Lisette was raised by non-relatives in Honduras. At intake, she was caring for her "father" who was very sick. Home visits were very difficult because she was tending to her "father's" needs. After her "father" passed away, she and her partner Manuel moved to their own place. Lisette was very consistent in attending her home visits. When her daughter's developmental screening indicated that the communication skills were low, the FSW worked closely with them to improve the child's vocabulary. Manuel has a construction company and works hard to save money so that the family can return to Honduras. At graduation. Lisette said that she is 'very grateful for the patience, dedication and love" for her family shown by the Family Support Workers who worked with them over the years.

V. STAFF

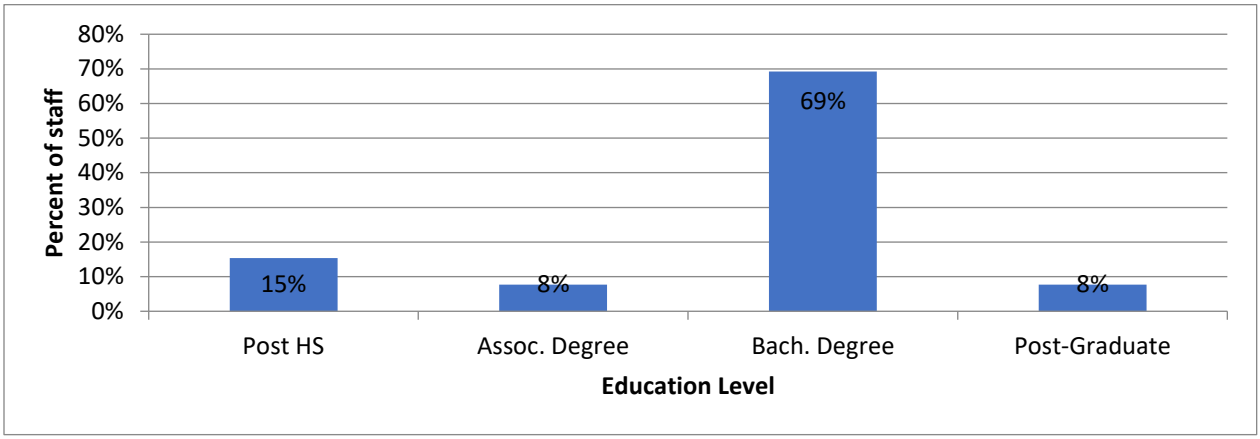
Program Staffing

During Year 22, the HFM program employed 13 individuals in 13 positions (12.5 FTEs). Staff positions were adjusted this year to better serve the needs of the community; an additional Family Resource Specialist position was added, increasing the capacity to assess more referrals from the Montgomery County Health Department. An additional Family Support Worker position was also added, as well as an additional Team Leader. In total, there are now one Program Director, two Team Leaders, two Family Resource Specialists, one Program Support Specialist, 6 Family Support Workers, one part-time Data Specialist. 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 French as well.

The collective educational level of the staff remains high (see Staff Training section below also). As seen in ***Figure 21. 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 75% having some college or higher.

FIGURE 21. 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. No staff left the program during FY18. The Program Director has been employed by HFM for 22 years, since the program began in 1996. One FRS has been with the program for 16 years. The average length of staff tenure is 7.5 years. Staff information is summarized in ***Table 13. Profile of Staff Characteristics.***

TABLE 13. PROFILE OF STAFF CHARACTERISTICS

Bilingual English/Spanish*	100% (11/11) direct service staff
Education Level Post HS/Some College Associate Degree Bachelor's degree Post-Graduate	 15% 8% 69% 8%
Mean Age at Hire Range	39 23 – 63
Mean Length of Tenure Range	7.5 years 1 – 22 years

*One bilingual FSW also speaks French

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.

Staff were able to attend 80 unique trainings covering numerous topics were provided. 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. The extensive number and type of trainings offered demonstrate the program's dedication to expanding the knowledge and skill set of its staff. 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. Service levels and their associated weight are described in ***Table 14. Caseload Weight, Home Visit Frequency.*** Consistent with best practice standards, an FSW carries no more than a weighted caseload of 24 and no more than 20 families (no more than 12 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.

TABLE 14. CASELOAD WEIGHT, HOME VISIT FREQUENCY

Service Level	Caseload Weight	Frequency of home visits, circumstance
2P	2	Prenatal: home visits every other week until 31 weeks gestation
1P	2	Prenatal: home visits weekly from 31 weeks gestation
1	2	Weekly home visits
1SS	3	Weekly or more frequent home visits during temporary periods of intense crisis
2	1	Two visits per month
3	0.5	Monthly home visits
4	0.25	Quarterly home visits
CO	0.5 – 2	Creative Outreach (attempted contact depending on frequency for level prior to creative outreach)
TO	0.5	Participant temporarily out of area for up to 3 months
TR	0.5	Temporary re-assignment, during extended staff leave or turnover, up to 3 months

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 FSW. Maximum caseload ***size*** is no more than twenty at any combination of service levels per full-time FSW and a maximum case ***weight*** of 24 points.

When making caseload assignments, the supervisor will take into consideration the experience and skill level of the FSW, 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 15. Annual Weighted Caseload Report, FY18 demonstrates the weighted caseloads of all FSWs throughout FY18. The maximum weighted caseload was 24.0. New FSWs build up their caseload over several months (HFM77, HFM79, HFM80). HFM67 transitioned to a Family Assessment Worker position in the second quarter.

TABLE 15. ANNUAL WEIGHTED CASELOAD REPORT, FY18

FSW	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March	April	May	June
HFM7	20.5	18.5	19.0	18.5	19.3	20.3	18.3	18.0	14.3	15.8	18.8	19.8
HFM49	22.5	19.5	23.0	23.0	20.0	17.8	19.0	14.5	18.5	16.5	16.8	16.3
HFM67	21.0	17.5	1.0	1.0	1.0	1.0						
HFM74	24.0	23.0	22.5	22.5	22.5	22.5	24.0	24.0	23.5	22.5	22.5	22.5
HFM75	24.0	22.5	23.5	22.5	20.5	22.5	22.5	21.5	21.5	23.5	23.5	23.5
HFM77		2.0	10.0	10.0	14.0	20.0	22.0	23.0	22.0	22.0	22.5	19.5
HFM79				8.0	12.0	18.0	20.0	18.0	22.0	20.0	21.0	21.0
HFM80							6.0	8.0	10.0	14.0	20.0	18.0
Total	112.0	103.0	99.0	105.5	109.3	122.0	131.8	127.0	131.8	134.3	145.0	140.5

Staff Satisfaction

HFM evaluates and reports on personnel satisfaction annually. In July 2018, thirteen staff members completed a questionnaire designed to elicit 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***). (#BPS 9-4)

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

"We have a lot of support in our group that helps us do a better job with our families."

The questionnaire consisted of statements accompanied by a 5-point scale, in which to indicate level of agreement for each item. Topics cover Orientation and Training, HFM Program, Supervision, Compensation & Benefits, and Cultural Sensitivity. Staff were overwhelmingly positive about HFM orientation, training, and the program overall. Several team members were "not sure" about some aspects of supervision, which is understandable given that three FSWs and one supervisor were new to the program. Ratings were 97% positive for aspects such as materials, opportunities for professional development, morale, co-worker relationships, program values.

In the area of compensation and benefits, 10% of responses to the statements indicate they are "Not Sure" or "Disagree" that they are appropriately compensated for the work they do (this is better than previous years). Management is aware of these sentiments and is constantly working to address them.

Cultural sensitivity is an ongoing learning process in a diverse area like Montgomery County. Responses to these statements were 92% positive/agreeable, meaning 8% were not sure or uncomfortable.

At the end of the survey were open-ended questions about what makes the program strong, and what areas need improvement. Staff indicated they 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.

"I appreciate the sincerity with which the team performs their mission!"

When asked which areas of the program need improvement, they expressed a desire for more father-friendly materials, and increased salary.

As seen in ***Table 16. Staff Satisfaction Survey Results,*** most staff members agree or strongly agree with the positive statements about the program.

TABLE 16. STAFF SATISFACTION SURVEY RESULTS

	Strongly Agree	Agree	Not Sure	Dis-agree	Strongly Disagree
Orientation and Training					
My job description clearly defines my position.	11	2			
The expectations about my position are clearly communicated.	10	2	1		
Training is available to me on a variety of topics important to my work	11	1	1		
Program Specific					
I understand the program adheres to HFA Best Practice Standards.	13				
HFM is a strength-based and family-centered program.	13				
I know where to find information about policies and procedures.	12	1			
HFM is a valuable resource for families.	11	2			
Supervision					
I feel supported by my supervisor.	12	1			
My supervisor is available to answer my questions outside of supervision.	12		1		
My supervisor recognizes me for my accomplishments.	12		1		
I have opportunities to reflect on the way my work impacts me.	11	1	1		
My supervisor helps me determine ways to work with challenging families & situations.	9	1	1		
Compensation & Benefits					
I am satisfied with my salary.	2	5	3	1	2
I receive paid time off and am able to use the time each year.	11	2			
The benefits I receive are adequate.	5	6	1	1	
Other Aspects of Your Experience					
I have opportunities to share my ideas.	12	1			
I have the materials and tools I need to be successful in my work.	9	3	1		
I have opportunities for professional development.	8	4	1		
My skills and abilities are being appropriately utilized.	12	1			

	Strongly Agree	Agree	Not Sure	Dis-agree	Strongly Disagree
Morale in my program is high.	12	1			
I have a good relationship with my co-workers.	12	1			
The program values a strength-based approach to staff and families.	12	1			
I have opportunities to learn and grow.	9	3	1		
Cultural Sensitivity					
Materials are available to represent the race, ethnicity & language of the families I visit.	6	5	1		
Communication with families is conducted in the family's primary language or in a language they understand through an interpreter.	12	1			
I receive training on topics unique to specific cultures.	6	5	1		1
There is fairness in employment/advancement opportunities.	10	1	2		
HFM allows me to honor the cultural beliefs and traditions of my families without compromising my own cultural beliefs and traditions.	10	2	1		
The materials I share are interesting, easy to understand, and encourage positive parent-child relationships.	8	4			

SUMMARY AND FUTURE PLANS

For the past twenty-two 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, FSWs 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.

Future Plans

- 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.

- 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 2017– June 2018

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 2017– June 2018

Program Funding	
Montgomery County DHHS	$566,045
Montgomery County Collaboration Council	170,296
City of Rockville	17,500
William S. Abell Foundation	10,456
Morris and Gwendolyn Cafritz Foundation	17,597
Clark-Winchcole Foundation	12,794
Other support and training fees	14,566
Total Funding	$799,254
Program Expenses	
Personnel salaries	$435,066
Personnel fringe benefits	132,216
Building occupancy	58,194
Professional services and evaluation	894
Transportation, local travel	17,947
Telephone	6,182
Training/conferences	24,677
Program activities/supplies/equipment	21,040
Subtotal Expenses	**$696,216**
General and administration	$101,217
Total Expenses	**$797,433**
Excess/Deficit	$ 1,821

APPENDIX B. HFM ADVISORY BOARD

July 2017– June 2018

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)	HFM Program Director
Joan Liversidge	Community Member
Carol May	Community Member
Meredith Myers (Ex-Officio Member)	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	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.

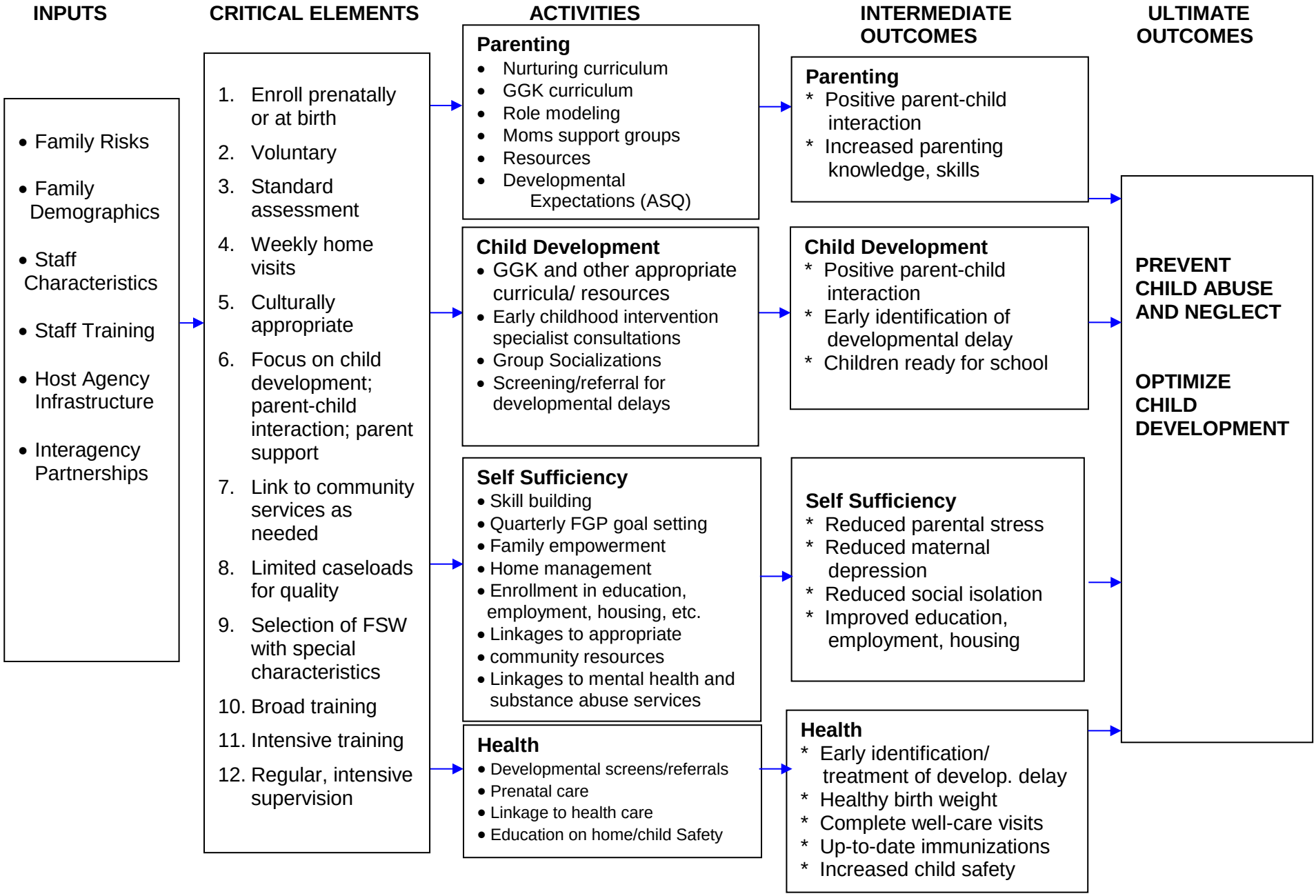
11. Service providers have a framework, based on education or experience, for handling the variety of experiences they may encounter when working with at-risk families. All service providers receive basic training in areas such as cultural competency, reporting child abuse, determining the safety of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

Level	Definition	Number of Home Visits Expected
2P	Up to 7 months prenatal. (1-27 weeks of pregnancy)	2-4 per month
1P	7 months prenatal to birth. (28 weeks-birth)	4 per month
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
CO	Creative Outreach - Families on creative outreach. (This level is activated when scheduled visits results in a “no show” and subsequent attempts to reschedule are unsuccessful. Families stay in creative outreach status for 3 months unless they re-engage or refuse services).	No visits required; attempted visits will be made, if appropriate
1-SS	Special Services – (Temporary assignment) – Activated for families who have a temporary elevated risk level and require more visits than current level requires, more intensive case management services, or additional time due to appointment attendance and other collateral contacts with therapists or other service providers.	More visits/time than the current level of service allows
TO	Temporary Out of Area – Activated when parent/family temporarily leaves the area or is hospitalized for 2 weeks for families on Level 1 (4 weeks for families on Levels 2 or 3) or longer (up to 3 months) but is expected to return.	No visits required: other attempts at communication are recommended
TR	Temporary Re-Assignment – Activated when the assigned FSW has ended employment and a new FSW has not yet been hired, or when the FSW is out on extended leave, or any other type of staff leave that will result in services being interrupted for longer than 2 weeks for families on Level 1 and 4 weeks or more for families on Levels 2 or 3.	No visits required: other staff attempt to stay in contact with the family

APPENDIX F. HFM DESCRIPTION OF EVALUATION MEASURES

Ages & Stages Questionnaire (ASQ-3)
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 0.84.

Ages & Stages Questionnaire: Social-Emotional (ASQ:SE-2)
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.

Home Safety Checklist
Authors: Healthy Families Maryland.
Description: The Safety Items included on the HFMD Home Safety Checklist measures a parent's knowledge and use of safety practices within the home and car. It focuses on parents' awareness of potential safety hazards in the child's environment. The instrument measures such hazards as access to poisons, stairs, windows, and electrical outlets. Parents are also asked about emergency phone numbers, presence of smoke alarms, presence of firearms, and age-appropriate automobile safety restraints. The safety items are administered in an interview format and can be done during a home visit. It takes approximately 5 minutes to complete.

Two-Item Conjoint Screening Test (TICS)
Authors: Brown, R. L., Leonard, T., Saunders, L. A., & Papasouliotis, O. (1997).
Description: The TICS (Two-Item Conjoint Screening Test) is a two-item screen developed for use in primary care settings. The two items are well chosen regarding the DSM-IV diagnostic criteria for substance dependence and tend to be among the items included longer screens. This test can be easily administered verbally from memory and incorporated into other interviews. Even a very small number of well-chosen items can detect at least a portion of individuals with alcohol and other drug problems with a minimal investment of time. Source: Article by Brown, R. L., Leonard, T., Saunders, L. A., & Papasouliotis, O. (1997). A two-item screening test for alcohol and other drug problems. Journal of Family Practice, 44, 151–160.

Relationship Assessment Tool (RAT)
Authors: Dr. Paige Hall and colleagues
Description: The Relationship Assessment Tool (RAT) is a screening tool for intimate partner violence (IPV). The tool was developed by Dr. Paige Hall and colleagues in the 1990's, originally named the WEB (Women's Experiences with Battering). Terminology has since evolved in the field and the unique characteristic of this assessment tool which measures women's experiences in abusive relationships is more accurately reflected by using the name Relationship Assessment Tool. As opposed to focusing on physical abuse, the Relationship Assessment Tool (WEB) assesses for emotional abuse by measuring a woman's perceptions of her vulnerability to physical danger and loss of power and control in her relationship. Research has shown that the tool is a more sensitive and comprehensive screening tool for identifying IPV compared to other validated tools that focus primarily on physical assault. Evaluation studies of the Tool have demonstrated its effectiveness in identifying IPV among African-American and Caucasian women. This tool can be self-administered or used during face-to-face assessment by a provider. A series of 10 statements ask a woman how safe she feels, physically and emotionally, in her relationship. The respondent is asked to rate how much she agrees or disagrees with each of the statements on a scale of 1 to 6 ranging from disagree strongly (1) to agree strongly (6). The numbers associated with her responses to the 10 statements are summed to create a score. A score of 20 points or higher on this tool is considered positive for IPV.

APPENDIX G. HFM EVALUATION ADMINISTRATION SCHEDULE

HFPI	Baseline	Postnatal administration or Baseline	12 months	24 months	36 months
	Prenatal	Prior to 3 months enrollment	One month before & up to one month after the child's first birthday	One month before & up to one month after the child's second birthday	One month before & up to one month after the child's third birthday

Safety	Baseline	Postnatal administration	Subsequent administration	Subsequent administration	Subsequent administration	Subsequent administration
	Prior to 3 months enrollment	Child's age: 4-6 months	Child's age 9-12 months	Child's age – 18 months	Child's age – 24 months	Child's age – 36 months

CES-D	Prenatal Baseline	Postnatal administration or Baseline	12 months	24 months	36 months
	Administered at the time of the Parent Survey visit	45 to 60 days after TC's birth	One month before & up to one month after the child's first birthday	One month before & up to one month after the child's second birthday	One month before & up to one month after the child's third birthday

ASQ-3	Age 0-12 months	Age 13-24 months	Age 25-36 months
	Administered 1 month before or after age: 4 months 6 months 8 months 12 months	Administered 1 month before or after age: 16 months 18 months 20 months 24 months	Administered 1 month before or after age: 30 months 36 months

ASQ:SE-2	Age 0-12 months	Age 13-24 months	Age 25-36 months
	Administered 1 month before or after age: 6 months 12 months	Administered 1 month before or after age: 18 months 24 months	Administered 1 month before or after age: 30 months 36 months

TICS	Baseline	Annually thereafter
	Administered by FRS at time of Parent Survey	

RAT	Baseline	Annually thereafter
	Within 3 months of enrollment	

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 Home 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
Family Satisfaction Survey

Dear Parents:
Every year we evaluate our program. Your input is very important to us and is used to improve our services. Please help us by completing this survey. Your comments will be kept anonymous and confidential, so please respond honestly.

1. **How long have you worked with a home visitor from Healthy Families Montgomery?**
   a. Less than six months
   b. Six months to one year
   c. One year or more

2. **Usually, how long are your visits with your home visitor?**
   a. 30 minutes to an hour
   b. 1 hour
   c. 1-2 hours

3. **How often does your home visitor talk with you about parenting your baby and your baby's health and development?**

4	3	2	1
Most visits	*About half the time*	*Once in a while*	*Never*

4. **How often does your home visitor bring an activity for you to do with your child?**

4	3	2	1
Most visits	*About half the time*	*Once in a while*	*Never*

5. **Does your home visitor come when she says she will, or call to reschedule?**

4	3	2	1
Most visits	*About half the time*	*Once in a while*	*Never*

6. **Have you and your home visitor talked about goals that you and your family wanted to work toward?**
   a. Yes
   b. No ***Please name a goal that you have worked on:*** _____

7. **Has your home visitor offered to connect you with other agencies or programs that you are interested in?**
   a. Yes
   b. *No* **If no, why not?** _____

8. **Are you more confident that you can do a good job of raising your child because you are a part of Healthy Families Montgomery.**

4	3	2	1
Yes, definitely	*Yes, probably*	*No, probably not*	*No, not at all*

9. **Does your home visitor speak clearly to you in a language you understand?**
   a. Yes
   b. No

10. **Does your home visitor provide materials (videos, handouts, fliers, and brochures) that represent your race, language, and ethnicity?**
    a. Yes
    b. No

11. Does your home visitor give you opportunities to share information about your culture?

4	3	2	1
Yes, definitely	*Yes, pretty much*	*No, not really*	*No, definitely not*

12. Does your home visitor respect and understand your culture and beliefs?

4	3	2	1
Yes, definitely	*Yes, pretty much*	*No, not really*	*No, definitely not*

13. Does your home visitor respect and understand your parenting style and the choices you make for your child(ren)?

4	3	2	1
Yes, definitely	*Yes, pretty much*	*No, not really*	*No, definitely not*

14. Do you feel safe when receiving services from Healthy Families Montgomery?

a. Yes *b. No*

15. I know that the program has a Grievance Process that I can use if I have a concern.

a. Yes *b. No*

16. Are the materials and information presented in a way that allows you to determine what is best for your child?

4	3	2	1
Yes, definitely	*Yes, pretty much*	*No, not really*	*No, definitely not*

17. If you have attended any group gatherings, have you been satisfied with the group?

4	3	2	1	N/A
Yes, definitely	*Yes, pretty much*	*No, not really*	*No, definitely not*	*haven't attended*

What group did you attend? _____

Suggestions to make our groups better: _____
_____

18. Which areas of your life have improved since joining Healthy Families Montgomery (please check all that apply)?

- ☐ My ability to solve problems
- ☐ More patience with my child's behavior
- ☐ My ability to control my temper
- ☐ My appreciation of my child
- ☐ My ability to read my child's cues
- ☐ My support system
- ☐ My understanding of child development and parenting
- ☐ My relationship with my family
- ☐ My relationship with my partner
- ☐ Nothing in my life has improved
- ☐ Other: _____

Would you recommend Healthy Families Montgomery to a family member of friend?

a. Yes *b. No*

What would make Healthy Families Montgomery a better program for you?

_____
_____

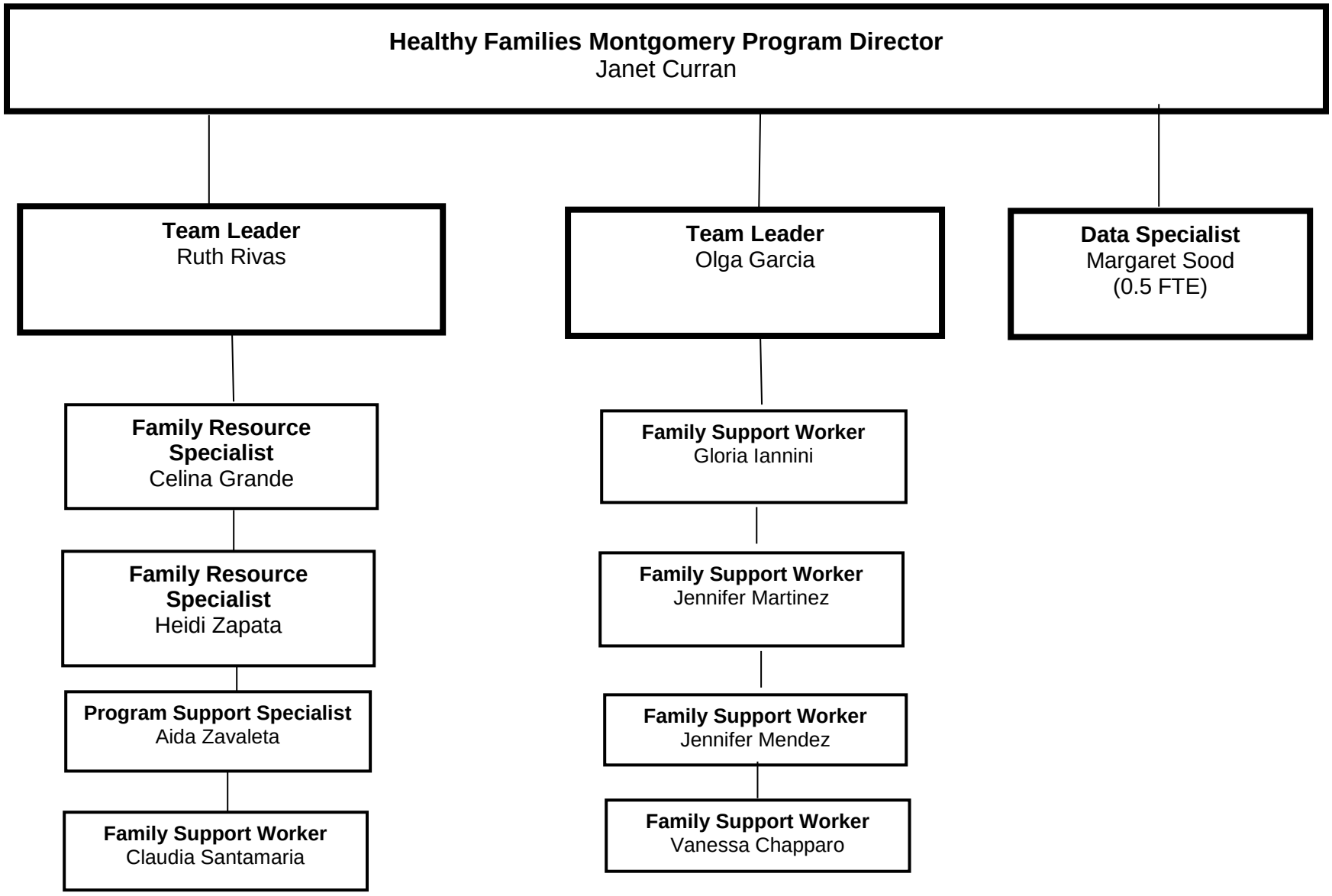
Would you recommend Healthy Families Montgomery to a family member of friend?

a. Yes *b. No*

What would make Healthy Families Montgomery a better program for you?

_____
_____

APPENDIX K. HFM ORGANIZATIONAL CHART



APPENDIX L. HFM STAFF SATISFACTION SURVEY FORM

June 2018

Healthy Families Montgomery
Staff Satisfaction Survey

	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
Orientation and Training					
My job description clearly defines my position.					
The expectations about my position are clearly communicated.					
Training is available to me on a variety of topics important to my work					
Program Specific					
I understand the program adheres to HFA Best Practice Standards.					
HFM is a strength-based and family-centered program.					
I know where to find information about policies and procedures.					
HFM is a valuable resource for families.					
Supervision					
I feel supported by my supervisor.					
My supervisor is available to answer my questions outside of supervision.					
My supervisor recognizes me for my accomplishments.					
I have opportunities to reflect on the way my work impacts me.					
My supervisor helps me determine ways to work with challenging families & situations.					
Compensation & Benefits					
I am satisfied with my salary.					
I receive paid time off and am able to use the time each year.					
The benefits I receive are adequate.					
Other Aspects of Your Experience					
I have opportunities to share my ideas.					
I have the materials and tools I need to be successful in my work.					
I have opportunities for professional development.					
My skills and abilities are being appropriately utilized.					
Morale in my program is high.					
I have a good relationship with my co-workers.					

The program values a strength-based approach to staff and families.					
I have opportunities to learn and grow.					
Cultural Sensitivity					
Materials are available to represent the race, ethnicity & language of the families I visit.					
Communication with families is conducted in the family's primary language or in a language they understand through an interpreter.					
I receive training on topics unique to specific cultures.					
There is fairness in employment/advancement opportunities.					
HFM allows me to honor the cultural beliefs and traditions of my families without compromising my own cultural beliefs and traditions.					
The materials I share are interesting, easy to understand, and encourage positive parent-child relationships.					

Which areas of the program are particularly strong?

Which areas of the program need improvement?

Additional Comments and Suggestions: