100 Years of Service

Family Services, Inc.

An affiliate of Sheppard & Enoch Pratt Foundation

HEALTHY FAMILIES MONTGOMERY

YEAR 14 REPORT
JULY 2009 – JUNE 2010

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

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EXECUTIVE SUMMARY

The Healthy Families Montgomery (HFM) program concluded its fourteenth year of service to high-risk families in Montgomery County, Maryland. As such, it continues to exceed its target objectives, which are designed to reduce family risk factors and enhance protective factors in order to prevent child abuse and neglect and promote optimal child development. The program, among the top 2% in the nation, has consistently maintained high quality standards and achieved positive maternal and child health outcomes despite funding challenges, relocating and renovating office space, and a changing political landscape.

To date, over 11,000 positive screens for risk of child maltreatment have been made by HFM. Of the 990 screens that scored positive in Year 14, only 44 families (4%) were able to be enrolled due to capacity limitations. This continues to underscore the significant gap in services for the at-risk population in Montgomery County. However, HFM's efforts in referring families it is unable to serve to other appropriate services in the community highlight its commitment to helping overburdened families, as well as its value as a resource in the community.

In Year 14, the program served 141 families. Demographic data reveals a population that continues the trend of increasingly older mothers; the mean age of Year 14 participants is 25 years, the oldest to date. The majority of these mothers were single (85%), although about half of this group reported living with their partner. As in the past, most mothers were Hispanic (91%) and speak Spanish as their primary language. At enrollment, approximately half of mothers had less than a HS education (48%) and most were unemployed (72%). HFM continued to achieve success in strengthening family sufficiency. By the end of Year 14, marital status had improved slightly as the percentage of mothers who were either married or living with a partner increased from 57% to 62%. Additionally, 58% (n=66) improved their education level and had obtained a high school degree or higher. More notable is the increase in the percentage of working mothers from 28% to 61%. Also, at the end of Year 14, 97% (n=111/115) either maintained stable housing or improved their housing status.

For the fourth consecutive year, there were no founded Child Welfare Services (CWS) reports among families in the HFM program. This finding provides solid evidence of the positive impact that prevention can have on reducing the incidence of child maltreatment with high-risk families. Over the fourteen years of program implementation, there have only been six cases of founded child maltreatment, all of which were cases of neglect.

In the area of health, HFM continues to exceed its goals. In Year 14, almost all children (99%) were linked with medical providers and were enrolled in Medical Assistance (MA). In addition, 94% of all target children were current with their immunizations. This not only exceeds the program goal, but national (76%) and State of Maryland (91%)

rates. Of the mothers who gave birth during Year 14, 96% received post-partum care, affording them the opportunity to monitor their health and discuss family planning options with their doctors. Moreover, 99% did not have a repeat birth within a 24-month period during their enrollment in the HFM program. Although all mothers enrolled in HFM either in their third trimester or postnatally, they had received their first prenatal care in their first or second trimester. As a result, of the 40 target babies born to mothers enrolled during Year 14, 90% (n=36) were born at a healthy birth weight. For babies born at healthy birth weight to **all** mothers active in Year 14, regardless of the year they were born, the percentage increases to 92%. This again exceeds the program's goal, as well as national, state, and ethnic rates.

To promote optimal child development, Healthy Families Montgomery administers the Ages and Stages Questionnaire (ASQ) at regular intervals throughout a child's participation in the program to monitor social, emotional, cognitive, language and motor development. During Program Year 14, 95% (n=88) of target children who were due for an ASQ received one. Of these, 91% demonstrated normal child functioning and are meeting developmental milestones. This data provides strong evidence of the impact of the program's developmental activities in mediating environmental factors that may interfere with optimal child development. Nineteen program children were identified with a developmental delay and were receiving services from MCITP or MCPS Child Find. By the end of the fiscal year, seven of these children were on target developmentally and ceased services.

The goal of positive parenting includes the areas of home safety, parent-child interaction, and parenting knowledge. 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. Statistically significant increases ($p=.000$) were measured in parents' knowledge of child safety, with 100% of parents demonstrating adequate safety knowledge after one year of program participation. Results from the recently re-normed Healthy Families Parenting Inventory (HFPI) revealed a higher percentage of participants identified as "at risk" at program entry than had previously been identified with the measure. Despite this, statistically significant improvement was made after 12 months of enrollment in three areas: *Home Environment* (safety, organization, availability and quality of stimulating materials/activities in the home); *Mobilizing Resources* (knowledge of available resources in the community and comfort level in seeking help); and *Depression Risk* (participants' mood, self-esteem, optimism, outlook and feelings of sadness).

Participant satisfaction with the program remains high. Comments on the annual survey focused on how the program has helped participants to be better parents by teaching them about child development and giving them strategies for helping their children learn. Parents value the support and guidance they receive from their FSWs, as well as the information they give them about community resources. They appreciate opportunities to interact with other parents and would welcome increased group activities.

INTRODUCTION

In June 2010, Healthy Families Montgomery (HFM) concluded its fourteenth year of service to high-risk families in Montgomery County, Maryland. The comprehensive services offered by the HFM program are designed to reduce family risk factors and enhance protective factors in order to prevent child abuse and neglect and promote optimal child development. Over the past fourteen years, HFM has demonstrated its ability to maintain high quality standards and consistently achieve positive maternal and child health outcomes despite funding challenges, relocating and renovating office space, and a changing political landscape pertaining to early childhood and home visitation at the state level. This was affirmed in Year 13 when HFM received an expedited four-year credential from Healthy Families America in December 2008. The reviewers indicated that HFM is an extremely strong site – among the top 2% nationwide. FSI's HFM program was first accredited in November 1999, when it became the first nationally credentialed Healthy Family America site in the State of Maryland. The HFM program was built on research-based best practices and has drawn upon these practices as it has grown over the years. Additionally, HFM has twice received awards from the Montgomery County Council for the excellence of its services to families, once with a special mention with regard to cultural competence.

This report describes the program implementation and outcomes achieved in Year 14. Detailed historical and program information is also available in the HFM Year 10 Longitudinal and Year 12 Annual Reports.

Family Services, Inc. (FSI)

Family Services, Inc., (formerly the Family Services Agency, Inc), an affiliate of the Sheppard and Enoch Pratt Foundation, is the oldest private nonprofit social service and behavioral health organization in Montgomery County, Maryland. Founded in 1908, FSI has extensive experience developing and implementing in-home and community-based services for children, adolescents, and families. Prevention and early intervention programs operated by FSI address family functioning and child development, while a day treatment program offers psychiatric rehabilitation services to persons with persistent mental illness.

In addition to operating the Healthy Families Montgomery Program, FSI hosts a variety of other programs and activities, including:

Baby Steps nurses provide universal hospital-based health screenings to over 5,400 new mothers and babies at Shady Grove Adventist and Holy Cross Hospitals. Baby Steps nurses link new parents to community health services and provide appropriate follow up as needed through telephone consultations and/or home visits. The program also distributes over 3,000 new parent packets in English and Spanish each year.

DARE to be you is a substance abuse prevention education program that provides a 10-week program to preschoolers and their families which is designed to improve parent and child interaction in the areas of self concept, self responsibility, communication and decision-making. They provide family meals, techniques to enhance family resilience, and financial incentives for successful completion of the program.

Early Head Start, a federally funded child development program, serves 147 very low-income families with children from birth to three years in upper Montgomery County. The program provides home visitation services and/or the Discovery Station child development center that focuses on the needs of teen parents. Child development class and summer programs are offered to teen parents from area high schools. Home visitors use the Parents as Teachers curriculum and utilize Ready at Five materials when working with families.

Early Childhood Education and Training offers training and consultation services to home visitors and child care providers. As the Maryland State office for *Parents as Teachers*, FSI sponsors state-wide trainings for home visitors. MSDE-approved trainings are provided on many aspects of early childhood development, as well as strategies to support school readiness. Early childhood professionals offer mental health consultation and mentoring services to child care providers.

The **Ed Bohrer Parent Resource Center (PRC)** serves over 3,000 Spanish and English speaking persons each year as they access needed services in the community and pursue educational goals for themselves and their children. The PRC hosts a Parent Homework Club, three levels of Adult ESOL classes taught by instructors from Montgomery College, and basic literacy, computer, and parenting classes. This program is available only to residents of the City of Gaithersburg.

Frameworks for Families provides home, group, and community-based services to 80 families identified by Child Welfare Services as being at low to moderate risk of child abuse and neglect.

The **Housing Counselor** provides relocation assistance, renter assistance and assistance in applying for county rental subsidy programs, eviction prevention, money/dept management, fair housing assistance, coordination of housing resources with area foreclosure counseling agencies, and other community resources with area foreclosure counseling agencies. These programs are available to the residents of the City of Gaithersburg.

Montgomery Station is a Psychiatric Rehabilitation Program. Staff work with adults with serious mental illnesses in a variety of settings to reach their full potential in all aspects of their lives. Montgomery Station's philosophy is based on the Mental Health Recovery Model. The Recovery Model emphasizes that people can make progress and positive changes in their lives, despite having mental illness. It emphasizes hope and the fact that, although people don't have full control over their symptoms, they can

have full control over their lives. Montgomery Station and the Recovery Model take a holistic view that focuses on the person, not just the symptoms. This is why it is important to work closely with the individual, his or her family and friends, and his or her doctors and therapists.

Neighborhood Opportunity Network is a partnership with Montgomery County's Department of Health and Human Services, IMPACT Silver Spring, Interfaith Works, the City of Gaithersburg and the MC Community Foundation to bring emergency food and housing stabilization services to Montgomery County residents. Staff assist residents with filling out complicated applications for temporary cash assistance, food stamps, utility assistance, eviction prevention, medical and health services, home energy programs and rental assistance, as well as collecting documentation required for the applications and making referrals to other resources as needed.

Outpatient Mental Health Clinic provides individual, family and group counseling for over 800 children, adults, couples and families each year. Its professional staff includes child and adult psychiatrists, licensed clinical social workers, and licensed professional counselors.

Watch Me Grow Child Development Center (WMG) in Clarksburg, MD, is dedicated to providing high quality childcare for preschool children (ages 6 weeks to 5 years). Our mission is to create a warm, secure and nurturing environment that encourages children to explore, grow, thrive and develop a life-long love of learning. WMG promotes the gifts and talents of each individual child and meets the highest quality standards established by the Maryland State Department of Education (MSDE). The program uses the MSDE-approved *Creative Curriculum for Preschool* that translates early care research and theory into a fun program that will interest and challenge children.

As the host agency, FSI provides HFM with support through its strong infrastructure, in-kind services and information sharing among its other programs. Its expertise in advocacy and resource development is also an asset to HFM. In addition to providing access to these services, FSI is located within a complex of other nonprofit providers, including HomeFree-USA, Manna Food, the Dwelling Place, Guide Youth Services, Interfaith Clothing Center, Teen and Young Adult Health Connection (TAYA), Community Clinic and WIC. Referrals are made to each of these providers by FSI staff in order to provide additional services to customers who need further assistance.

See Appendix A: HFM Organizational Chart

Partners

HFM's partnerships with child development, behavioral/mental health, education and physical/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 it meet its goals and objectives.

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

- Montgomery County Department of Health and Human Services (Health, Child Welfare, Early Childhood and Family Support Services)
- Child Center and Adult Services, Inc.
- Judy Centers
- Montgomery County Infants and Toddlers Program
- Montgomery County Home Visitation Consortium
- Healthy Families Maryland Site Network
- Rockville Caregivers Association
- Gaithersburg Coalition of Providers
- Shady Grove Adventist Hospital
- Holy Cross Hospital
- Betty Ann Krahnke Center
- Teen and Young Adult Health Connection (TAYA)

Funders

During Year 14, the HFM program maintained its diversified funding streams, including public sources such as State funding through the Montgomery County Collaboration Council, the Montgomery County Department of Health and Human Services, and the City of Rockville; as well as private foundations such as the William S. Abell Foundation, Bank of America, Morris and Gwendolyn Cafritz Foundation, CSG Foundation, Freddie Mac Foundation, TD Charitable Foundation, PNC Bank Foundation. The HFM program also receives private donations and in-kind funding from Barnes and Noble at the Washingtonian Center, Christ Child Society, First Books of Montgomery County, Friendship Star Quilters, Mom's Club of Germantown/Kingsview, Weichert Realty in Gaithersburg and North Potomac, and Woodworkers for Charity. Although overall funding increased by about $8,500 in Year 14, the program had to use all funding in order to retain all staff and services (see Appendix B: Healthy Families Montgomery Funding Sources: July 2009-June 2010 and Healthy Families Montgomery Program Expenditures: July 2009-June 2010).

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 14, the HFM Advisory Board was comprised of 11 local private and public stakeholders who serve a 2-year term and meet regularly. The Board is comprised of individuals representing diverse ethnic and professionals sectors, which bring a range of expertise and cultural perspectives. Members are able to provide support to ensure that the program serves the community to the best of its ability. Over the course of the year, the HFM program solicited feedback and encouraged members to attend a participant group meeting in order to

increase engagement and participation of the board. See Appendix C: List of Advisory Board Members 2009-2010.

National Accreditation

The HFM program was built on research-based best practices and has drawn upon these practices as it has grown over the years. All Healthy Families programs must participate in the accreditation process in order to be considered an official Healthy Families site. During this intensive process, sites prepare a lengthy written self-assessment that is submitted to a team of peer reviewers for evaluation prior to a two to 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 program has been accredited since November 1999 (Year 4 of the program), when it received the first national credential of all the Healthy Family America sites in the State of Maryland. In Year 8 of the program, HFM received an expedited credential with no follow-up work needed, which is rare, based on exemplary scores on the Preliminary Credentialing Report. In Year 13, HFM underwent the new accreditation process, during which revised standards and criteria were applied. Upon completion of the site visit in September 2008, HFM once again received an expedited accreditation.

METHODS

Donna D. Klagholz, Ph.D. & Associates, LLC designed the HFM program evaluation over fourteen years ago. Since then, DDK & Associates has conducted an annual external evaluation of the program, creating a detailed historical record of HFM's evolution and outcomes. The continuity of the external evaluator and consistency of methodology and measures for the past thirteen years has enhanced quality and increased the credibility of longitudinal outcomes.

The comprehensive evaluation of the HFM program is a quasi-experimental pre/post-test research design that utilizes both qualitative and quantitative data and methods data. It includes a formative evaluation of the program's implementation and an outcome evaluation of the program's impact on participants. Over the past thirteen years, 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 Program Assistant and Program Manager ensure the consistency and quality of data entry. Quality Assurance is monitored regularly and data entry is reconciled monthly. Team Leaders review all scoring of standardized measures. As reports are run, the Program Manager reviews them for completeness and accuracy. Through monthly tracking of screening, assessment and enrollment data, HFM is also able to identify gaps in service. Furthermore, adding a supplemental tracking system for outcome measures to the database has enabled the program to monitor compliance to the measures administration schedule, as well as to report on participant progress and program outcomes on a more frequent basis.

The Program Information Management System (PIMS) developed by the HFA national office is the primary repository of program data. HFM began using PIMS in 2001 and since that time the external evaluators have relied on data exports and reports from the PIMS database for the bulk of participant data. During Year 12, HFM transitioned to the recently updated PIMS6 version and received training on its applications and new features. The data from PIMS6 is imported on a quarterly basis for the quarterly reports to the county and for the annual report. The repository for all data, from program inception to the present, is an SPSS longitudinal dataset created by the evaluators in 1996.

A. Theory of Change

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

B. Target Population

The HFM program targets first-time parents residing in Montgomery County who receive prenatal care through Montgomery County Health Services and become involved while the mother is pregnant or at the time of birth. These parents are identified to be at risk for child abuse and neglect based on a standardized screening and assessment process. All HFM families screened and assessed in Year 14 were identified at one of three Montgomery County Health Centers (Germantown, Silver Spring or Piccard). As initial points of entry for the majority of pregnant women throughout the county who are in need of government health assistance for themselves and their unborn babies, these health centers are ideal screening locations for HFM's target population. A much smaller number of screens are completed on women who utilize other community services and are referred to the program. Potential participants represent a wide range of racial and ethnic backgrounds.

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

C. Sample

All Year 14 participants (n=141) are included in the analysis of enrollment data (attrition, retention, duration and service levels) and all target children (n=138) are included in ASQ analysis. However, in order to accurately represent the impact of program participation on outcomes, a subset of participants (research sample) is created based on a minimum amount of documented program participation. To be included in the research sample, participants must have been enrolled by the end of the Year 14 fiscal year (June 30, 2009), and must have completed a minimum of eight home visits. Thus, the Year 14 research sample includes n=123 families.

For some variables, data was not available or was unknown, and therefore the sample size (*n)* varies within the report. Finally, sample sizes are larger when examining goals pertaining to screening and assessment. This is either due to the inclusion of families who participated in these aspects of the program, yet do not meet the criteria for the research sample described above, or due to staffing limitations are unable to be enrolled in services.

D. Procedure

The evaluators have worked with HFM to develop and implement mechanisms for participant protection, including consent and confidentiality procedures (see Appendix E: Parental Consent for Participation). Evaluation components were implemented consistently across all program years. The consent forms are written at an appropriate

reading level for the client base and also available in Spanish. Consent forms were also given to parents to allow minors to participate in the HFM program (see Appendix F: Parental Consent for Minors to Participate). Finally, clients were given consent forms to be used in evaluative studies. This too was written at an appropriate reading level and provided in Spanish (see Appendix G: Parental Consent to Participate in Program Evaluation).

E. Process Evaluation

The process evaluation documents the evolution and implementation of the program in order to provide feedback to administrators, interpret mediating influences on outcomes, and replicate the program. Two major sources of data were used for this task: 1) existing program reports and 2) the PIMS database. Reports and data to support this include DHHS Quarterly Reports, the Annual Statistical Report, and staff and participant satisfaction survey data. This data was collected by HFM staff and provided to evaluators.

The HFM program database (PIMS6) includes data on enrollment, demographics, dates and content of home visits and other services, number and types of referrals for outside services, and program management (administration, staffing, and organizational linkages). This data was imported into SPSS by the evaluator and analyzed with outcome measures data. Enrollment is defined as initial contact with the FSW and a signed consent to participate in the program. Duration of enrollment was calculated using enrollment and termination dates.

F. Outcome Evaluation

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

Table 1. HFM Instrument Administration Matrix

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

The Year 14 outcome evaluation examined the impact of program activities on participants and progress towards meeting stated goals and objectives from July 1, 2009 - June 30, 2010. Repeated measures research design and program service statistics were used to determine program efficacy.

G. 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.

I. Reduce Incidence of Child Maltreatment

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

II. Promote Preventive Health Care

1. 95% of participating children will have a primary health care provider or will complete certification for Medicaid within 2 months of enrollment.
2. 90% of participating children will receive all immunizations on schedule and completed by the age of two.
3. 90% of mothers will not have an additional birth within two years of target child's birth.
4. 85% of enrolled mothers will complete post-partum care.
5. 90% of mothers enrolled within the first two trimesters will deliver newborns weighing 2500 grams (5.5 lbs.) or more.

III. Optimize Child Development

1. 95% of children will demonstrate normal child functioning through ASQ developmental screening.
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 Family Self-Sufficiency

1. 75% of families will have improved self-sufficiency within 12 months of enrollment as measured by improved education or employment status.
2. 95% of families will have improved self-sufficiency within 12 months of enrollment as measured by improved housing.

V. 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.
2. 90% of participants will score at or above program-determined level for knowledge of child safety after one year and annually thereafter as measured on the Safety Checklist (version 5).

RESULTS

A. PROCESS EVALUATION

Program Description

Healthy Families Montgomery (HFM) is based on the Healthy Families America (HFA) model, a nationally recognized voluntary program for the prevention of child maltreatment. HFA was first implemented by Prevent Child Abuse America (PCA America) in 1992, building on two decades of research in the field of home visitation. The program connects expectant parents and parents of newborns with health and child development assistance in their homes. Highly trained home visitors, with an average of four years home visiting experience and three years tenure with their HFA program, provide the services. Nationally, 76% of HFA home visitors have some college experience or college degrees. The home visitors provide guidance, information and support to parents to promote optimal long-term mental and physical health for their children.

The quality of HFM services is assured through adherence to best practice guidelines defined through twelve Critical Elements based on 20 years of research. An HFA site accreditation is required every three to four years. The accreditation process involves an in-depth examination of each site's operation, as well as the quality of the home visits (see Appendix J: HFM Critical Elements). This means that the program has high quality practices across program services, from the amount of participant contact and supervision to the content of home visits and supervision. Other key elements of the model include intensive, comprehensive, long-term (3-5 years), flexible and culturally competent services. In this way, the program is able to best serve the community and ensure that it is delivering quality program services to promote healthy growth and development to the parents and children it serves.

Screening and assessment are the processes through which families are either identified as eligible for HFM home visitation services or may be referred to other community agencies based on family need and willingness. Most families are referred to the program through local clinics and outreach efforts. Families who may be in the "high risk" category are identified based on their score on the initial screen and assessment workers make efforts to contact these families. A highly trained Family Resource Specialist conducts individual family interviews, or assessments, with potential HFM families to identify family assets and challenges. Since most target families are Spanish speaking, HFM retains a bi-lingual Family Resource Specialist to conduct the initial home visit and assessment. Through the use of the standardized Parent Survey (formerly the Kempe Family Stress Checklist-FSC), the assessment/survey process offers one-on-one time with the family so that they can discuss stressors in their lives and potential concerns for welcoming a new baby into the world, and identify those families most in need of supportive services and offer them home visitation services. If the FRS is unable to enroll families into the HFM program due to full caseloads, the family is presented with the best available service at that time which will include a

number of community resources. In addition to referrals, the FRS provides families with a Parent Packet filled with enrichment materials. Due to the voluntary nature of the program, families may decline services if for any reason they do not wish to participate. Furthermore, a family may terminate services at any time during their program participation.

Through the HFA Leveling System (see Appendix K: HFM Service Levels), HFM ensures that families are seen regularly and frequently, especially early in their program tenure. 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. From this point on, the family is seen weekly until a minimum of six months after the birth of the baby. The program has the flexibility to provide the intensity of services based on the needs of the family. Some may continue with weekly home visits for a year or more. However, once families are meeting certain guidelines regarding self-sufficiency, child development knowledge, and understanding of external support, they will progress through the level system to bi-weekly, monthly, and then quarterly home visits. Home visits terminate only after a family has been in the program for three to five years, graduates, ages out, or voluntarily discontinues program services.

Home visits are at the core of the HFM program and can be a balancing act of focusing on the parent, child, and parent-child interaction. The principal aim of the home visits is to ensure that children are healthy and ready for school by conducting developmental activities with children and modeling positive parent-child interaction. In addition, FSWs focus on the parents' needs, goals, stressors, and strengths to empower them to provide the best possible care for their children. In utilizing empowering, strength-based techniques, parents come to see their FSW as an individual who advocates for their best interests. Visits are scheduled based on the level of services for each family.
If a family had been in the program and received 6 months of intensive (weekly home visits) after the birth of the baby and the family situation is stable, the family may be promoted to Level II, at which time visits take place every other week, instead of weekly. If the family is promoted to Level III, visits take place once a month. Families promoted to Level IV receive quarterly home visits. If a family enters the program at the end of the month, they will probably only receive one visit during the month. When families are temporarily unavailable for service and do not want to terminate from the program, they may discontinue home visitation services for up to 3 months. HFM monitors the number of home visits expected and completed based on the FSWs caseload on a monthly basis and consistently exceeds national standards for intensive home visiting compliance.

Parents as Teachers (PAT), a nationally recognized child development curriculum that outlines common behaviors children display at varying ages, is used regularly with parents. Additionally, the Ages and Stages Questionnaire (ASQ), a screen administered with all target children of appropriate developmental stages, allows parents the opportunity to increase and solidify their knowledge of developmental milestones and to ensure that they have realistic expectations of child behavior patterns. To provide

further support in identifying potential delays, the HFM program has an Early Intervention Specialist (EIS) on staff. The EIS is a shared position with the Montgomery County Infants and Toddlers Program (MCITP) and is responsible for accompanying FSWs on home visits upon request, FSW and Supervisor consultation regarding developmental delays, staff trainings on child development, and the referral coordination with MCITP for HFM families that have children with a suspected developmental delay. The EIS is also responsible for planning the Early Literacy Learning Parties that promote healthy parent-child interaction. Other duties of the EIS include attending agency meetings, intake information following referral, case presentations, and assessments.

Family Support Plans (FSPs) 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, FSPs 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. Every three to six months goal plans are reviewed, achievement of goals is assessed, and new goals are formulated.

The Baby Steps Program works closely with HFM as a partner and conducts hospital screens and universal assessments of newborns and mothers in order to determine medical risk. If additional health consultation is necessary, Baby Steps nurses can spend up to 10 hours a month following-up on health referrals, which may include, but is not exclusive to the following: FSW consultation, educational information, follow-up phone calls or home visits with the family, etc. HFM offers translation services to assist Baby Steps Nurses with phone calls or home visits.

Additional key features of the HFM program are the attributes of the program staff and the quality and quantity of supervision and trainings offered. HFM staff members are chosen based on a variety of factors including personal and professional experience, education and personality traits that make them qualified to work with an overburdened population (see Appendix L: Staff Tenure). HFM staff members, past and present, have high tenure with most staying with the program for multiple years. This attribute allows the HFM program to have more consistency in the services and programs it provides.

The program also emphasizes the importance of ongoing supervision and staff training. Supervisors provide a minimum of one-and-a-half to two hours per week of one-on-one supervision to all direct service staff. Supervision, like home visits, is strength-based. HFM believes that in order to prevent burnout and to ensure that staff members feel supported when working with families with multiple stressors frequent strength-based supervision is a necessity. During both supervision and in-group training sessions, the staff is offered high-quality trainings in work-related areas. Topics such as domestic violence, cultural competency and/or burnout prevention are explored to ensure that staff members feel fully equipped in their roles. Additionally, supervisors may arrange for individual or group trainings based on specific needs or desires identified during supervision sessions (see Appendix M: Staff Trainings).

The HFM program also supports its staff members by assigning each a limited caseload. Each full-time FSW has a maximum caseload capacity of 15-25 families. A weighted system is used to determine the amount of time the FSW spends with a family based on their level, allowing a maximum case weight of 24. This helps the FSWs to devote time and attention to each family without feeling overwhelmed or rushed.

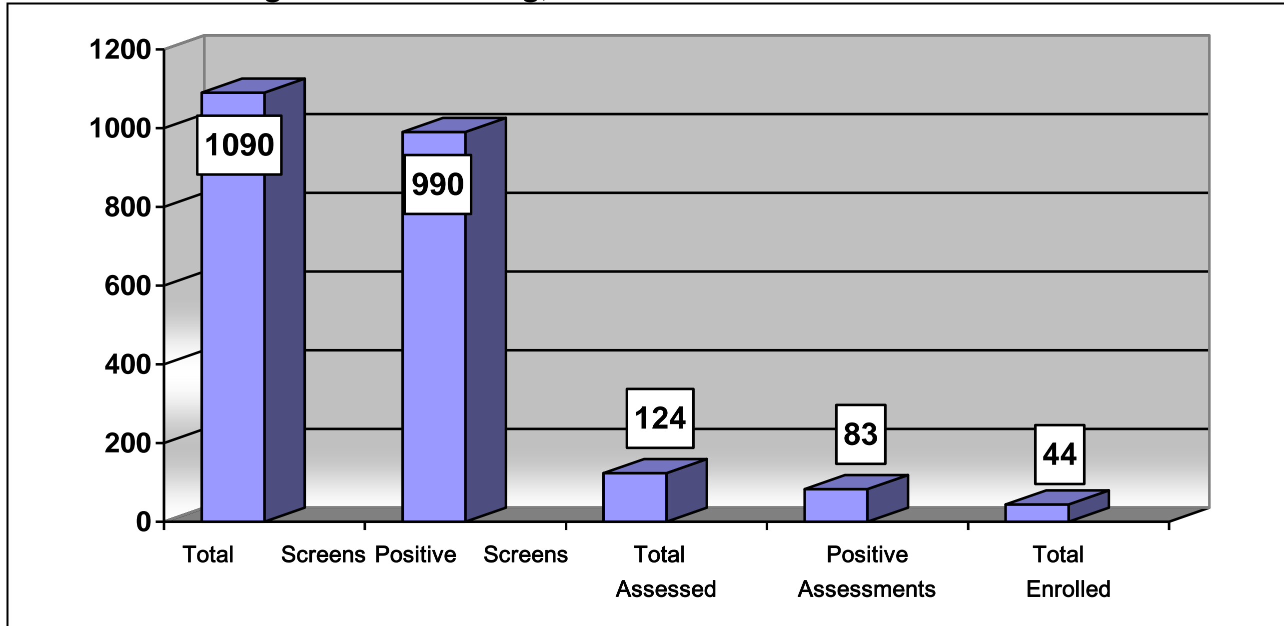
Screening, Assessment and Enrollment

The HFM program has a longstanding partnership with the Montgomery County Department of Health and Human Services. As the major provider of reproductive health and social services to income-eligible families in the County, DHHS conducts universal screening of all prenatal, perinatal and postnatal female clients. The screen consists of 15 items measuring self-sufficiency and psychosocial factors, such as marital status, income, housing status, history of substance abuse, depression, etc. If the woman is single, has had late or no prenatal care, or unsuccessfully sought or attempted an abortion, the screen is positive. If any two factors are true or if seven factors are unknown the screen is also positive. All positive and negative screens are sent to the HFM program for tracking. Positive screens are reviewed by the Family Resource Specialist (FRS), who completes assessments on families in the order of their due date.

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

Figure 1 below shows the total screening and assessment data for Program Year 14. Almost all screens that were completed resulted in a positive outcome, 91% (n=990). Of these, only 13% (n=124) were assessed because there was only one Family Resource Specialist available to assess families. Of those assessed, 67% (n=83) were eligible for the program, only half of which (53%; n=43) were able to be enrolled due to capacity limitations. Finally, when the number of families enrolled (n=44) is compared to the total number of positive screens (n=990), only a small fraction (4%) of families determined to be at-risk ultimately receive the intensive home-based services offered by HFM. This shows a large gap in services for the at-risk population in Montgomery County. However, HFM makes every attempt to refer families to other services as appropriate.

Figure 1. Screening, Assessment and Enrollment: Year 14



Over the past fourteen years, over 11,000 positive screens for risk of child maltreatment have been made by HFM. **Table 2** below displays information for all program years regarding screening, assessment and enrollment. In Year 14, only eleven eligible families declined enrollment, which provides evidence of the program's ability to engage families. The refusal rate (those who were offered services but refused participation) has ranged from 0% in Year 3 to 8% in Year 14, with an average refusal of 13% over the lifetime of the program.

Table 2. Screening, Assessment and Enrollment: Years 1-14

YEAR*	Total Positive Screens	Total Assessments Completed	Total Positive Assessments	Total Negative Assessments	Total New Enrollments	Total Refusals	Program Capacity
YR 1	-	-	-	-	45	-	50
YR 2	393*	-	-	-	54	-	75
YR 3	787	49	49	0	49	0	75
YR 4	824	110	108	2	104	4	150
YR 5	828	63	60	3	50	3	160
YR 6	854	146	127	19	116	10	150
YR 7	941	259	192	67	66	77	150
YR 8	934	190	136	54	39	15	150
YR 9	934	293	179	114	86	36	150
YR 10	755	298	180	118	60	11	140
YR 11	1090	162	110	49	65	28	130
YR 12	1244	165	100	53	43	25	130
Yr 13	1144	147	80	62	34	4	130
Yr 14	990	124	83	41	44	11	130
TOTAL	11,718	2,006	1,404	582	855	224	--

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

Enrollment and Attrition

A total of 141 families and 137 children were served in Year 14. Of these, 44 families were new enrollees. During Program Year 14, *a total of 11 families met all of their program goals and graduated from the program.* In addition to these graduating families, a total of 33 families terminated services for a variety of reasons, as shown in **Figure 2** below. In contrast to previous years in which most cases terminated due to participant refusal of services, one-quarter of terminations (25%; n=11) were due to the family moving out of the service area. An equal percentage of families graduated (25%; n=11), while 21% (n=9) were terminated due to scheduling conflicts with their job or school. Fourteen percent (14%; n=6) were closed due to the participant refusing services or the program's inability to contact or locate the family. Another 2% (n=1) were closed because they refused a change in their FSW. The remaining six cases (14%) were closed due to other reasons, such as the target child reaching the age of five years, or the family was never engaged.

Figure 2. Reasons for Case Closures: Year 14 (n=44)

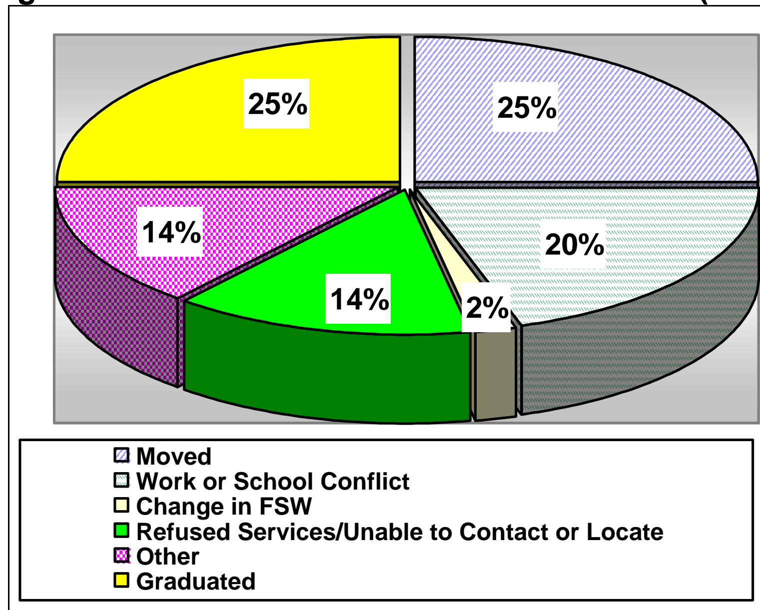


Table 3 shows attrition rates across the fourteen years of the program. During Year 14, the HFM program served 141 families. Of these, 44 families terminated during the fiscal year. A total of 15 families left due to graduation or the child reaching five years of age, leaving 29 families who closed for other reasons. The Year 14 attrition rate of 21% continues the trend for decreasing attrition rates begun in Year 12.

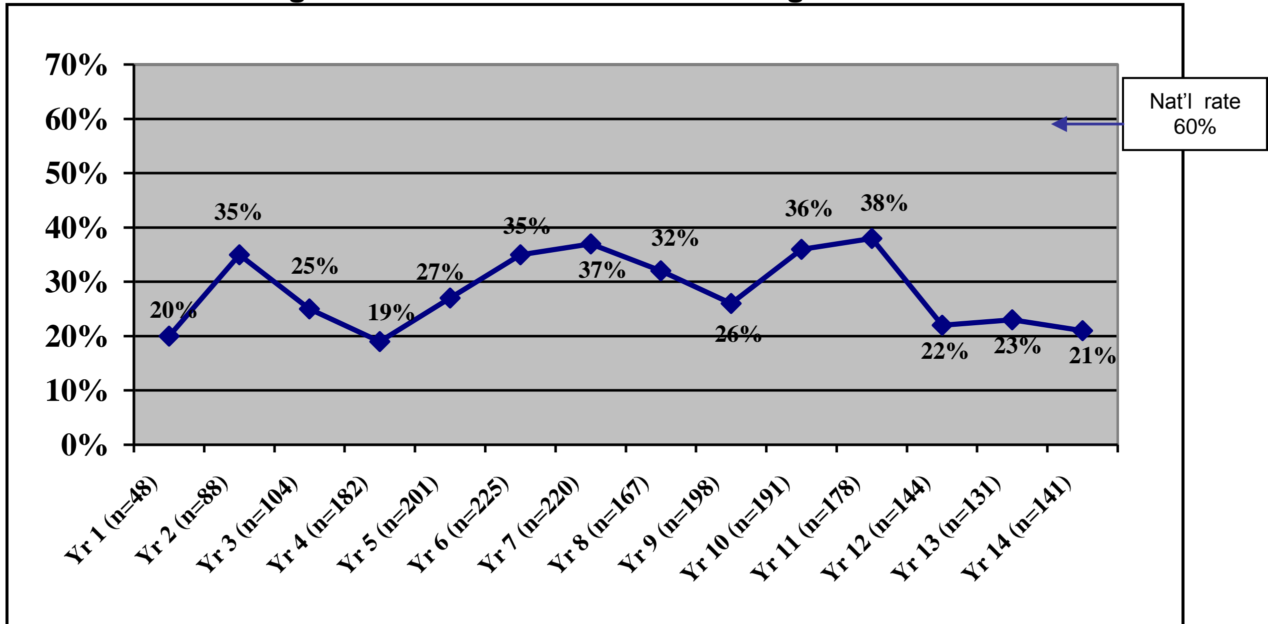
Table 3. HFM Attrition: Years 1-14

Year	Carryover from previous yr	Enrolled in fiscal year	Total enrolled during fiscal year	Closed* during fiscal year	Graduated / Age > 5 years	Attrition Rate*
Year 1	-	48	48	10	-	20%
Year 2	38	50	88	31	-	35%
Year 3	57	47	104	26	-	25%
Year 4	78	104	182	34	-	19%
Year 5	148	53	201	54	7	27%
Year 6	140	86	226	78	11	35%
Year 7	137	83	220	82	10	37%
Year 8	128	39	167	53	2	32%
Year 9	112	86	198	51	16	26%
Year 10	131	60	191	69	9	36%
Year 11	113	65	178	67	9	38%
Year 12	101	43	144	33	15	22%
Year 13	96	34	130	30	3	23%
Year 14	97	44	141	29	15	**21%**
Longitudinal						**X=28%**

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

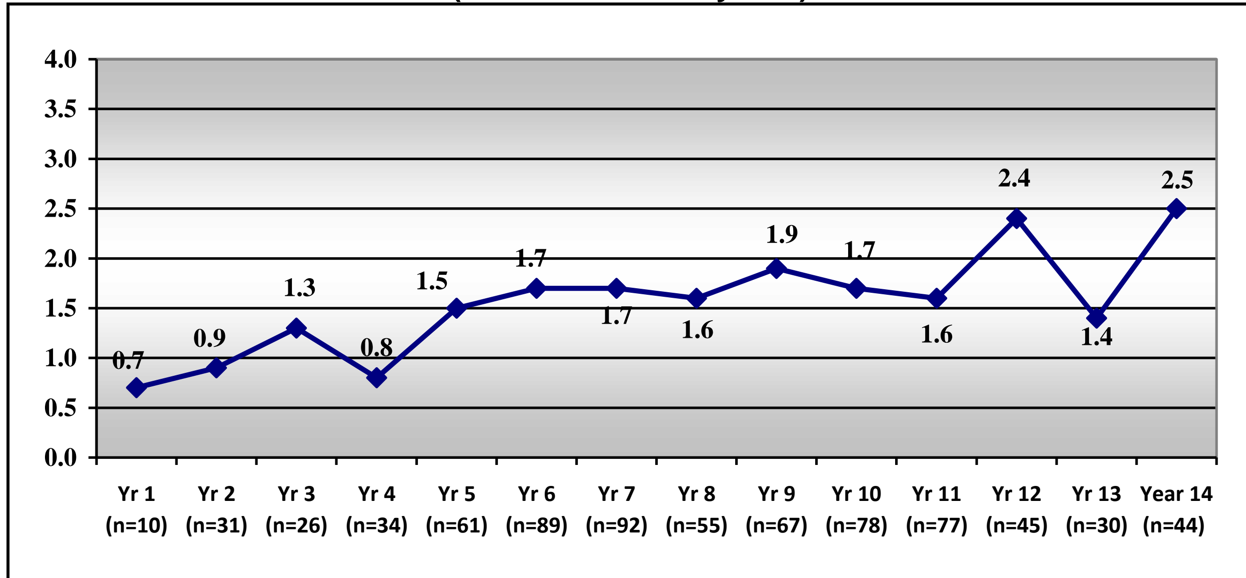
Over the course of 14 years, attrition rates ranged from a low of 19% in Year 4 to a high of 38% in Year 11. The average attrition rate of 28% is less than half of the national rate of 60%. See **Figure 3**.

Figure 3. Attrition Rates: Percentage Profile



Low attrition typically indicates a longer duration of enrollment for participants. When examining how long families remain in the program before termination, it can be seen that the lower attrition rates since Year 12 corresponded with a greater length of enrollment for Year 12 and 14, but not in Year 13. **Figure 4** displays the duration of enrollment for closed cases over the past 14 years.

Figure 4. Duration of Enrollment/Closed Cases for Years 1- 14 (Mean number in years)



Attrition and retention analyses were completed on Year 14 participants to ascertain if there were any trends or mediating variables that influence program retention. When length of enrollment was analyzed by attrition status and reason for termination, it is evident that program graduates remain in the program for the longest average time (5 years). As seen in **Table 4**, duration of enrollment for open cases and cases that closed by the end of Year 14 was equivalent in both average length and range. This is in contrast to last year when there was a significant difference in average length of enrollment for the two groups.

Table 4. Enrollment Mean and Range: Year 14

Enrollment Status	**Mean Length of Enrollment *(in years)***	**Enrollment Range *(in years)***
Open	1.9	.10 to 4.87
Closed (non-Graduates)	1.7	.07 to 5.12
Closed (Graduates)	5.0	4.4 to 5.2
Total Year 14	2.5	.07 to 5.2

Population Demographics

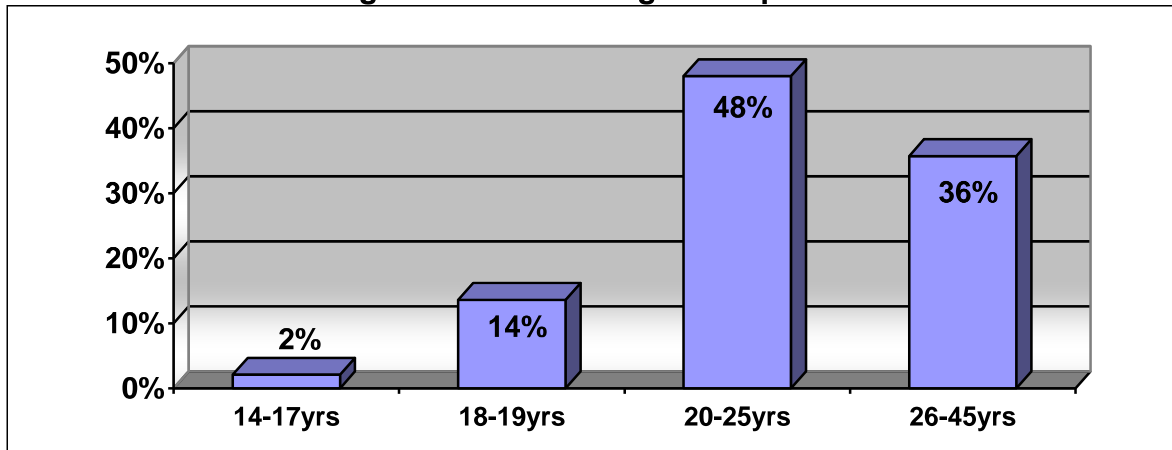
The characteristics that define the program population are important because they act as mediating influences on the program effects. These demographics illuminate the risk, strength and resiliency factors with which families enter the program and assist in

interpreting outcome-evaluation results. Both standard population demographics, such as level of education and marital status, and measured risk factors, such as assessments from the Parent Survey or depression symptomology, can contribute to a participant's level of risk for child maltreatment and add to the strains on already stressed families.

Age

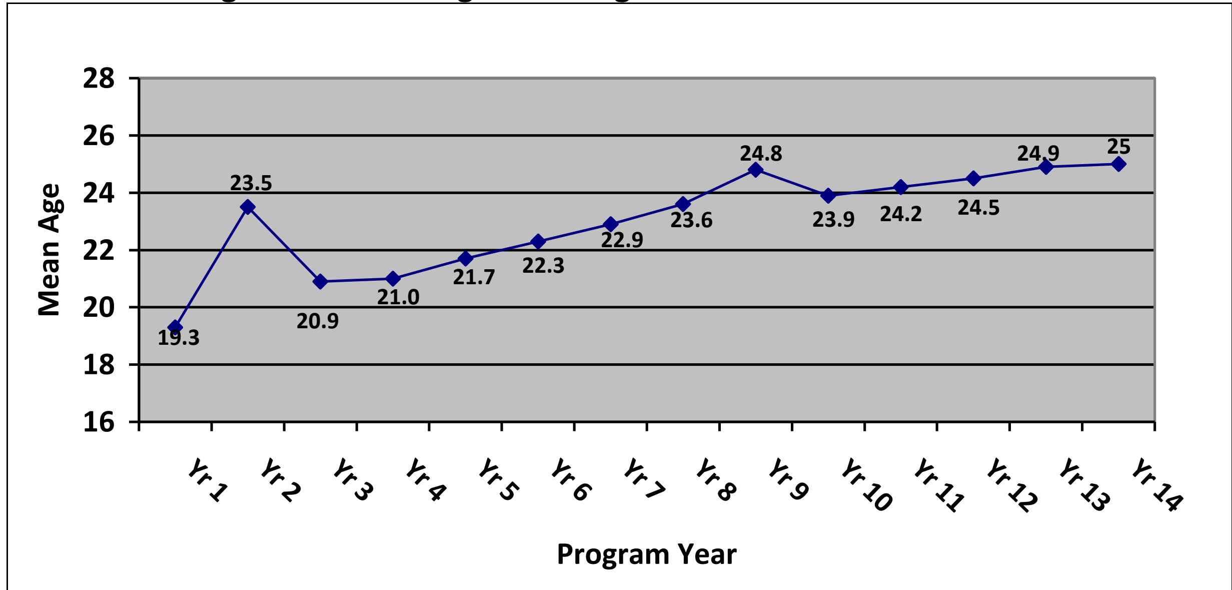
As seen in **Figure 5**, almost half of the mothers (48%) in Year 14 were between the ages of 20-25 years at the time of enrollment. More than a third (36%) of mothers were older, between the ages of 26-45 years. Only a small percentage of mothers (14%) were teenagers at enrollment, however, it is notable that 2% (n=3) were 17 and under, significantly increasing their risk status.

Figure 5. Mothers' Age Groups: Year 14



Data collected across all program years on mother's age at enrollment is shown below in **Figure 6**. There has been a general trend toward increasingly older participants entering the program. The sudden rise and drop in mean age in Year 2 reflects the creation of a separate "Teen Mothers Program" by the County. However, it is unclear if the trend from Year 3 to Year 14 is indicative of a decline in teen pregnancy over the past decade or if there are other programs that are specifically targeting teens.

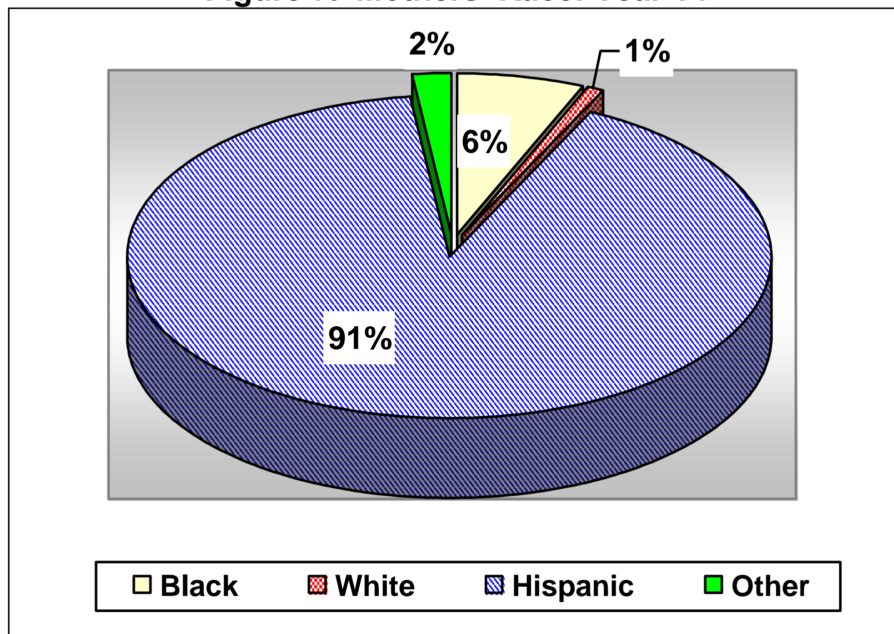
Figure 6. Mean Ages of Program Enrollees: Years 1 – 14



Race

As seen in **Figure 7**, the majority of families in the HFM program during Year 14 were Hispanic (91%, n=129/141), as compared to 6% Black and 1% White. The remaining 2% of participants were Asian/Pacific Islander or multi-racial.

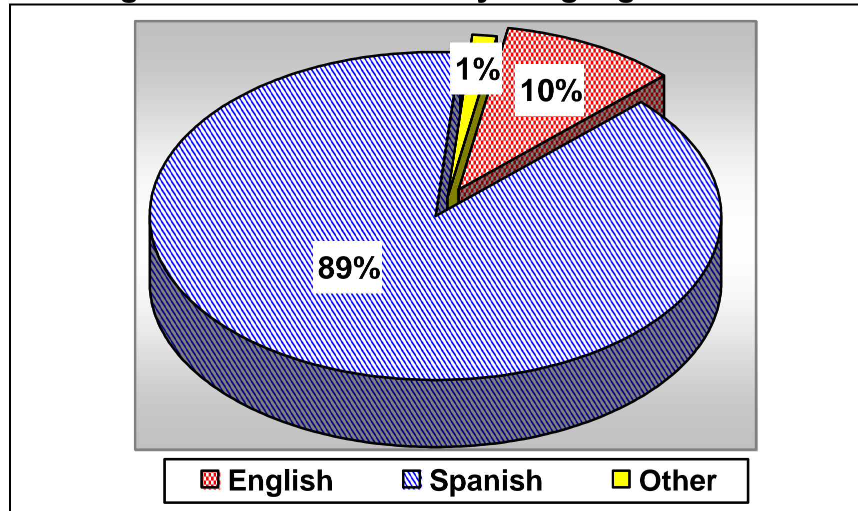
Figure 7. Mothers' Race: Year 14



Language

It is not surprising that the majority of participants speak Spanish. In Year 14, the primary language of participants is 89% Spanish, 10% English and 1% other, as depicted by **Figure 8** below.

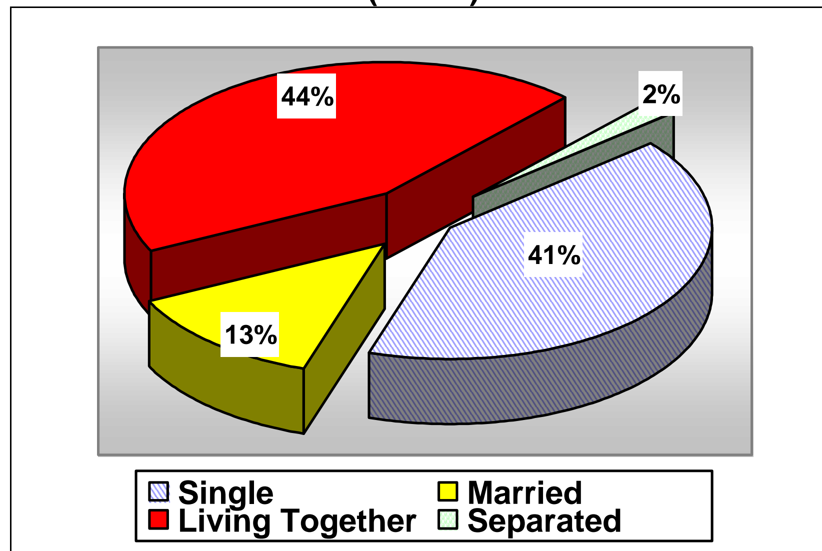
Figure 8. Mothers' Primary Language: Year 14



Marital Status

As depicted in **Figure 9** below, the majority (44%) of HFM participants in Year 14 were living together, but not married. This is a change from previous years when the majority of HFM mothers were single. However, the second largest percentage of mothers reported being (41%) single at the time of enrollment. The remaining percentages of mothers were married (13%) or separated (2%). Overall, 85% of mothers had 'single' marital status at enrollment, which research has indicated is significantly associated with economic risk and instability and places them and their babies at greater risk.

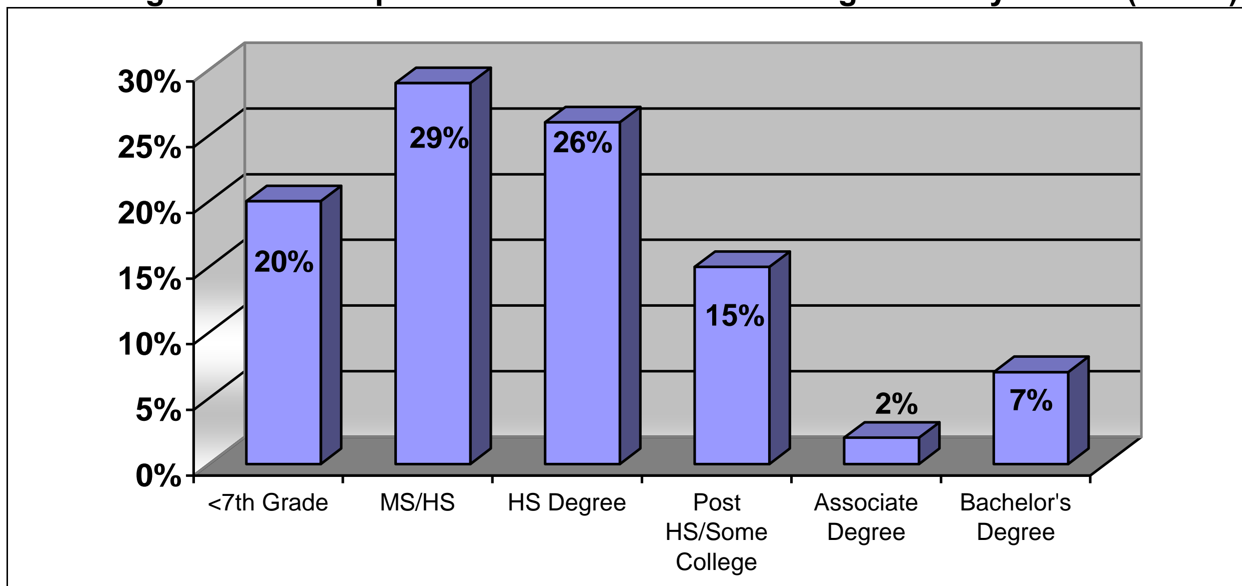
Figure 9. Mothers' Marital Status: Year 14 (n=141)



Education

Education is strongly encouraged in the HFM program because it plays an essential part in the development of self-sufficiency, resiliency and economic independence. Quality education also helps participants learn parenting skills and foster a love of learning in their children. Our past findings have noted a significant relationship between having a high school degree and increased scores on measures of parenting knowledge. In examining the highest level of education achieved by participants at enrollment, more than half (51%; n=71) of active participants 18 years of age or older had obtained their high school diploma, GED or higher. As seen in **Figure 10**, 24% (n=34) of active participants had also attended at least some post high school training as well, and 9% (n=13) obtained an Associates or Bachelor's Degree. However, a large percentage of mothers had less than a 12th grade education (49%) and 20% had less than a 7th grade education. This is not due to age, since teens younger than 18 years were not included in this analysis. It is more likely attributable to large proportion of newly immigrated mothers from Latin America and the lack of education offered young women in their native countries. As adults, it is extremely difficult for them to increase their education level, particularly if they are not English speaking, but many do pursue a GED.

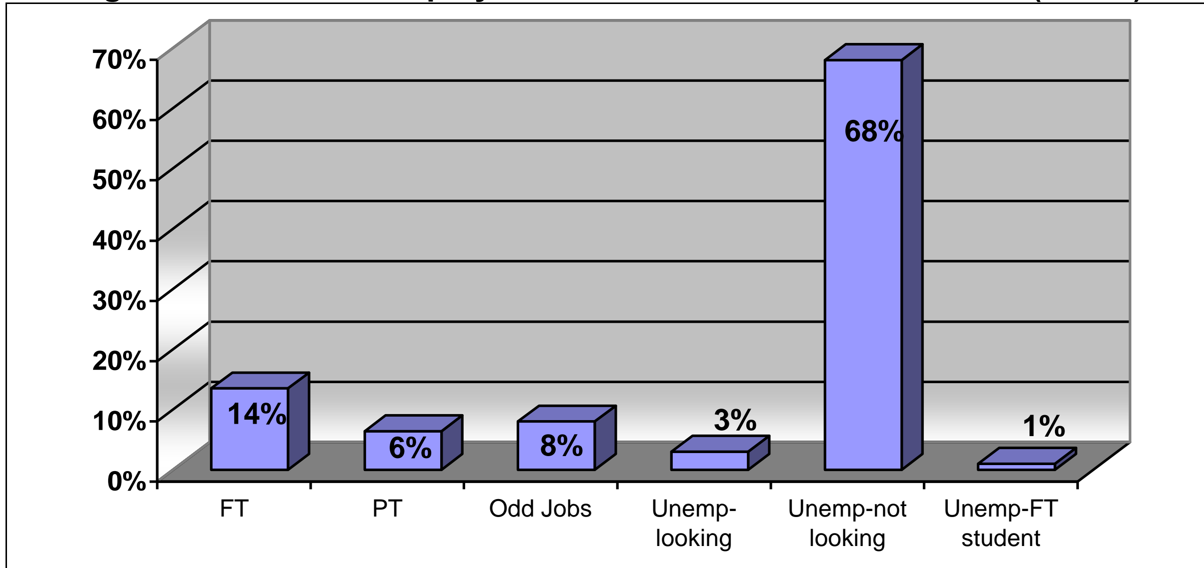
Figure 10. Participants' Education Status at Program Entry:* Yr 14 (n=140)



Employment

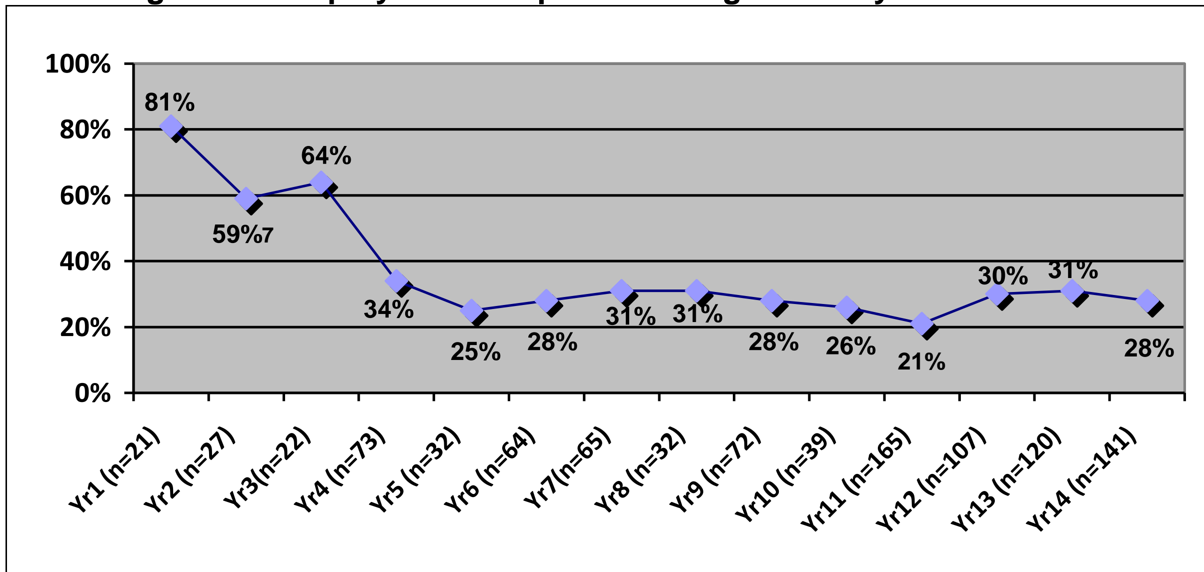
Financial stability is also integral to self-sufficiency and plays a role in participant resiliency. The HFM program fosters financial stability by offering assistance with employment-related issues, connecting families to community resources and opportunities, and providing encouragement. Data from Year 14 on participants' employment status at enrollment was examined for participants who were not enrolled in school (n=141). As seen in **Figure 11**, most (68%) participants were unemployed and not looking for a job at enrollment; this is not surprising since the mothers were either perinatal or within 3 months postnatal. Eleven mothers were in school at enrollment.

Figure 11. Mothers' Employment Status at Enrollment: Year 14 (n=141)



As seen in **Figure 12**, employment rates were higher in the initial years of the program, but decreased significantly in Year 4. Mothers' employment rates at program entry have remained approximately 25%-31% over the years, in Year 14, 20% (n=28) of participants were employed full or part-time at enrollment.

Figure 12. Employed Participants at Program Entry:* Years 1 - 14



**Excludes enrollees that are full-time students*

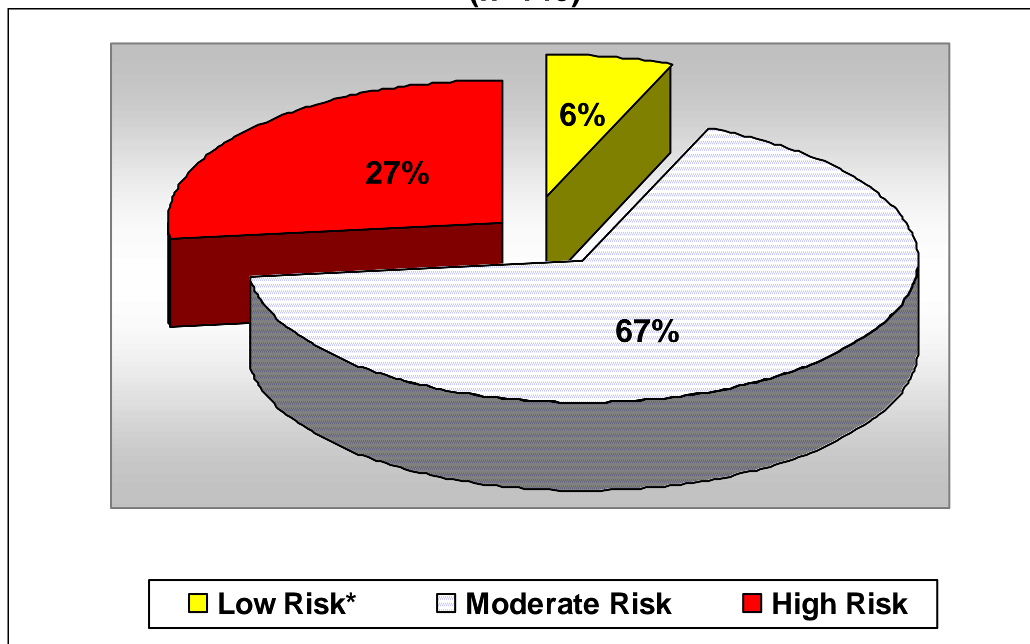
Risk Factors

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 scores of 25 or greater are offered services. Mothers who are enrolled with FSC <25 were found eligible based on the father's FSC score

While eligibility criteria pre-selects a participant population that is at moderate risk or greater for child abuse and neglect, many families present a constellation of factors that place them at severe risk. **Figure 13** below shows the categorization of the FSC/Parent Survey scores of 140 active enrollees during Year 14. For those mothers who scored in the low range, they were found eligible for the program based on the father's FSC risk score.

Figure 13. FSC/Parent Survey Risk Scores at Program Entry: Year 14 (n=140)



** Eligibility based on FOB score*

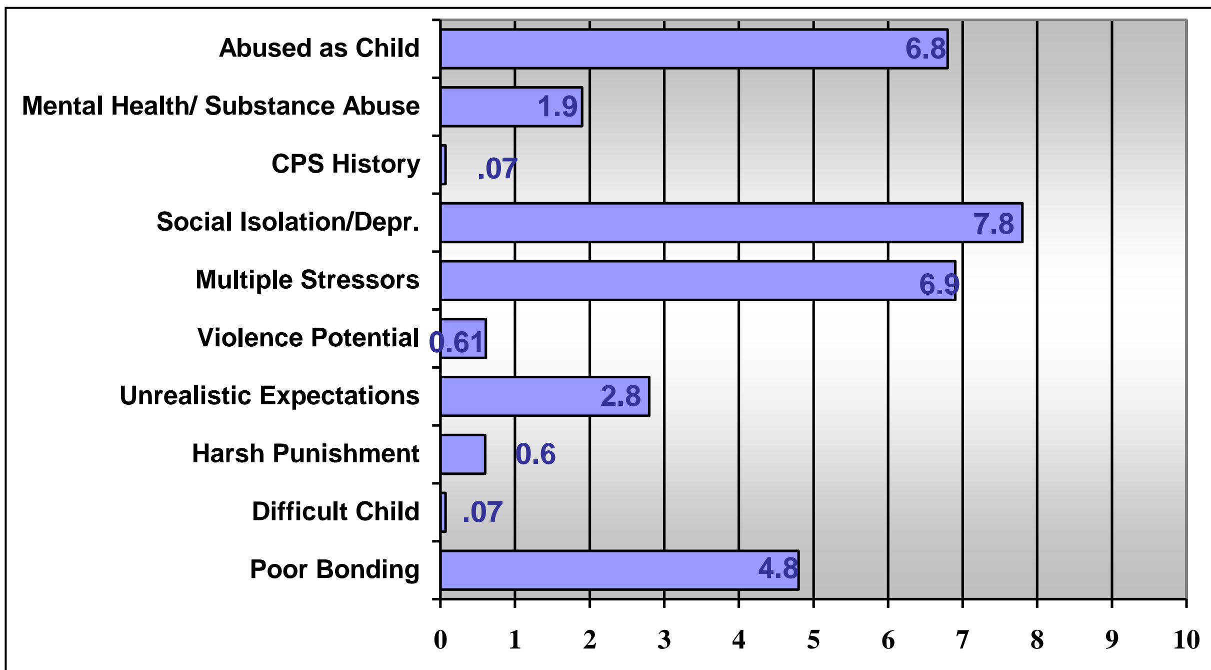
It has been found that psychosocial factors play a significant role in assessing the mother's level of risk. Examination of the individual factors addressed on the Parent Survey shows the areas associated with the highest levels of risk for the HFM mothers as they entered the program. The possible scores 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 14 indicate that the four most significant risk factors based on mean score are displayed in **Table 5** in rank order. This constellation of severe risk factors places these mothers and their children at very high risk for child maltreatment.

Table 5. Risk Factors with Highest Mean Score (n=140)

Parent Survey Risk Factor	Mean Score
1. Social Isolation/Depression	7.8
2. Multiple Stressors	6.9
3. Being Abused as a Child	6.8
4. Poor Bonding	4.7

The mean scores for all ten factors on the Parent Survey are shown below in **Figure 14**. These scores assist the HFM program in targeting their interventions to address the overall risk of the participants and to guide the FSW's individual work with the family.

Figure 14. Parent Survey Item Mean Scores by Subscale: Year 14 (n=140)

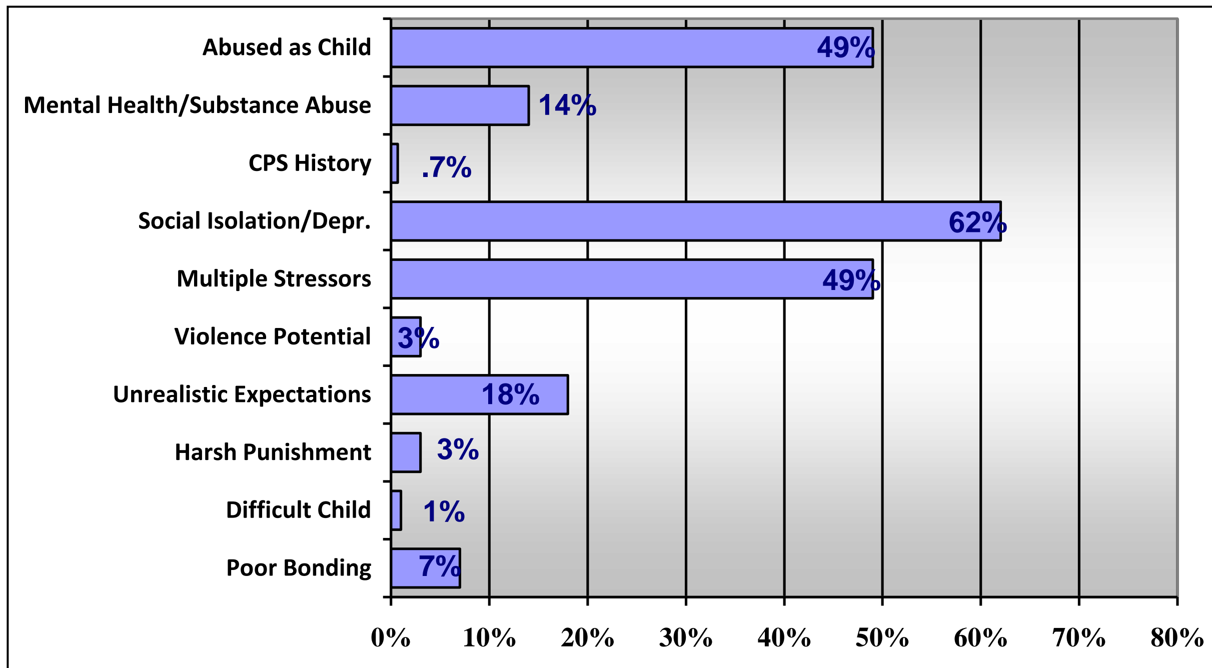


In order to get a better sense of the number of mothers who are high/severe risk on all factors, Parent Survey results are examined in terms of the percentage of participants who scored in the "severe' risk range in each factor. As seen in **Figure 15**, the ranking of the top four risk factors parallels that of the mean scores. In rank order, they are:

1. *Factor #4: Social Isolation and Depression*. This is consistent with the highest mean score (x=7.8) and is the highest percentage (62%) of mothers in the severe risk range
2. *Factor #5: Multiple Stressors.* This is also consistent with the mean score (x=6.9) and indicates that most mothers (49%) are at high risk for violence.
3. *Factor #1: Abused as Child*. This factor also has a high mean score (x=6.8) and almost half (49%) of mothers have poor bonding and attachment.
4. *Factor #10: Poor Bonding.* Although this factor had one of the highest mean scores (x=4.8), the percentage of mothers (7%) who scored in the severe

range is relatively small. However, the mean score is elevated due to the fact that most mothers (80%) have experienced at least moderate poor bonding with their child.

Figure 15. Percentages of Mothers Scoring in Severe Range by Subscale

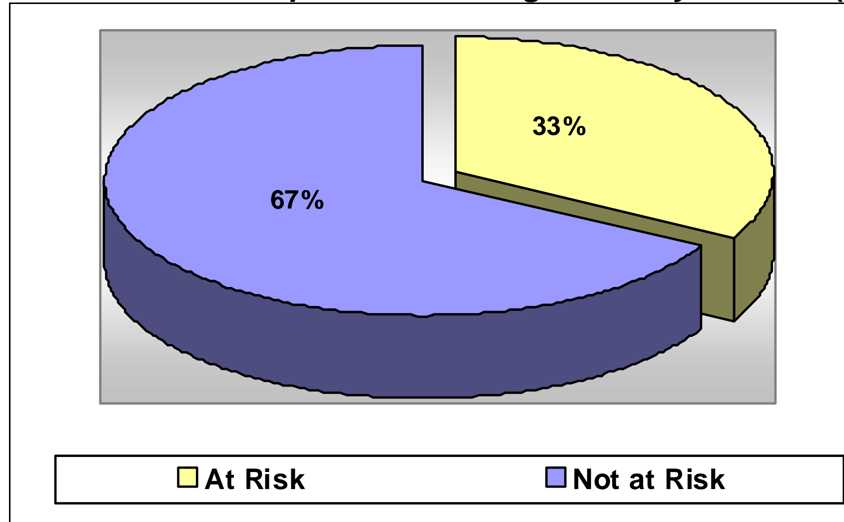


The pattern that emerges from the Year 14 profile of risk factors is one that reflects an increased potential for child maltreatment, particularly neglect. The prevalence of social isolation and depression are more closely associated with potential for neglect. However, the high incidence of mothers (88%) that experienced moderate to severe abuse as a child places them at much higher risk for 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.

Maternal Depression

Depression is a potent correlate of child abuse and neglect, thus it is important to screen for depression and provide linkages to intervention services. The HFM program has used the Center for Epidemiologic Studies-Depression (CES-D), a self-report measure, to determine risk for maternal depression prenatally, post-partum and on an annual basis. Scores of 16 or above indicate risk for maternal depression. As seen in **Figure 16**, at program entry, *over one-third (33%; n=29) of Year 14 participants scored at risk for depression.*

Figure 16. Maternal Depression at Program Entry: Year 14 (n=75)

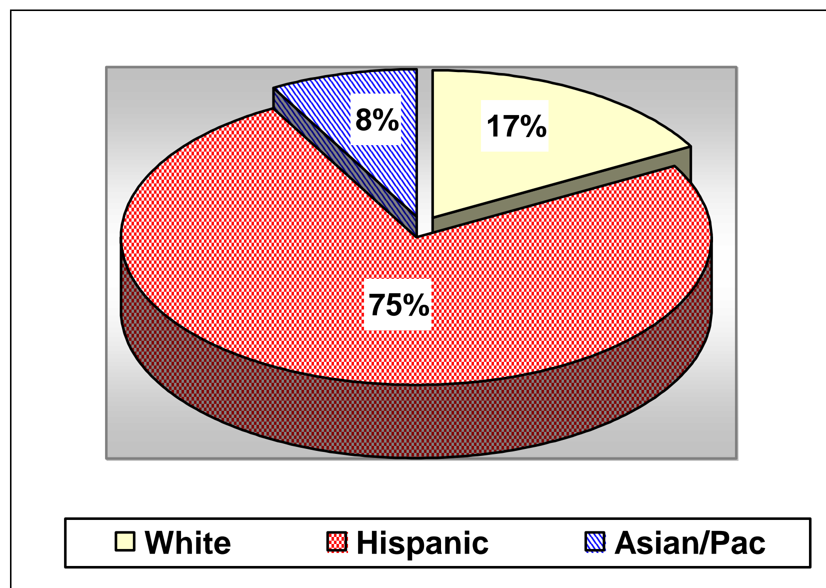


Staffing

During Year 14, the HFM program employed 12 staff members (11.5 FTEs). Staff positions include one Program Manager, 1.5 Clinical Supervisors, one Family Resource Specialist, 7.5 Family Support Workers, one part-time Early Intervention Specialist; and one full time Program Assistant. However, before the end of the fiscal year, one FSW position was transferred to the FSI Early Head Start, reducing the number of FSW positions to 6.5.

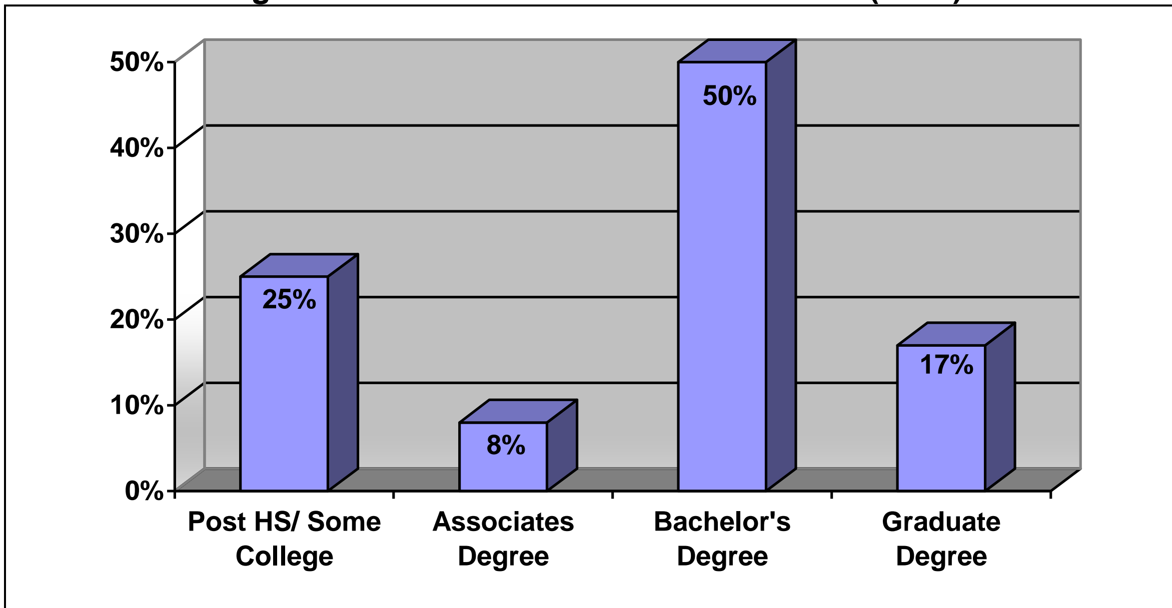
In order to ensure cultural and linguistic competence, the HFM program hires staff that reflects the ethnic and cultural composition of the target population. All staff were female and most were Hispanic (75%; n=9), while the remaining staff were White (17%; n=2) or Asian Pacific Islander (8%; n=1). See **Figure 17**. Almost all staff were bilingual in English and Spanish (75%; n=9) or English and Hindi/Punjabi (8%; n=1).

Figure 17. Staff Ethnicity: Year 14 (n=12)



The collective educational level of the staff remains high. The staff employed during Year 14 is well-educated and highly trained, as evidenced by individuals' education levels and the extensive trainings completed (see Staff Training section below). As seen in **Figure 18**, all staff has obtained a high school degree and had some post-high school training or college. Additionally, the majority of staff had attained either an Associates Degree (8%; n=1), a Bachelor's Degree (50%; n=6) or a Graduate Degree (17%; n=2).

Figure 18. Staff Education Levels: Year 14 (n=12)



Staff Attrition/Retention

The HFM program has retained many of its staff over the past fourteen years. High levels of staff retention reflect a stable program that values its staff and provides opportunities for feedback and growth. Staff retention has also been linked to family retention, particularly retention of the Family Support Workers who engage the families and are directly involved with them on a regular basis. All staff members have been with the program for at least one year and several staff have been with the program for over ten years, one of whom has been employed by HFM since the program began in 1996. During Year 14 two staff members left for an 83% (n=10/12) staff retention rate (see Appendix L. Staff Tenure Dates: Years 1-13).

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, and 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 core trainings, such as those mentioned above, are required prior to FSWs completing any home visits with families. Other trainings are required within six months or one year of hire. 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.

Trainings for Year 14 are provided in detail by date (see Appendix M: HFM Year 14 Staff Trainings). The extensive number and type of trainings offered demonstrate the program's dedication to expanding the knowledge and skill set of its staff by providing 53 trainings covering over 43 different topics. Ten topics were offered on at least two occasions. In addition, staff attended a variety of other external trainings and professional conferences. The trainings can be divided into four topic areas: Professional Development, Family Mental Health and Well-Being, Family and Child Health Care, and Child Development. Most trainings fell within Professional Development, while Child Development trainings were the second most frequently offered. This pattern is indicative of HFM's emphasis on developing highly professional staff who are well-equipped to focus on helping parents optimize their child's growth and development.

- *Professional Development*

Twenty-five trainings and conferences were offered in this area and are related to program implementation, management, data and evaluation. These included: PIMS, PEMINIC Training, Diversity Training, Motivational Interviewing, Establishing Boundaries, HFM Enrollment and Referral Process, Chart Documentation, Community Resources, Child Welfare Indicators and Reporting, Evaluation Tools, Developing Family Support Plans, Communication Skills, the Community Interpreter, PIMS Retention Webinar, and Avoiding Job Burnout. A variety of local, national and federal conferences, as well as the HFA core training, was also provided.

- *Family Mental Health and Well-Being*

Five trainings were offered in this area and focused on general family functioning and parenting, as well as mental health, substance abuse and domestic violence. Topics included Treating Children with Relational Trauma, Responding to Problematic Behaviors, Coaching on Positive Parenting Strategies, Parents as Teachers (PAT), and Working with Teens.

- *Family and Child Health Care*

Ten trainings in this area covered topics related to the health care of children and families, including First Aid, CPR, Health Care Coverage for Marylanders, Preparing Mother for Birth and Beyond, and Peminic Training.

- *Child Development*

Thirteen trainings were offered in this area that focused on the child development and education. Topics included ASQ-3 and ASQ:SE, DIAL3, CFSEL Social Emotional Functions, Fostering Infant and Child Development, Keeping Babies Healthy and Safe, Growing an In-sync Child, Wee Cuddle and Grow, Play-Meaning Interactions and Fun, Exploring the Path to Literacy.

Staff Satisfaction

In September 2010, twelve staff members and one temporary staff person (total n=13) completed a questionnaire designed to solicit feedback on HFM staff's perceptions regarding job satisfaction and work-related stress, views on program strengths and areas for improvement, as well as perceptions of support and benefits they have received while working for HFM (see Appendix N: Staff Satisfaction Survey). Respondents were asked to identify their position. Four respondents identified themselves as manager/team leader; 8 identified themselves as FSW/FRS category; and one marked the 'Other' category.

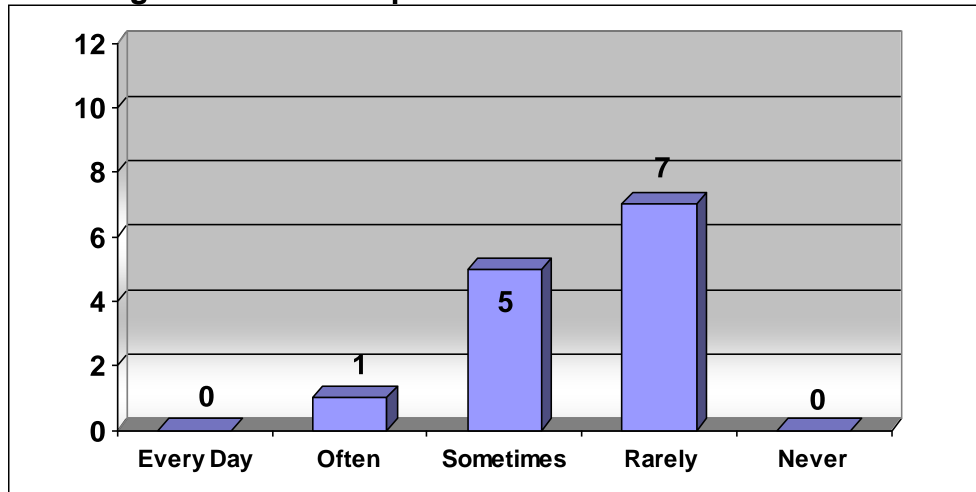
The questionnaire consisted of 13 statements accompanied by a 5-point Likert scale. Respondents were asked to indicate if they *strongly agree*, *agree*, are *not sure*, *disagree* or *strongly disagree* for each item. As seen in **Table 6**, most staff members agree or strongly agree with the positive statements about the program. However, consistent with previous years, they do not feel that they are adequately compensated for the work they do. Compared to last year's responses, staff members appear more positive about the impact they are having on children and families, but they feel less appreciated by the HFM management. There also appears to be concern about feeling safe in the communities they visit, which could be addressed through supervision or additional trainings in this area.

Table 6. Staff Agreement with Various Program Aspects

	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
I understand the goals and objectives of HFM.	10	3			
HFM is a strength-based and family centered program.	10	3			
HFM trainings adequately prepared me for my position.	10	3			
My supervisor is responsive and supportive of my needs.	8	3		2	
The program uses materials that are culturally and linguistically appropriate.	10	3			
The program uses bilingual materials as appropriate.	9	4			
I feel comfortable working with the culturally diverse families served by HFM.	9	4			
I enjoy being part of the HFM team.	12	1			
My work is worthwhile and has a positive impact on children and families.	12	1			
The work I do uses my skills, knowledge and experience.	10	3			
I generally feel safe in the communities I visit (one did not answer; one said n/a).	2	6	3		
HFM management shows appreciation for the work I do for the program.	5	6	2		
I am adequately compensated for my position.	1	3	4	5	

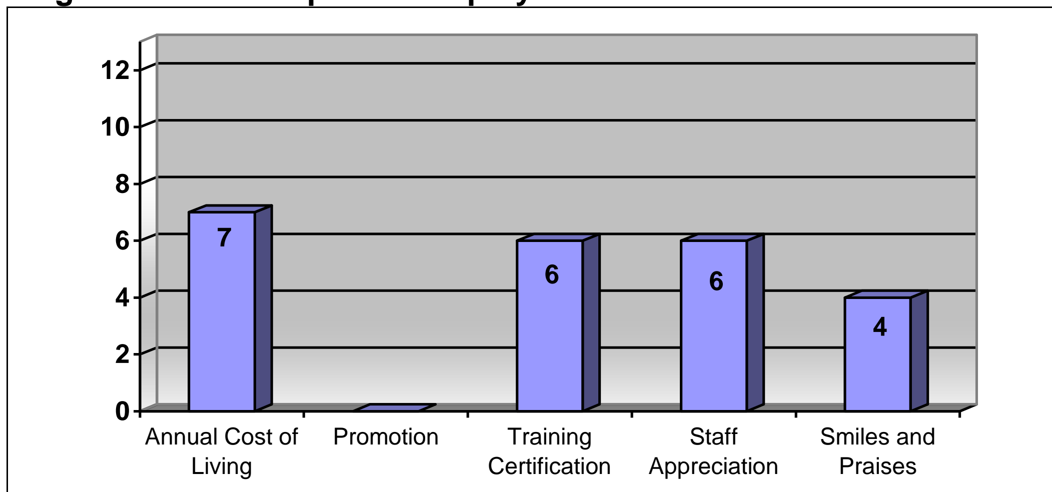
Staff members were asked to indicate how often they feel stressed at work. In contrast to previous years, most staff reported "Rarely" (n=7) feeling stressed, while the remainder of staff members (n=6) feel a moderate degree of stress associated with their work, as indicated by the number who responded "Sometimes" or "Often." See **Figure 19**.

Figure 19. Staff Report of Job Stress: Year 14



Staff members were asked to respond to a question about whether they had received or taken part in any employment incentives during the past year. Consistent with last year, the majority of staff (n=7) reported receiving a pay increase (annual cost of living increase), while almost half of staff members participated in a staff appreciation event (n=6), received a Training Certification (n=6) or "Smiles and Praises", FSI's internal staff recognition program (n=5). No staff received promotions. **Figure 20** shows staff reports of the employment incentives received within the past year.

Figure 20. Staff Report of Employment Incentives Received: Year 14



In order to assess the staff's perception of the strengths and weaknesses of the program, they were presented with two open-ended questions. Additional strengths were noted in the "comments" section. When asked what areas of the program are particularly strong, nine staff members provided responses. The three areas mentioned the most were: 1) staff training; 2) the program focus on prevention and child development; and 3) the quality of the staff and organization. **Table 7** shows all current strengths cited by the staff in rank order, along with the frequency with which they appeared.

"…the program uses a strength-based approach to deal with any challenges encountered."

Table 7. Program Strengths Identified by Staff (n=9)

Strength	Frequency
Staff Training	4
Program Focus on Prevention and Child Development	3
Staff and Organization Quality	4

When asked which areas of the program need improvement, six individuals offered responses. Additional recommendations were provided in the "comments" section. Two key areas emerged as targets for improvement: 1) additional training and support in family support plans; program design and critical elements; and serving multi-ethnic families; and 2) financial support for technological materials, administrative staff, raises and promotions. One staff member suggested additional training for supervisors aimed at increasing their ability to provide support to the Family Support Workers.

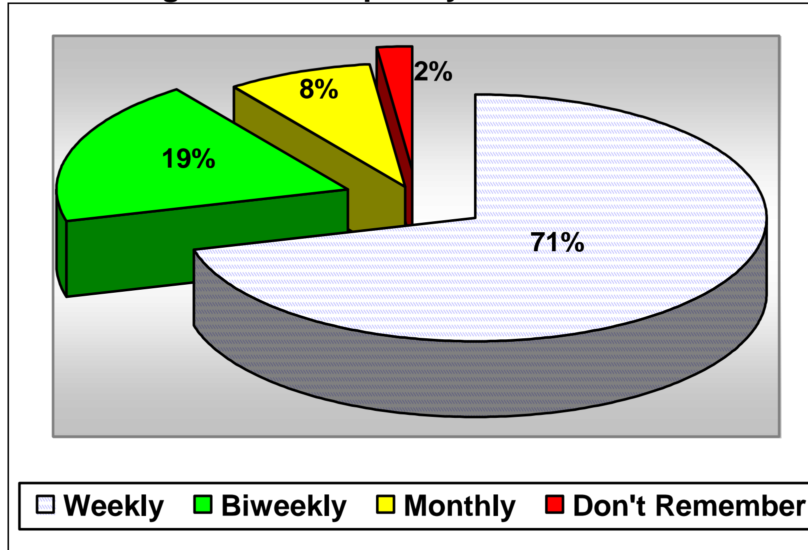
Participant Satisfaction

The Healthy Families Montgomery program strongly values fidelity to its model and to providing its families with the best quality support, information, and services. To this end, HFM administers annual participant satisfaction surveys to gather anonymous information from families regarding various program areas (see Appendix O: Participant Satisfaction Survey). As in past years, surveys in English and Spanish were distributed to all active participants during home visits. In Year 14, 97 surveys were distributed with 65 participants returning the survey. This represents a response rate of 67%. The majority of respondents were between 21 and 30 years old (65%; n=41), while 21% (n=13) were 31 years old or older and 13% (n=8) were teens between 16 and 20 years old.

"I became a good mother and understand more about my baby's needs."

Home visits are a core component of the HFM program. Survey results show that the majority of participants were receiving the most intensive level of services, as indicated by frequent home visits, reflecting that they were at the highest level of risk. A majority of the respondents reported that they received home visits once a week (70%), as depicted in **Figure 21** below. An additional 19% reported that they were visited twice a month and 8% indicated that they were visited once a month. One participant reported that they did not remember how frequently they were visited. *All 64 respondents reported that they received their first home visit before their babies were 3 months old.*

Figure 21. Frequency of Home Visits

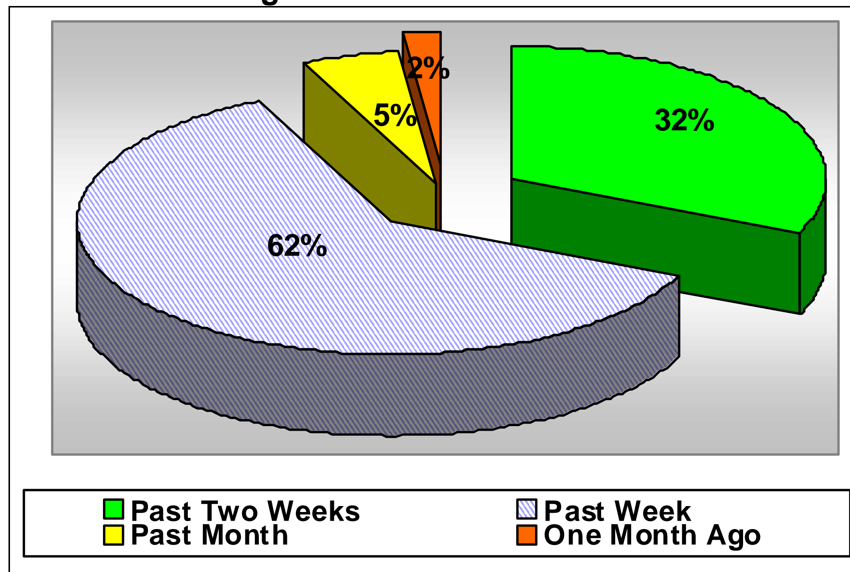


> *"I like the information my FSW gives me and the advice as well."*

Participants were also asked when their most recent home visit occurred. Results for Year 14 indicate a larger percentage of participants were visited weekly (70%; n=45) than last year (62% in Year 13). As depicted in **Figure 22** below, a lower percentage of respondents reported being visited within the past two weeks (19%; n=12) and those reporting being visited within the past month remained the same, 8% (n=5). These responses correspond to participants' report of frequency of visits.

> "*I love this program because it teaches me a lot about how to be a good mom. Healthy Families helped me become a better parent."*

Figure 22. Last Home Visit



Participants were asked how effective they thought the program was in various areas by circling "Yes" or "No." **Table 8** below shows the percentage of "Yes" answers. Respondents unanimously perceived the program to be effective in all categories, with the exception of 98% (n=64) stated that the FSW helped them to be more independent by helping them make their own decision.

Table 8. Participant Perception of Program Effectiveness (n=67)

1. My Family Support Worker visited me as agreed upon.	100%
2. My Family Support Worker gives me information on how to care for my baby.	100%
3. My Family Support Worker is helping me learn about my child's development.	100%
4. My Family Support Worker helps me with my needs and the needs of my baby and family.	100%
5. My Family Support Worker is respectful of my baby, my family and me.	100%
6. My Family Support Worker accepts and respects my culture.	100%
7. My Family Support Worker speaks to me in a language I can understand	100%
8. My Family Support Worker helps me to be more independent by helping me make my own decisions. (n=64)	98%
9. My Family Support Worker has helped me to become a better parent.	100%
10. My Family Support Worker has made a positive impact.	100%

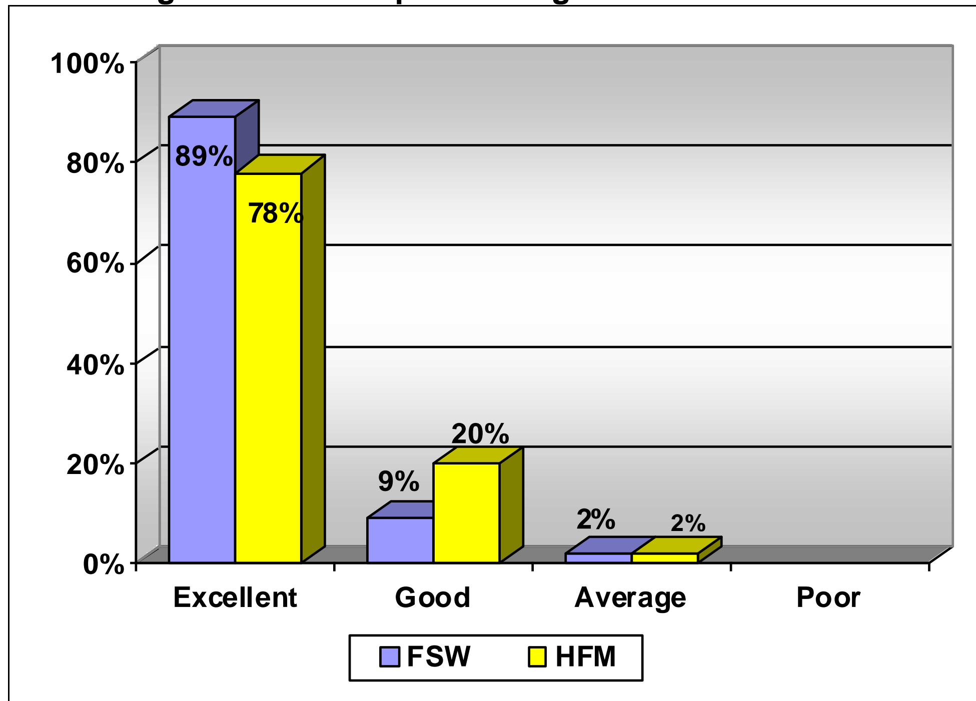
"This program helps you move forward in life and develops self-confidence."

When asked what they liked best about the program, 64 participants responded with positive comments about the program. Most of the comments 54% (n=32/59) focused on how the HFM program has helped them to be a better parent by teaching them about child development and strategies for helping their child learn. Parents also value the support and guidance they receive from their FSWs when the family is in need, as well as the information they give them about community resources. When asked what they did not like about the program and recommendations for improvement, almost all responded that there was nothing that they did not like. Of those who made recommendations for improvements, four respondents indicated they wanted visits to be longer (1½ hours), the amount of paperwork decreased (although recognizing that it is necessary), and that they did not want the removal of the Mother Goose activity. Six respondents focused on having more activities and opportunities to interact with other parents or offering classes, such as English or First Aid classes. Three individuals suggested that offering childcare would improve the program. Finally, one respondent noted that assistance with transportation would be helpful, while another felt that having dads participate directly in some of the activities would help them learn about the needs of the babies.

"They have taught me to be a better mother."

Families were also asked to rate their FSW and the HFM program. The majority of respondents reported that both their FSW and the HFM program were "Excellent." As shown in **Figure 23**, one participant rated her FSW and the HFM program as "Average", but no respondents rated their FSW or the program as "Poor".

Figure 23. Participant Ratings of FSWs and HFM



All respondents (100%; n=67) agreed that they would recommend the program to a friend or relative, with 90% responding "Strongly Agree."

In summary, HFM participants continue to report high levels of satisfaction with the program. Comments focused on how the program has helped them be better parents by teaching them about child development and giving them strategies for helping their children learn. Parents value the support and guidance they receive from their FSWs, as well as the information they give them about community resources. They appreciate opportunities to interact with other parents and would welcome increased group activities.

B. OUTCOME EVALUATION

Achievement of Goals and Objectives

In the past fourteen years, Healthy Families Montgomery has continually met its goals and outcomes successfully, as well as exceeded many of its targets for key outcomes. As seen below, current outcomes confirm the program's ability to sustain its successes through its fourteenth year of operation as well (see Table 10: Summary of Goals, Objectives, and Program Outcomes: Years 1-14 and Table 11: Summary of Goals, Objectives, Program Outcomes and Comparative Statistics: Year 14).

Goal I: Reduce Incidence of Child Maltreatment

Families will have no founded reports 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. Given this level of risk, it is particularly impressive that *100% of families during Program Year 14 had no founded Child Welfare Services (CWS) cases.* This finding provides solid evidence of the positive impact that prevention can have on reducing the incidence of child maltreatment with high-risk families. Over the fourteen years of program implementation, there have only been six cases of founded child maltreatment, all of which were cases of neglect.

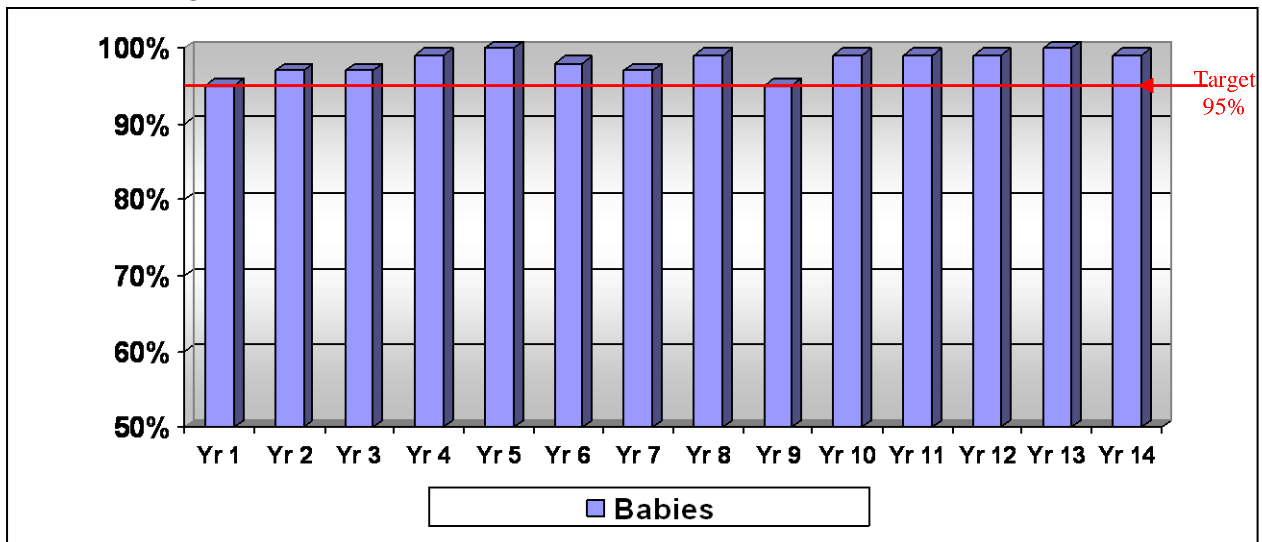
Goal II. Promote Preventive Health Care

Health Care Provider

An important goal of the HFM program is ensuring that program participants are linked with primary health care providers and health insurance, specifically Medical Assistance (MA) or private insurance. The State of Maryland provides health coverage for low-income children through its MCHIP program. All mothers are covered prenatally, but medical coverage is generally not available for the working poor through the state, particularly for undocumented immigrants. The Montgomery Cares (formerly Rewarding Work) and Project Access programs were established in Montgomery County to fill these gaps, increasing coverage for the uninsured. HFM has consistently been able to link families to health insurance programs and primary care physicians ever since its inception in 1996.

As seen in **Figure 24**, at the end of Year 14, of the 138 target children, *99% (n=136) were linked with medical providers, exceeding the program's goal. In addition, 99% (n=125) of eligible children were enrolled in MA.* These results indicate that children are linked to a medical provider for immunizations and well-child checkups.

Figure 24: Access to Health Care Provider:* Babies Years 1-14

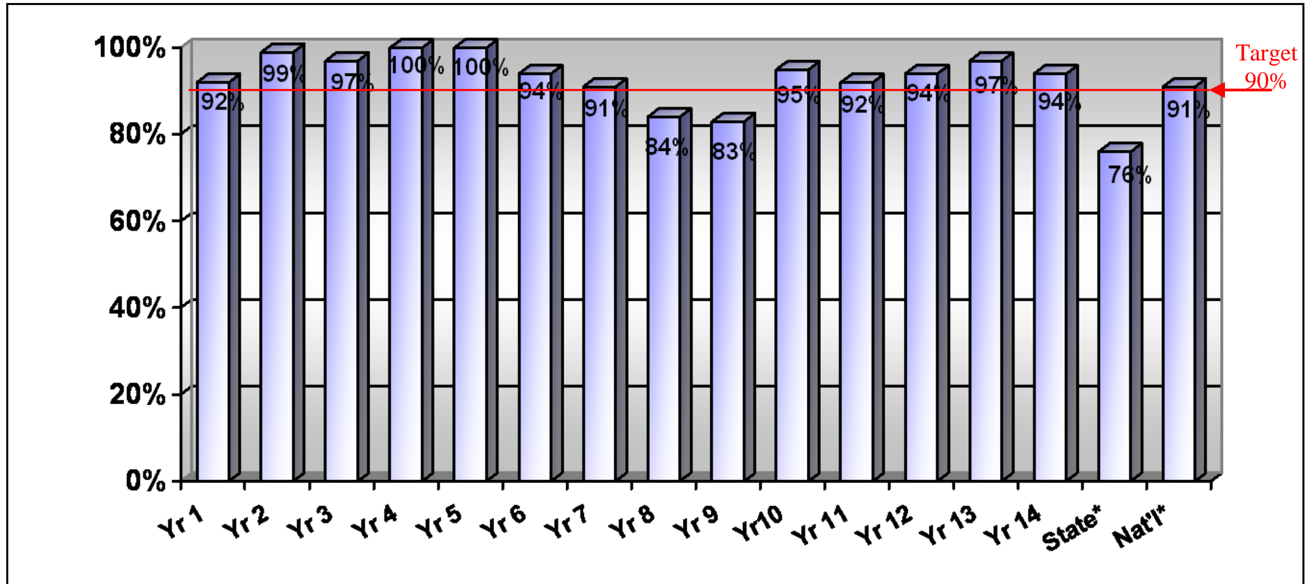


**Access is defined as having health insurance and/or linked to a provider.*

Current Immunizations

FSWs work with families to ensure that babies are immunized in a timely fashion. This is done through providing information to families on the importance of immunizations for preventing serious medical diseases and by assisting with linkage to healthcare providers, helping to set up appointments when needed, and giving reminders about appointments as necessary. As a result, HFM has achieved impressive success rates with infants receiving their immunizations on schedule. Families are more likely to follow up on immunizing their children if they have both health insurance and a medical provider. Consequently, this goal is closely linked to the previous goal of assisting families in securing medical homes. When examining children who were active during Year 14 and were old enough to be due for immunizations, HFM exceeded their goal by having *94% of all target children (n=129/138) current on their immunizations* as recommended by their medical provider. As seen in **Figure 25** below, this is especially impressive when compared to the Centers for Disease Control 2008 findings on immunization rates for the nation (76%). It also exceeds the State of Maryland (91%) immunization rate (CDC, 2008).

Figure 25. HFM Immunization Rates: Years 1-14



**National and State average taken from the CDC immunization 4:3:1:3:3:1 series 2009 report*

Additional Births

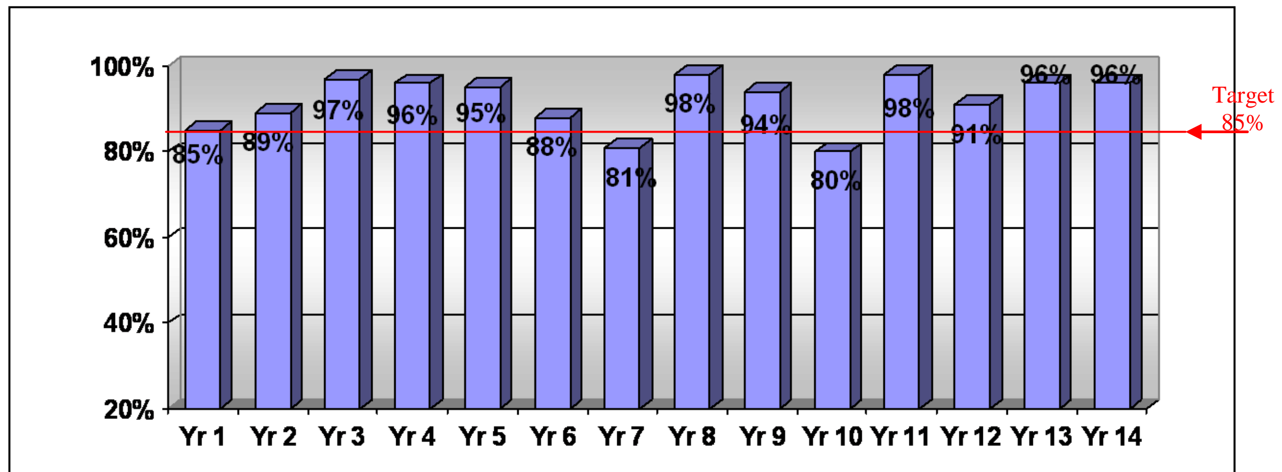
It is recommended that mothers, and particularly teenage mothers, wait a period of at least 24 months between pregnancies. The HFM program provides information on family planning to participants immediately upon enrolling in the program. FSWs alert new parents to the fact that additional pregnancies 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. 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.

In Year 14, 99% (n=141) of mothers did not have a repeat birth within a 24-month period during their enrollment in the HFM program. Two mothers had a second birth approximately one year after the target child. Neither mother was a teen at the time of the repeat birth. HFM's success rate in this area has consistently exceeded both state and national statistics.

Post-Partum Care

Post-partum visits provide physicians with the opportunity to evaluate both the physical and emotional status of the mother post-natally and to discuss family planning options. Related to the low percentage of repeat births is the high rate of post-partum visits completed by program mothers. Of the 40 mothers who gave birth during Year 14, 28 mothers were due for their post-partum visit by the end of June 2010 and of these, 96% (n=27/28) completed their post-partum care (see **Figure 26** below).

Figure 26. Percentage Mothers Completing Post-Partum Care: Years 1-14



Healthy Birth Weight

The HFM program indicator for healthy birth weight targets mothers who enrolled in the first or second trimester. However, almost all HFM participants enroll in the third trimester or immediately after the birth of the baby. Despite this, the program strives to educate participants about how to ensure the most positive health outcomes for their babies by encouraging all prenatal enrollees to attend their scheduled prenatal care visits and by providing information on healthy eating and lifestyle habits during pregnancy. During Program Year 14, 40 target babies were born to active participants in the program. Of these, *90% (n=36) were born at a healthy birth weight (>2500 grams or 5.5 lbs).* Although all mothers enrolled in HFM either in their third trimester or post-natally, they had received their first prenatal care in their first or second trimester. All mothers of the four babies who were born at low birth weights enrolled in the program just prior to the birth of the baby, but had received prenatal care in the first or second trimester. When examining this outcome for babies born of all mothers active in Year 14, regardless of the year they were born, the percentage increases to *92% (n=126/137) of babies born at a healthy birth weight.*

National and Maryland statistics indicate that when birth weight is examined by ethnicity, African-Americans are twice as likely to have babies with low birth weight. As seen in the comparative statistics below, HFM has exceeded National and State percentages overall and for each ethnicity (CDC, 2009). Most striking is the 100% healthy birth weight for African-Americans.

- **2008 National: Total=92%, Latino=93%, African-American=86%**
- **2008 Maryland: Total=91%, Latino=93%, African-American=87%**
- **HFM Year 14: Total=92%, Latino= 92%(n=125), African-American=100%(n=9)**

Goal III. Optimize Child Development

Through a holistic approach to the child and family, optimal child development is emphasized with parent education activities and curriculum, regular screenings for developmental delays and age-appropriate activities designed to stimulate the child.

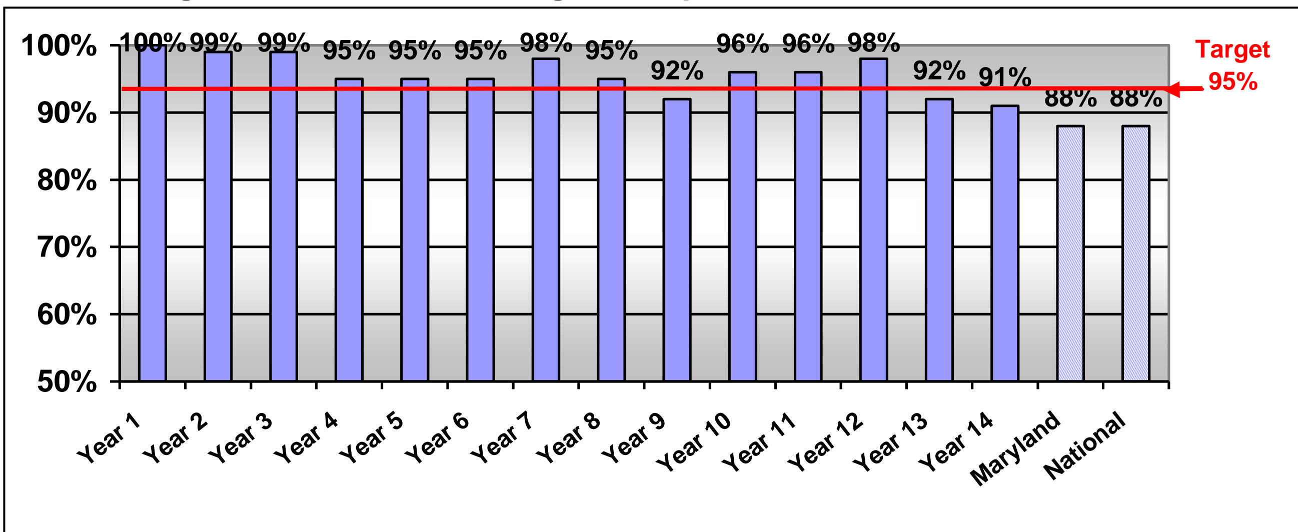
Developmental Delay

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

During Program Year 14, there were 138 target children who participated in the program. After excluding children who left the program less than five months after the beginning of the fiscal year and those born less than five months before the end of the fiscal year or their termination date, there were 93 target children who should have been screened at least once during Year 14. Of these, **95% (n=88) received an ASQ during the past year,** only 5 children did not get an ASQ during Year 14.

During Program Year 14, a total of 19 children were identified with a developmental delay and were receiving services from MCITP or MCPS/Child Find. By the end of the fiscal year, seven of these children were on target developmentally and ceased services, while 12 children continued to receive services. Therefore, ***91% (n=125/138) of children demonstrated normal child functioning and were meeting developmental milestones.*** When comparing this percentage to the prevalence rates at the National level and for the State of Maryland, this data provides strong evidence of the impact of the program's developmental activities on mitigating the role of environmental factors in developmental delay. At both the national level and in Maryland the prevalence for developmental delay that would qualify a child for Part C is approximately 12% (NECTAC, 2010). (see **Figure 27** below).

Figure 27. Children Meeting Developmental Milestones: Years 1-14



Goal IV. Promote Family Self-Sufficiency

Family self-sufficiency is a "composite variable" encompassing factors such as employment, education and housing status that serve as indicators of a participant's autonomy and ability to live without outside aid or support. These factors were examined at entry and again at the close of Program Year 14. Participants who worked either full or part-time or who were enrolled in school are viewed as demonstrating positive self-sufficiency. In addition, participants who had improved or stable housing are also viewed as demonstrating positive self-sufficiency. Conversely, participants who are neither working nor enrolled in school are viewed as having decreased or negative self-sufficiency. Participants who did not have improved or stable housing are also viewed as having decreased or negative self-sufficiency.

Marital Status

Marital status was compared at enrollment and at the end of Year 14 for all active participants. At baseline, 57% (n=80/141) were either married or living together with their partner. At the end of Year 14, this percentage increased slightly to 62% of participants who were either married or living together with their partner. Of those who entered Year 14 living with their partner but never married, three (5%) married by the conclusion of the reporting period. Of those who were single at baseline, six (10%) were married for the first time by the end of Year 14.

Employment and Education

Year 14 baseline and follow-up data was available for almost all of the 141 participants in the active sample. There was an increase in the percentage of working mothers from just 28% (n=38) at program entry to 61% (n=68) at the end of Year 14.

At enrollment, there were three mothers who were under the age of 18 years, two of whom were in school at the time of enrollment. These three mothers were excluded

from percentages calculated for a HS diploma or higher. At enrollment, 52% (n=71) of Year 14 mothers over the age of 18 years had a high school degree or higher. At the end of Year 14, 58% (n=66) improved their education level and had a HS degree or higher. Of these, four received their HS diploma/GED.

When both employment and education factors are considered together and assessed for either remaining positive or improving, 86*% of mothers (n=95) had improved or maintained their educational or employment status.*

- Positive or improved educational *and* employment status n=37
- Positive or improved educational status only n=30
- Positive or improved employment status only n=28

Housing

Data on housing status at enrollment was available on all 141 program participants from the sample. Records indicate that at program entry, the majority of participants were renting (80%; n=113). Of that group, 46% (n=52) lived with family and paid rent, while an additional 21% (n=24) were renting a house, apartment or trailer, and the remaining 33% (n=37) lived with friends and paid rent. Fifteen percent (n=21) reported living with family and paying no rent, while 4% (n=6) were guests in others' homes. One participant (0.7%) reported owning their own home. One participant was living in a shelter or group home. Follow-up data on housing status was available for 115 participants. ***At the end of Year 14, 97% (n=111/115) either maintained stable housing or improved their housing status.*** Two participants who had been renting at enrollment had purchased a home during Year 14, raising the number of participants who own their own home to 3 (2%). Seven participants, who were either living as guests, living with friends and paying rent, or living with family while paying rent, were renting their own house, apartment, or trailer by the end of Year 14. One participant who was renting their own home, apartment or trailer at entry ended up moving in with family and paying no rent. Of the four participants who had unstable housing at the end of the year, three were living as guests in another family's home, and the one participant who was living in a shelter at enrollment was still in the shelter at the end of the year.

Goal V. Promote Positive Parenting and Parent-Child Interaction

1. Parents will have adequate knowledge of child development

The Healthy Families Parenting Inventory (HFPI) 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. Last year the risk criteria were re-normed and the specific cutoffs in each subscale indicating areas of concern or risk were revised. This resulted in a higher percentage of participants identified as 'at-risk'. All existing HFPI data was re-analyzed using the new criteria and results below reflect the new criteria (see **Table 9**). Subscales with consistent decreases in the percentage of mothers at-risk are highlighted in yellow. These include Problem Solving, Mobilizing Resources; Home Environment; and Parenting Efficacy.

Table 9. HFPI Risk Status-Percent Mothers At Risk

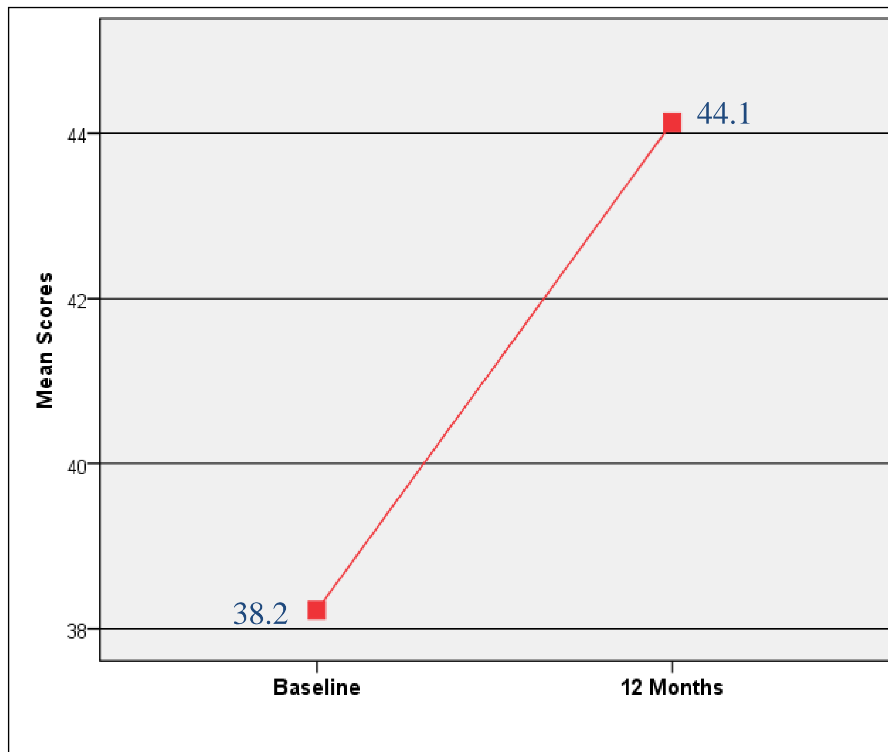
Subscale	Baseline	12- Months	24- Months
Social Support	23% (n=20/87)	23% (n=11/47)	28% (n=16/57)
Problem Solving	22% (n=19/86)	17% (n=8/48)	12% (n=7/57)
Depression	34% (n=29/86)	52% (n=25/48)	39% (n=22/57)
Personal Care	9% (n=8/86)	17% (n=8/48)	9% (n=5/57)
Mobilizing Resources	26% (n=22/86)	13% (n=6/48)	4% (n=2/57)
Role Satisfaction	24% (n=17/70)	32% (n=15/47)	35% (n=20/57)
Parent-Child Interaction	22% (n=16/72)	20% (n=10/49)	23% (n=13/57)
Home Environment	25% (n=17/69)	4% (n=2/47)	4% (n=5/57)
Parenting Efficacy	16% (n=11/69)	9% (n=4/47)	9% (n=5/57)

**Results based on all HFPIs administered to Year 14 participants*
***the N may be lower for some subscales because if any question within a subscale was not asked/answered, the subscale score cannot be calculated.*

It should be noted that the number of participants available at follow-up time points decreased significantly, thus increasing relative percentages and making it difficult to make assumptions regarding participant change over time. A more valid comparison is provided using *GLM Repeated Measures Analysis*, which compares the same subject's scores from baseline to follow-up time points. Using this method, statistically significant improvement was found in three subscales: Home Environment, Depression, and Mobilizing Resources.

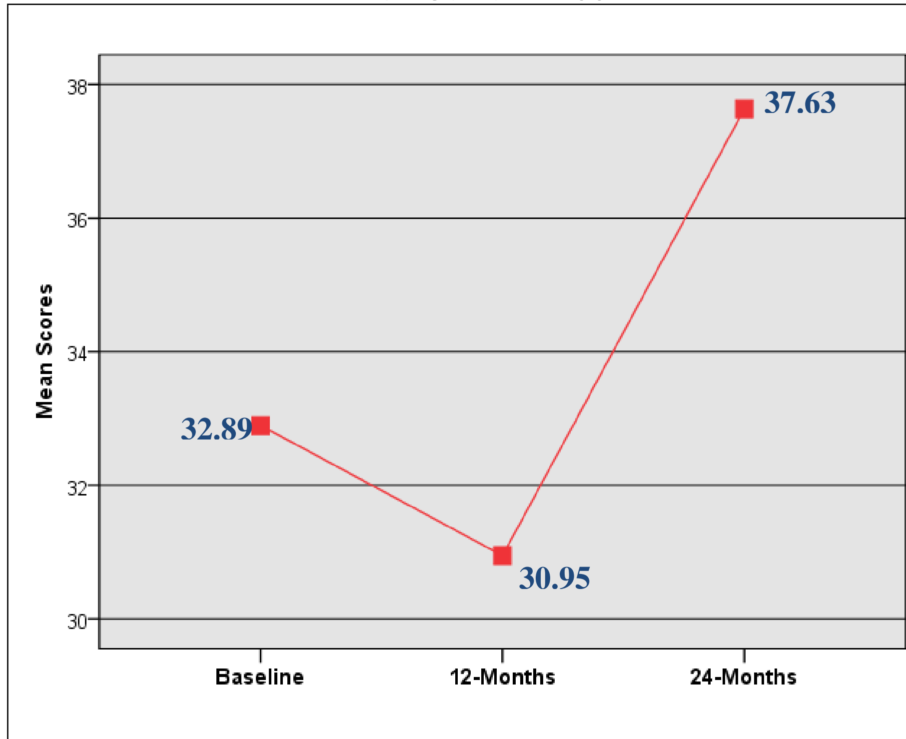
The Home Environment subscale measures the safety, organization, availability and quality of stimulating materials and activities in the home. Although the mean score at baseline was already above the risk cutoff, there was significant improvement in the group's score (F=19.306; df(1,30); p=.000) from baseline (x=38.23) to the 12-month follow-up (x=44.13). (see **Figure 28**) Using partial eta squared, an effect size of .392 was calculated, indicating that 39% of the variance in Home Environment mean scores can be accounted for by time in the program. This is a particularly important finding as the HFM program places emphasis on teaching parents child development activities through the use of ASQ and Parents as Teachers (PAT) curriculum.

Figure 28. Home Environment Subscale (n=31)
Risk Cut-off =<33



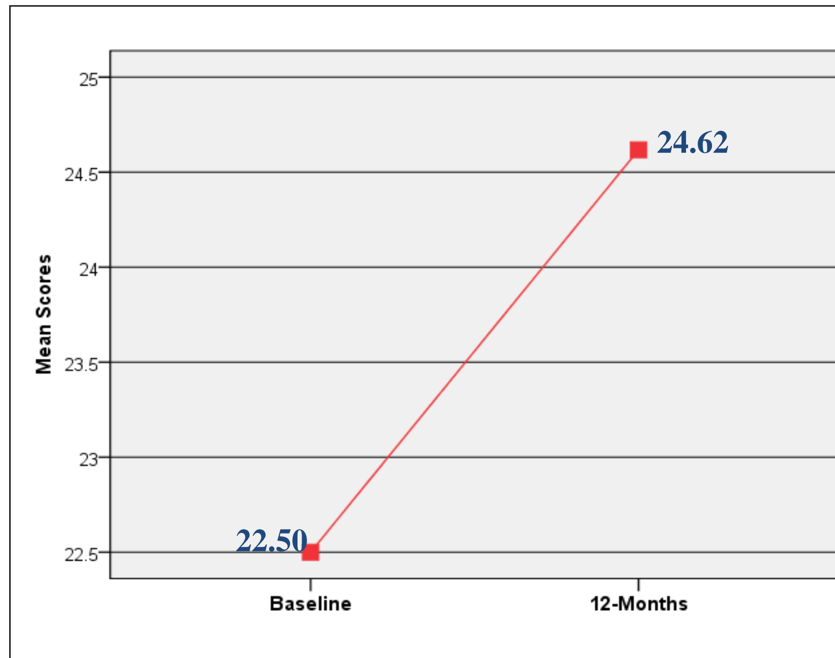
The Depression Subscale measures participants' mood, self-esteem, optimism, outlook and feelings of sadness. GLM Repeated Measures analysis of the Depression subscale results indicates that significant score increases were attained, but only after 24 months of program participation. Due to the fact that the program is not currently providing mental health services, improvement in psychosocial factors takes longer to demonstrate. A group of 19 individuals participated in the program for two years and were assessed at three time points. As seen in **Figure 29**, scores after 12 months decreased slightly, but significant improvement was realized at the 24-month assessment, indicating a decrease in risk for depression (F=7.817; df(1,18); p=.012) from baseline (x=32.89) to the 24-month follow-up (x=37.63). Using partial eta squared, an effect size of .303 was calculated, indicating that 30% of the variance in risk for Depression mean scores can be accounted for by time in the program.

Figure 29. Depression Subscale Mean Score (n=19)
Risk Cut-off =<33



The Mobilizing Resources Subscale measures participants' knowledge of available resources in the community, as well as their comfort level in seeking help if needed. GLM Repeated Measures results indicate that a significant increase in mean scores was attained after 12 months of program participation, thus significantly reducing risk (F=4.964; df(1,33); p=.033). As seen in **Figure 30**, mean scores increased from baseline (x=22.50) to the 12-month follow-up (x=24.62). Using partial eta squared, an effect size of .131 was calculated, indicating that 13% of the variance in Mobilizing Resources mean scores can be accounted for by time in the program.

Figure 30. Mobilizing Resources Subscale Mean Score (n=34)
Risk Cut-off =<18

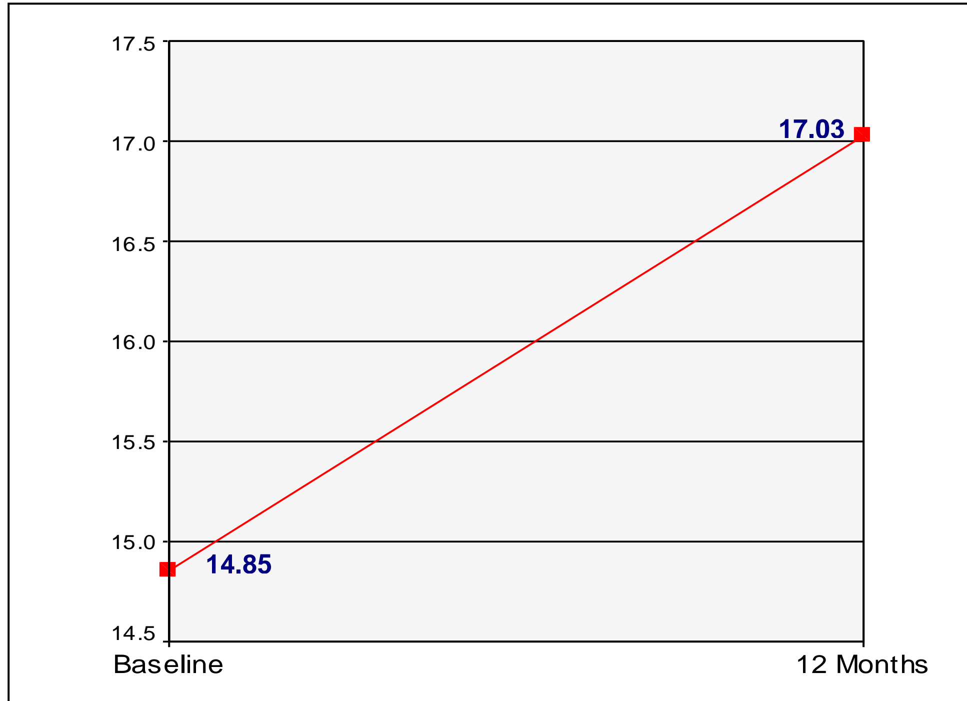


2. Parents have adequate knowledge of child safety

Parents' knowledge of safety in the home is measured through the use of the Safety Checklist. Through interview and observation, the FSW assesses a variety of safety factors, such as knowledge of emergency phone numbers, installation of safety devices, use of automobile safety restraints, monitoring of lead, radon, and CO levels, and the presence of firearms in the home. At baseline, 99% (n=100) of the Year 14 sample earned scores in the average to high knowledge ranges, while after one year of program participation, *100% of parents (n=54) had done the same, demonstrating adequate knowledge of child safety.*

GLM repeated measures analyses were conducted on Safety Checklist scores from Baseline to 12 months (n=40). Across this time period, a significant increase in safety scores was found (F=21.592; df(1,39); p=.000). As seen in **Figure 31**, mean scores increased from 14.85 to 17.03, indicating a higher level of safety knowledge.

Figure 31. Parent Knowledge of Safety: Baseline and 12 Months (n=40)

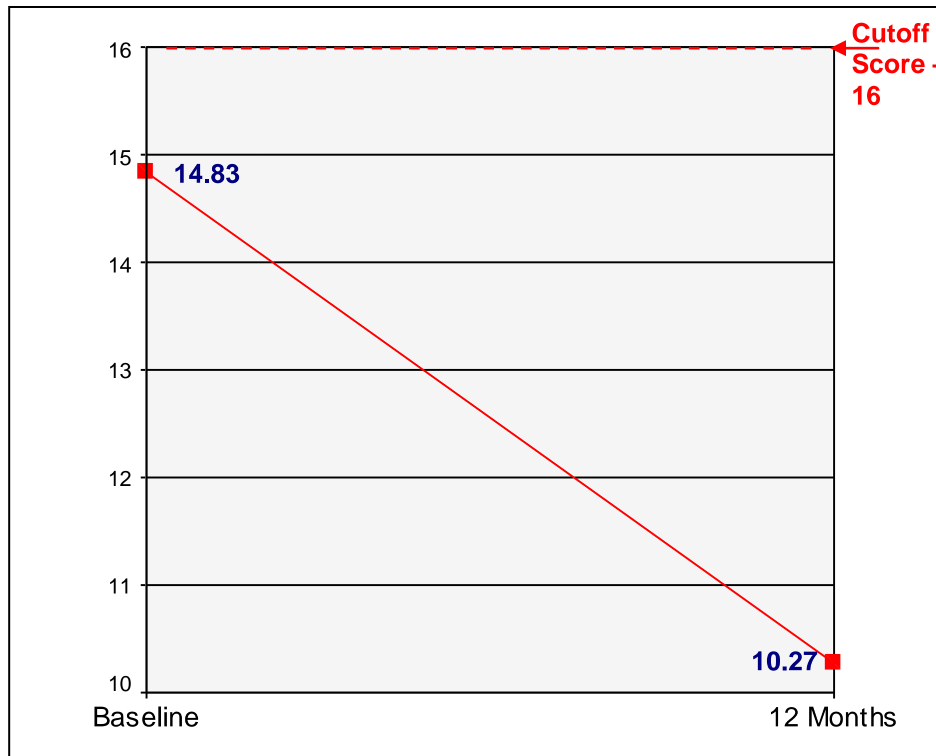


3. Psychosocial Factors

<u>Center for Epidemiological Studies – Depression (CES-D)</u>

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. Results of the CES-D parallel those on the Depression subscale of the HFPI, however the CES-D indicates significant change occurred after 12-months of participation. GLM repeated measures analyses were conducted on CES-D scores from baseline to 12 months. Of the 141 HFM sample, 30 had CES-D scores for both time points. These mothers entered the program around the time of the birth of their baby and stayed in the program for at least one year. As illustrated by **Figure 32** below, this group's mean baseline score (x=14.83) was already slightly below the cutoff. However, after 12 months of program participation, this group's mean dropped significantly (F=6.822; df(1,29); p=.014) to x=10.27, well below the risk cutoff. These results highlight the success of the program in providing mental health services and linking participants to appropriate mental health professionals, resulting in decreases in depressive symptomology after one year of enrollment.

Figure 32. Repeated Measures: Maternal Risk for Depression (n=30)



SUMMARY

Outcome Evaluation results for HFM Years 1 -14 are summarized in **Table 10**. Outcome highlights are presented in **Table 11** with local, state and national comparative statistics. As seen in the tables, there were no founded CWS reports among families in the HFM program in Year 14. This was achieved despite the initial risk status of families enrolled in Year 14. In the area of health, almost all children (99%) were linked with medical providers and were enrolled in Medical Assistance (MA), exceeding the program's goal. In addition, 97% of all target children were current with their immunizations. This is especially impressive when compared to the national immunization rate of 76% (CDC, 2008). The high percentage of mothers who completed post-partum care (96%) was no doubt linked to the fact that almost all mothers (99%) did not have a repeat birth within a 24-month period. In addition, 92% of all babies born in Year 14 had a healthy birth weight.

During Year 14, 91% of children demonstrated normal child functioning and are meeting developmental milestones. In the area of positive parenting, significant increases were measured in parents' knowledge of child safety, as well as in parents' knowledge and ability to mobilize community resources and in providing a stimulating and safe home environment for their baby. Additionally, significant decreases in parents' risk for depression were achieved, a potent factor in reducing risk for child maltreatment.

Table 10. Healthy Families Montgomery Years 1-14
Summary of Goals, Objectives, and Program Outcomes

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

*[1]Each year that the percentage is less than 100%, the percentage represents one case of founded neglect for that year. [2]This goal was changed in Year 5 to include only mothers enrolled in 1st or 2nd trimester. However, beginning in Year 12, most mothers enrolled in the 3rd trimester or postnatally, so percentages reflect 1st & 2nd trimester of prenatal care. *HFM changes to long version of KIDI ** HFM changes to parenting measure- HFPI ***Re-normed HFPI*

Table 11. Healthy Families Montgomery: Year 14
Summary of Goals, Objectives, Program Outcomes, and Comparative Statistics

Goals and Objectives	HFM TARGET	Year 14	Montgomery County	State of Maryland	National
Goal I: Reduce Incidence of Child Maltreatment Enrolled families will not have founded CWS reports	95%	100%	3,036 investigations 398 indicated Rate of 1.8 per thousand [5]	11,610 investigations 5,815 indicated Rate of 4.3 per thousand [5]	10.3 per thousand [1]
Goal II: Promote Preventive Health Care Children will have a health care provider	95%	99%		89% [6]	92% [2]
Eligible families will be enrolled in MA	95%	99%	88% [10]	90% [8]	23 million Total Medicaid 84% [2]
Children immunized on schedule	90%	94%	91%	80% [9]	76%*[3]
Mothers will not have an additional birth within two years of the target child's birth. (Teens <20 Yrs)	90%	100% 99%		Teens-83% [8]	Adults - 65% [4] Teens - rate of 7 per thousand [4] Teens-80%** [7]
Babies Born with Healthy Birthweight	90%	90%*	94% [5]	91% [4]	92% [4]
Mothers will complete post-partum care.	85%	96%			
Goal III: Optimize Child Development Children will demonstrate normal child functioning	95%	91%	-	88%[12]	88% [13]

** Represents complete series of immunizations (4:3:1:3:3:1 series) in order to be comparable to HFM reporting.*
***Comparative National Percentages for African-American (64%) and Hispanic (62%) teens with no repeat births are much lower.*

Data Sources:

[1] US Department of Health & Human Services, Child Maltreatment Fact for 2008 (Spring 2010). Available at http://www.cdc.gov/violenceprevention/pdf/CM-DataSheet-a.pdf

[2] Center for Disease Control and Prevention: National Center for Health Statistics (2009). Available at http://www.cdc.gov/nchs/fastats/hinsure.htm

[3] Center for Disease Control and Prevention: Vaccines and Immunizations Data Table, 2008 (4:3:1:3:3:1 series). Available at http://www2a.cdc.gov/nip/coverage/nis/nis_iap2.asp?fmt=r&rpt=tab26_431331_race_iap&qtr=Q1/2008-Q4/2008

[4] Center for Disease Control and Prevention, National Vital Statistics Report 2009: Live Births and Percentage Low Birthweight. Available at http://www.cdc.gov/nchs/data/nvsr/nvsr59/nvsr59_03.pdf

[5] Governor's Office of Children-Results and Indicators 2008. Available at http://www.ocyf.state.md.us/Indicators/6-CSFC/CSFC_ChildAbuseNeglect.xls and Montgomery County Department of Health and Human Services: 2009 Annual Report-Child Welfare Services. Available at http://www.montgomerycountymd.gov/content/hhs/pdf/annualreport2009.html

[6] National Center for Children in Poverty: State Profiles-Maryland 2007. Available at http://www.nccp.org/profiles/MD_profile_32.html

[7] Child Trends Research Brief-Repeat Teen Childbearing 2004 data. October 2007. Available at http://www.childtrends.org/Files//Child_Trends-2007_11_27_RB_RepeatCB.pdf

[8] Annie E Casey Foundation. Kids Count Online 2008. Available at http://datacenter.kidscount.org/data/bystate/stateprofile.aspx?state=MD&cat=910&group=Category&loc=22&dt=1%2c3%2c2%2c4

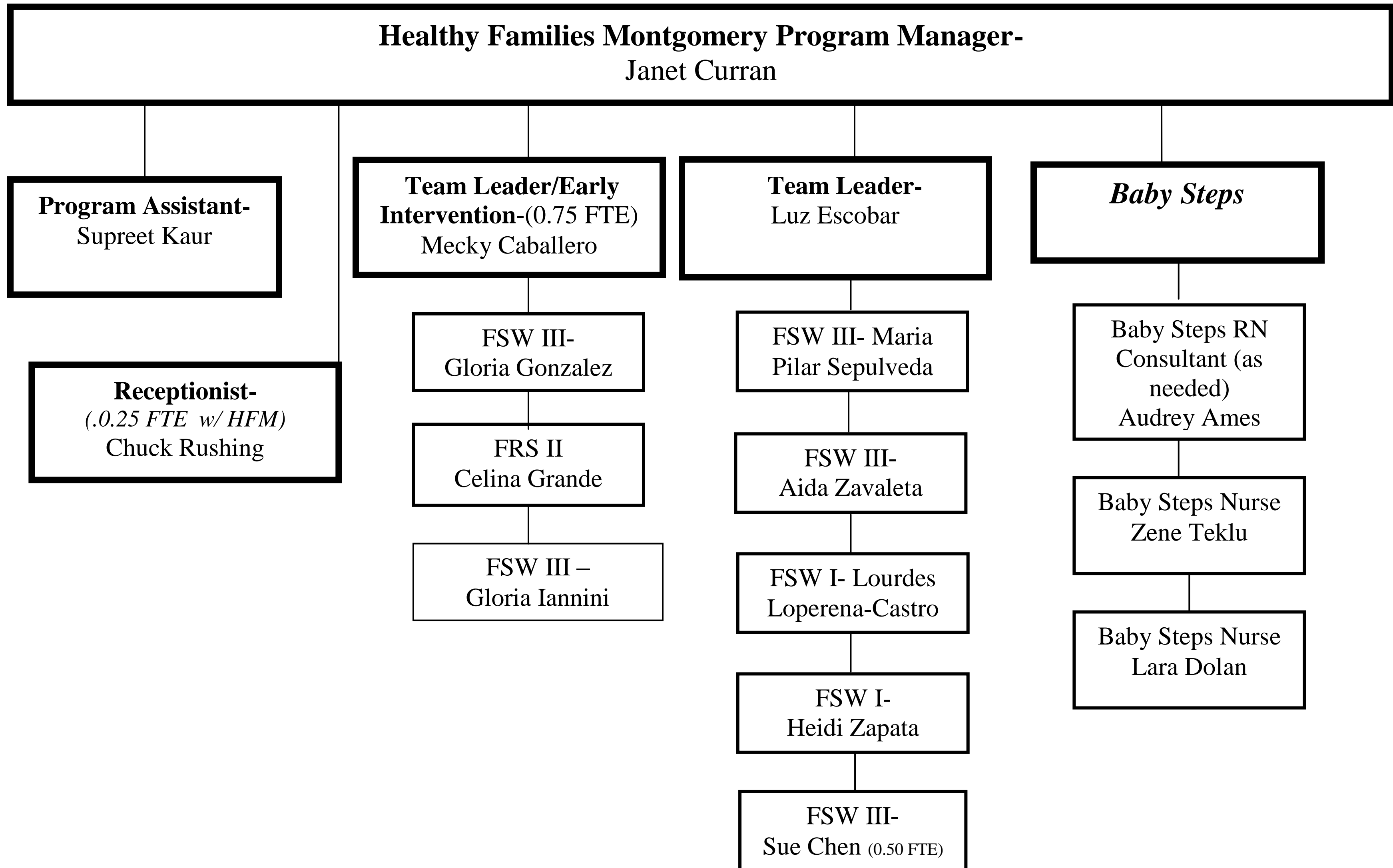
[9] Centers for Disease Control and Prevention: MMWR-National, State, and Urban Area Vaccination Levels Among Children Aged 19-35 Months (2009) Available at http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5833a3.htm?s_cid=mm5833a3_e#tab2

[10] Annie E Casey Foundation. Kids Count Online 2008. Available at http://datacenter.kidscount.org/data/bystate/stateprofile.aspx?state=MD&cat=910&group=Category&loc=3315&dt=1%2c3%2c2%2c4

[11] Individuals with Disabilities Act 2008 Data: Number/Percentage of children receiving services under IDEA. Available at https://www.ideadata.org/tables32nd/AR_C-13.xls

[12] National Early Childhood Technical Assistance Center (NECTAC). Webinar series March 2010-*Early Identification and Part C Eligibility (Steven Rosenberg, Ph.D. and Duan Zang, Ph.D.*)

APPENDIX A **HFM Organizational Chart**



APPENDIX B

Healthy Families Montgomery Funding Sources
July 2009– June 2010

Private Foundations

William S. Abell Foundation
Bank of America
Morris and Gwendolyn Cafritz Foundation
CSG Foundation
Freddie Mac Foundation
TD Charitable Foundation
PNC Bank Foundation

Public Funding

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

Individual Donors and Other

Individual Donors

In-Kind Donations

Barnes and Noble, Washingtonian Center
Christ Child Society
First Books – Montgomery County
Friendship Star Quilters
Mom's Club of Germantown/Kingsview
Weichert Realty – Gaithersburg/North Potomac
Woodworkers for Charity

APPENDIX B

Healthy Families Montgomery
Program Expenditures
July 2009 – June 2010

Program Funding

Fees/Grants: Montgomery County	$521,295
Fees/Grants: State and County	$266,748
Fees/Grants: City and Local	10,000
Foundation Support	116,558
Total Funding	**$914,601**

Program Expenses

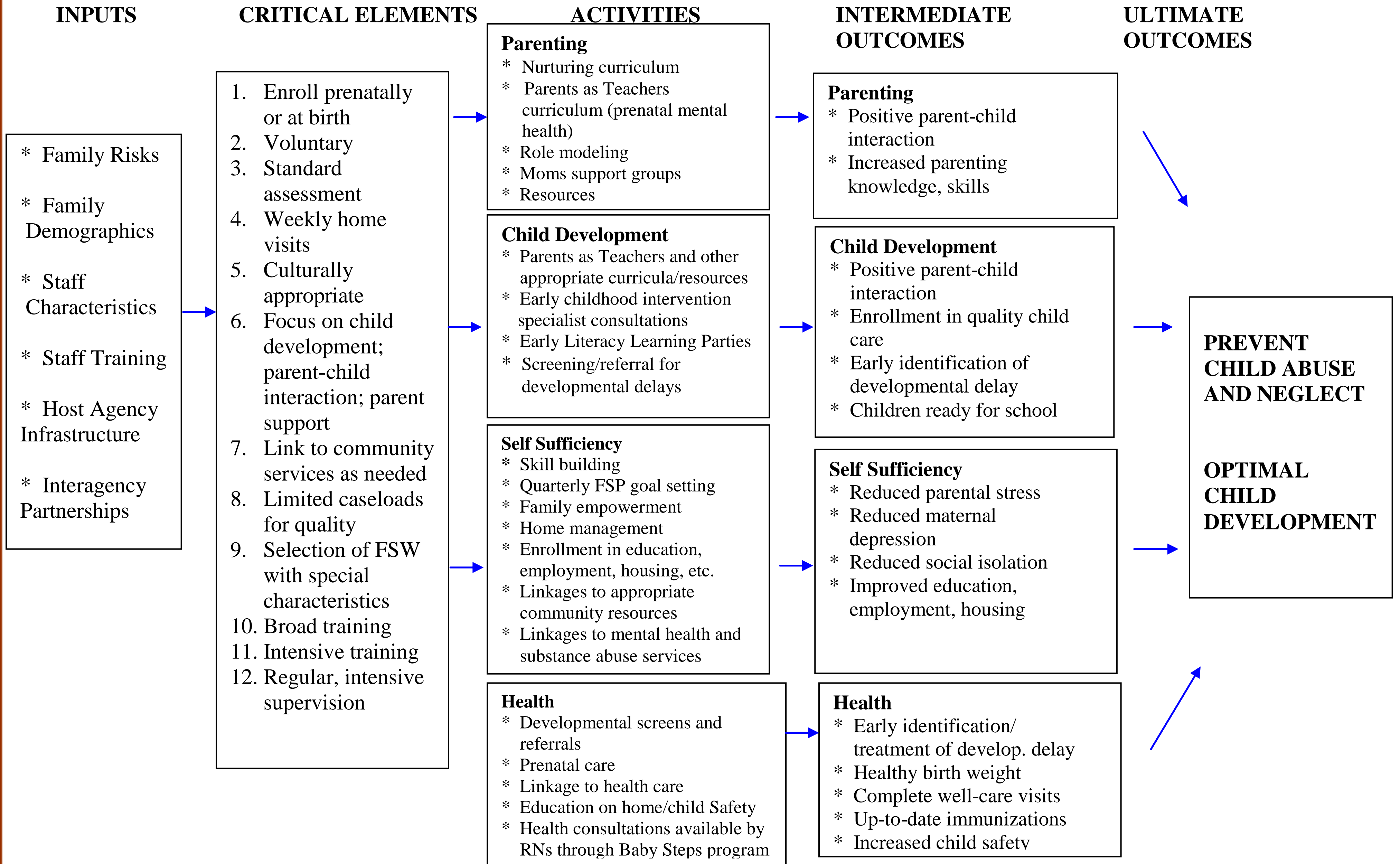
Personnel (salaries, benefits, taxes)	$653,059
Occupancy	63,138
Printing	2,704
Professional services and evaluation	19,933
Transportation, travel	20,677
Telephone	7,405
Training/conferences	11,050
Program activities/supplies/equipment	23,906
Subtotal Expenses	**801,872**
Management and General	112,419
Total Expenses	**$914,291**
Excess/Deficit	$310

APPENDIX C

Healthy Families Montgomery Advisory Board
July 2009 – June 2010

Member	Organization/Title
Janet Curran (*Ex-Officio Member*)	FSI/HFM Program Manager
Beth Molesworth (*Ex-Officio Member*)	MC DHHS Early Childhood Services
Janet Ceasar	HFA Credentialing Consultant
Joan Liversidge	Community Member
George Cohen, MD	Retired Pediatrician, Mobile Med
Traci McLemore (*Ex-Officio Member*)	Montgomery County Collaboration Council
Jamie Ambrosi	Community Member
Meredith Myers (*Ex-Officio Member*)	FSI/FCP Director
Beth Arcarese	Saint Rose of Lima
Ruth Hayn	League of Women Voters
Ruth Rivas	FSI/Help Me Learn Team Leader
Zelma Sciaudone	FSI/Help Me Learn Team Leader
Supreet Kaur (*Ex-Officio Member*)	HFM Program Assistant

APPENDIX D



APPENDIX E

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

PARENTAL CONSENT FOR PARTICIPATION

I, ____,

residing at ____,

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

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

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

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

______________________________ Parent's Signature Date	______________________________ Witness' Signature Date
______________________________ Printed Name of Parent	______________________________ Printed Name of Witness
______________________________ Relationship to Target Child	
______________________________ Parent's Signature Date	______________________________ Witness' Signature Date
______________________________ Printed Name of Parent	______________________________ Printed Name of Witness
______________________________ Relationship to Target Child	

Consent Withdrawn

______________________________ ______________________________

Healthy Families Montgomery
Family Services, Inc.
610 E. Diamond Avenue, Suite 100
Gaithersburg, MD 20877-5323
(301) 840-2000

Consentimiento para Participación

Yo, ___________________________________, residiendo en ____

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

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

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

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

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

____
Firma de la madre / tutora Fecha

____
Nombre de imprenta de la madre

____
Parentesco con el niño(a)

____
Firma del testigo(a) Fecha

____
Nombre de Imprenta del testigo

____
Firma del Padre / tutor Fecha

____
Nombre de imprenta del padre / tutor Fecha

____
Parentesco con el niño(a)

____
Firma del testigo(a) Fecha

____
Nombre de Imprenta del testigo

A. Consentimiento Revocado

____
Firma Fecha

APPENDIX F

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

PARENTAL CONSENT FOR PARTICIPATION OF A MINOR

I, ____,
(Parent or Guardian of the Minor Mother of the Baby)

residing at ____,

hereby consent for ____
(Minor Mother of the Baby)

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

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

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

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

____
Parent's/Guardian's Signature Date

____
Witness' Signature Date

____
Printed Name of Parent/Guardian

____
Printed Name of Witness

____
Relationship to Target Child

Consent Withdrawn

____
Signature

____
Date

Healthy Families Montgomery
Family Services, Inc.
610 E. Diamond Avenue, Suite 100
Gaithersburg, MD 20877
(301) 840-2000

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

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

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

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

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

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

______________________________ Firma de la madre / tutora	______________________________ Parentesco con el niño(a)
______________________________ Nombre de imprenta	______________________________ Fecha
______________________________ Firma del padre / tutor	______________________________ Parentesco con el niño(a)
______________________________ Nombre de imprenta	______________________________ Fecha
______________________________ Firma del testigo(a)	______________________________ Fecha
______________________________ Nombre de imprenta	

Consentimiento Revocado

______________________________ Firma	______________________________ Fecha

APPENDIX G

Healthy Families Montgomery

Family Services, Inc.
610 E. Diamond Ave., Suite 100
Gaithersburg, MD 20877-5323
301.840.2000

Parental Consent to Participate in Program Evaluation

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

Please be aware of the following:

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

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

Donna D. Klagholz, Ph.D.
Program Evaluator

________________________________ __________________________
Participant's Signature Date Print Name

________________________________ __________________________
Witness' Signature Date Print Name

________________________________ __________________________
Parent or Guardian of Participant Date Print Name

Healthy Families Montgomery

Family Services, Inc.
610 E. Diamond Ave., Suite 100
Gaithersburg, MD 20877-5323
301.840.2000

Consentimiento para Participar en el Proyecto de Evaluación

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

Por favor tome nota de lo siguiente:

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

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

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

______________________________ ______________________________
Firma del Participante Fecha Nombre de Imprenta

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

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

APPENDIX H

HFM Description of Evaluation Measures

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

Ages & Stages Questionnaire: Social-Emotional (ASQ:SE)
Author: Jane Squires, Ph.D., Diane Bricker, Ph.D., and Elizabeth Twombly, M.S.
Description: The ASQ:SE is a screening tool that identifies infants and young children whose social and emotional development may require further evaluation. Designed to be used in conjunction with the ASQ that was originally released in 1995, the ASQ:SE provides additional information that targets the social and emotional behavior of children ages 3 to 66 months. The ASQ:SE is a series of eight questionnaires for use at 6, 12, 18, 24, 30, 36, 48, and 60 month age intervals that focuses 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 Epidemologic 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 casual 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.

Safety Checklist-version 5
Authors: adapted from the Early Head Start Safety checklist by Healthy Families Maryland
Description: The Safety Items included on the HFMD Safety Checklist measure 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 9-item instrument measures such hazards as access to poisons, stairs, windows, and electrical outlets. Parents are also asked about presence of smoke alarms 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.

APPENDIX I

HEALTHY FAMILIES MONTGOMERY

Evaluation Administration Schedule

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

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

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

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

APPENDIX J

HFA Critical Elements of Successful Home Visitation Programs

1. Initiate services at birth or prenatally.
2. Offer services voluntarily and use positive, persistent outreach to build family trust in accepting services.
3. Use a standardized assessment tool to differentiate between families who need intensive service and those who do not.
4. Offer home visits intensively (1x per week) with well-defined criteria for changing intensity of service and maintaining service over the long term (3-5 years).
5. Services should be culturally competent.
6. Services should focus on supporting the parent-child relationship and child development as well as supporting the parent.
7. Link families to community services as needed, including medical home.
8. Limit caseloads of staff or ensure time and energy for quality services.
9. Select service providers for their personal characteristics that reflect their ability to do this demanding work.
10. All service providers must have a framework for handling the variety of situations they may encounter and therefore must receive training on a broad range of topics.
11. Service providers must receive intensive training specific to their role.
12. Regular, ongoing, effective supervision is required for all staff.

APPENDIX K

HFM Service Level System Descriptions

ACTIVE LEVELS		
Level	**Definition**	**Number of Home Visits Due**
1-P1	Up to 7 months prenatal.	2 per month (biweekly)
1-P2	7 months prenatal to birth.	4 per month (weekly)
1-SS	Special Services- The family is in crisis and needs additional services for a temporary period of time.	More than 1 per week or longer home visits.
1	Begins once the baby is born and is residing in the home.	4 per month
2	When criteria for promotion are met.	2 per month
3	When criteria for promotion are met.	1 per month
4	When criteria for promotion are met.	1 per quarter
XA	Creative Outreach - Families on creative outreach. (FSW has been unable to locate or have regular contact with family for three weeks. Families usually stay on XA for 8 weeks.)	1 per month
XC	Inactive -Pending closing have not been able to engage in services during the first two months of creative outreach.	1 per month

APPENDIX L

HEALTHY FAMILIES MONTGOMERY STAFF TENURE DATES

1996 – 2010

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

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

APPENDIX M

Healthy Families Montgomery
Year 14 Staff Trainings

DATE	TOPIC	# HFM STAFF ATTENDED
09/25/2009	Peminic Training	8
09/30/2009	CPR	1
10/9/2009	ASQ-3	9
10/13/2009	Health Care Coverage for Marylanders	4
10/14/2009	Cumulative Stress Response: Avoiding Job Burnout	5
10/16/2009	ASQ-SE	7
10/19/2009	DIAL 3	6
11/06/2009	Treating Children with Relational Trauma	1
11/12/2009	Diversity Training	4
11/12/2009	Motivational Interviewing, Part 1 & 2	1
11/12/2009	H1N1 – What Home Visitors Need to Know	1
11/12/2009	SEFEL	3
11/12/2009	Establishing Boundaries	2
11/12/2009	Responding to Problematic Behaviors	1
11/12/2009	Play: Meaningful, Interactions & Fun	3
12/1/2009	First Aid	2
12/1/2009	CPR	2
12/02/2009	HFM Enrollment & Referral Process	2
12/02/2009	HFM Program Evaluations: Home Safety, CES-D & HFPI	2
12/02/2009	Chart Documentation	2
12/03/2009	Program's Relationship with Community Resources	2
12/03/2009	Diversity Training	2
12/03-04/2009	Working with Teens	1
12/07/2009	Boundaries & Confidentiality	2
12/07/2009	Child Abuse & Neglect Indicators & Reporting Requirements	2
12/08/2009	Curriculum Overview	2
12/15/2009	Diversity Training	4
02/05/2010	Developing a Family Support Plan	5
02/25/2010	First Aid	1
03/05/2010	Wee Cuddle and Grow	8
03/11-14/2010	FSW Core Training	2
03/22/2010	HFM Program Evaluation/Tools Overview	2
03/31/2010	Communication Skills	8
04/06/2010	PIMS Retention Webinar	1
04/09-10/2010	The Community Interpreter	3
04/14/2010	Time Management	3
04/15-16/2010	CSEFEL Socio-Emotional Functions	1
04/16-17/2010	The Community Interpreter	3
04/23/2010	Exploring the Path to Literacy	10
04/24/2010	The Community Interpreter	3
04/23/2010	The Internet & Sex: A Tangled Web	1
05/05/2010	Fostering Infants and Child Development	1
05/06/2010	Keeping Babies Healthy and Safe	1
05/10/2010	Fostering Infants and Child Development	1
05/10/2010	Preparing Mother for Birth and Beyond	1
05/13/2010	Growing an In-sync Child	7
05/13/2010	Preparing Mother for Birth and Beyond	1
05/13/2010	Coaching on Positive Parenting Strategies	1
05/13/2010	First Aid	3
05/13-14/2010	Social Emotional Foundations (CSEFEL)	1

DATE	TOPIC	# HFM STAFF ATTENDED
05/17-21/2010	Parents As Teachers (P-3)	2
05/19/2010	Coaching on Positive Parenting Strategies	1
06/18/2010	Review of HFM Services	6

Healthy Families Montgomery Staff Satisfaction Survey

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

1. What is your job with HFM?

- ❒ Family Support Worker (FSW) or Family Resource Specialist (FRS)
- ❒ Manager/Team Leader
- ❒ Other (Early Intervention, Administrative)

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

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

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

❒ Never ❒ Rarely ❒ Sometimes ❒ Often ❒ Every day

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

❒ Annual Cost of Living increase ❒ Promotion ❒ Training certification

❒ Staff appreciation event ❒ Smiles and Praises ❒ Other (list) ____________

5. **Which areas of the program are particularly strong?**

____

____

____

6. **Which areas of the program need improvement?**

____

____

____

7. **Additional Comments and Suggestions:**

____

____

____

Thank you for sharing your thoughts and suggestions today.
The completed survey should be put in Supreet Kaur's box –
but please do not sign the form.

APPENDIX O

Healthy Families Montgomery
Participant Satisfaction Survey

Today's Date:____________

Please share the following information:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8. My Family Support Worker speaks to me in a language that I understand.

YES **NO**

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

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

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

Please give us your opinion on the following questions.

What do you like most about Healthy Families?

___

___

___

What do you not like about Healthy Families?

___

___

___

How do you think we could improve our program?

___

___

___

How would you rate your Family Support Worker?

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

How would you rate Healthy Families?

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

I would recommend Healthy Families to a friend or relative.

☐**Strongly Agree** ☐**Agree** ☐**No Opinion** ☐Disa**gree** ☐**Strongly Disagree**_____

THANK YOU!

HEALTHY FAMILIES MONTGOMERY
Encuesta de satisfacción de los participantes

Fecha de hoy: ______________________

Por favor comparta con nosotros la siguiente información:

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

¿Qué tan frecuente la visita su trabajadora de apoyo familiar?
☐Una vez por semana ☐Dos veces al mes ☐Una vez al mes ☐No me acuerdo

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

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

¿Cuándo fue su ultima visita? ☐ Hace una semana ☐Hace dos semanas ☐Hace un mes
☐Más de un mes ☐Hace varios meses ☐Me Salí del programa

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

Por favor conteste SI o NO a las siguientes declaraciones.

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

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

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

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

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

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

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

8. Mi trabajadora de apoyo familiar conversa conmigo con un lenguaje que yo le pueda entender.
SI **NO**

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

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

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

Por favor denos su opinión en las siguientes preguntas.

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

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

¿Cómo cree que podemos mejorar el programa?
____
____
____

¿Cómo calificaría a su trabajadora de apoyo familiar?

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

¿Cómo calificaría al programa de Healthy Families?

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

Yo recomendaría este programa a un familiar o un amigo.

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

Muchísimas gracias por participar en esta encuesta.