



Healthy Families Montgomery

Year 8 Annual Evaluation Report FY 2003-2004

Prepared by
Donna D. Klagholz, Ph.D. & Associates, LLC
766-B Walker Road
Great Falls, VA 22066
April 2005

This evaluation was funded in part by the Freddie Mac Foundation.

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Table of Contents

I.	Introduction	1
	a. Overview	1
	b. Statement of the Problem	1
	c. Background and History	2
	d. Program Description	3
	e. Funding	3
	f. Partners	4
	g. Advisory Boards	5
	h. Credentialing	5
II.	Methods	6
	a. Program Goals and Objectives	6
	b. Target Population	6
	c. Research Sample	7
	d. Procedure	7
III.	Results	9
	a. Process Evaluation	9
	i. Program Implementation	9
	ii. Staffing	10
	iii. Staff Development	11
	iv. Staff Satisfaction	12
	v. Participant Satisfaction	17
	vi. Screening, Assessment, and Enrollment	23
	vii. Enrollment and Attrition	25
	viii. Population Demographics	27
	ix. Risk Factors	31
	b. Outcome Evaluation	32
	i. Achievement of Goals and Objectives	32
	ii. Health Care Provider	32
	iii. Current Immunizations	33
	iv. Additional Births	33
	v. Post-Partum Care	34
	vi. Healthy Birthweight	35
	vii. Developmental Delay	35
	viii. Positive Parenting	36
	ix. Self-Sufficiency	39
	C. Summary	41

List of Appendices

- Appendix A. HF Montgomery Logic Model with Critical Elements
- Appendix B. HFM Service Level Descriptions
- Appendix C. HFM List of Funding Sources
- Appendix D. HFM Organizational Chart
- Appendix E. HFM List of Advisory Board Members
- Appendix F. HFM Goals and Objectives
- Appendix G. HFM Evaluation Consent Form
- Appendix H. HFM Outcome Measures Description
- Appendix I. HFMD Schedule of Assessment
- Appendix J. HFM Staff Tenure Dates
- Appendix K. HFM List of Staff Trainings
- Appendix L. Staff Satisfaction Survey
- Appendix M. Participant Satisfaction Survey

List of Tables and Figures

Table 1:	Outcome Domains and Standardized Measures	8
Figure 1:	HFM Staff Demographics	11
Table 2:	Staff Knowledge and Perception of HFM Program	13
Figure 2:	Staff Benefits Received	14
Figure 3:	Stress on the Job	15
Table 3:	Staff Perceptions of Program	15
Figure 4:	Program Meeting Cultural Needs of Families	17
Figure 5:	Language of Respondents	18
Figure 6:	Frequency of Home Visits	19
Figure 7:	Ages of Children at Last Home Visit	19
Figure 8:	Date of Last Home Visit	20
Table 4:	Program Effectiveness Response (Participants)	21
Table 5:	Screening, Assessment, and Enrollment	24
Figure 9:	Screening, Assessment, and Enrollment	25
Figure 10:	Length of Enrollment	25
Table 6:	HFM Attrition Year 2-8	26
Figure 11:	Attrition Rates-Percentage Profile	26
Figure 12:	Reasons for Case Closures	27
Figure 13:	Mother's Age at Program Entry	27
Figure 14:	Mother's Race	28
Figure 15:	Primary Language	28
Figure 16:	Mother's Marital Status	29
Figure 17:	Mother's Education Status at Enrollment	29
Figure 18:	Mother's School Status at Entry	30
Figure 19:	Mother's Employment Status at Entry	30
Figure 20:	FSC Risk Score at Program Entry: Year 8	31
Figure 21:	Mean FSC Risk Subscale Scores	31
Figure 22:	Babies and Mothers-Access to Health Care Provider	32
Figure 23:	HFM Immunization Rates	33
Figure 24:	Mothers with No Repeat Birth < 24 Months	34
Figure 25:	Mothers Completing Post-Partum Care	34
Figure 26:	Children Meeting Developmental Milestones	36
Figure 27:	KIDI-Long Version Baseline and 12 Months	37
Figure 28:	Parent Knowledge of Safety Scores	38
Figure 29:	Parent Knowledge of Safety at Four Timepoints	38
Figure 30:	MOB Self-Sufficiency at Entry and Year 8 Follow-Up	40
Table 7:	Summary of Goals, Objectives, and Outcomes	43
Table 8:	Summary of Year 1-8 Outcomes and Comparative Statistics	44

INTRODUCTION

Launched in 1992 through a partnership between Prevent Child Abuse America and Ronald McDonald House Charities, the Healthy Families America home visitation model provides intensive support to families determined to be potentially at-risk for child abuse and neglect. With extensive financial support from the Freddie Mac Foundation, Healthy Families Programs have expanded to serve increasingly more communities and now exists in 35 states with 430 sites. Within these sites, 90% of those families offered home visiting services accept and become part of the program.

Healthy Families Montgomery, currently in its ninth year of program operation, continues to adhere to the rigorous quality standards and research-based effective practices delineated by the Healthy Families America model, offering intensive home visitation services throughout Montgomery County. Through its comprehensive and strength-based approach, services to families include a focus on child development, well-baby care, parent-child bonding and attachment, child safety, family self-sufficiency and linkages to critical community services such as childcare, mental health services, and domestic violence. Healthy Families Montgomery is a program of The Family Services Agency, Inc. (FSAI) in Gaithersburg, MD. The Family Services Agency, founded in 1908, is the oldest private nonprofit social service and behavioral health organization in Montgomery County, Maryland. Through a range of programs and services, FSAI serves thousands of Montgomery County residents each year, from newborns to seniors.

Over the past eight years, HFM has successfully established critical community partnerships in order to ensure that families are referred quickly to the program and that once engaged in the program they are able to link with other community agencies as needed. In response to family needs identified through its services and evaluation, HFM has also enhanced the core program services with additional mental health and child development supports. Further evidence of program quality and fidelity is its status as a credentialed Healthy Families site. HFM even received an expedited re-credential during Program Year 8 due to exemplary scores on their Preliminary Credentialing Report.

This report provides an in-depth look at the Healthy Families Montgomery program and primarily focuses on program Year 8. With specific attention to HFM program goals and outcomes, this narrative will highlight how the program has evolved and its impact on maternal and child health outcomes with its participants.

Statement of the Problem

Child abuse and neglect continues to be a pervasive problem in the United States, with over 1,800,000 children referred to Child Protective Services (CPS) nationally and 896,000 determined to be victims of child abuse and neglect by CPS agencies (NCANDS, 2002). Children who experience child abuse and neglect are at increased risk for a variety of poor educational and health outcomes including depression and suicide, substance abuse, and obesity. These poor outcomes not only affect the quality of life of the victims who suffer the abuse, but cost millions of dollars to treat the illnesses and to assist the victims in making the most out of their lives.

Though considered a wealthy suburb of Washington, DC, Montgomery County includes residents from diverse ethnic, cultural and economic backgrounds. With a large enclave of Latin American families, new to this country and often not speaking English, and low-income families from

diverse cultural backgrounds including Hispanic, African, Asian, and African-American, Montgomery County is far more diverse than most people realize. Reflecting similar trends across the United States, Montgomery County's rapidly expanding population of newly immigrated families faces multiple economic, linguistic and cultural barriers. These stressors exacerbate parenting, health, substance abuse, mental health and domestic violence issues in new families. There exists a tremendous need to support these families as they struggle with financial pressure, acculturation and communication issues, as well as the stress associated with raising young children. Programs such as Healthy Families Montgomery, offering bilingual intensive home visiting and support services, are critical in helping these families to assimilate into their new environment, raise healthy children, and become self-sufficient.

In 2003, the Office of Child Abuse and Neglect at the U.S. Department of Health and Human Services, HHS, launched a prevention initiative that endorsed strategies such as home visiting and parenting education as an effective way to support families. The Task Force on Community Preventive Services at the CDC issued a report in which they determined home visiting programs such as Healthy Families to be effective in reducing risk of child maltreatment in high-risk families (CDC, 2003).

Background and History

Montgomery County is the largest jurisdiction in Maryland and historically considered affluent. In 1996, Montgomery County was home to an increasingly poorer and more diverse population. Due to the tremendous growth in the immigrant community, the County had the largest minority population (40%) in the state and the largest Latino population in the greater metropolitan Washington DC area. There were an estimated 16,000 to 20,000 undocumented immigrants and approximately 13,000 births per year. Recognizing these population trends and the implications for social services, the program's founder, Mary C. Jackson, brought the Healthy Families America model to the county.

Healthy Families Montgomery was the first Healthy Families America site established and credentialed in the State of Maryland. A program of the Family Services Agency, Inc. (FSAI), Healthy Families Montgomery (HFM) was established simultaneously with the agency's Early Head Start (EHS) program in 1996. The two home visiting programs were initially structured to be managed together by the EHS Director. However, because of the underlying differences between the two models in terms of eligibility, required program practices and performance standards, staff training and qualifications, and program emphasis resulted in a separation of the two programs with discrete program managers and staff. Notably, over the past six years, the HFM and EHS programs have sustained a strong partnership through shared resources, trainings, and joint parenting programs.

The successful outcomes achieved by HFM in its first two years of operation led the Maryland legislature to allocate 3.5 million dollars to replicate the program in fifteen counties throughout the state. Over the past eight years, HFM has expanded to provide services to over 150 families annually. This represents a 200% increase over its original capacity of 45 families in 1996.

Healthy Families Program Description

Healthy Families Montgomery is based on the 25 year old Hawaii "Healthy Start" model, a voluntary program for prevention of child maltreatment. Key elements to the model include intensive, comprehensive, long-term (3-5 years), flexible, and culturally appropriate services. Highly trained paraprofessional staff receive intensive and regular supervision to prevent staff burnout and provide

support and education to home visitors. Healthy Families programs are premised on a strength-based philosophy, which pervades all aspects of the work. (*See Appendix A – HFM Logic Model and Critical Elements*)

Screening and assessments (parent surveys) conducted throughout the county not only identify families as eligible for enrollment, but also serve to link families with other needed community services. As such, the screening/assessment process plays a vital role in identifying the amount of outstanding need in the community, as well as determining the individual families' levels of need. Families may not be eligible for home visitation services, but may still have referral needs that can be met through the Family Resource Specialist, or they may refuse home visitation services, but might be open to being linked to other needed community supports. Highly trained Family Resource Specialists are skilled at coordinating services with staff from other agencies, as well as at conducting assessments with families and building rapport with diverse families enabling them to share highly personal information in just one single meeting.

Although a variety of services and linkages are available, home visitation is at the core of the Healthy Families model. It is within the home environment that the worker is better able to understand the challenges and strengths that each family has. Through recognition of the cultural, linguistic, intergenerational, economic and social context within which the participant lives, the FSW is able to meet the family at their level and more clearly identify pathways for growth. Each Family Support Worker can work with up to 25 families, depending on the intensity of services offered. Caseloads are limited to ensure that staff has sufficient time to spend with families, prepare for home visits, and to attend required trainings and supervision. All families move through a level system (*see Appendix B-HFM Service Levels*), receiving weekly or bi-weekly home visits prenatally, then weekly visits for at least six months after the birth of the baby, and then progressing to less frequent visits as demonstrated by the need and desire of the family. Home visits focus on the child, the parent, and the interaction between the two. Family Support Workers are highly trained to implement a three-prong approach that addresses the parents' needs, while simultaneously ensuring child development is optimized and family functioning is stabilized. The strategy is based on the premise that a highly stressed parent will not be able to focus on their child to their best ability until they have resolved important issues in their own lives. However, the infant's bonding and the child's development cannot be placed on hold. The FSW focuses on assisting the parent in caring for the child while they build attachment and parental self-sufficiency. Workers use a variety of techniques to engage parents, including reflective listening, role modeling, positive reinforcement, wondering curiosity, sharing child development information, goal-setting, bringing developmental activities to do with the child, and connecting them with vital resources.

Funding

HFM has worked hard since program initiation to develop a diverse range of funding streams. On an annual basis, public/private partnerships are supplemented with foundation and corporate funds. The agency and program directors also direct efforts towards advocacy at the state and local levels, which has resulted in significant support from Montgomery County and the Maryland State legislature. A significant increase in public funding was awarded in Year 4 from the Montgomery County Health and Human Services (HHS) Public Health Services, the Montgomery County Collaboration Council for Children, Youth and Families (MCCC), and the Governor's Office for Children, Youth and Families (OCYF). These increases have enabled HFM to expand capacity to serve more families.

During Year 8, the HFM program continued its efforts to secure the resources to expand and diversify funding sources. The program submitted proposals to and were awarded grants from organizations such as: Freddie Mac Foundation, the City of Rockville, City of Gaithersburg, United Way, Montgomery County DHHS/Child Welfare Services Frameworks for Families program, Citibank, Target Foundation, and Mead Foundation. Additionally, contracts were renewed with Montgomery County DHHS, Early Childhood, and the Montgomery County Collaboration Council. Other grant opportunities were pursued throughout the fiscal year but were not funded (*See Appendix C for FY 2003-2004 List of Funders*).

Partners

Through a broad array of partnerships, HFM is able to link its families to supplemental services and more intensive medical, behavioral health, child development, and educational services. Additionally, within the Family Services Agency, Inc., there are multiple programs with which HFM coordinates services and links families (*See Appendix D-Organizational Chart*). These include:

- ***Baby Steps*** - provides hospital based identification health screening for all moms to ensure that all moms will be given the opportunity to request or be referred to health, early childhood and/or community support services.
- ***Early Head Start*** - a federally funded child development program serving low-income families with children from birth to three years old and pregnant women residing in the Upcounty area of Montgomery County. The program provides a combination option of home visitation and center-based services, with group activities on a regularly scheduled basis.
- ***Ed Bohrer Parent Resource Center*** - provides parents with information and referrals to community resources, a Parent Homework Club, and classes in computer skills, basic literacy in Spanish/English, ESL, and parenting.
- ***Connect for Success*** - a unique intervention service providing consultation and training to child care programs and other educational settings. Training seminars are also available for both childcare staff and parents on a variety of topics.
- ***The Family Works*** - Maryland's Parent Information and Resource Center, supporting parents as their child's first teacher and providing opportunities for families to be involved in their children's education. The Family Works is the state leader for the *Parents As Teachers* Program, a curriculum used by Early Head Start as well as HFM staff.
- ***Outpatient Mental Health Clinic*** - provides counseling and therapy services to children, adolescents, adults and families. Individual and group methods are offered to ensure the most effective care.

FSAI also hosts several educational programs (Partners in Caring; Saturday Academy; and Substance Abuse Prevention-Dare to be You); counseling programs for seniors; and behavioral health programs (Montgomery Station-psychiatric rehabilitation; medication assessment, and monitoring). Additionally, HFM established formalized partnerships with the following outside agencies for FY 2003-2004:

- Department of Health and Human Services (Health Services, Child Welfare Services, Early Childhood and Family Support Services)
- Center for Adult and Children Services
- Judy Centers

- Even Start
- Montgomery County Infants and Toddlers Program
- Montgomery County Home Visitation Consortium
- Healthy Families Maryland Site Network
- Rockville Caregivers Associations
- Gaithersburg Providers Coalition
- Holy Cross Hospital
- Shady Grove Hospital

Advisory Board

The Healthy Families Montgomery Advisory Board (*See Appendix E - List of Advisory Board Members*) works to provide the program with oversight and guidance, and during Program Year 8 it was able to review and assist with program operations in numerous areas. The Board is comprised of individuals representing diverse ethnic and professional sectors, as well as a range of expertise and culture. Members are able to provide support to ensure that the program serves the community to the best of its ability. Some of the areas on which the Advisory Board focused attention during program Year 8 included expanding and diversifying funding sources, reviewing and approving a new Policies and Procedures Manual (in preparation for the Credentialing Self Assessment and Site Visit) and on strengthening the existing participant groups the program now offers. Further, the Board lent support to the Program Director in her efforts to reward and recognize the hard work of staff in ways other than wage increases since a freeze on wage compensation was in effect. The program sent all staff members to the PCA National Conference in Florida, which staff members found to be not only beneficial in terms of information learned, but also in terms of team building. It is HFM's good fortune that the Advisory Board is extremely committed to making Healthy Families Montgomery the most successful program in the country.

Healthy Families America – Credentialing Process

The HFA credentialing process is the most effective means to ensure that sites replicating the HFA model implement evidence-based effective practices and adhere to quality standards on a regular basis over time. Healthy Families Montgomery received their original credential in November 1999 and was the first Healthy Families program in the State of Maryland to receive a credential. At that time, the site was awarded immediate credential due to outstanding ratings, receiving the highest possible score on 85% of the items on the preliminary credentialing report. In order to maintain affiliation with HFA, sites must undergo a re-credentialing process every four years. Healthy Families Montgomery was due to be re-credentialed during Program Year 8. After a lengthy self-evaluation process, the program sent in their completed Self Assessment Tool on October 3, 2003 and scheduled a site visit for November 15 – 18 2003. On December 18, 2003, HFM was notified that they obtained an expedited credential based on exemplary scores on the Preliminary Credentialing Report from the site visit. It is extremely rare for a site not only to be awarded their credential without any follow-up work needed, but also to have the credential expedited as it was in this case. This is a testament to the high quality program that HFM offers to its community.

METHOD

Over the past eight years, Healthy Families Montgomery (HFM) has contracted with Donna D Klagholz, Ph.D. & Associates, LLC to conduct an external evaluation of the program, including a formative evaluation of the program's implementation and an outcome evaluation of the program's impact on participants. To its credit, 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. A full-time Data Entry position ensures consistency and quality of data entry. A Quality Assurance Team Leader reviews all data entry, runs quality assurance reports on the data to verify integrity, reviews all scoring of standardized measures, and generates reports. Through monthly tracking of screening, assessment and enrollment data, HFM is also able to identify gaps in service. Furthermore, the addition to the database of a supplemental tracking system for outcome measures has enabled the program to monitor compliance to the measures administration schedule, as well as 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 date the external evaluators have relied on data exports and reports from the PIMS database for the bulk of participant data. On an annual basis, this data is imported into the existing longitudinal dataset created in SPSS, which contains participant data from program inception in 1996 through 2004.

Program Goals and Objectives

The HFM program established goals and objectives in Year I that were aligned with the national HFA model. Several supplemental outcomes were also targeted as outlined in the independent evaluation plan developed at program inception. This expanded framework of goals and objectives was fortified further in Year 5 when the program incorporated ten additional objectives developed by the State of Maryland as part of the statewide Healthy Families Maryland initiative (*See Appendix F – Goals and Objectives*).

Target Population

The HFM program targets first-time parents residing in Montgomery County who receive prenatal care through Montgomery County Health Services or who are two to three months post-partum. These parents are identified to be at risk for child abuse and neglect based on a standardized screening and assessment process. The overwhelming majority (96%) of HFM families are identified at one of the two Montgomery County health centers in Germantown and Silver Spring. 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 diversity.

Women with a positive screen indicating multiple stressors (i.e., teen pregnancy, self-report of depression or history of abuse) are contacted by the HFM Family Resource Specialist to schedule a home visit to complete an in-depth assessment. The C.H. Kempe Family Stress Checklist (FSC) is designed to assess risk on ten 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 FSC to all eligible individuals. Families who score at or above 25 are considered overburdened and at risk for poor outcomes. Due to staffing limitations, HFM is unable to offer the intensive services to all families with an identified need for intervention. In those instances, Family Resource Specialists work diligently to connect the families with the best available service in the community at any point in time. Thirty-nine new families were enrolled in HFM during the past year; and a total of 213 families and 208 children participated in the program during Year 8.

Research Sample

All participants (n=213) are included in the analysis of enrollment data (attrition, duration, and service levels). 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 8 fiscal year (July 30, 2004), and must have completed a minimum of eight home visits. Families from previous reporting periods are included in the analysis if they have met these criteria. Thus, the research sample for this report includes 157 children (including one twin and 10 siblings) and 146 mothers/families. The research sample is used for all demographic and outcome analyses. For some variables, data was not available or unknown; therefore, the *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 participate 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.

Procedure

The HFM program has operated with a comprehensive evaluation plan since the program's inception. The evaluators have worked with HFM to develop and implement mechanisms for participant protection, including consent and confidentiality procedures. A copy of the consent form is provided in *Appendix G (HFM Consent to Participate in Program Evaluation)*. Evaluation components for Year 8 included:

Process Evaluation – Quantitative data was collected on service utilization and population demographics from the program's database. This was supplemented with qualitative data collection derived from interviews with the program manager and from required reports submitted to County and State funders; and an analysis of participant and staff satisfaction surveys, which are completed annually.

Outcome Evaluation – A quasi-experimental design with repeated measures has been implemented since program inception. Baseline assessment is collected within 90 days of enrollment and subsequent assessments are collected annually. A brief description of the standardized measures and the schedule of assessment are provided in *Appendix H-HFM Outcome Measures Description*; and *Appendix I-HFMD Schedule of Assessment*.

Measures

In addition to demographic, health, service utilization, staff and program data that are collected in PIMS, several standardized outcome measures have been selected to assess participant baseline risk and change over time. Four key areas are measured with standardized tools: maternal social

support/social isolation; parenting knowledge of infant and child development; parent knowledge of child safety in the home; and child developmental delay. **Table 1** displays the domain and name of each instrument. Use of these measures allows staff to identify areas of strength and weakness, set goals and plan activities for each family. Evaluators use measures to develop a profile of baseline risk within the participant population as well as measure the impact of the program over time, and compare these results to a standardized comparable population.

Table 1. Outcome Domains and Standardized Measures

Domain	Instrument
Parenting Knowledge of Child Development/Behavioral norms	Knowledge of Infant Development Inventory (KIDI-long)
Parenting Knowledge of Infant Development/Behavioral norms	Knowledge of Infant Development Inventory (KIDI-short)
Parent Knowledge of Child Safety in the home	Home Safety Checklist
Child Developmental Delay	Ages and Stages Questionnaire

Evaluation activities in Year 8 focused on the collection and analysis of process and outcome data collected and maintained by the program. Satisfaction surveys were also distributed at the conclusion of the fiscal year to participants and staff to solicit feedback on program services, to ascertain perceptions of program efficacy, and determine participant satisfaction with services, and staff job satisfaction. Additionally, the assessment, enrollment, service utilization data, and participant demographic data were extracted from the program’s PIMS database for participants. Attention was focused on quality assurance, collection of missing data from PIMS, and data integrity.

Results

Process Evaluation

Program Implementation

Healthy Families Montgomery continued to demonstrate its commitment to providing high quality home visitation services to families throughout Program Year 8. Core services were supplemented with a variety of support services as well as professional interventions when necessary. The addition of an Early Intervention Specialist (EIS), health consultations with a registered nurse (RN), and mental health and substance abuse consults and linkages, as well as group activities such as support groups and early literacy learning parties have provided critical support and information for HFM families. The ability to link with a wide range of programs within the host agency (Family Services Agency, Inc-FSAI) has further enhanced HFM's ability to provide comprehensive services for families with varying levels of need.

Though home visits comprise the core of program services, HFM continues to enhance the program through groups and socialization opportunities for participants. These enable families to meet one another and begin to create informal support networks amongst themselves. Further, many of the groups are educational, giving the families increased opportunities to learn about topics related to maternal and child health. For example, HFM offers regular Early Literacy Learning Parties, in which parents get together to discuss and learn how to promote early literacy. Also, New Mom Support Groups provide an opportunity for new parents to get together and discuss issues, concerns, stresses, and joys related to having young children.

Additionally, the program held its eighth annual picnic and graduation in June 2004. The day was a huge success, with 106 family members and 20 special guests in attendance. Eight family members graduated from the program, were awarded diplomas from the Governor's Office for Children, Youth, and Families (GOCYF), and were provided with a backpack filled with learning activities and supplies. Each family was also provided with a transition plan, established to foster continued support of their children's growth and development.

In addition to the core home visitation services and supplemental group activities, the availability of additional services through FSAI enhances the program's ability to screen, assess and serve families with varying levels of risk. One example is the incorporation of the Baby Steps Program into FSAI. Baby Steps is a health assessment and referral service for all new parents and newborns. The purpose of this program is to accomplish universal health screening for all families in the county. Over the past fiscal year, the Baby Steps program focused on creating a database system for tracking information, establishing a protocol for administering services, hiring highly qualified staff, developing strong collaboration with the Early Childhood Services Public Engagement Campaign partners, securing MOU's with Shady Grove and Holy Cross Hospitals, and submission of proposals to support and expand the program for FY '05. It is anticipated by the end of FY '05 approximately 5,000 new parents will be screened through this program.

Through a contract between FSAI's parent organization (Sheppard Pratt) and Montgomery County, HFM families also benefit from an increased access to behavioral health services. The Outpatient Mental Health Clinic provides mental health services to families who do not have health insurance and therefore would be ineligible for these services otherwise. A total of fifteen families benefited from mental health services through the Clinic during Program Year 8. These families would have gone without mental health services if not for the connection brought through HFM and FSAI.

Finally, Healthy Families Montgomery was chosen from among Healthy Families Maryland sites to receive two Technical Assistance site visits funded through Freddie Mac Foundation. The purpose of these visits was to provide feedback to sites in order to strengthen program services. The site visits occurred during Program Year 8. The first was October 14th – 15th 2003 and the second June 17th – 18th 2004. Feedback confirmed the high quality of work within all program components. Particular areas of strength included: maintaining limited caseloads in accordance to the Critical Elements; contracting with an independent outside evaluator to ensure continuous program improvement; having access to a nurse to support FSWs with any medical issues; having an Advisory Board that meets regularly, is a well-organized, and comprised of a diverse group of community leaders; and providing an array of parent support groups to enhance its services. No deficiencies were noted, only recommendations to continue the valuable services the program now offers to its community.

Staffing

Healthy Families Montgomery employs a diverse group of highly skilled individuals for all positions. The Family Support Worker position is a “paraprofessional” model, where staff are hired based on an array of personal, educational or professional experiences with a strong emphasis on intensive and ongoing supervision and training. Emphasis is also placed on hiring staff that are culturally competent and representative of the community they serve. As seen in the staff tenure list, there are several workers who have been with the HFM program since its first year. Most of the staff have been employed with HFM or FSAI for at least two years, while five new staff (4-FSWs and 1-EIS) were hired during Year 8. ***Staff retention for Year 8 was 68%***, indicating the HFM program is doing an excellent job of retaining its most qualified and competent staff.

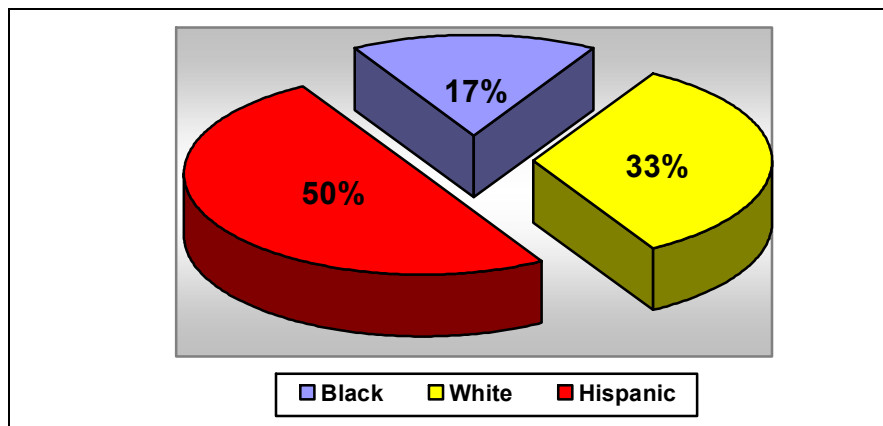
At the end of program Year 8, HFM employed a total of 20 staff members, two of which are part-time. At the end of the fiscal year there were two position vacancies. Ten of the total positions were Family Support Workers, one Program Director, one Quality Assurance Team Leader, one HFM Lead Coordinator, one FSW Team Leader, two Family Resource, a half-time Early Intervention Specialist (EIS), a half-time Health Education Coordinator, a Program Assistant, and a Data Entry Specialist. In order to provide Family Support Workers with an array of support services, the Early Intervention Specialist accompanies FSWs on home visits as needed and is available for FSW or supervisor consultation regarding child development issues. In this capacity, the EIS assesses possible developmental delays, provides assistance in referral coordination, and conducts staff training. This position also oversees the Family Support Groups offered to parents, such as the Early Literacy Learning Parties.

Through County funds, Baby Steps nurses provide health consultations and support and assistance to FSWs in a variety of ways. They are available to accompany FSWs on home visits and

consult with staff on maternal and child health issues. Nurses also provide in-service trainings to ensure staff are informed on the latest maternal and child health information.

It is of the utmost importance to provide and maintain close and trusting relationships with families and is therefore critical that staff have a deep understanding and respect for families they are serving. Therefore, the program hires a culturally diverse mix of professionals who are representative of the community they serve. As shown in **Figure 1** below, half of the staff members are of Hispanic/Latino background, reflective of the large portion of Latino families served by the program. Additionally, four staff members are African-American/Black and six (including the two BS nurses) are Caucasian/white.

Figure 1. HFM Staff Demographics (n= 22*)



* Demographics include 2 Baby Steps nurses

Staff Development

Healthy Families Montgomery places a strong emphasis on ensuring that staff are supported and trained in all areas pertinent to their jobs. HFM follows the training schedule recommended by Prevent Child Abuse America to ensure that all basic content areas are covered, but also enhances required trainings with staff development throughout the year. This is evident from a review of trainings provided to staff in Program Year 8 (*See Appendix J –List of Staff Trainings*).

Several highlights in the area of staff development point to the strong commitment HFM has in creating an environment of learning. First, it is a real testament to HFM's commitment to ensuring staff feel supported and well-trained that the entire staff attended the Healthy Families America/ Prevent Child Abuse Conference in Orlando, Florida from May 16th – 19th 2003. This was the first time that the program was able to send the entire team to the conference, which is offered every other year. This was not only a remarkable opportunity for staff to participate in numerous high quality trainings related to their roles, but it also allowed for a wonderful team building experience. Secondly, the Quality Assurance Team Leader participated in the *Train the Trainer Training* for Family Resource Specialists through Great Kids. This will allow HFM to provide Maryland FRS/Parent Visitor Core Trainings, which is a prerequisite for all Family Resource Specialists. Finally, the HFM Director participated throughout the year in the HFMD Training Workgroup, which serves as the coordinating body for Healthy Families Maryland trainings. The Workgroup's purpose is to coordinate high quality

trainings for home visitation staff throughout Maryland and to ensure that all HFA required trainings are offered to HFA sites on a consistent schedule and are standardized.

A total of 175 trainings were offered to HFM supervisors and staff during Year 8, covering a wide range of topic areas. The trainings can be categorized into the following four subject areas, although some trainings may fall into more than one topic area: 1) Child Health and Development; 2) Family Health and Well-being; 3) Community; and 4) Professional Development.

1. *Child Health and Development* - Fifty-nine trainings were offered to staff throughout the year that covered topics related to child health and development, including language development, infant care, CPR and First Aid, infant mental health, potty training and prevention of Shaken Baby Syndrome.
2. *Family Health and Well-being* - HFM staff were offered eighty-six trainings on areas related to family health and well-being, promoting positive parenting techniques and empowering and strengthening families. Training topics included substance abuse, violence prevention and the effects of violence on children, the importance of involving fathers and teaching parents to play.
3. *Community* - Trainings related to community included trainings geared towards increasing knowledge of community resources, reasons to refer families to various agencies, child abuse and neglect indicators and reasons for reporting CAN, and understanding current laws and regulations regarding child and family health. Twenty-three trainings were offered to staff on topics related to community.
4. *Professional Development* - Finally, a total of seventy trainings were provided to supervisors and direct service staff on areas related to enhancing professional delivery of their roles. A wide range of topics included history and philosophy of home visitation, various aspects of program operations such as service levels, the importance of maintaining client confidentiality and Core and Advanced Trainings for both FSWs and FRSs.

Staff Satisfaction

Healthy Families Montgomery annually distributes a staff satisfaction survey to all current program employees in order to obtain input on job satisfaction and solicit staff impressions of the program's success in effectively serving the community. The new program director, hired in FY'02, instituted a variety of procedural and structural changes to improve the program. Staff perceptions of program effectiveness and satisfaction were considered critical formative feedback in affecting these program refinements. As such, the staff survey was distributed on two different occasions: first in February 2004 and secondly in June 2004. The following is a summary of findings from the two survey distributions.

Staff members were asked to identify their roles. Of the 14 respondents in February '04, eight were direct service staff, five were management and one self-identified as administrative. Of the 19 respondents in June '04, eight self-identified as direct service staff, five as management, one as administrative, while five did not answer.

The following nine questions were asked on both surveys. As seen in **Table 2** below, overall responses were very positive. 100% of staff who responded said that they understood the HFA Critical Elements, find their work worthwhile, find that their work uses their skills, enjoy their work, and have participated in trainings in the past six months, in both February and June 2004. Significantly, 94% of respondents were satisfied with their positions with the program in June 2004, versus just 85% in February. Based on initial results in February, the program instituted several changes to try to bolster job satisfaction. Programmatic changes included clinical and administrative meetings, birthday celebrations and attendance of all staff at the HFA Conference held in Orlando, Florida. Clearly, these changes had an impact!

Table 2. Staff Knowledge and Perceptions of HFM Program

Statement	% Agree Feb. 2004 N = 14	% Agree June 2004 N= 19
1. I understand the HFA Critical Elements	100%	100%*
2. I receive an adequate amount of supervision to help me get my job done in a quality manner	100%	95%
3. I find the work I do is hard	36%	32%*
4. I find my work is worthwhile	100%	100%*
5. I find my work boring	7%	--
6. The work I do uses my skills	100%*	100%*
7. I am satisfied with my position with the Healthy Families Program	85%*	94%*
8. I enjoy my work	100%	100%
9. I have participated in trainings in the past six months	100%*	100%

**Not all staff responded to these questions.*

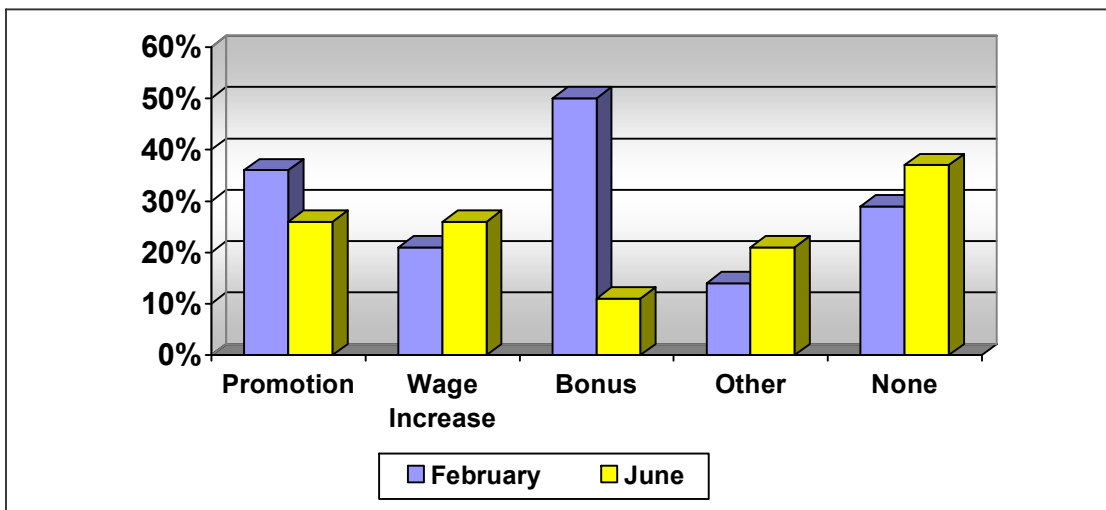
Staff members were asked to write about what areas of the program they felt were particularly strong or weak. Areas of strength for both February and June included supervision, sharing of child development information with families, providing support and services to families and staff working very hard and being very dedicated. Interestingly, there were many more comments written on the June survey that pointed to relationships between staff members, for example, “team building and support,” “staff relationships,” “efforts to bring staff together,” “director,” “teamwork.” There was just one comment relating to this on the February survey: “management listening to concerns and complaints.” The management responded to staff satisfaction concerns expressed in the February staff survey, through additional all-staff team building and staff appreciation experiences, and the outcome has, in fact, led to an increased feeling of positive teamwork. One person wrote “all areas” as strengths in the June 2004 survey.

Staff cited compensation and salaries as the greatest areas of concern in both the February and June surveys. Other areas that were listed as program weaknesses in both February and June were trainings not always being helpful, and communication. However, it is interesting to note that there are many more comments regarding communication as being a concern in the February survey and just one statement about it in June. In June, one respondent wrote, “communication among different programs and organization with upper management.” It is not clear from this statement if this

individual is referring to Family Services Agency management or Healthy Families. In contrast, in February, the following comments related to communication problems: “communication – further clarification by management,” “communication with administration staff of the agency,” “consistent communication with agency,” and simply “communication.” This would point, again, to communication being less of a concern for staff after the team building efforts that were made during the months in between the two administrations of the staff satisfaction surveys.

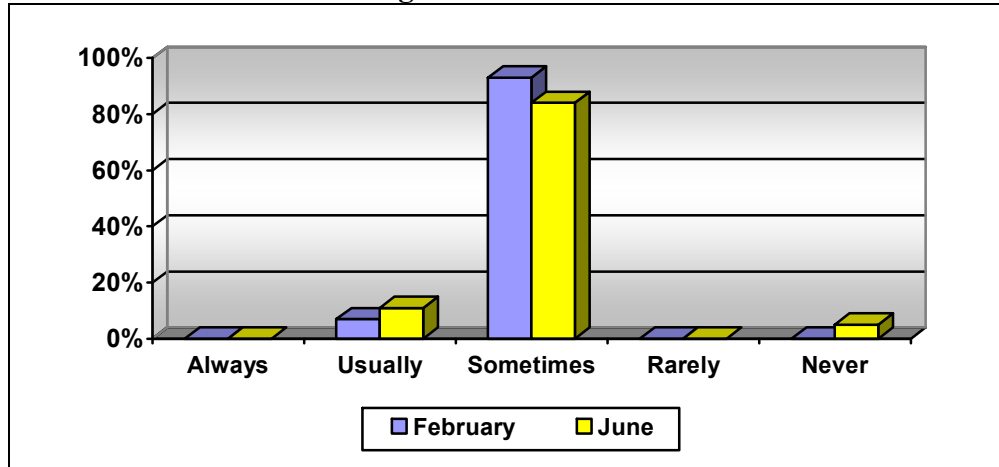
Finally, two additional questions were asked on both surveys about benefits received and stress on the job. **Figure 2** below shows the results of benefits received by staff. A slight decrease in employees who stated they received a promotion was shown from February to June, from 36% in February to 26% in June. Another decrease over time was in the area of bonuses, from 50% stating they had received a bonus in February down to 11% in June. This may be due to the fact that there was wage freeze or that often bonuses are given right around the new year, and perhaps staff had just received a bonus at the time of the February survey. By June, there may have been new employees who had not been employed long enough to receive a bonus. In other areas there were slight increases in benefits received by staff, including an increase in percentage of employees who stated they received a wage increase from 21% in February to 26% in June. There was also an increase in the number of staff who indicated they had received some sort of “other” benefit: from 14% in February to 21% in June. The respondents in June stated that they had received certification. When asked to specify what the “other” meant, in the June survey staff wrote “knowledge,” “encouragement,” “appreciation,” and “information to utilize with families.” Since the staff had all attended the national HFA Conference, some of these comments may refer to what they were able to learn from this opportunity.

Figure 2. Staff Benefits Received



Lastly, staff members were asked how stressful their jobs were. As seen in **Figure 3** below, in both survey administrations, the vast majority of staff members responded that their jobs were “sometimes stressful.”

Figure 3. Job Stress



In addition to the two Staff Satisfaction Surveys, a Cultural Competency Evaluation was completed during Program Year 8 as part of the credentialing process. The survey asked staff 12 questions relating to how people feel the program is doing with providing services to families in a way that is culturally competent. Sixteen staff members responded to the survey. **Table 3** below illuminates ten of the statements and responses given by staff.

Table 3. Staff Perceptions of Program

Statement	Agree	Disagree	No Answer
1. The program respects the culture of the families that it supports.	100%	0	0
2. The program takes into account culture of family, age of parent, dynamics in family (i.e., alcohol and drugs) and geography when assigning staff to a family.	100%	0	1
3. The program praises each family for their accomplishments.	94%	6%	0
4. The program has an interest in father involvement and addresses ways to inform Dads that their presence in the life of the child makes a difference.	94%	6%	0
5. The program has provided me adequate information on supporting families with substance abuse issues.	94%	6%	0
6. The program has provided me with adequate information on supporting families with domestic violence issues.	94%	6%	0
7. The program has provided me with adequate information on supporting families with mental health issues.	88%	12%	0
8. I feel I am trained to work with families in culturally appropriate ways.	81%	19%	0
9. The program provides educational material (i.e., videos curriculum, and literature) that reflect the culture of the population.	81%	19%	0
10. Supervision helps me overcome obstacles I might be having with families of different cultures.	100%	0	1

All staff members agree that the program respects the culture of families that it works with, most feel that the program takes into account issues such as the culture of the family when assigning families to FSWs (n=15), and that supervision is helpful in supporting home visitors around cultural issues that arise (n=15). Further, fifteen out of the sixteen respondents, or 94%, feel that the program praises families when they achieve accomplishments, that the program is invested in assisting parents in understanding the critical role that fathers' play, and that the program has provided adequate information to home visitors on supporting families with substance abuse and domestic violence issues.

Fewer staff members feel supported when it comes to working with families with mental health issues, with 88% (n=14) of staff members feeling that they are adequately prepared to handle mental health issues and 12% (n=2) of the sixteen respondents feeling that they are not prepared to work with these families. The program may want to look into additional trainings in the area of mental health and/or focus discussions in supervision around mental health issues in order to better support staff in working with families facing mental health concerns. In many instances the challenge is getting the family to accept behavioral services. HFM has found it to be effective to collaborate with other agencies such as Child Center and Adult Services and Behavioral Health Partners who are able to provide therapy in the home environment.

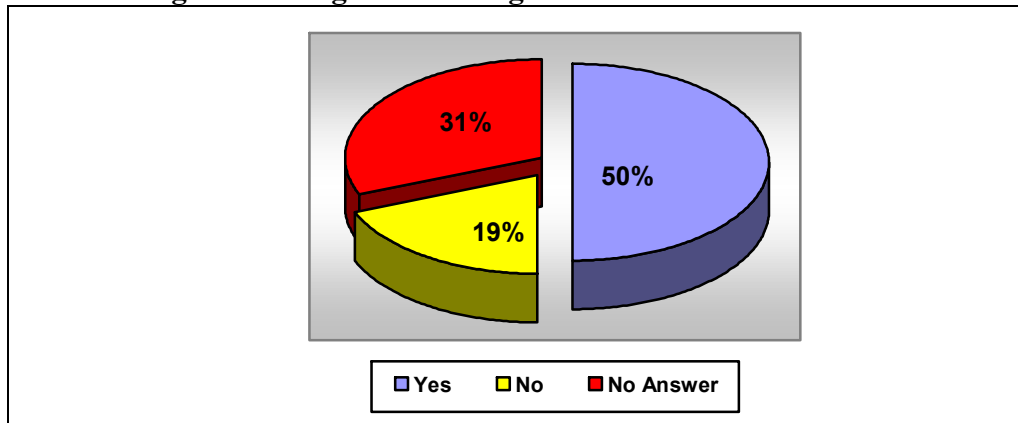
On two of the cultural competence statements, 81% (n=13) agreed and 19% (n=3) disagreed. These related to perceptions of adequate training to work with families in culturally appropriate ways and that the program provides educational materials to families that are culturally competent. Again, the program may want to look into additional trainings in the area of working with culturally diverse families and also may want to conduct a review of their materials to ensure information is reflective of all cultures served and enhance program materials as needed.

An additional question asked if staff members feel that the program is doing its best to meet the varying cultural needs of the families when providing services. As is shown in **Figure 4** below, only 50% (n=8) of staff members responded that "yes," they feel the program is doing its best. 19% (n=3) responded "no," they do not feel the program is doing its best in this area, and an additional 31% (n=5) checked "no answer" to the question. It is unclear why so many people responded with "no answer." Whether they did not understand the question or did not feel comfortable answering the question is unknown. The fact that only 50% felt the program is clearly doing all it can to meet the cultural needs of families is reason to review ways the program could strengthen its cultural competency, possibly through increased staff training, supplementing program materials to ensure they are more representative of the community, and having an ongoing dialogue with staff either in supervision or in team meetings about how the program can be more responsive to staff and family needs in the area of culture.

"Need to be more sensitive to the culture of African and African American families. Provide more material directed to the culture. Recognize difference in preferred child rearing."

"Literature given should be basic (reading level of families)."

Figure 4. Program Meeting Cultural Needs of Families



*“More training specific to the culture of each family, for example, family background, social status, poverty, etc...”
“To have deep training on culture.”*

Question # 12 asked staff members for ideas and suggestions on how to improve home visits with those families of varying cultures. Four of the six statements pertain to trainings and the importance of additional trainings, especially trainings related to culture. The other two comments both relate to materials given to families and to ensuring that they are reflective of the community served. Finally, statement #5 also specifies African culture in particular and that the program needs to work on being more sensitive to child rearing practices within this culture.

Overall, staff feels that the program does well with respecting the cultures of the families it serves and the staff generally feel supported in working with families of diverse backgrounds. However, the program could strengthen its dedication to cultural competence through increased trainings on working with families of diverse cultural backgrounds, as well as providing more trainings on mental health and other issues pertaining to family functioning. Finally, the program would benefit from a review of its educational materials distributed to families to ensure cultural competence.

“More training on issues that interfere with family success, e.g., substance abuse, domestic violence, practical information on cultural norms for various groups.”

Participant Satisfaction

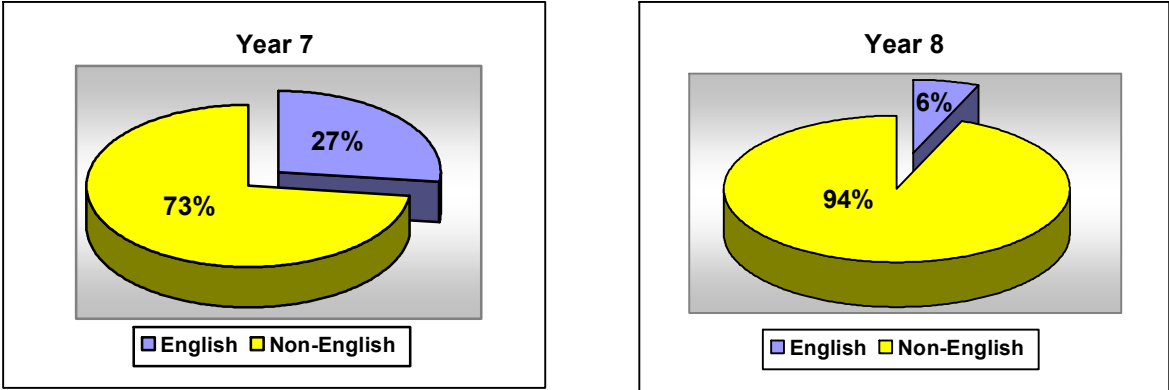
As in past years, the annual Participant Satisfaction Survey was distributed during Program Year 8 in order for the program to obtain critical input directly from families as to how well the program is meeting the needs of the families it serves. A range of questions was posed to families from frequency and duration of visits to attitudes of Family Support Workers towards the families. The age range of participants was 14 – 33 years old. Questionnaires were distributed to families by FSWs during routine home visits in both English and Spanish and were completed anonymously. Participants were asked to complete the survey and place it in a self addressed sealed envelope to be mailed to the program.

*“My FSW became a friend, a close one.”
-Year 8 Survey Respondent*

A total of 46 surveys were returned from the 213 total participants who participated in program services during Year 8 (22% of the program population). This is a decrease from Year 7, when 64 surveys were returned from the 204 participants, yielding a 31% completion rate.

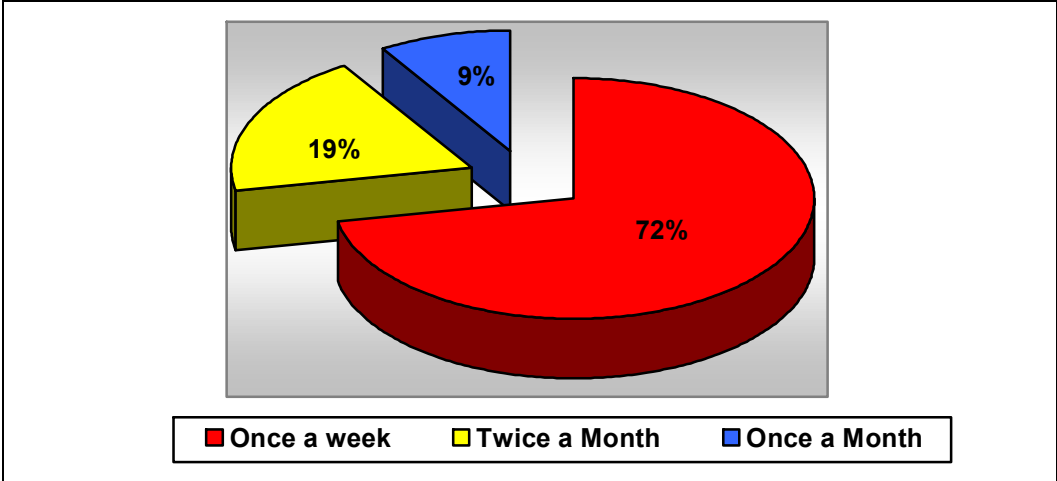
As seen in **Figure 5** below, 94% of surveys returned in Program Year 8 were from non-English speaking families, and only 6% from English speakers. This is notable in light of the fact that 36% of program participants are English speaking and only 64% non-English speaking (58%= Spanish and 6%=other). This is a drop in the number of English surveys returned from 19% in Program Year 7. Further, there were only 22% English speakers in Program Year 7 and 78% non-English speakers. This highlights the engagement of the non-English speaking families who wanted to provide their feedback (mostly positive) to the program.

Figure 5. Language of Respondents



Participants were asked how often they received visits from their FSWs to indicate differences in level of services received. **Figure 6** below illustrates that the majority of families responded that they receive weekly visits (72%; n=33), with 9 families reporting bi-weekly visits (19%) and just 4 participants indicating that they receive once a month home visits (9%). The high percentage of participants receiving weekly visits is a testament to the intense nature of the Healthy Families Montgomery Program, an opportunity for families to receive information and support on a consistent and frequent basis.

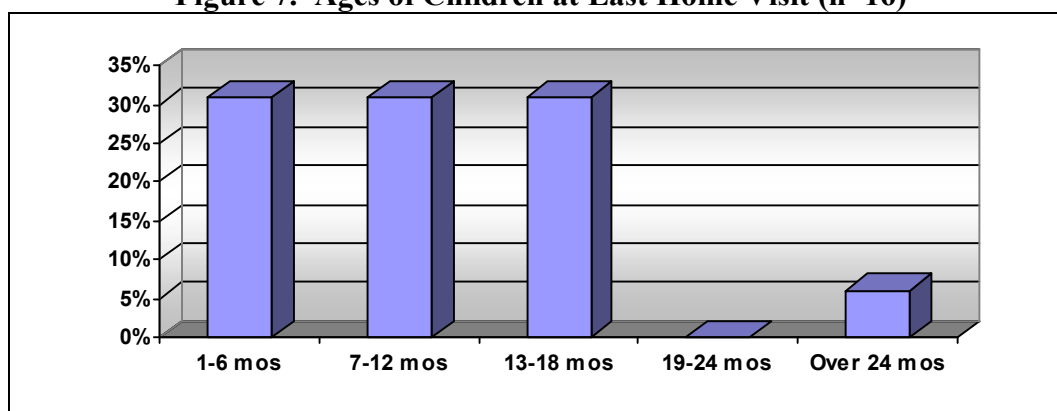
Figure 6. Frequency of Home Visits



The next question asked participants about the age of the child at their first home visit. First, participants were asked if their child was under three months of age when the first home visit occurred. Twelve participants did not answer this question, but of the 34 participants who did respond, all 34 indicated that they received their first home visit prior to their child turning three months old. This shows that the program is starting contact with families very early, either before the child is born, or at minimum prior to the child turning three months old, adhering to the critical element that services are provided right from the birth of the baby, so that positive parenting practices can start immediately.

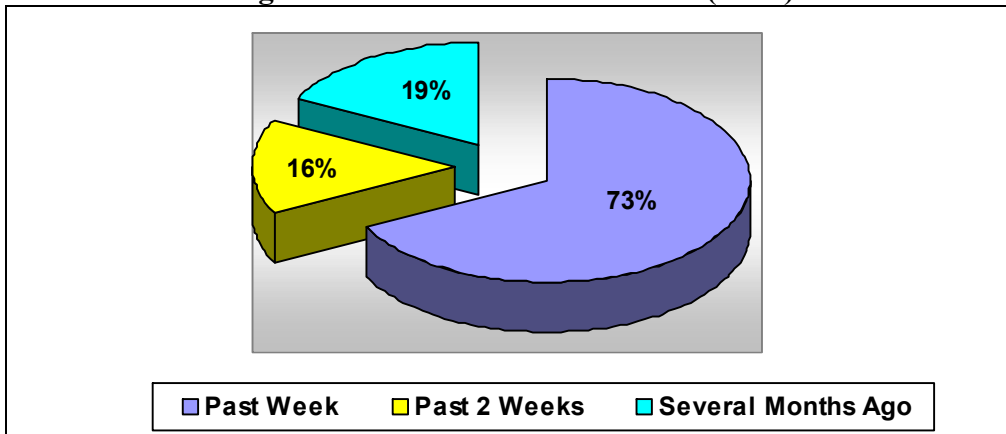
Next, participants were asked their child's age at the last home visit they received. **Figure 7** shows that of the 16 participants who responded, 15 of them had children 18 months or younger and one child was over 24 months. This result appears to reflect the high percentage of families who indicated receiving weekly home visits. Possibly due to the frequent visits and the fact that the FSW may have been able to remind families to return their surveys, many of the participants who returned their surveys have younger children and are still receiving the most intensive level of services provided by HFM.

Figure 7. Ages of Children at Last Home Visit (n=16)



Participants were asked about when their last home visit took place. As shown in **Figure 8** below, of the 31 participants who responded to this question, 73% (n=30) of respondents indicated that their last home visit occurred within the past week. This is close to the 72% who indicated they receive weekly home visits. 19% (n=6) responded that their last home visit was several months ago. When asked to explain why, no answers were recorded. Finally, 16% stated that their last home visit occurred within the past two weeks.

Figure 8. Date of Last Home Visit (n=31)



Finally, the survey asked participants to respond “Yes” or “No” to 26 questions regarding program effectiveness. Questions were geared towards getting a better understanding of the program’s performance regarding cultural competency, support and encouragement of parents and children, and providing information to families. As noted in **Table 4** below, the overwhelming majority of families responded with positive feedback in all areas.

On well over half of the questions, 100% of participants responded with positive answers (67%, n=19/27). This is an even more impressive number than on the Year 7 responses where 54% (n=14/26) were 100% in agreement. In the following areas 100% of participants agreed that the program was excellent: home visitors gave information on how to care for the child; visitor helped them to understand child’s development and behavior; visitor provides with positive feedback; visitor is responsive to needs; visitor respects family’s culture and ethnicity; visitor understands that their family may be different from other cultures; visitor accepts religious and other beliefs; communication goes well; participant trusts visitor; visitor helps to become more independent; visitor helps to understand and provide for child’s health; program is helpful to participant as a parent; program has helped with baby; participant had opportunity to agree to plan of service; the program has assisted in arranging for services elsewhere; participant would recommend program to a friend; questions asked by visitor are easy to understand; participant feels comfortable answering visitor’s questions; and questions are explained well.

“The [program] information is educational and easy to understand.”
-Year 8 Survey Respondent

In examining responses in comparison to the previously administered survey, certain questions stand out. For example, on question #23 about the program assisting in arranging for services elsewhere if they could not provide the participant with something, 100% of respondents currently indicate that they are assisted in this way as compared to 91% in Year 7. This speaks to the excellent job the program does in linking participants to needed community resources. On question #11, just 89% of participants currently indicate that the program materials are sensitive to their cultures, where 94% felt so in Program Year 7. The program may want to review their materials for cultural competency, as this represents a 5% decrease. Interestingly, exactly 81% of families in both program years felt that visitors avoided imposing their own childcare values on the participant (question #7). This is notable as participants tended to have such overwhelmingly positive feelings towards their visitors in other areas, including questions regarding respect for the families’ culture and values. One

“Thanks for this program. It gives me knowledge about the development of babies and how to handle stress that may come about with babies.”

-Year 8 Survey Respondent

possibility is that the question may be worded in a way that is confusing with the word “avoid”. The program may want to try re-wording this question for the next distribution. In addition, the program may want to look at how home visitors share information on childcare to ensure that they are not inadvertently trying to steer participants into certain practices with which they are not comfortable. Finally, 100% of respondents on question #8

currently feel that the visitor understands that the family may be defined differently from other cultures, up from 95% in Year 7. This again speaks to high levels of cultural competency, respect, and acceptance that staff demonstrate to the families.

Table 4. Comparison of Participant Perceptions of Program Effectiveness Year 7-8

Questions	Year 7 Agree n=64	Year 8 Agree n=46
1. Do you feel you were visited often enough?	97%	95%
2. Did your home visitor give you information on how to care for your child?	100%	100%
3. Did your visitor help you understand your child’s development and behavior?	100%	100%
4. Does your home visitor provide you with positive feedback and support?	100%	100%
5. Do you feel your visitor responsive to your needs?	100%	100%
6. Do you feel your home visitor respects your family’s way of doing things including you family’s culture and ethnicity?	100%	100%
7. Does your home visitor avoid imposing childcare values of her own that may conflict with those of your culture or ethnicity?	81%	81%
8. Does your visitor understand that your family may be defined differently from those in different cultures (e.g., extended family members, godparents, etc.)?	95%	100%
9. Does your home visitor accept that your religious and other beliefs may play an important role in how your family makes decisions?	98%	100%
10. Did your home visitor accept and respect that the inter-generational roles in your family may vary from other cultures?	100%	98%
11. Do you feel that the program materials used by the program are sensitive to your culture?	94%	89%
12. Are the materials used by the program in your primary language?	94%	98%
13. Does your visitor communicate with you in your primary language and in a way that is easy for you to understand?	94%	98%
14. Did your visitor interact with you in a strength-based and culturally relevant?	100%	96%
15. Do you generally feel understood when talking with your home visitor and feel that you both communicate well?	100%	100%

Questions	Year 7 Agree n=64	Year 8 Agree n=46
16. Do you trust your home visitor to look after your best interests?	100%	100%
17. Does your home visitor help you to become more independent by encouraging you to make your own decisions?	100%	100%
18. Does your home visitor help you understand and provide for your child's health needs?	100%	100%
19. Has the program been helpful to you as a parent?	100%	100%
20. Has being in the program helped your baby?	98%	100%
21. Were you given the opportunity to participate in and agree with a plan of service?	100%	100%
22. Was there any service or help you expected or needed from the program that you did not receive? If yes, explain.	2%	2%
23. Did the program assist you in arranging for services elsewhere if they could not provide something you needed?	91%	100%
24. Would you recommend that a friend or neighbor use this program's service?	100%	100%
25. The questions asked by the FSW are easy to understand.	Not Asked	100%
26. The participants feel comfortable answering the types of questions the FSWs ask.	Not Asked	100%
27. The questions are explained well.	Not Asked	100%

* Not all participants responded to these questions.

Finally, program participants offered several additional comments:

"The FSW was nice and dedicated to her work."

"The FSW was there for me when I needed her."

"The FSW understood me. If I couldn't ask something correctly in English, she would answer my question well so that I [could] understand it."

"The FSW did a good job in helping me."

Two main areas were reflected in respondents' comments: the content of the information shared and the nature of the relationship with the FSWs. Regarding information shared, participants feel that the information they receive is understandable and helpful, is presented in a way that is easy to process, and is useful to them in raising their children. In the area of relationships with the FSWs, feedback indicated that participants feel comfortable with their FSWs, feel that they can trust and open up to them, and that they are understood by their FSWs. Further, some participants indicated that the FSWs had become close friends or confidants, that they feel very close to their FSWs, and that they are able to help them handle stress related to having children.

Overall, the participant surveys clearly reflect the tremendous amount of support and information families feel they receive from their visitors. The program is clearly doing well in assisting families with caring for their children and striving for increased independence. As stated earlier, the program may want to review their materials for cultural sensitivity, as some participants indicated materials not being appropriate to their cultures.

"This program is excellent!"

-Year 8 Survey Respondent

While the great majority of questions relating to cultural competency indicated that families feel very comfortable, the program may want to increase training or support on sharing childcare information. Healthy Families Montgomery continues to provide a high quality program to its community where participants feel they benefit from their home visits in a variety of ways.

Screening, Assessment and Enrollment

Families who screen positive for the HFM program (i.e., teen pregnancy, self-report of depression or history of abuse) are asked to complete a more in-depth interview. The C.H. Kempe Family Stress Checklist (FSC) is an in-depth measure designed to assess risk on ten domains, including substance abuse, self-esteem and depression, as well as perceived expectations about childrearing and bonding and attachment. A trained Healthy Families staff member, the Family Resource Specialist (FRS), administers the FSC to all eligible individuals. Families who score at or above 25 are considered at risk and are recommended for the HFM program. However, the screenings and assessments enable staff to determine the most appropriate and best available service for the family based on the continuum of need, so even if a family does not score high enough to be eligible for home visitation services, referrals and linkages with other community services are made as appropriate. HFM's efforts have been aligned with and supported by Montgomery County's Early Childhood Comprehensive Plan, which established an interagency consortium to create a universal screening and system of care for early childhood.

Table 5 below highlights screening and assessment data across the last eight years of the Healthy Families program. Screening data was maintained at the screening sites during the first two years of the program and therefore is unavailable for inclusion in the table. As can be seen in the table, an overwhelming number of mothers screen positive for risk. Screens conducted in the last six years alone have identified over 5,000 first time parents in need of family support services for themselves and their new child.

While the Healthy Families Montgomery program staff have done an outstanding job of enrolling nearly all women (93%) who score positive on the parent surveys for moderate to severe risk, working tirelessly to increase program capacity every year, their efforts are only benefiting a small number in need. **Indeed, across the last six years, only 16% (n=817/5168) of all positive screens were followed up with an assessment and enrolled in the program.** Historically, Healthy Families Montgomery would not assess clients for enrollment unless they had adequate space and resources to provide services. More recently, however, in order to utilize the Parent Survey as a means to identify specific areas of family need and connect families to the most appropriate and available service at any point in time in the community, HFM shifted their philosophy and stepped up efforts to complete assessments on as many families as possible who have a positive screen. They are working in close collaboration with referral agencies and partners to find social service programs throughout the county that can provide immediate assistance.

Table 5. Screening, Assessment and Enrollment (July 1996-June 2004)

YEAR*	Total Positive Screens	Total Assessments Completed	Total Positive Assessments	Total Negative Assessments	Total Enrollments	Total Refusals	Program Capacity
YEAR 1	-	-	-	-	45	-	50
YEAR 2	393*	-	-	-	54	-	75
YEAR 3	787	49	49	0	49	0	75
YEAR 4	824	110	108	2	104	4	150
YEAR 5	828	63	60	3	50	3	160
YEAR 6	854	146	127	19	116	10	150
YEAR 7	941	259	192	67	66	77	150
YEAR 8	934	190	136	54	39	15	150

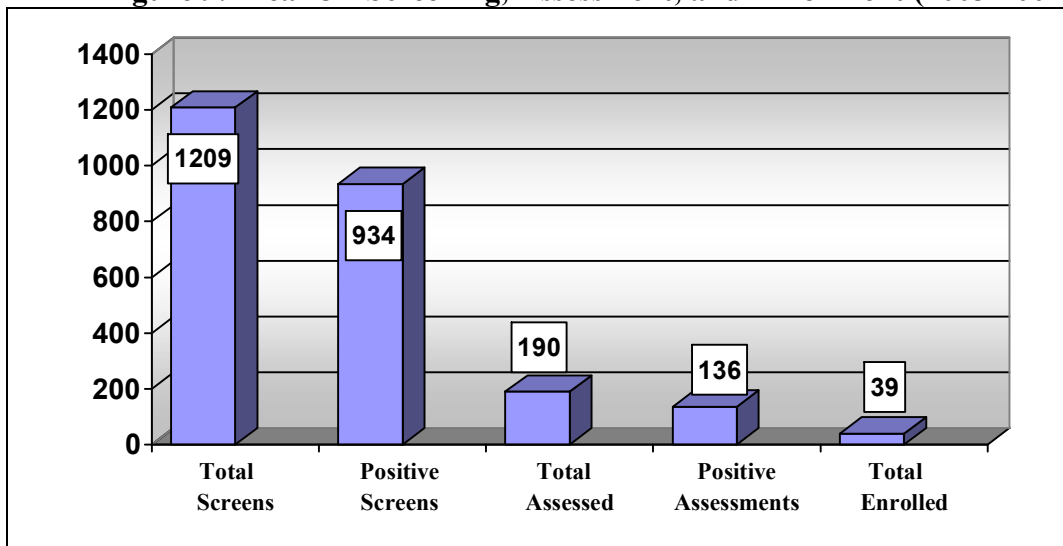
* Screening and Assessment Data from DHHS incomplete for Years I and II of the program-Not included in Totals.

**Due to the number of families at a high level of risk and requiring intensive Level I services, the HFM program is necessarily limiting its current maximum capacity to 145-150 participants.

Figure 9 below shows the total screening and assessment data for Year 8. As seen below, the majority (77%) of the total screens conducted were positive (n=934/1209). Of these, the program was only able to assess 20% (n=190), primarily due to staff limitations. Of the families who received an assessment, 72% (n=136) scored positive and were eligible for HFM services, but only about one third (29%; n=39) of these were enrolled for services primarily due to full caseloads in the program. **In fact, in Year 8, ninety-seven families in need of intensive service were not enrolled due to staffing limitations.**

The HFM program has done an excellent job in identifying, assessing, and engaging the target population. Additionally, the screening and assessment services provided by HFM have yielded valuable information on family risk and need for services, as well as enabled FRSs to link families to other services in the County. *However, when the number of families enrolled is compared to the number of positive screens, only a fraction (4%) of these at-risk families ultimately received HFM intensive home visiting services, demonstrating a tremendous gap in services for at-risk families in the County.*

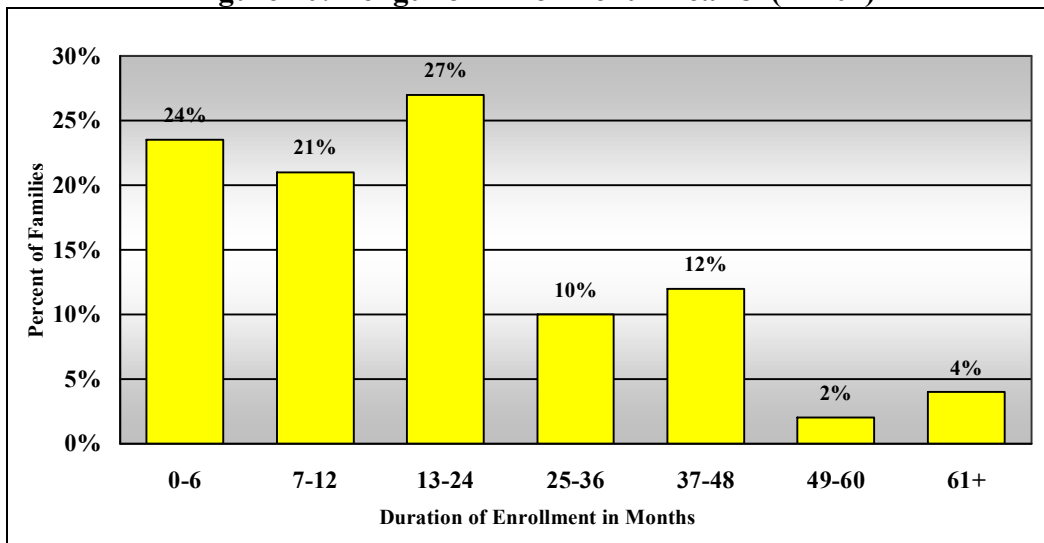
Figure 9. Year 8 – Screening, Assessment, and Enrollment (2003-2004)



Enrollment and Attrition

A total of 213 families and 208 children participated in the HFM program in Year 8. Of these, 39 families were newly enrolled during the current reporting year. Length of enrollment for all active participants ranged from 1 to 68 months with a mean of approximately 1.6 years of participation, comparable with the mean length of enrollment reported for Years 1-7. **Figure 10** indicates that almost half of families in Year 8, 45% (n=91) have been enrolled for 1 year or less with another 27% (n=55) enrolled for up to two years, 10% (n=20) for up to 3 years and 18% (n=38) for more than three years.

Figure 10: Length of Enrollment - Year 8 (n=204)



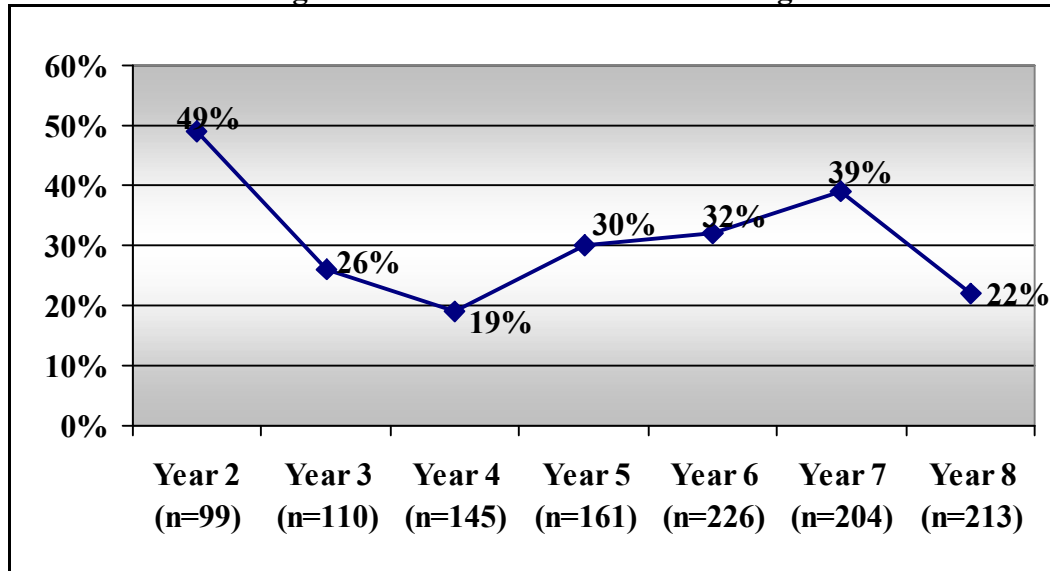
Attrition rates across eight years of program operation include an examination of all active families within each year of program operation. Attrition percentages do not include case closures due to program graduation, child aging out, transfers to other Healthy Families programs, and/or due to full-time work. As seen in **Table 6**, HFM experienced an initial decline in attrition in Years 3 and 4, but an increase in Years 5 through 7. Rising attrition rates in those years may have been related to staff turnover or a program shift toward referral of high-risk families and families who are not progressing within recommended participatory guidelines.

Table 6. HFM Attrition – Year 2 through Year 8

	Enrolled	Open	Closed*	Attrition Rate
Year 2	99	51	48	49%
Year 3	110	82	28	26%
Year 4	145	118	27	19%
Year 5	161	113	48	30%
Year 6	226	140	72	32%
Year 7	204	113	79	39%
Year 8	213	112	56	22%

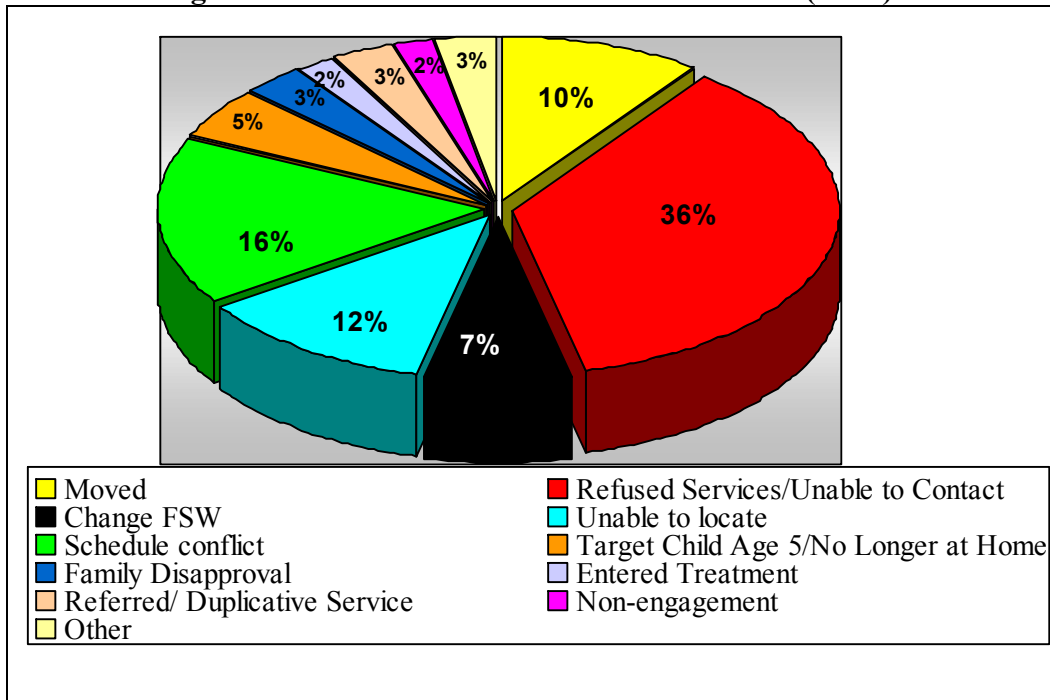
However, this trend reversed in Year 8 (see **Figure 11**) and there was a significant decline in the attrition rate from 39% to 22%. Additionally, HFM’s current attrition rate is well below the range (30% - 60%) of other Healthy Families programs.

Figure 11. Attrition Rates – Percentage Profile



During Year 8, *a total of 8 families had met all their goals and graduated from the program.* Excluding these families, a total of 58 families terminated services for a variety of reasons, as shown in **Figure 12**. Over one-third of terminated cases (36%; n=21) were due to the family’s refusal of services or to the program’s inability to contact the family. An additional 16% of families (n=9) had scheduling conflicts and were thus unable to keep their appointments with their Family Support Workers. Seven families (12%) were unable to be located, while an additional 6 families (10%) moved out of the area and were not able to connect with another Healthy Families program. Several families (7%; n=4) were no longer interested in participating after they were reassigned to a new FSW.

Figure 12. Reasons for Case Closures- Year 8 (n=58)*

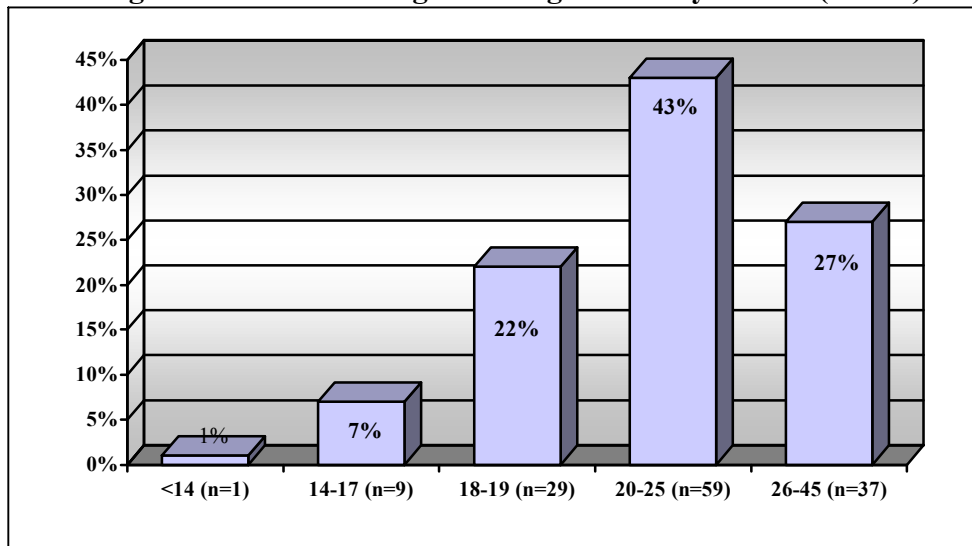


*Program graduates not included

Population Demographics

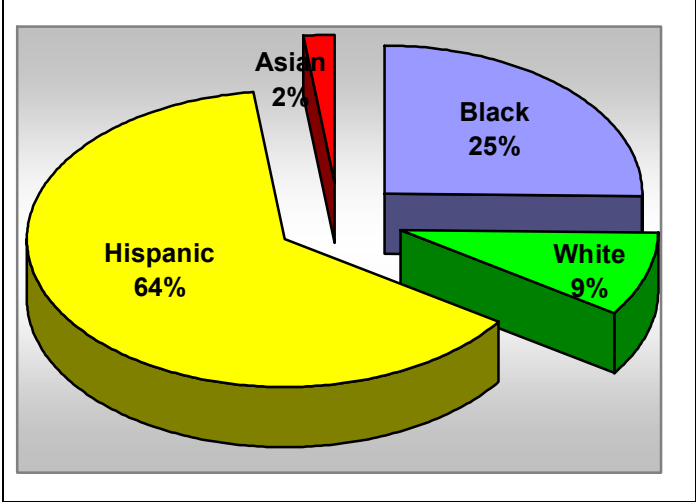
Mother's Age. Mother's age at enrollment in the HFM program is displayed in **Figure 13**. Data was available for 135 mothers. In recent years there has been a trend toward enrollment of mothers over the age of 20. Previously, the majority of mothers were teens (<20 years). In Year 8, mother's age continued that trend with 70% (n=96) of newly enrolled mothers being over the age of 20. Older teens, aged 18-19 comprised 22% of new enrollees.

Figure 13. Mothers' Ages at Program Entry-Year 8 (n=135)



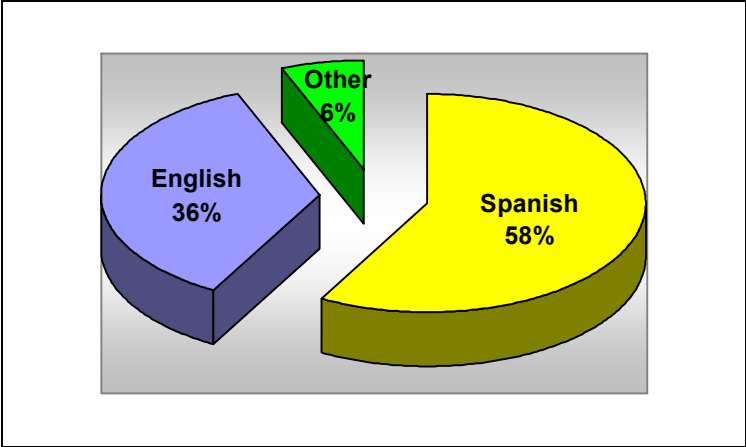
Mother's Race. Consistent with data from the past seven years, Hispanic mothers make up the greatest percentage (63%; n=87) of the Year 8 HFM population. One-quarter of participants identify themselves as Black (25%; n=35), and 9% (n=13) are White. The remaining 2% (n=2) are Asian/Pacific Islander.

Figure 14. Mothers' Race (n=137)



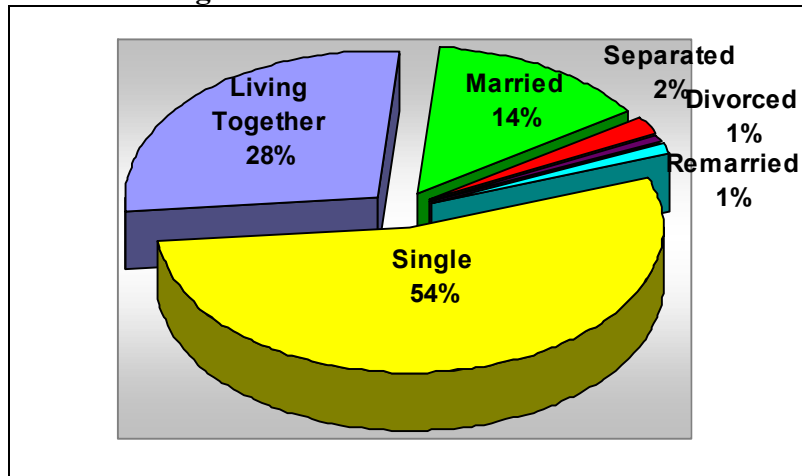
Mothers' Language. Given the findings regarding mothers' race, data on participants' primary language were not surprising. As seen in **Figure 15** below, the information on language, available for 137 participants, indicates that 58% (n=79) speak Spanish as their primary language. Thirty-six percent of participants (n=50) identified English as their primary language, while an additional 6% (n=8) categorized their primary language as "Other."

Figure 15: Primary Language (n=137)



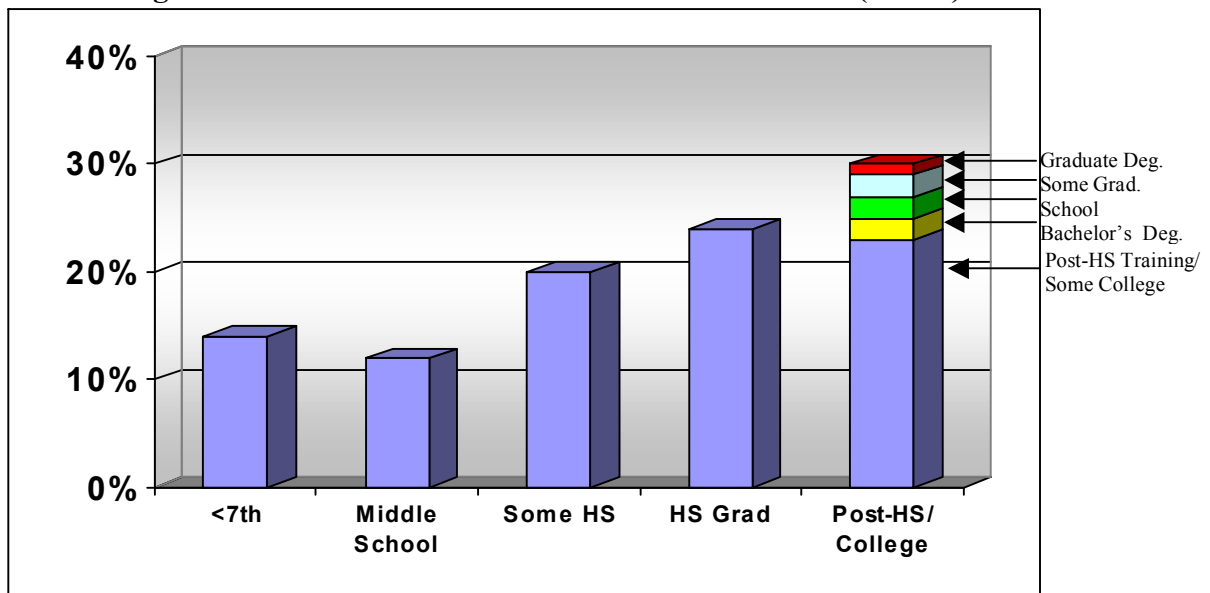
Marital Status. As seen in **Figure 16**, over half (54%; n=74) of participating mothers are single (never married). An additional 28% are unmarried, but living with their babies' fathers or their boyfriends. Fifteen percent (n=21) are married or remarried. The remaining 3% of mothers are single due to separation or divorce.

Figure 16. Mothers' Marital Status



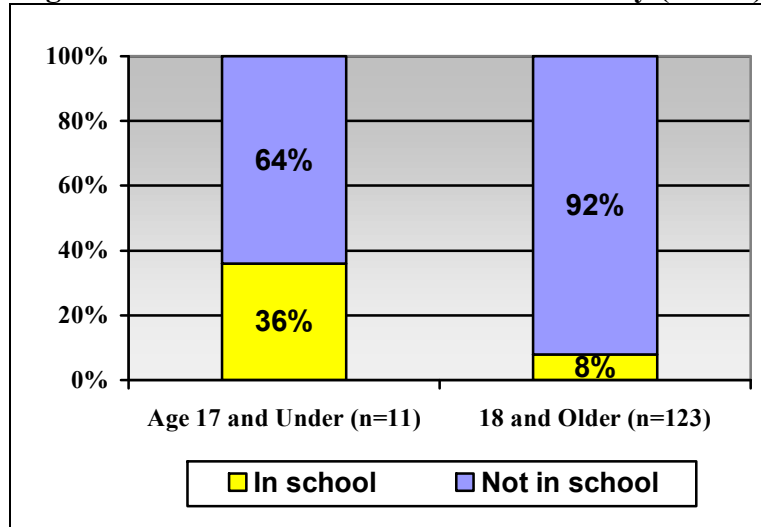
Mother's Education. As seen in **Figure 17**, the majority of mothers (54%; n=73) are high school graduates. Of those, over half (n=40) have gone on to post-high school training and/or college, with several (n=8) earning Associate's, Bachelor's, or Graduate degrees. Whereas the increase in enrollment of young and older adults enrolled in Year 7 did not yield higher education levels as expected, Year 8 data shows that education levels are, in fact, increasing, as only 26% of Year 8 mothers entered the program with a middle or elementary school education, compared to 34% in Year 7. Additionally, the percentage of Year 8 mothers entering the program with a high school degree or higher is 9 percentage points higher than that in Year 7 (54% vs. 45%). These figures indicate that education levels are beginning to increase as the ages of the enrolling mothers are increasing as well, which may portend a corresponding decrease in risk for poor self-sufficiency outcomes.

Figure 17: Mothers' Education Status at Enrollment (n=135)



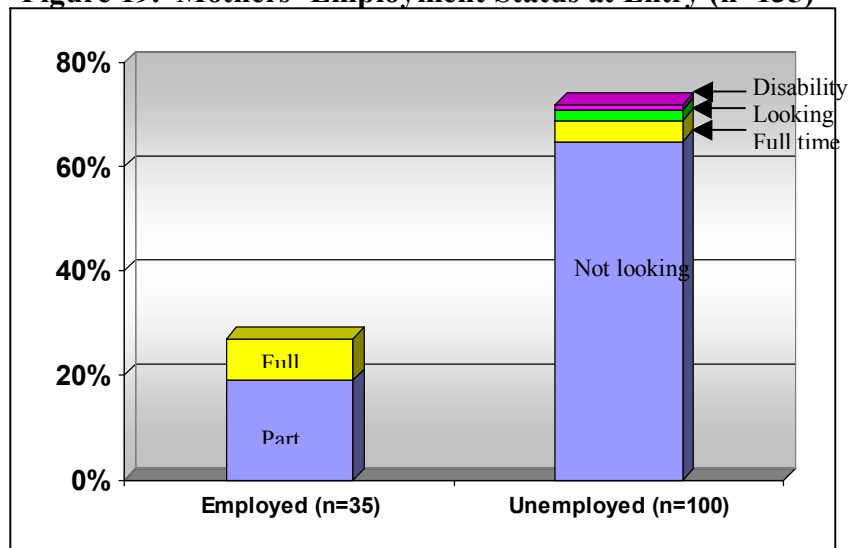
Data representing mothers' school status at program entry was available for 134 participants. **Figure 18** shows that of school age participants (n=11), about one-third (36%, n=4) were attending school at program entry. However, 8% of participants over the age of 18 (n=10) were also enrolled in school, six of whom possessed a high school diploma and were continuing on for an advanced education.

Figure 18. Mother's School Status at Entry (n=134)



Mother's Employment. Two mothers were under the legal age to work (16 years) when they entered the program (one of whom was in school) and were not included in this analysis. Data on employment status was only examined for all mothers age 17 and older. As seen below in **Figure 19**, slightly more than one-quarter of mothers (26%; n=35) were employed when they entered the program (Full time – n=11; Part time-n=24). The remaining 74% of mothers (n=100) were unemployed, with the majority not seeking work.

Figure 19. Mothers' Employment Status at Entry (n=135)

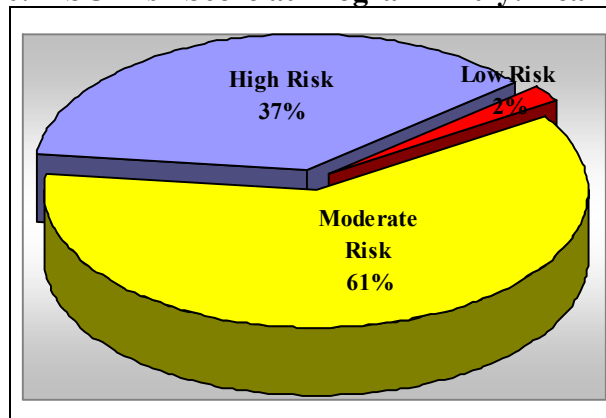


Risk Factors

In addition to examining participant demographics, Healthy Families Montgomery also examines performance on initial risk using the HFA assessment measure, The C.H. Kempe Family Stress Checklist (FSC). The Family Stress Checklist, an assessment instrument implemented by HFM and numerous other Healthy Families sites across the country, examines a family's degree of risk for child maltreatment to determine program eligibility or the need for referral to more appropriate community services. A family must demonstrate the presence of certain indicators associated with child abuse and neglect and poor childhood outcomes; such as a history of child abuse, substance abuse, mental health concerns, family stressors, lack of knowledge regarding child development or limited self-sufficiency, in order to qualify for Healthy Families services. Family Stress Checklist scores are grouped into three categories of risk: High/Severe (≥ 40), High/Moderate (25-35), and Low (< 25).

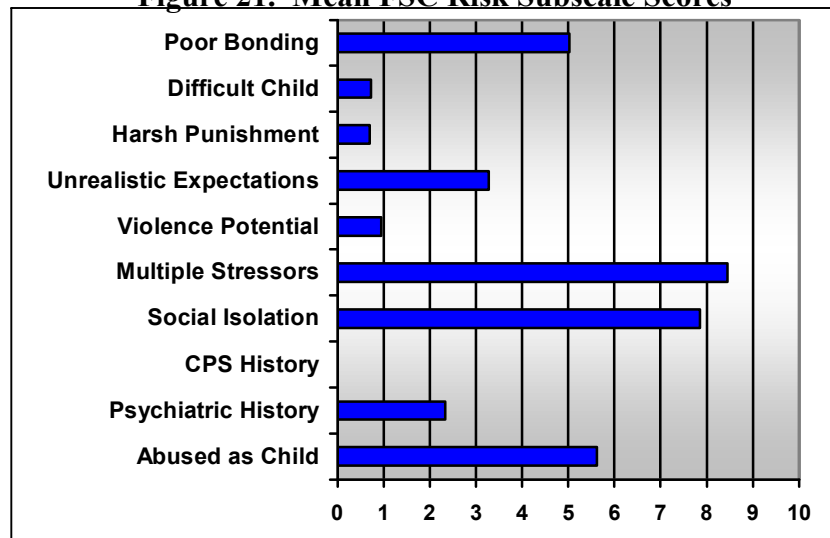
As seen in **Figure 20**, more than half (61%, $n=83$) of Year 8 participants scored in the Moderate risk range, and another 37% ($n=51$) were in the High/Severe Risk range at program entry. Only 2% ($n=3$) of mothers were considered Low risk at program entry.

Figure 20. FSC Risk Score at Program Entry: Year 8 ($n=137$)



When examining the subscales, there were several risk factors that stood out as high for a significant number of families. As seen in **Figure 21**, the most prominent included: multiple stressors; social isolation; mother abused as a child; and poor bonding with child.

Figure 21. Mean FSC Risk Subscale Scores



Outcome Evaluation

Achievement of Goals and Objectives

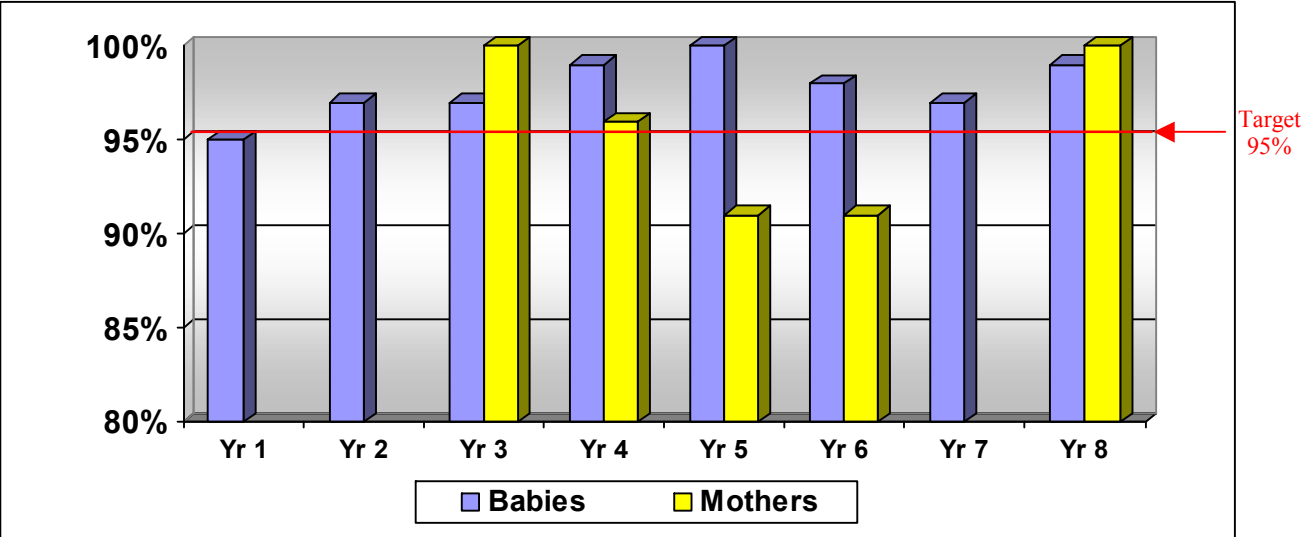
For the past eight years, the Healthy Families Montgomery Program has consistently met with success not only in achieving its goals and objectives, but also by exceeding many of its targets for key outcomes. Current outcomes confirm the program’s ability to sustain its successes through its ninth year of operation as well (*see Table 7 – HFM Outcomes Chart: Years 1-8; and Table 8 - HFM Outcomes and Comparative Statistics*).

Goal I: Promote Preventive Health Care

Health Care Provider

A primary focus of Healthy Families Montgomery is linkage of participating families to preventive health services, specifically Medical Assistance (MA), private insurance, and/or primary care physicians. The State of Maryland provides health coverage for all low-income children through its MCHIP program. Mothers are covered prenatally, but medical coverage for low-income adults and the working poor are generally not available through the state, particularly for undocumented immigrants. Montgomery County has established several programs fill this gap and increase access and coverage for the uninsured through its Rewarding Work and Project Access. Since the program’s inception in 1996, HFM has consistently been successful at linking families to a health care provider and enrolling eligible mothers and children in publicly funded health insurance programs. Each program year HFM has exceeded its target (95%) by ensuring children and parents have a health care provider. Year 8 data indicates that **99% of children, as well as 100% of parents, have been linked with a health care provider. Additionally, current data confirms that 100% of eligible families have been enrolled in MA.** Figure 22 below shows the percentages of babies and mothers linked to health care providers for each year of program operation. Specific data on mothers is available only from Year 3 onward.

Figure 22: Babies and Mothers-Access to Health Care Provider: Years 1-8

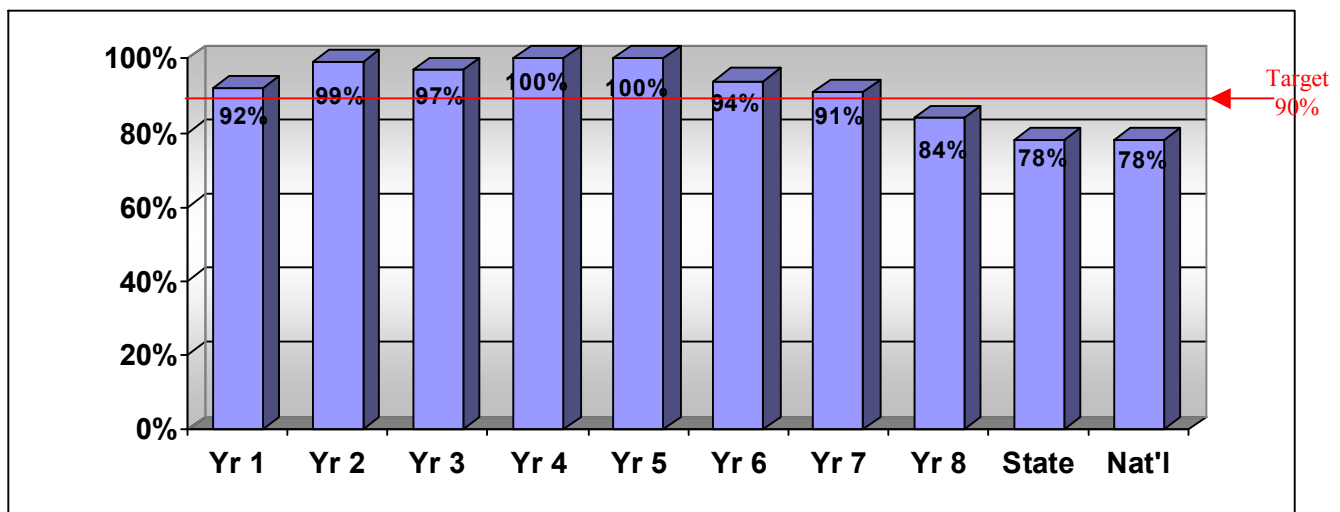


Current Immunizations

The HFM program has achieved impressive success rates in ensuring that children are immunized on schedule. This success is related to the high rates for linkage with health insurance and a health care provider. Families are more likely to complete immunizations when they are covered by insurance and have a medical home. As seen below in **Figure 23**, the program consistently exceeded its target of 90% and comparable State and National immunization rates. Year 8 data reveals a decline in rates of children being immunized on schedule from 91% in Year 7 to 84% in Year 8. This decline is likely due to more rigorous data verification of immunization status by the program. Whereas in the past, the FSW would rely on mother's report and her own observation, beginning in Year 6, the program has required the yellow immunization booklet to be reviewed for verification. Additionally, it is likely that the pediatric vaccine shortages and subsequent delays in administration experienced nationwide over the past several years ago have impacted the current rates.

Despite this, the program's immunization rates continue to surpass those at both the state and national levels. In recent years, immunization rates for the complete series in Maryland have ranged from 78% to 79%. Similarly, national rates have ranged from 76% to 78% for the complete series of immunizations. In Year 8, **84% of HFM children were current in their immunizations, exceeding comparable State and National rates.**

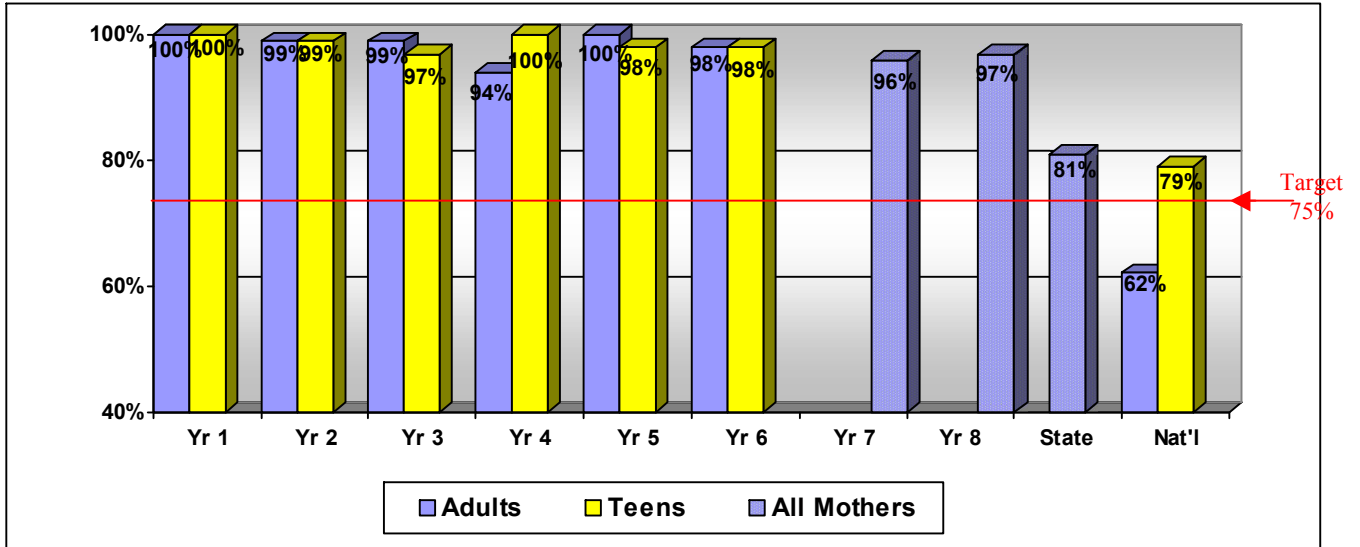
Figure 23: HFM Immunization Rates – Years 1-8



Additional Births

It is recommended that young mothers, particularly teens, have an interval of at least 24 months between births. Family planning is an important area covered in the post-partum care visits and through ongoing preventive health care. 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 participating mothers in family planning with the goal of decreasing unwanted pregnancies. While data for Years 1 through 6 was available for both teens and adults, data for Years 7 and 8 is available only in aggregate form for all mothers. Nevertheless, as seen in **Figure 24**, the HFM program continues to exceed its target rate of 75%, as well as State and National rates, with **97% of Year 8 program mothers having no additional birth in less than 24 months.**

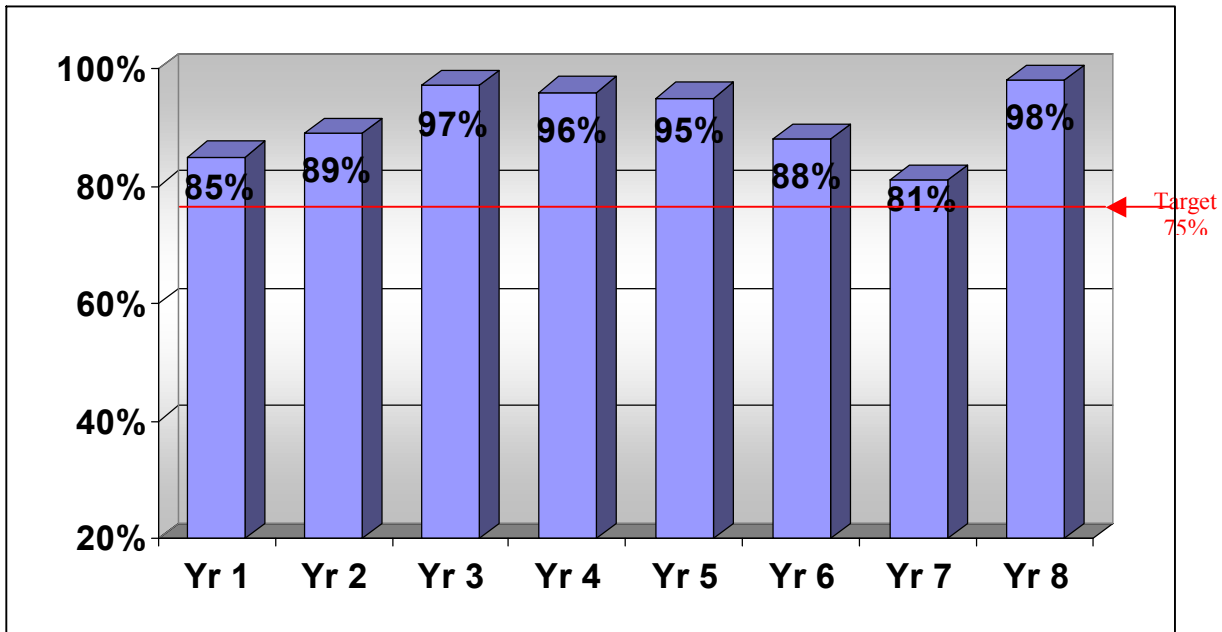
Figure 24. Mothers with No Repeat Birth < 24 Months – Years 1-8



Post-Partum Care

Directly related to the low percentages of repeat births is the corollary high rate of post-partum visits completed by program mothers. The linkage to maternal health care provided by HFM ensures that mothers receive the important information about family planning, but it also provides the physician an opportunity to evaluate the physical and emotional status of the mother postnatally. The percentage of mothers who complete these critical visits ranged from a low of 85% in Year 1 to a high of 98% in Year 8. As seen in **Figure 25**, the HFM program has been consistently successful in surpassing its target of 75% of mothers accessing post-partum care and in Year 8 achieved its highest percentage *as 98% of program mothers completed post-partum care.*

Figure 25: HFM Percentage Mothers Completing Post-Partum Care – Years 1-8



Healthy Birthweight

While the HFM program strongly encourages early prenatal care and seeks to enroll mothers early in their pregnancies, most mothers are typically not referred until their second or third trimester, which does not afford HFM the opportunity to ensure early care in compliance with ACOG standards. Of the 42 participants who gave birth during Year 8, for example, all were enrolled either in their third trimester (57%; n=24) or postnatally (43%; n=18). However, the percentage of babies born with a healthy birth weight (>2500 grams or 5.5 lbs.) for singleton, non-premature births is 100% (n=40). When premature infants (n=2) are included, the percentage of healthy birth weight babies only decreases to 96%. *For Year 8, 100% of singleton births and 96% of all births were of healthy birth weight.*

Goal II: Optimize Child Development

The HFM program fosters optimal child development through a holistic perspective incorporating emphasis on infant and child health care, parent education on appropriate developmental expectations, activities designed to stimulate the child and enhance the home environment, and regular screenings for developmental delay.

Developmental Delay

The program adheres to a rigorous standard in monitoring children's cognitive, motor, language, social, and emotional development. The Ages and Stages Questionnaire (ASQ) is administered to program children beginning at 4 months of age, again at 6 months, and every four months up to 24-months. From the age of 2-5 years, the ASQ is administered every six months. The ASQ is a child-monitoring system designed to identify, through a combination of observation and parental interview, infants and young children who demonstrate potential developmental problems in any one of 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." These regular screenings with the ASQ enable HFM staff and parents to monitor children's developmental progress, provide appropriate stimulation at each stage, and identify potential delays.

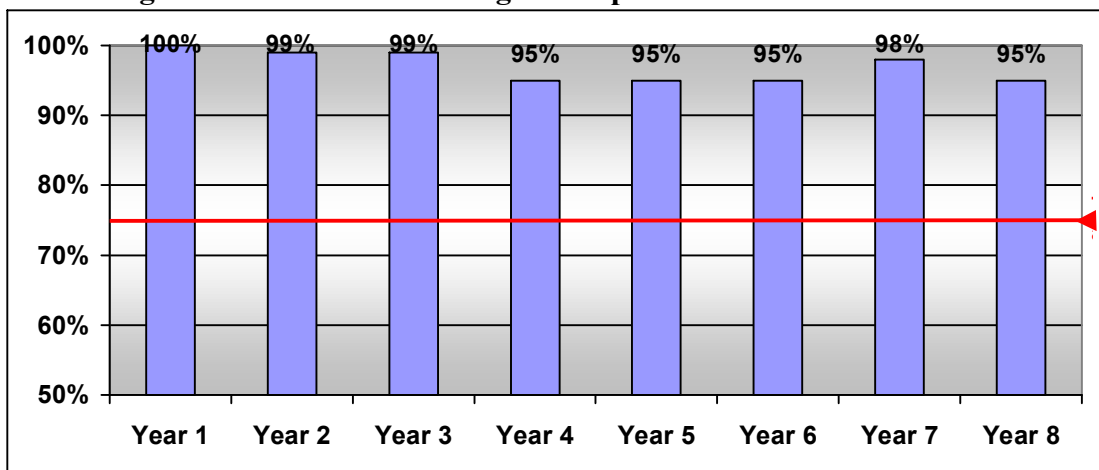
Children identified as being at risk are first referred to the Early Intervention Specialist (EIS), which is a shared position between HFM and the Montgomery County Infant and Toddler Program (MCITP) for consultation. The EIS conducts additional observation or assessment and determines the necessary follow up in collaboration with the FSW and the family. The EIS also trains staff to conduct developmental activities that will stimulate areas identified as weak, and attends supervision at which the target child is being discussed. Often, referrals to MCITP are not necessary after the EIS and FSW have collaborated with the family to strengthen the child's development. However, after consultation with the EIS, if there is a suspected delay, the child is referred to MCITP for an in-depth assessment and intervention services. For Year 8, there were seven children who had a suspected delay on the ASQ. Of these, five were referred to MCITP, while two improved sufficiently from the program's developmental activities that a referral was not necessary. The EIS, however, serves as a liaison with MCITP for the children dually enrolled in both programs to ensure that services are mutually reinforcing.

In addition to screening all children, the ASQ is used as a teaching tool with the parents to build their knowledge of child development and to have appropriate expectations of their child. It also

helps parents anticipate growth and use activities that foster positive development. This is supplemented with strong parenting and child development curricula (i.e., Parents As Teachers), which extends the parent’s skills and knowledge.

County and national figures indicate that approximately 3-5% of children over the age of three experience congenital developmental delay. Above that, delay is most often a result of environmental factors, which are targeted by the program in its prevention activities (screening process and curricula for both parents and children). As shown in **Figure 26** below, the percentages of children each year who demonstrate normal child development and who meet developmental milestones have consistently exceeded the program’s target of 75%. ***In Year 8, 95% of target children met developmental milestones, providing strong evidence of the preventative impact of the program’s developmental activities on the role of environmental factors in developmental delay.***

Figure 26: Children Meeting Developmental Milestones – Years 1-8



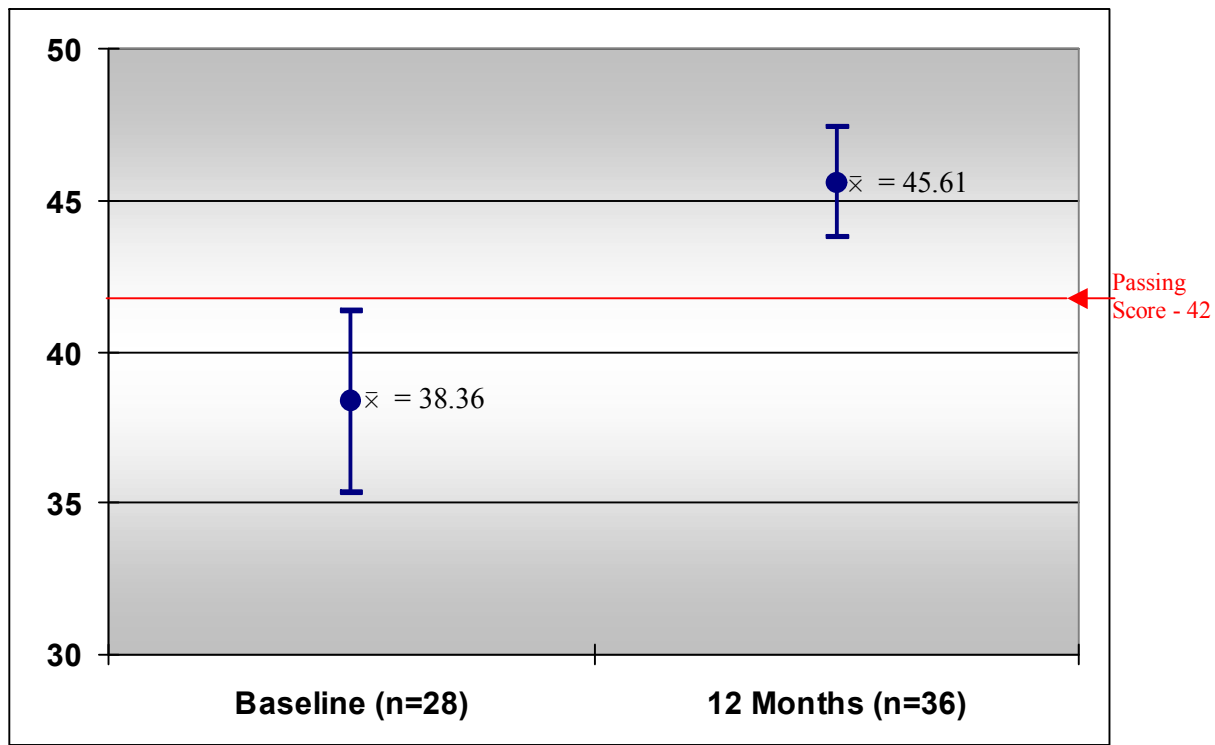
Goal III. Promote Positive Parenting and Parent-Child Interaction

Parents will have adequate knowledge of child development.

The HFM program uses multiple approaches in developing parenting knowledge and skills in its participants. In addition to use of evidenced based parenting curricula, such as the Parents as Teachers (PAT) and the Nurturing Curriculum, FSWs use role modeling and support groups to build parent-child bonding and attachment, parent understanding of child development and milestones, use of strategies as the child’s first teacher, and build awareness of warning signs of child developmental delay or social-emotional problems.

The Knowledge of Infant Development Inventory (KIDI) is used to assess knowledge of parental practices, developmental processes, and infant norms of behavior. For the first six years of program operation, HFM used the 14-item short version of the KIDI, valid for infants up to one year of age. Over the past two years, however, the program has transitioned to the more comprehensive 58-item versions, the KIDI (0-3 years) and the KIDI-P (3-6 years). As seen in **Figure 27**, twenty-eight Year 8 participants were administered the new KIDI at Baseline, earning a mean score of 38.36. After one year in the program, the mean score of 36 parents had risen to 45.61, indicating a significant increase in knowledge of child development (t=51.598; p>.001).

**Figure 27. Means and Confidence Intervals for KIDI-Long Version
Baseline and 12-Months**

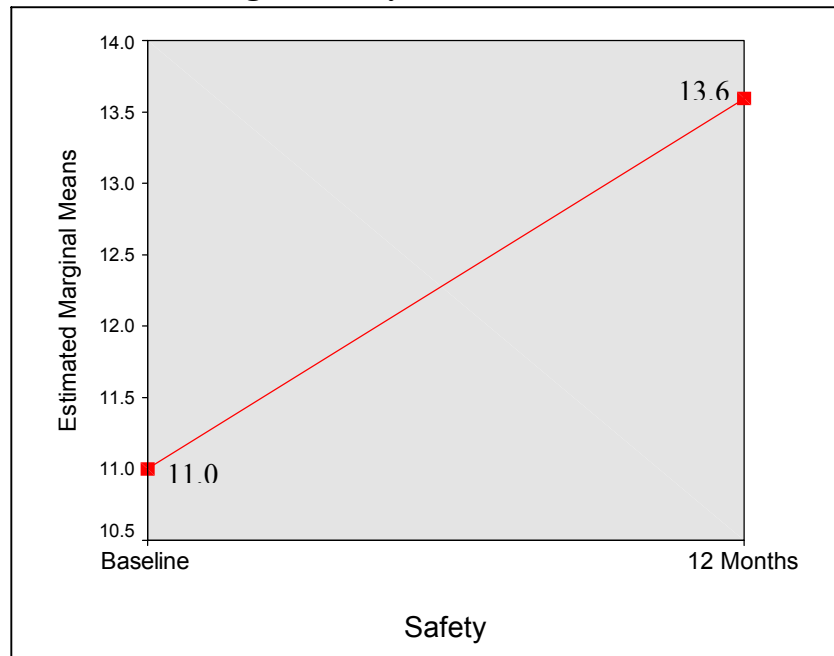


Parents have adequate knowledge of child safety

During home visits, FSWs assess a family’s cognizance of environmental safety through several means. In addition to observation, parents are interviewed on a variety of safety factors, such as knowledge of emergency phone numbers, installation of safety devices (smoke detectors, safety gates, outlet covers) and use of automobile safety restraints. This interview was used exclusively during Years 1 through 4. In Year 5, however, the program began the transition to a more comprehensive measure, the HFMD Safety Checklist, which contains all the items on the original instrument, as well as questions regarding (as appropriate) lead, radon, and CO. As of FY ’04, the checklist included a question about the presence of firearms in the home. After one year of program participation, ***100% of parents had adequate knowledge of child safety.***

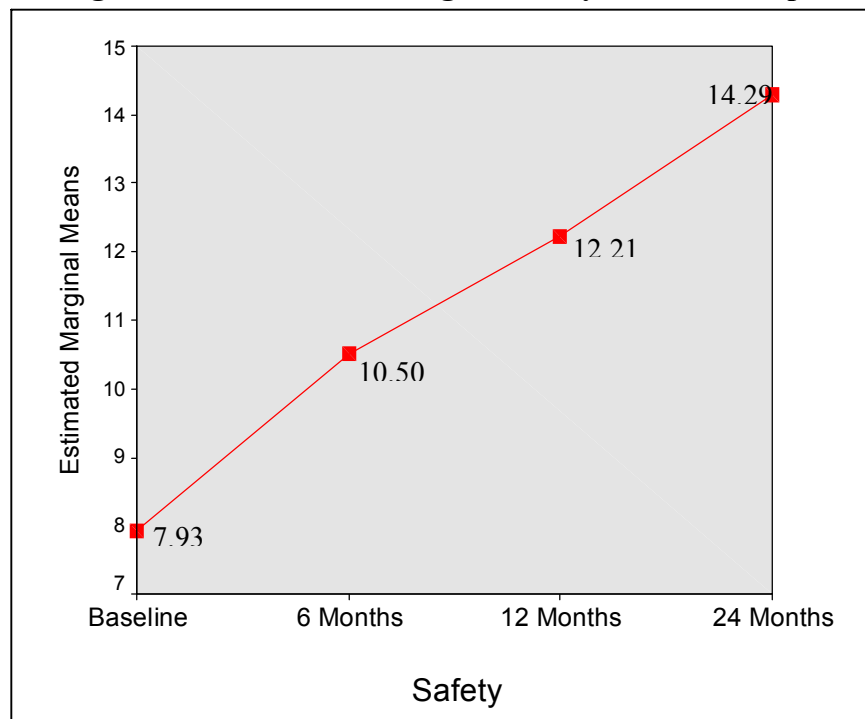
GLM repeated measures were conducted on Safety Checklist scores of 42 participants from Baseline to 12-months. As seen in **Figure 28**, across the Baseline to 12-month period, a statistically significant increase in KIDI scores was found ($F(1,41)=15.462; p=.000$). Mean scores increased from 11.0 to 13.6.

Figure 28. Parent Knowledge of Safety Scores at Baseline and 12-Months (n=42)



GLM repeated measures were also conducted on Safety Checklist scores of 14 participants from Baseline through 24-months, at four time points. As seen in **Figure 29**, across the two-year period, consistent increases in safety knowledge and implementation of safety practices occurred at each time point. Increases from Baseline to 6-months approached statistical significance, while significant increases ($F=24.976$; $df1, 13$) were found from Baseline to both 12 Months ($p=.018$) and 24 Months ($p=.002$). A statistically significant increase was also found from 6 Months to 24 Months ($p=.016$).

Figure 29. Parent Knowledge of Safety at Four Timepoints



Self-Sufficiency

Families will have improved housing, education, and employment status

Family empowerment and building self-sufficiency are vital components of HFM's comprehensive work with families. Each family's individual Family Support Plan (FSP) is developed in collaboration with the Family Support Worker, and contains a minimum of three goals, focusing on 1) the child and his/her development, 2) the family as a whole, and 3) the mother. The collaborative process by which the plan is developed enables the FSW and the families to delineate the small steps that must be taken in order to successfully accomplish the targeted goals. The initial FSP is reviewed, approved, and signed off on by the FSW's supervisor, and is then reviewed quarterly. The family's progress is assessed using information gained by the FSW through her regular contact and communication with the family, observations, and standardized measures administered at regular intervals during their enrollment in the program.

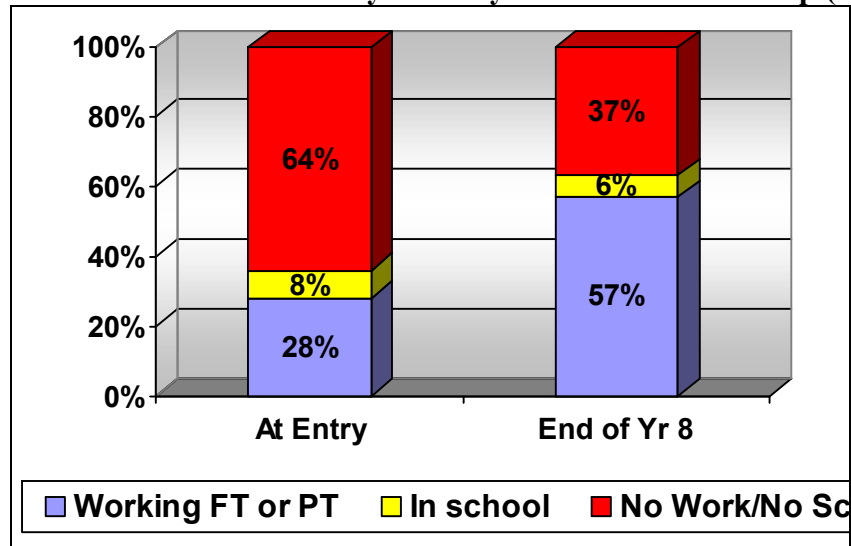
Three indicators of participants' progress toward self-sufficiency were examined at program entry and at the close of Year 8: employment, school status, and stability of housing. Participants who are working, either full-time or part-time, or are enrolled in school are viewed as demonstrating positive self-sufficiency. Negative or decreased self-sufficiency refers to participants who are not working or enrolled in school. ***Overall, 63% of families on which Year 8 data is available (n=126) were employed or in school at the end of the reporting period.***

Employment

In Year 8, HFM focused efforts on refining their definition of employment and training staff on documenting employment activity with more clarity. Thus, if MOB or FOB worked part-time at a mobile food stand several days a week or were providing informal childcare for pay, they were included in the 'employed' category. Further, families supported each other in seeking and maintaining employment through the HFM support groups. Within this forum, families formed bonds and helped one another to meet childcare needs, transportation, etc., ultimately making employment viable.

Baseline and follow-up employment status data were available for 126 participants. **Figure 30** below shows improvements in overall self-sufficiency at the end of the reporting year. Most noteworthy is ***the considerable increase in working mothers from 28% (n=35) at entry to 57% (n=71) at the end of Year 8.*** Additionally, the percent of unemployed mothers decreased from 64% (n=81) at entry to 37% (n=47) at follow-up. The number of participants enrolled in school and not working decreased slightly, from 8% (n=10) at entry to 5% (n=6) at follow-up. (At the end of Year 8, four mothers were both employed *and* enrolled in school.) Three mothers who had been enrolled in school at entry had attained their HS Diploma (n=1), GED (n=1), or had gone on to post HS training or college by the end of the reporting period. Results indicate that the HFM program is especially successful in assisting mothers secure employment, as the program realized an impressive 102.9% increase in participants employed either full or part-time.

Figure 30. MOB Self-Sufficiency at Entry and Year 8 Follow-Up (n=126)



Educational Attainment/School Status

Educational status was examined for those mothers who enrolled in the program at age 17 or younger. The HFM program is committed to ensuring that teen mothers stay in school, encouraging them to earn a High School Diploma or General Education Diploma (GED). Of the 11 mothers who entered the program at the age of 17 or younger, four were enrolled in educational programs. By the close of the reporting period, one mother had earned her HS Diploma, one had earned her GED, and two were still in school.

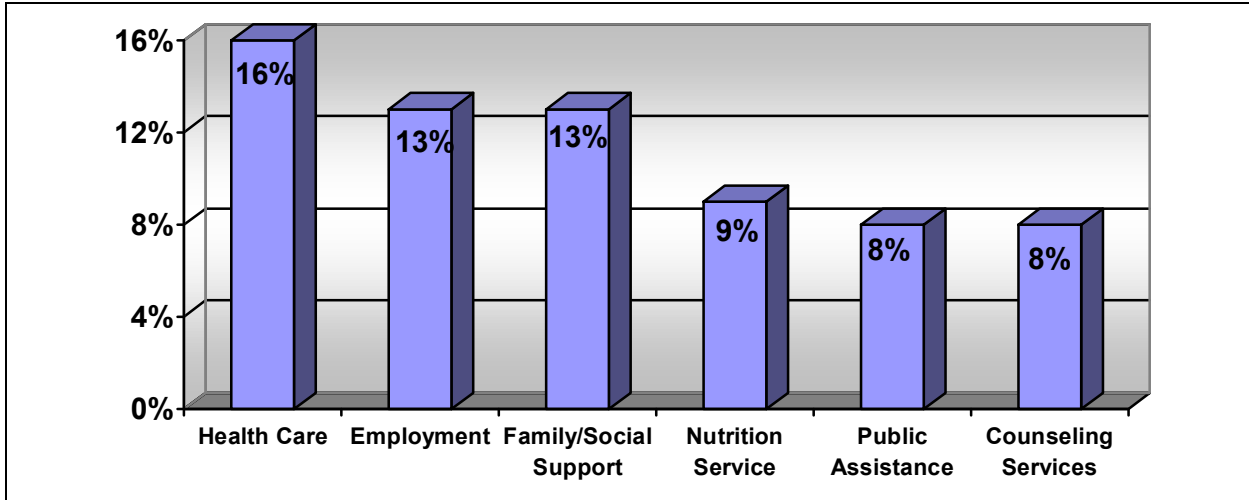
Housing

Data on housing status both at program entry and at the end of the reporting period was available for 124 families, with **99% (n=123) either maintaining stable housing or improving their housing status**. At the end of the reporting period, slightly less than half (45%; n=56) of the participants shared an apartment or home with relatives, a slight decrease from the percentage at program entry (48%; n=60). The number of families who own a home increased from 3 (2%) to 8 (7%), while the number of families living as guests in friends' homes dropped from 14 (11%) to 7 (6%). At program entry, one mother had no permanent housing and was living in a shelter or group home. Her status was unchanged at the end of the reporting period.

Community Referrals

In addition, HFM is successful at referring families to other community services with 672 referrals provided in FY04. More than three-quarters of enrolled families received at least five referrals, while approximately half of the families received at least eight referrals. Most (16%) of the initial referrals were for health care, while comparable percentages of referrals were also for employment/training (13%) and family social support (10%). When the first five referrals for families are collapsed, it is evident that the primary areas of referral were health care, employment and training services, and family/social support services. These referrals likely account for the level of success achieved by HFM in health care outcomes and in family self-sufficiency, particularly employment.

Figure 31-HFM Year 8 First Five Referrals to Community Services



SUMMARY

Throughout its eighth year of program implementation, Healthy Families Montgomery (HFM) continued to demonstrate its effectiveness at improving maternal and child health and developmental outcomes and preventing child abuse and neglect with a very high-risk target population. The program's strict adherence to rigorous quality standards and research-based effective practices in its core services, coupled with a wide range of support services and program enhancements that address varying levels of need, have earned HFM local and state recognition, as well as an expedited re-Credential from the national Healthy Families America office.

Montgomery County has the largest newly immigrated Hispanic population in the State and over 13,000 births annually. In partnership with its local health center and hospital partners, HFM provides the critical service of identifying family needs across a range of risk levels through its screening and assessment process. However, the program is still only able to screen less than one-tenth of the families delivering new babies. More than three-quarters of the screening and assessments conducted with these families score positive for multiple stressors, most frequently a history of abuse as a child, social isolation, and poor bonding with their baby. HFM enrolls families voluntarily for intensive home visitation services as program capacity allows. However, only 4% (n=39) of families with positive screens could be enrolled in the program during Year 8 due to full caseloads.

Program highlights for Year 8 include high quality home visitation as evidenced by the HFA expedited credentialing and the high rate of participant satisfaction; the use of family support plans as a means to both address risk factors identified in baseline assessments and as a motivational tool for families; support groups and learning literacy parties that provide families opportunities to exchange information, support each other in parenting and self-sufficiency, and reduce social isolation; and the annual HFM picnic, at which families celebrate successes, graduations are recognized, and fun activities are shared with each other and outside guests. These core activities were supplemented with enhancements that are targeted to specific family needs and require a higher level of professional expertise, such as health consultations provided by RNs, developmental support by EIS, and mental health and substance abuse assessments and consultations. If needs are identified that cannot be met by HFM staff, referrals are made as appropriate. The sheer number and percentage of families that received referrals for community services, including health, employment/training services, and family/social support services is evidence of HFM's commitment to providing the most comprehensive services possible.

Significant accomplishments were achieved in maternal and child health, as HFM not only exceeded its own targets, but National percentages and those of the State of Maryland in all areas. The program has successfully enrolled 100% of its eligible families in MA, as compared to only 50% for the state of Maryland, and 99% of HFM children have a health care provider, a significantly higher percentage than both Maryland (90%) and National figures (89%). When all births are examined, 96% of HFM babies had healthy birthweights, compared to 91% for the state and 92% nationally. However, when premature infants are excluded, 100% of babies born during Year 8 had healthy birthweights. The program also exceeded its targets and achieved significantly higher percentages than the State and the Nation for mothers delaying additional births until at least two years after the target

child's birth, and delivering newborns with healthy birthweights. The HFM child immunization rate was 84% as compared to Maryland (78%) and the Nation (78%). Furthermore, 100% of HFM families had no founded CWS reports. The long-term health and cost benefits for these achievements is considerable.

Likewise, the cost-benefits of early identification and intervention of developmental delay are widely recognized. Without the use of standardized instruments like the Ages and Stages Questionnaire (ASQ), pediatricians identify only about 50% of children with developmental or behavioral disabilities. County and national figures indicate that approximately 3-5% of children over the age of three experience congenital developmental delay. Percentages that exceed this are most often a result of environmental factors, which are targeted by the program in its prevention activities (screening processes and curricula for both parents and children). The percentages of children each year who demonstrate normal child development and who meet developmental milestones have consistently exceeded the program's target of 75%. In Year 8, 95% of target children met developmental milestones, providing strong evidence of the preventative impact of the program's developmental activities on the role of environmental factors in developmental delay.

Using standardized tools, the HFM program measured the impact of the services on several key areas in parenting. Parent knowledge of child development, parent-child interaction, and the creation of a nurturing, safe home environment play a significant role in fostering a child's cognitive development and social-emotional well-being, as well as in preventing child maltreatment. Results indicate that significant increases were made in parental knowledge between program entry and 12 months of participation, as mean scores increased significantly from 38.4 to 45.6. Additionally, this increased knowledge appears to be reflected in significant improvements in safety knowledge and implementation of safety practices ($F(1,9) = 15.917; p = .003$), where consistent improvement is evident through two years of program enrollment.

In conclusion, during Year 8 HFM continued to evolve as a program and adapt to the needs, opportunities, challenges and constraints of its target population and community context. The program management actively seeks out services for unmet needs, and develops programmatic solutions if services are not available. This is accomplished through advocacy, partnering, program development, resource development, and training for staff that builds capacity to provide a greater range of services. Additional efforts in the development of culturally competent strategies and materials to better meet family needs are needed. The identification of this need through participant and staff feedback is the first step.

Table 7 - Healthy Families Montgomery Years 1-8 (1996-2004)--Summary of Goals, Objectives, and Program Outcomes

Goals and Target Objectives	HFM TARGET	Year 1 N=38	Year 2 N=71	Year 3 N=73	Year 4 N=145	Year 5 N=159	Year 6 N=196	Year 7 N=191	Year 8 N=146
Goal I: Reduce Incidence of Child Maltreatment No founded CWS reports	95%	95%*	100%	99%*	100%	98%*	99%	99.6%	100%
Goal II: Promote Preventive Health Children have a health care provider	95%	97%	97%	99%	100%	99%	98%	97%	99%
Eligible families will be enrolled in MA	95%	100%	99%	99%	99%	97%	99%	97%	100%
Children immunized on schedule	90%	92%	99%	97%	100%	100%	94%	91%	84%
Mothers will not have an additional birth within two years of the target child's birth.	75%	All Ages and Teens 100%	99% Teens - 99%	99% Teens - 97%	94% Teen - 100%	100% Teens - 98%	98% Teens - 98%	96%	97%
Mothers will deliver newborns of healthy birthweight (>2500 grams or 5.5 lbs.)	90%	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%
Mothers will complete post-partum care.	75%	85%	89%	97%	96%	95%	88%	81%	98%
Goal III: Optimize Child Development Children demonstrate normal child functioning	75%	100%	99%	99%	95%	95%	95%	98%	95%
Goal IV: Positive Parenting Parents have adequate knowledge of child development.	85%	78%	90%	97%	95%	96%	96%	97%	85%**
Parents have adequate knowledge of child safety.	85%	79%	100%	100%	93%	97%	92%	96%	100%
Parents demonstrate positive parent-child interaction	85%	77%	100%	100%	100%	99%	96%	95%	97%
Goal V: Improved Family Self-Sufficiency Families will have improved housing, education, employment	75%	Housing - 100% Educ/Em 68%	Housing- 100% Educ/Em 73%	Housing- 99% Educ/Em 86%	Housing- 95% Educ/Em 88%	Housing- 96% Educ/Em 90%	Housing- 97%	Housing- 100%	Housing 99% Educ/Em 63%

*1 indicated report of neglect **HFM now using long version of Knowledge of Infant Development Inventory, replacing 14-item short version used previously

**Table 8. Healthy Families Montgomery-Year 1-8 Aggregate
Summary of Goals, Objectives, Program Outcomes, and Comparative Statistics**

Goals and Objectives	HFM TARGET	Aggregate % Years 1-8	Montgomery County	State of Maryland	National
<i>Goal I: Reduce Incidence of Child Maltreatment</i> Enrolled families will not have founded CWS reports	95%	99%	1,775 investigations 465 indicated Rate of 2.3/ thous.	9,169 indicated Rate of 5.8 per thousand	88%
<i>Goal II: Promote Preventive Health Care</i> Children will have a health care provider	95%	98%	89%	90%	89%
Eligible families will be enrolled in MA	95%	99% insured	50% eligible for MA insured	50% eligible for MA insured	23 million Total Medicaid
Children immunized on schedule	90%	95%	87%	78%	78%**
Mothers will not have an additional birth within two years of the target child's birth. (Teens <20 years)	75%	Adults - 98% Teens - 98%	Adults - 68% Teens - 88%	- Teens - 81%	Adults – 62% Teens –79%***
Babies Born with Healthy Birthweight	90%	86%	Not available	91%	92%
Mothers will complete post-partum care.	75%	91%			
<i>Goal III: Optimize Child Development</i> Children will demonstrate normal child functioning	75%	97%	97.8%	98%	96%

** Represents complete series of immunizations 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] - Center for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics Reports, Vol. 50, No. 5., 2000.

[2] - US Department of Health & Human Services, Administration for Children and Families. Child Maltreatment, 2002. (Table 2-5)

[4] - US Census Bureau: Income, Poverty, and Health Insurance Coverage in the United States, 2003.

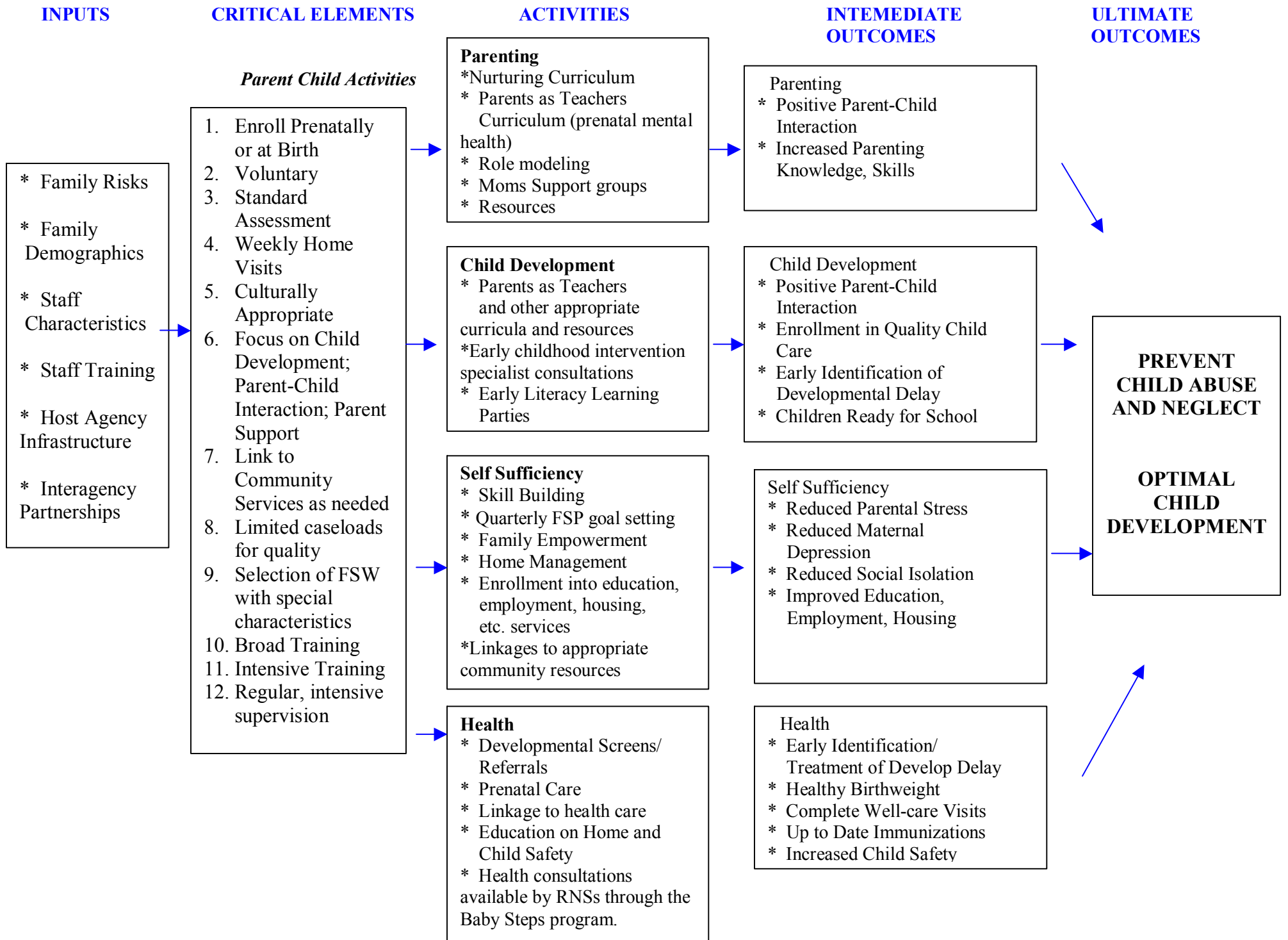
[5] - US Census Bureau, Current Population Survey (2002 Annual Social and Economic Supplement).

[6] - Center for Disease Control and Prevention, FASTATS A to Z, 2002.

[7] - Center for Disease Control and Prevention, FASTATS A to Z, 2002. (*Health, United States: 2001, Table 71*).

APPENDIX A

HFMontgomery Logic Model



APPENDIX B

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-D	Parent has a disability.	As possible
1	Begins at birth of the baby.	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
W/S	Family working or in school full-time (Target child must be at least 6 months old).	2 per month
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 C

Healthy Families Montgomery Funding Sources July 2003 – June 2004

Private Foundations

United Way
Mead Foundation
Freddie Mac Foundation
Target Foundation

Public Funding

City of Gaithersburg
City of Rockville
Governor's Office of Children, Youth and Families
Montgomery County Collaboration Council (Local Management Board)
Montgomery County Department of Health and Human Services

Individual Donors and Other

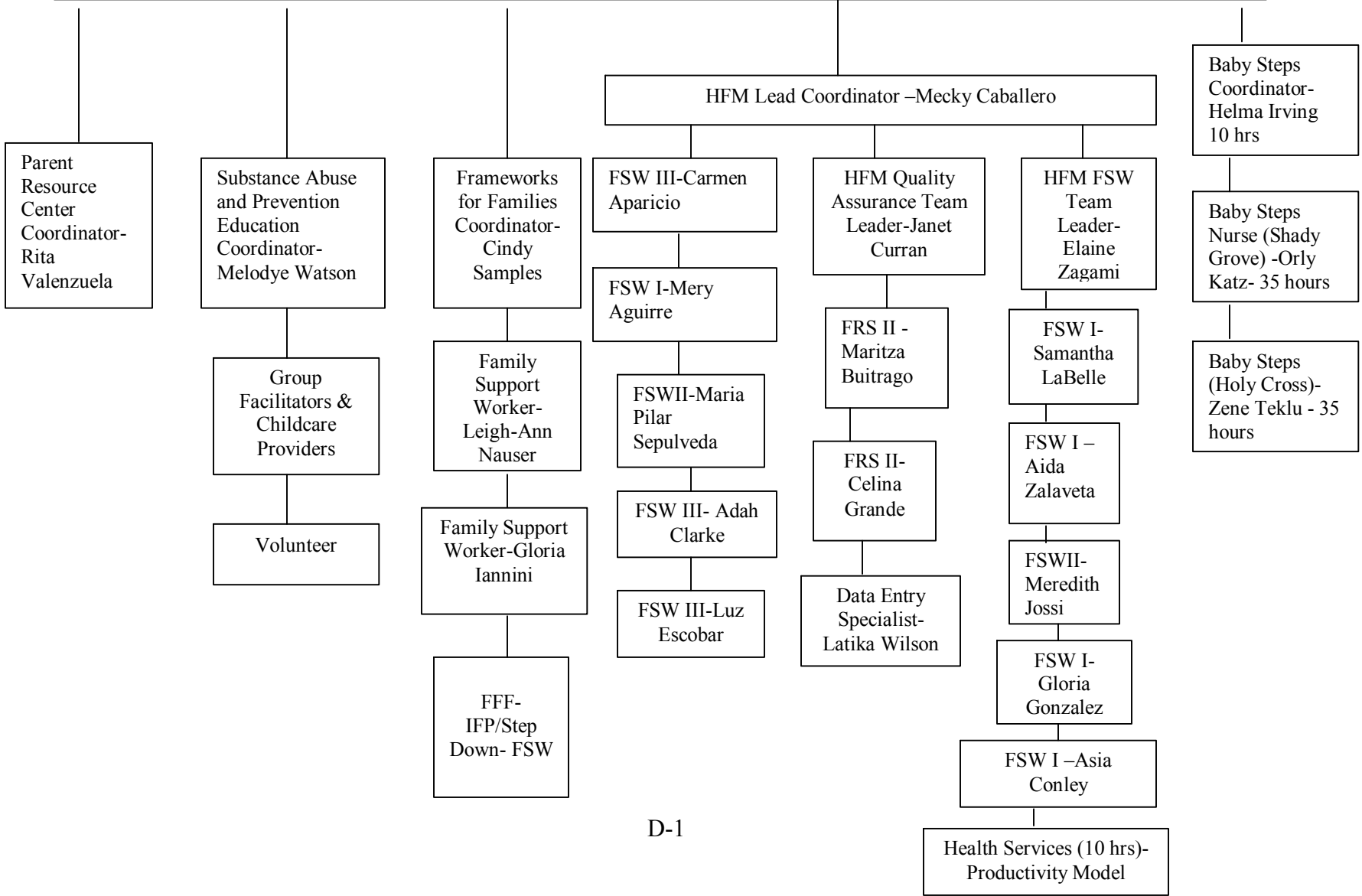
Individual Donor
Montgomery County Runner's Club

In-Kind Donations

Pack and Plays
Gap
Office Depot
Bed, Bath, and Beyond
Woodworking for Toys
Barnes and Noble
ABC Quilts

Appendix D

HFM Organizational Structure
Administrator of Family Support Programs-
Crystal Carr



APPENDIX E**HFM List of Advisory Board Members
FY 2003-2004**

Member	Organization/Title
Crystal Carr (ex-officio member)	FSAI/HFM Administrator
Marian Green	Community Member
Beth Molesworth (ex-officio member)	MC Early Childhood Service/Nurse
Janet Ceasar	HFA Credentialing Consultant
Pat Plunkett	League of Women Voters
Helma Irving	FSAI/Baby Steps Coordinator
Janie Stoll	Healthcare Consultant/Nurse
Joan Liversidge	DHHS, Human Services Program Manager
Dianne Fisher	DHHS/Nurse Administrator
George Cohen, MD	Mobil Med
Patricia Arriaza	Collaboration Council
Jamie Ambrosi	NIST/FSAI Board Member
Maria Savio	HFM Participant
Ynez Castelo	HFM Participant
Alisha Lowe	HFM Participant
Tatiama M. Cawley	HFM Participant
Stacy Stryer, MD	Pediatrician
Aleta Pedreira	FSAI/Program Assistant

APPENDIX F

Healthy Families Montgomery Goals and Objectives

I. 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 by age two years.
3. 75% of mothers will not have additional births within two years of target child's birth.
4. 75% of enrolled mothers will complete post-partum care.
5. 80% of all mothers enrolled within their first two trimesters will meet the expected number of prenatal care visits.
6. 90% of mothers enrolled within the first two trimesters will deliver newborns weighing 2500 grams (5.5 lbs.) or more.

II. Optimize Child Development.

1. 95% of children will demonstrate normal child functioning through ASQ developmental screening.
2. 100% of children will be screened for developmental delays in accordance with a ASQ schedule
3. 100% of children who screen at risk for developmental delay will be referred to the Montgomery County Infant and Toddlers Program (MCITP) for assessment/services.

III. Promote Positive Parenting and Parent -Child Interaction.

1. 85% of participants will score at or above normal range for knowledge of child development after 1 year and annually thereafter as measured on the KIDI.
2. 85% of participants will score at or above program-determined level for knowledge of child safety after 1 year and annually thereafter as measured on Safety Checklist.

IV. Family Self-Sufficiency.

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

V. Reduce Incidence of Child Maltreatment.

2. 95% of families with no previous CWS history will not have founded reports to Child Welfare Services while enrolled.

VI. Satisfaction with Care

1. 90% would refer individuals to the program
2. 90% satisfied with success

APPENDIX G



HEALTHY FAMILIES MONTGOMERY

Parent Consent to Participate in Program Evaluation

Purpose of the Project:

The purpose of the Healthy Families Montgomery program is to assist first time parents to access community resources and to develop positive parenting skills. The program focuses on child health and development, family health, family self-sufficiency, and parenting. The Healthy Families program was started in Hawaii and has been very successful in many other states. Participation in the program is **voluntary** and you can withdraw at any time. There is no penalty for refusing to participate.

Participation in the Evaluation of the Project:

In order to better plan our program, meet families' needs, and determine what activities work the best, we need to learn more about parents' ideas and attitudes about child rearing. Everyone agrees that raising children today is a difficult task, but people often disagree on how to do it. Your participation in the evaluation will help us to learn what parents think about those issues and how the Healthy Families Program can best meet the families' needs.

Information on your child's development, as well as your views on parenting will be gathered by Family Support Workers (FSWs). To assess your child's developmental progress, the FSW will observe your child and speak with you about your child's development. You will also be asked to share information with the FSW about your child's daily routines, home safety, as well as your views on parenting. Satisfaction surveys will be distributed once a year while you are in the program. Questions about parenting will be asked at enrollment and annually. Developmental screening is ongoing. We would like you to answer all the questions, but if there is any question that you don't want to answer for any reason, just let the interviewer know. Participation in the project and the evaluation is entirely voluntary. Should you decide not to participate in the evaluation, this will *not* prevent you or your child from receiving services or participating in the program.

Protection of Privacy:

All information is **confidential** and is kept in locked files at the Healthy Families office. Program staff will be looking at the information gathered from the group as a whole and using your answers to help the HF program better meet the needs of all participants. Any data that is sent to the Maryland State Healthy Families Office will be subjected to the same confidentiality procedures. This ensures that your and your family's privacy is protected and you will not be individually identifiable in evaluation analysis or reports. Certain exceptions to confidentiality are legally required in cases of continuing child abuse and specific court ordered disclosures.

Risks and Benefits to Participants:

Research indicates that home visiting and other program activities are very successful in improving parenting, child health and development, and family self-sufficiency; and in reducing risk for child maltreatment. Participation in the program should be of benefit to both children and families. Results of the program evaluation will be used by the Healthy Families Research Network to develop programs to help families in other communities. Risks are minimal, and are similar to those in any home visiting program. To minimize these, safety precautions will be taken during all activities. Strict confidentiality procedures are in place to guard against any disclosure of confidential information. The exception to this confidentiality would be in cases of child abuse, where authorities would need to be informed.

If you have any questions or concerns, please call me at 301-840-3231. If you agree to participate in the program evaluation, please complete the information below, sign, and date. Thank You! We look forward to working with you!

Thank You.

Crystal Carr
Program Manager

I have been informed about the services offered by the program in a language which I understand. I understand participation is voluntary, and that the staff will collect the above described information on me and my child for the program evaluation. I understand that everything is confidential and anonymous. I hereby agree to participate in the *HFM Program Evaluation*.

I understand that this consent will terminate ____/____/____ (the date should be 6 years from the date signed) unless revoked by the undersigned in writing.

Please Print Name _____

Please Sign _____ **Date** _____

Program Copy
Parent Copy

APPENDIX H

HFM Measures Descriptions

Knowledge of Infant Development Inventory: (KIDI / KIDI-P)

Author

David MacPhee, Ph.D.

Description

The Knowledge of Infant Development Inventory (KIDI) and the Knowledge of Infant Development Inventory – Preschool Version (KIDI-P) are designed to assess one's knowledge of parental practices, developmental processes, health and safety awareness, and infant/child norms of behavior. The use of this instrument in evaluation is supported by its prior use in the Infant Health and Development Study (IHDS) where it demonstrated strong psychometric properties and proved sensitive to intervention effects. Studies also indicate that the KIDI is strongly correlated to the HOME, especially to scales related to age-appropriate stimulation.

Items/Scales

The KIDI consists of 58 items, which reflect parents' knowledge of how infants and children behave, how they develop, and how to best care for them. Three responses are provided for each item: "Agree", "Disagree", and "Not Sure."

Populations

Standardization was established using data collected from 198 pediatricians, 100 PhD child psychologists, 320 college students in child psychology, and 256 mothers from all social classes. Half the mothers had more than one child and their mean education level was 13.5 years. The average mother's age was 26 years, 77% were married, and 59% were Caucasian. The KIDI is designed to be accessible to individuals without extensive education; it is written at the 6th to 7th grade reading level.

Administration

The KIDI may be self-administered or administered by interview. It is used as a baseline measure to obtain information on parental knowledge of infant development, and at follow-up points of 6, 12, and 24 months. It takes an average of 30 minutes to complete.

Reliability

- Internal: Alpha coefficient - .82
- Test-Retest: two-week retest coefficient - .92

Validity

- Content: Most issues commonly found in the literature on parent concerns or well-child care are included on the KIDI.

Source

David MacPhee, Ph.D., Associate Professor, Human Development and Family Studies, Colorado State University, Fort Collins, CO 80523-1570. (970-491-5558)

Safety Checklist

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.

Items/Scales

This 8-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.

Administration

The safety items are administered in an interview format and can be done during the same visit in which the HOME is conducted. It takes approximately 5 minutes to complete.

Ages & Stages Questionnaire (ASQ)

Authors

Jane Squires, LaWanda Potter, and Diane Bricker

Description of the Measure

The ASQ is a child-monitoring system designed to identify infants and young children who demonstrate potential developmental problems. Questionnaires are used when the child is 4, 8, 12, 16, 20, 24, 30, 36, 48, and 60 months of age, with optional forms available at 6 and 18 months. Children are identified as needing further testing and possible referral for early intervention services when scores fall below designated cutoff points. In addition to being used as a screening mechanism, the ASQ is a valuable tool for family support workers to use in teaching parents appropriate expectations for their children's developmental stages as well as play strategies to foster language, motor skills, and cognitive growth.

Items/Scales

Each questionnaire consists of 30 developmental items divided into five areas: communication, gross motor, fine motor, problem solving, and personal-social. For each item, the parent responds "Yes" to indicate that the child performs the behavior specified, "Sometimes" to indicate an occasional or emerging behavior, or "Not Yet" to indicate that the child does not yet perform a specified behavior. Responses are converted to point values, which are totaled and compared to established screening cutoff points.

APPENDIX I

Healthy Families Maryland Description of Evaluation Measures and Schedule

Name of Measure	Administration Schedule
<i>Evaluation Consent</i>	At enrollment
Required Measures	
<i>ASQ</i>	At four months and six months, and Every four months up to two years of age, and then Every six months up to five years of age. Programs may decide to administer developmental screens more frequently, as needed (previous ‘suspect’, or FSW or parent concern)
<i>KIDI</i>	First within three months of enrollment or prior to completion of 8 HV Annually thereafter (baby’s birthdate + 60 day window)
<i>HFMD Safety Checklist</i>	First within three months of enrollment or prior to completion of 8 HV Second, 30-60 days after the birth of the baby. Annually thereafter (baby’s birthdate + 60 day window)
<i>HFMD Parent Satisfaction Questionnaire</i>	Completed by the conclusion of the fiscal year. May also complete for closed families at the time of discharge from the program.

APPENDIX J

HEALTHY FAMILIES MONTGOMERY STAFF TENURE DATES 1996 – 2004

NAME	TITLE	% TIME	START DATE	EXIT DATE
Brenda Barnes-Tucker	Program Coordinator	100	1/96	6/96
Rita Pridgen	FSW III	100	02/11/96	09/28/01
Janet Curran	Quality Assurance Team Leader	100	03/06/96	
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	100	05/06/97	
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	100	01/21/99	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	11/2000
Jodi Glick	Supervisor	100	12/01/99	05/2000
David Rocha	Dads Coordinator	100	12/16/99	07/14/00
Elizabeth O'Connell	Nurse	100	03/01/00	11/2000
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	
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	
Victor Quiroz	Dads Coordinator	100	06/01/01	02/28/02
America	Lead Coordinator	100	07/23/01	

NAME	TITLE	% TIME	START DATE	EXIT DATE
Caballero				
Maritza Buitrago	FRS II	100	08/06/01	
Patricia Paredes	Nurse	50	09/04/01	
Helma Irving	Early Intervention Specialist	50	09/10/01 08/1/03	07/31/02
Leigh-Ann Nauser	FSW I	100	12/03/01	06/30/04
Melodye Berry	FSW I	100	12/03/01	12/00/03
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	
Crystal Carr	Program Director	100	11/04/02	
Diana Hawley	Early Intervention Specialist	50	02/11/03	11/00/03
Aleta Pedreira	Program Assistant	100	06/02/03	
Meredith Jossi	FSW I	100	12/15/03	
Helma Irving	Early Intervention Specialist	50	02/00/04	
Bridget Kish	FSW I	100	02/02/04	
Megan Broadbent	FSW I	100	02/23/04	
Maria Pilar Sepulveda	FSW I	100	04/21/04	

APPENDIX K

Healthy Families Montgomery Year 8 Staff Trainings

07/12/2003	HFA Train the Trainers Institute-FAW Trainer
07/14/2003	HFA FSW Core Training
07/17/2003	KIDI
07/25/2003	Well Baby & Immunization Requirements, Part 2
08/08/2003	CPR
08/16/2003	Learning Party Training of Trainers
08/20/2003	Building High Functioning Successful Teams
08/22/2003	MCITP In-service: New Employee & Contractor Orientation
08/23/2003	Learning Party Training of Trainers
08/24/2003	Infant Care
09/12/2003	Corporate Compliance
09/12/2003	Corporate Compliance
09/24/2003	Creating Positive Change: Treatment of Co-Occurring Disorders
09/24/2003	Prenatal Health
09/26/2003	Corporate Compliance
09/26/2003	The Culture of Poverty
09/29/2003	Bipolar Depression, Mania, Depression
10/06/2003	Basic Counseling Skills
10/14/2003	MCITP In-service: Policies & Procedures & New IFSP
10/15/2003	The Writer's Edge
10/17/2003	Mental Health Issues
10/20/2003	FAW Core Training, Great Kids, Inc. - Observation
10/20/2003	PAT: The Sixth Day of Institute
10/27/2003	Boundaries
10/30/2003	Infant Safety & CPR
11/10/2003	Measuring the Social-Emotional Domain
11/10/2003	The Adult Learner: Applications of Adult Learning
11/11/2003	The Adult Learner: Introduction to Relationships
12/03/2003	Crossway Community Orientation
12/03/2003	Families Foremost
12/08/2003	Supervision-MD Assoc. of Resources for Families & Youth
12/09/2003	Blood-borne Pathogens
12/15/2003	Child Abuse & Neglect Indicators & Reporting
12/15/2003	Confidentiality
12/15/2003	FSAI Orientation
12/15/2003	HFM Orientation
12/15/2003	Program Orientation
12/17/2003	Review of Chart Forms
12/24/2003	<i>Bonding with Baby Videos</i>
12/24/2003	<i>PAT Training Videos</i>
12/26/2003	<i>First Feelings Book</i>
01/05/2004	"Breaking Peaces"
01/05/2004	Boundaries
01/05/2004	Understanding Corporate Compliance
01/07/2004	Community Resources
01/09/2004	CPR Training
01/09/2004	First Aid Training
01/15/2004	ASQ
01/15/2004	Child Development-Social Behavior in Infants
01/20/2004	KIDI Implementation
01/21/2004	Child Safety Videos
01/26/2004	"Conducting an Infant Mental Health Family Assessment"
01/26/2004	"Psychological Dimensions of Pregnancy"
01/26/2004	"The Birth of the Sick/Handicapped Child"

01/26/2004	"The Nature of Human Attachments in Infancy"
01/26/2004	"The Newborn, the Family, the Dance"
01/28/2004	"Infant Mental Health: A Psychotherapeutic Model"
02/02/2004	HFM Orientation
02/02/2004	Training Videos
02/03/2004	FSAI Orientation
02/04/2004	Child Placement Decisions: Application of Attachment Theory
02/04/2004	Infection Control & OSHA Regulations
02/09/2004	Shadowing of FSWs and FAWs
02/11/2004	Advanced FSW Supervisor Training
02/11/2004	Advanced FSW Training
02/12/2004	Boundaries
02/12/2004	Child Abuse & Neglect Indicators and Reporting
02/12/2004	Confidentiality
02/17/2004	Program's Relationship w/Community Resources
02/19/2004	CPR
02/19/2004	First Aid
02/20/2004	Working with Substance Abuse Disorders
02/24/2004	HFA/HFM Model, Policies & Procedures
02/24/2004	Review of Chart Organization
02/26/2004	Advanced Family Assessment Worker
02/26/2004	Boundaries
02/26/2004	Child Abuse & Neglect Indicators/Reporting
02/26/2004	Family Issues
02/26/2004	Issues of Confidentiality
02/27/2004	Corporate Compliance
02/27/2004	Program's Relationship with other Community Resources
03/01/2004	ASQ & Administration
03/01/2004	KIDI & Home Safety: Techniques for Administration
03/03/2004	HIV/AIDS: Yesterday & Today
03/05/2004	Gangs in the Community
03/08/2004	FSW Core Training
03/12/2004	Community Resources: DHHS Medical Services
04/02/2004	Corporate Compliance
04/05/2004	Prenatal Training: Healthy Beginnings
04/16/2004	Corporate Compliance
04/20/2004	Corporate Compliance
04/20/2004	Qualified Interpreter Training
04/21/2004	FSAI Orientation
04/22/2004	Child Abuse & Neglect Indicators
04/22/2004	HFA/HFM Model
04/24/2004	Great Kids, Inc. Parent Survey Trainer Mentoring
04/26/2004	Boundaries
04/26/2004	Issues of Confidentiality
04/26/2004	Program's Relationship with Community Resources
04/27/2004	Cultural Diversity Training
04/28/2004	Bonding & Attachment: Relation to Early Brain Development
04/28/2004	Children Exposed to Violence: Myth & Reality
04/28/2004	The Impact of Violence/Abuse on Brain Development
04/29/2004	Borderline & Histrionic Personality Disorders
04/29/2004	Working with Resistant & Unmotivated Clients
05/04/2004	Ounce Training
05/07/2004	Child Welfare System
05/10/2004	Child Health & Safety
05/10/2004	Infant Care
05/11/2004	Maternal & Family Health
05/11/2004	Role of Culture in Parenting

05/12/2004	Issues Around Parent/Child Relationships
05/17/2004	Child Maltreatment and Methamphetamine
05/17/2004	Introduction to Infant Mental Health
05/17/2004	Making Sense of Federal Budget & Tax Trends
05/17/2004	PCA Conference Keynote: A Promise to Keep
05/17/2004	Prevention Roundtable: Track 3-Federal Resources
05/17/2004	Secrets of the Ya-Ya Healthy Families Sisterhood
05/17/2004	Stop Shaken Baby: Effective New Strategies for Calm
05/17/2004	Understanding Research on Home Visitation
05/17/2004	Using Keys to Interactive Parenting Styles (KIPS)
05/17/2004	Wellness Seminar
05/17/2004	Wellness Seminar: Healthy Eating
05/18/2004	Beyond Surviving to Thriving
05/18/2004	Child Abuse Prevention Begins in the Womb
05/18/2004	Invisible Scars: Understanding Emotional Maltreatment
05/18/2004	PCA Conference Keynote: My Father's Hat, From Cycl
05/18/2004	Supervision: A Vehicle for Introspection & Growth
05/18/2004	Wellness Seminar: Mind Dynamics
05/18/2004	Young Parents Group
05/19/2004	A Toolbox Approach to Anger Management
05/19/2004	Bandaging Your Achilles Heel
05/19/2004	Conversational Techniques to Engage New Parents
05/19/2004	Cultivating Seeds of Prevention: Tools, etc.
05/19/2004	Cultural Competency: A Process of Self Awareness
05/19/2004	Guidelines for Potty Training
05/19/2004	Invisible Scars: Understanding Emotional Maltreatment
05/19/2004	PCA Conference Keynote: Renewing Our Commitment
05/19/2004	Preventing Child Abuse/Promoting Families w/Therapy
05/19/2004	Promoting Social-Emotional Competence in Infants
05/19/2004	Teaching Parents to Play
05/19/2004	The Art of Facilitation
05/19/2004	Tough Situation: Helpful Hints for Supervisors/Man
05/27/2004	HFM Chart Documentation
06/03/2004	CPR
06/03/2004	First Aid
06/04/2004	Guide to Home Visit Record/ASQ
06/10/2004	1st Annual Home Visiting Conf Special Presentation
06/10/2004	Assessment from a Strength-based Perspective
06/10/2004	Attachment Interventions w/Mentally Ill Parents of
06/10/2004	Daddy: The Beginning
06/10/2004	Enhancing Training by Understanding Adult Learning
06/10/2004	Gangs & Gang Violence-A Regional Perspective
06/10/2004	How to Develop an Action Plan for Results
06/10/2004	I Can Handle This? How to work with Challenging Parents
06/10/2004	Linking Parents with Language Strategies
06/10/2004	Men, The Silent Partner in Home Visitation
06/10/2004	More than Chocolate: Nurturing Ourselves on the Journey
06/10/2004	Response to Domestic Violence: Identification, Intervention
06/10/2004	Role of Culture in Parenting and Home Visiting
06/10/2004	Staff Retention: What Keeps Staff Motivated
06/10/2004	Strategies for Collaboration
06/10/2004	Strength-based Measures in the Personnel Process
06/10/2004	Success with Intervention Strategies
06/10/2004	The Parent Survey: A Powerful Tool-Enhancing IFSP
06/10/2004	Unequal Partners, Part 1
06/10/2004	Videotaping-A Valuable Tool for Parent/Professional
06/14/2004	Family Violence (12 month)

06/14/2004	GKI Family Support Worker Core Training
06/14/2004	Substance Abuse (12 month)
06/15/2004	Mental Health (12 month)
06/15/2004	Staff Related Issues (12 month)
06/16/2004	Advanced FAW Training
06/16/2004	Family Issues

APPENDIX L

Date ___/___/

Healthy Families Montgomery

Please share your experiences with the Healthy Families Montgomery (HFM) program by taking a few minutes to answer the questions below. Your answers and recommendations are important to us and will assist us as we continue to suggest program improvements and plan future activities. All surveys are confidential. Please do not put your name on your survey. We want them to remain anonymous. Thank you!

1. In what capacity do you work with HFM? (Please check one)

- Administrative
- Management/Supervisory
- Family Support Worker (FSW)
- Family Assessment Worker (FAW)
- Other _____

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

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

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

3. Which areas of the program are particularly strong?

4. Which areas of the program need improvement?

5. How stressful is your job? (Please check one)

- Always stressful
- Usually stressful
- Sometimes stressful
- Rarely stressful
- Never stressful

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

None _____ Promotion _____ Wage increase _____ Bonus _____ Certification _____

Other (Please specify) _____

Additional Comments (use reverse side for more space):

THANK YOU VERY MUCH!

Appendix M

HEALTHY FAMILIES MONTGOMERY Participant Questionnaire

Today's Date _____

My 5-digit zip code

Please share the following information:

Your age: _____

How often are you visited?

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? _____

How old was your baby at the time of your last or 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 NA, I left the program

If your last visit was over a month ago, is there a reason it wasn't more often?

Yes No NA

If YES, please explain:

Please circle YES or NO to the following questions:

Do you feel you are visited often enough? YES NO

Does your home visitor give you information about how to care for your baby? YES NO

Does your home visitor help you understand your child's development and behavior? YES NO

Does your home visitor provide positive feedback and support? YES NO

Does your home visitor avoid imposing child care values on you? YES NO

Does your home visitor understand that your family may be different from others? YES NO

Does your home visitor understand the importance of your religion and other beliefs? YES NO

Does your home visitor understand and accept the inter-generational roles in your family? YES NO

Does the home visitor provide you with materials that are sensitive to your culture? YES NO

Does your home visitor display pictures, etc., that reflect you? YES NO

Does your home visitor display videos that reflect your culture? YES NO

Is English your primary language? YES NO

Are the materials your home visitor uses in your primary language? YES NO

Does your home visitor communicate in your primary language?	YES	NO
Are your home visitor's interactions with you strength-based and culturally relevant?	YES	NO
Do you feel that there is good communication between yourself and your home visitor?	YES	NO
Do you feel your home visitor is responsive to your needs?	YES	NO
Do you feel your home visitor respects your family's way of doing things including your family's culture and ethnicity?	YES	NO
Do you trust your home visitor to look after your best interests?	YES	NO
Does your home visitor help you become more independent by encouraging you to make your own decisions?	YES	NO
Does your home visitor help you understand and provide for your child's health needs?	YES	NO
Has this program been helpful to you as a parent?	YES	NO
Has being in this program helped your baby?	YES	NO
Were you given the opportunity to participate in and agree with a plan of service?	YES	NO
Has there been any service or help you expected or needed from the program but did not receive?	YES	NO

If YES, please explain

Did the program assist you in arranging for services elsewhere if they could not provide something you needed?	DIDN'T NEED	YES	NO
Would you recommend that a friend or neighbor use this program's service?		YES	NO

Sometimes on the home visit your Family Support Worker asks you questions from forms to better understand the needs of your family, support you, and identify other ways we can support you and the community. How do you feel about these questionnaires?

The questions are easy to understand	YES	NO
I am okay with answering them	YES	NO
I feel that the reason for the questionnaires was explained well	YES	NO

Please provide additional comments about them in the space below:

_____ Don't Care
 _____ Never Done One

Please list what you like most about the program

Please list what you like least about the program

Can you think of any ways that we might improve the program?

Overall, how would you rate this program?

EXCELLENT _____

GOOD _____

AVERAGE _____

POOR _____