Over 100 Years of Service

Family Services, Inc.

PART OF THE SHEPPARD PRATT HEALTH SYSTEM

HEALTHY FAMILIES MONTGOMERY

Year 19 Report

July 2014 – June 2015

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

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EXECUTIVE SUMMARY

The Healthy Families Montgomery (HFM) program has concluded almost twenty years of comprehensive home visiting services to high-risk families in Montgomery County, Maryland. During its nineteenth year, the program continued to exceed its target objectives, reducing family risk factors and enhancing protective factors in order to prevent child abuse and neglect and promote optimal child development.

Since the HFM program was initiated in 1996, 15,283 positive screens for risk of child maltreatment have been received by HFM. Of 733 screens received from the collaborating county clinics in FY'15, 87% identified as positive risk. Due to limited resources, only 17% of these were further assessed. This represents an increase from the previous year and continues a trend for an increase in the number of assessments completed despite having only one Family Resource Specialist available to assess families. Of those assessed, 74% were positive and eligible for the program, but only one-third (39%) were enrolled due to space limitations. When the number of families enrolled based on assessment during FY'15 is compared to the total number of positive screens, only a small fraction (6%) of families determined to be at-risk ultimately receive the intensive home-based services offered by HFM. This reflects the ongoing gap in services for the at-risk population in Montgomery County. For those families who are at-risk but not enrolled, HFM refers them to other services as appropriate.

All participants are assessed for risk factors. The pattern that emerges from the Year 19 profile of risk factors, including childhood abuse, mental health issues, multiple stressors in their lives, poor bonding and attachment with their child, and unrealistic expectations of their child is one that reflects an increased potential for child maltreatment, particularly neglect. The prevalence of social isolation and depression are more closely associated with potential for neglect. However, the high incidence of mothers that experienced moderate to severe abuse as a child and who have unrealistic expectations of their child places them at much higher risk for harsh discipline with their child and may lead to physical abuse. The identification of these at-risk mothers provides the Healthy Families Montgomery program the opportunity to break the cycle of abuse with these new mothers and their babies.

In Year 19, the program served 122 families and 120 children. Demographic data reveals a population that continues the trend of increasingly older mothers; the mean age at entry is 27 years. Most mothers are Hispanic (92%) and speak Spanish (90%) as their primary language. More than one-third (36%) of mothers over the age of 18 had less than a HS diploma and most were unemployed (71%), factors that greatly increase their risk and affect their ability to support their children.

After eight years of using the Parents as Teachers (PAT) nationally recognized child development curriculum with its families, this year HFM transitioned to a new curriculum, Growing Great Kids (GGK). GGK emphasizes attachment and bonding, as well as its alignment with the HFM program model. HFM is utilizing the *Growing Great Kids Prenatal-36 Months Home Visiting* version of the curricula, which focuses on parenting, attachment, child development, and family strengthening with a strong

emphasis on social and emotional development and nurturing self-regulation. The skill-driven curriculum provides home visitors with an approach that is research informed, strength-based and solution-focused. The various modules provide a step-by-step guide that encourages interactive questions in order to actively engage parents with the information and skills being presented.

In the area of health (Goal I), HFM continues to exceed its target objectives. Of all target children older than two months of age, all (100%) were linked with medical providers and enrolled in Medical Assistance (MA). Likewise, all mothers were successfully linked with a medical provider. In addition, 98% of all target children over four months of age were current with their immunizations. This is especially impressive when compared to the Centers for Disease Control 2014 findings on immunization rates for the nation (75%). It also exceeds the State of Maryland immunization rate of 78%. Of the mothers who were due for their post-partum medical visit, 100% received timely post-partum care, affording them the opportunity to monitor their health and discuss family planning options with their doctors. This percentage also exceeds the national Medicaid rate of 63%. Additionally, 100% of all mothers did not have a repeat birth within a 24-month period during their enrollment in the program. This includes twelve mothers who were teens when they enrolled (ages 16-19 years old). HFM's success rate in this area has consistently exceeded both Maryland State (84%) and national statistics (82%) for teen repeat births. During Year 19, 37 target babies were born to active participants in the program. Of those who were enrolled prenatally, 100% were born at a healthy birthweight. When birthweight is examined for all active target babies regardless of year of birth, the percentage remains high at 92%. Percentages achieved for Year 19 babies exceeded both national (92%) and Maryland (91%) rates.

For child maltreatment (Goal II), during Year 19, there were no indicated cases of child maltreatment (100%). Over the nineteen years of program implementation, there have only been eight indicated cases of child maltreatment, seven of which were cases of neglect and one case of physical injury. These findings provide solid evidence of the positive impact that prevention can have on reducing the incidence of child maltreatment in high-risk families.

In order to monitor the social, emotional, cognitive, language and motor development of each participating child (Goal III), the HFM program administers the Ages and Stages Questionnaire (ASQ) at regular intervals throughout a family's participation. All of the 120 target children who were in the program in Year 19 received a timely ASQ. The HFM rate for developmental screening of participating children far exceeds the comparable national rate of 29%. All children (17) who were identified with developmental delays or concerns were followed by the Early Intervention Consultant (EIC). Many received county services, including Child Find, MCITP and PEP. For Year 19, 100% of children demonstrated normal child functioning and were meeting developmental milestones or were receiving appropriate services. The prevalence of developmental delay for the general population is 13.87%[1]. The HFM results for this objective indicate the positive impact of the program's developmental activities on

[1] CDC. 2015. Key Findings: Trends in the Prevalence of Developmental Disabilities in U.S. Children, 1997-2008. Available at http://www.cdc.gov/ncbddd/developmentaldisabilities/features/birthdefects-dd-keyfindings.html

mitigating the role of environmental factors in developmental delay within a high-risk population.

Positive Parenting and Parent-Child Interaction (Goal IV) includes the areas of home safety, parent-child interaction, and parenting knowledge, as well as mother's psychosocial status. Measurement of parents' knowledge of safety in the home focuses on a variety of factors, such as knowledge of emergency phone numbers, installation of safety devices, and use of automobile safety restraints. Statistical analysis of scores indicates that mothers' knowledge of safety in the home increased significantly after 12 months of program participation. 97% of parents demonstrated adequate safety knowledge after one year of program participation.

HFM measures parent-child interaction and parenting knowledge using the Healthy Families Parenting Inventory (HFPI). Results have consistently revealed statistically significant improvement from enrollment to one year in five subscales: 1) *Problem Solving*, which measures the parent's ability cope with unexpected situations and find solutions, increased significantly after 12 months in the program and the percentage of mothers at risk decreased from 13% at enrollment to 7% at 12-months; 2) *Mobilizing Resources*, including knowledge of available resources in the community and comfort level in seeking help, increased after 12 months and the percentage of mothers at risk decreased from 19% at enrollment to 2% at 12-months; 3) *Parent-Child Interaction*, which measures the quality of the parent-child relationship in the context of parental engagement, responsiveness to the child's needs, and the ability to provide positive reinforcement appropriately, also increased after 12 months of participation and the percentage of mothers at risk decreased from 17% at enrollment to 5% at 12-months; 4) *Home Environment*, which examines home safety, organization, availability and quality of stimulating materials/activities in the home, increased after 12 months and the percentage of mothers at risk decreased from 19% at enrollment to 5% at 12-months; and 5) *Parenting Efficacy*, which measures knowledge and skills related to childrearing, also increased after 12 months in the program and the percentage of mothers at risk decreased from 14% at enrollment to 12% at 12-months.

Mothers' risk for depression was measured using the Center for Epidemiologic Studies-Depression (CES-D) scale. Results indicate a non-significant decrease in parents' risk for depression, a potent factor in reducing risk for child maltreatment. The percent of mothers at risk decreased from 16% at risk for depression at enrollment to 13% at 12-months. As a result of the HFM screening and assessment process, which includes depression as a risk indicator, HFM mothers have higher prevalence rates of depressive symptomology than those reported by the Centers for Disease Control (CDC) in 2012 for post-partum women (8% to 19%) and non-pregnant women (11%). CES-D mean scores were also examined at three timepoints, Baseline, 12-months, and 24-months; mean scores demonstrated a trend for decrease from baseline to 12-months and 24-months. Results highlight the importance of the HFM program in ongoing screening for depression and linking participants to appropriate mental health professionals.

Improvements in mothers' self-sufficiency (Goal V) were measured primarily through marital status, education, employment, and housing status. Most mothers (61%) were married or reported that they lived with their partners. As in the past, most mothers are Hispanic (92%) and speak Spanish (90%) as their primary language. At enrollment, 36% of mothers over the age of 18 had less than a HS diploma and most were

unemployed (71%), factors that greatly increase their risk and affect their ability to support their children. By the end of Year 19, marital status and educational achievement had improved slightly However, there was a significant increase in mothers' employment status, from 29% at enrollment to 68% at the end of the reporting period.

In the area of housing stability, at enrollment, 97% of participants had stable housing. Follow-up data on housing status indicates that 97% either maintained stable housing or improved their housing status.

Staff and Participant Satisfaction are assessed annually by the HFM program. Participants continue to report high levels of satisfaction with the program. All respondents reported that both their Family Support Worker (FSW) and the HFM program were either "Excellent" or "Good", and all agreed that they would recommend the program to a friend or relative. When asked what they like best about the HFM program, most focused on how the program has helped them to become better parents by teaching them about child development and providing the education to care for their children. Many also commented on the helpful support and advice they get from their FSW.

Results of staff surveys found that most staff enjoy their work, find it worthwhile, and believe they are having a positive impact on families. All agree that they are satisfied with their position and feel appreciated by management for the work they do. When asked what areas of the program are particularly strong, comments focused on several key areas: the dedication and preparedness of staff, the strength-based approach of the program, and the respect for cultural diversity and the ability to connect with families.

I. INTRODUCTION

Healthy Families Montgomery (HFM) concluded nineteen years of service to high-risk families in Montgomery County, Maryland in June 2015. The comprehensive home visiting services offered by the HFM program are designed to reduce family risk factors and enhance protective factors in order to prevent child abuse and neglect and promote optimal child development. Over the past nineteen years, HFM has demonstrated its ability to maintain high quality standards and consistently achieve positive maternal and child health outcomes despite funding and other logistical challenges. HFM's longstanding success has been recognized in their outstanding scores by HFA accreditation experts and multiple awards for service excellence from Montgomery County, MD. The HFM program was first accredited in November 1999, when it became the first nationally credentialed Healthy Family America site in the State of Maryland. In 2008, HFM received an expedited four-year credential from Healthy Families America, when reviewers indicated that HFM was an extremely strong site – among the top 2% nationwide. Accreditation standards were revised again in 2012 and HFM successfully completed this rigorous new process, achieving high ratings across all standards. These results provide evidence that the HFM program was built on a solid foundation of research-based best practices and has adapted the program to reflect the most current research as it has grown over the years. The fidelity, quality, and consistency of

program implementation over the years have ensured its consistent success at achieving outcomes.

The purpose of this report is to describe the HFM program implementation during Year 19 and the outcomes achieved by the end of the fiscal year.

A. Family Services, Inc. (FSI)

Established in 1908, the mission of FSI is to promote the resilience, recovery and independence of individuals and families across the life span through integrated mental and physical health, social service and education programs, and thereby strengthening communities. FSI currently offers over 30 programs serving over 27,000 individuals annually in Montgomery and Prince George's County, Maryland. FSI staff of over 400 individuals represent 50 countries and speak 42 different languages. As part of the Sheppard Pratt Health System, FSI has extensive experience developing and implementing in-home and community-based services for children, adolescents, and adults who have limited access to critical resources.

FSI's programs fall within five major areas: Early Childhood Services, School Based Services, Mental Health and Substance Abuse Services, Community Support Services, and Victim and Domestic Violence Services. The following is a brief description of current programs:

EARLY CHILDHOOD SERVICES

● **Baby Steps** provides universal, hospital-based health screening at Shady Grove Adventist and Holy Cross Hospitals to as many new Montgomery County moms and newborns as possible. The Baby Steps nurses link new parents to community health services and provide appropriate follow up as needed through telephone consultations and home visits.

● **DARE to Be You** is a family focused, 10-week prevention program designed to improve parent and pre-school child interaction in the areas of self-concept, self-responsibility, communication and decision-making. The program provides family meals, techniques to enhance family resilience and financial incentives for successful completion of the program and is approved by Substance Abuse and Mental Health Services Administration (SAMHSA).

● **Early Childhood Education and Training** offers training and consultation services to home visitors and child care providers. MSDE approved trainings are offered on many aspects of early childhood development, as well as strategies to support school readiness. Early childhood professionals offer mental health consultation and mentoring services at child development centers.

● **Early Head Start (EHS)** serves 147 low-income families with children from birth to three years old and pregnant women who reside in the up-county area of Montgomery County. EHS offers home based child development services as well as the **Discovery Station Child Development Center** serving 36 children. Supports to parenting teens include the **Keys to Success** after school tutoring and a summer college and career readiness program. Monthly learning parties and bilingual group activities help reduce social isolation and enhance the knowledge and skills needed for healthy child development.

● **Family Discovery Center** in Rockville, MD, offers ESOL, GED, ABE, health, career and parenting classes for young parents whose education has been cut short. Their

children ages 0 to 4 attend the Exploration Station child development center while parents are in class.

● **Healthy Families Montgomery (HFM)** is a nationally accredited, bilingual, home-visiting service for 120 first-time parents facing multiple stressors, with the goal of preventing child abuse. Home-based services begin before the baby is born, and continue on a weekly basis for at least six months. Emphasis is placed on health care, child development, parenting education and support, family self-sufficiency and linkages to community resources.

● **Kids Spot** is a child-friendly waiting area for families who have business with the Montgomery County Circuit Court in Rockville, MD. Children between the ages of 2 and 12 are welcomed to Kids Spot while their parent or guardian is in the building, and there is no fee for this service.

● **Watch Me Grow Child Development Center (WMG)** is a fee-based, high quality childcare program serving the Clarksburg, MD, community with a full day program and before and after school services.

SCHOOL BASED SERVICES

● **Linkages to Learning (LTL)** provides a comprehensive array of school based social services in five elementary and two middle schools in Montgomery County, including individual, family and group therapy; psychiatric assessment and intervention; case management; and prevention /early intervention services.

● **Regional Youth Service Center,** serving Olney, Gaithersburg, and the Upper Montgomery County region, provides children, youth, and families an array of after-school, prevention, early intervention, and counseling service

● **Youth Mentoring** provides mentoring and academic supports to help middle school aged young men find the discipline and confidence to make safe and positive life choices.

● The **Ed Bohrer Parent Resource Center (PRC)** serves Spanish and English-speaking persons each year as they access needed services in the community and pursue educational goals for themselves and their children.

MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

● **CareLink Transitions** partners with area hospitals and provides services geared toward preventing unnecessary hospital readmissions through case management and coordinated care.

● **Tracks/TAY** is a community, recovery-focused psychiatric rehabilitation program serving transitional age youth (18-24 years) in Montgomery County with mental illness. Services include a day program, residential rehabilitation, a mental health vocational program, and support for independent living.

● **Psychiatric Rehabilitation Program** offers community and recovery-focused psychiatric rehabilitation programs in Montgomery and Prince Georges Counties to adults with mental illness. Services include a day program, residential rehabilitation, a vocational program and support for independent living.

● **The Landing** is an adolescent recovery club house in Gaithersburg that provides recovery support and related services to youth are currently in or recently discharged from substance abuse treatment.

● **OnTrack Maryland** offers specialized programs for the early identification, evaluation, and treatment of adolescents and young adults who have started experiencing troubling thoughts and/or experiences, or exhibiting changes in behavior,

● **Outpatient Mental Health Clinic** is a comprehensive community mental health center offering a full range of psychiatric assessment and treatment services.
● **Health Home** provides certified care specialists, registered nurses, entitlement specialists and other healthcare professionals to help manage overall health and wellness.
● **Step Ahead** is a satellite clinic in Germantown, MD that offers an array of integrated behavioral health services for adults, youth, and families with primary and co-occurring substance use problems. The clinic also offers a unique counseling for Veterans and their families focusing on Trauma, PTSD, and Substance Abuse.

COMMUNITY SUPPORT SERVICES
● **CAFE Montgomery MD** (Coalition for the Advancement of Financial Education) promotes high quality financial education to County residents by providing the tools for making informed decisions about saving, spending, borrowing and managing credit.
● **Housing Counselor** serves Gaithersburg, MD, residents providing relocation and renter assistance and help in applying for county rental subsidy programs, eviction prevention, money/debt management, fair housing assistance, coordination of housing resources with area foreclosure counseling agencies and other community resources.
● **Neighborhood Opportunities Network**, in partnership with Montgomery County and other nonprofits, provides assistance for emergency services – utilities, rent, food, health care, legal matters, foreclosure prevention, free financial literacy workshops, and workforce development.
● **The Support Center (Medical Day Adult Services)** provides day services to frail and/or disabled adults. Therapeutic activities assist individuals maintain a level of independence and functioning. The program is offered in English, Spanish and Vietnamese.
● **Creative Family Projects, LLC** identifies problems and provides solutions by synthesizing information from organizations, institutions and corporations into booklets and training modules for the benefit of children, youth and families.
● **Housing Initiative Project (HIP)** is designed to reduce the incidence of homelessness in Montgomery County by providing permanent supportive housing.
● **Financial Wellness** FSI and the Maryland CASH (Creating Assets, Savings, and Hope) Academy Program offers free financial education workshops in English and Spanish within the Gaithersburg community.
● **The Welcome Back Pilot Program** helps address workforce shortages faced by behavioral health employers by preparing underemployed internationally trained behavioral health professionals living or working in Maryland to fill high demand jobs.

VICTIM AND DOMESTIC VIOLENCE SERVICES
● **The Betty Ann Krahnke Center (BAK)** is the only emergency domestic violence shelter for women and their children in Montgomery County, MD. With a 54-bed capacity, BAK provides a safe and confidential short-term residence for families fleeing domestic violence and/or victims of sexual assault, where women can heal and begin planning for a safer future. Services include case management, group and individual counseling, advocacy, safety planning, and limited child care – all from a trauma informed orientation.
● **Frameworks for Families** provides home, group and community-based services in English and Spanish to families identified by Child Welfare Services as being at low to moderate risk of child abuse and neglect, utilizing an evidence-based family skills training program along with other social supports and resources.

B. Partners

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

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

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

C. Funders

The HFM program is supported through a diversified array of public and private funding streams, as well as through private donations. Program funding and expenses have either increased or remained approximately the same. During Year 19, the bulk of program funding was provided by local public sources, such as the Montgomery County Department of Health and Human Services, Montgomery County Collaboration Council for Children, Youth and Families (Local Management Board), and the City of Rockville. About 8% of the total revenue was provided by private sources such as the Morris and Gwendolyn Cafritz Foundation, the Clark Winchole Foundation, the Gratis Foundation, the O'Neill Foundation, and the Rite Aid Foundation. The HFM program also received individual private donations and in-kind funding from Barnes and Noble at the Washingtonian Center, Christ Child Society, First Books of Montgomery County, Friendship Star Quilters, and Woodworkers for Charity (see **Appendix B: HFM Funding Sources & Expenditures**).

D. Advisory Board

Since the program's inception, an advisory board has been in place to support HFM in efforts of advocacy, community awareness, strategic planning, and coordination of program services within the community. During Year 19, the HFM Advisory Board was comprised of 10 local private and public stakeholders who serve a 2-year term and meet regularly. The Board is comprised of individuals representing diverse ethnic and professional sectors, including medical, educational, political, and religious, that bring a

range of expertise and cultural perspectives. Members provide input and supports to ensure the quality, relevance, and success of program services in the community. See **Appendix C: List of Advisory Board Members 2014-2015**.

E. National Accreditation

The HFM program was founded on research-based best practices and has incorporated new effective practices as research has emerged over the years. As with all Healthy Families programs, HFM is required to complete the Healthy Families America accreditation process every four years in order to be considered an official Healthy Families site. During this intensive process, sites prepare a lengthy written self-assessment that is submitted to a team of peer reviewers for evaluation prior to a three-day site visit. It is through the self-assessment and site visit that the trained reviewers are able to assess the program's adherence to the 12 research-based critical elements, a set of guidelines for best practices in a home visitation program. Accreditation ensures that programs implement evidence-based effective practices and adhere to quality standards on a regular basis over time.

The program has been accredited since November 1999 (Year 4), when it received the first national credential of all the Healthy Family America sites in the State of Maryland. In 2003 (Year 8 of the program), HFM received a rare expedited credential with no follow-up work required, based on exemplary scores on the Preliminary Credentialing Report. In 2008 (Year 13), HFM underwent the new accreditation process, during which revised standards and criteria were applied, and once again received an expedited accreditation. Accreditation standards were revised again in 2012 and HFM successfully completed the rigorous new process during Year 17 (2012-2013) and received consistently strong ratings in several program areas, including:

- Having comprehensive, formal organizational relationships with local Health Centers and consistently screening over 90% of the target population over the past two years.
- Reducing the maximum caseload weight from 30 to 25 due to the increased stressors experienced by the enrolled families.
- Employing an Early Intervention Consultant (EIC) to provide consultation to FSWs. The EIS also coordinates home visits with the FSWs to provide activities, resources and follow-up services with the local Infant Toddler program when a child is suspected to have a developmental delay.
- Accomplishing a 36-month retention rate of 48.5% for those that enrolled between 7/1/07-6/30/08.
- Having a high home visitation completion rate of 88.92%.

HFM is in the process of preparing for the next accreditation process, which is scheduled to occur in FY'17.

II. METHODS

Donna D. Klagholz, Ph.D. & Associates, LLC designed the HFM program evaluation over 19 years ago. Since then, DDK & Associates has conducted an annual external evaluation of the program, creating a detailed historical record of HFM's evolution and outcomes. The continuity of the external evaluator and consistency of methodology and

measures for the past eighteen years have enhanced quality and increased the credibility of longitudinal outcomes.

The comprehensive evaluation of the HFM program is a quasi-experimental pre/post-test research design that utilizes both qualitative and quantitative data and methods. It includes an annual update of the program's implementation and an outcome evaluation of the program's impact on participants. HFM has also developed internal monitoring mechanisms that enable management to evaluate program operations and fidelity, staff training, quality assurance of data integrity, service utilization and participant dosage. The Data Specialist and Program Manager ensure the consistency and quality of data entry. Quality Assurance is monitored regularly and data entry is reconciled monthly. The Team Leader reviews all scoring of standardized measures. As reports are run from the program's database, the Program Manager reviews them for completeness and accuracy. Through monthly tracking of screening, assessment and enrollment data, HFM is also able to identify gaps in service. Furthermore, the tracking of outcome measures in the program database has enabled the program to monitor compliance to the measures administration schedule, as well as to report on participant progress and program outcomes on a more frequent basis.

The Program Information Management System (PIMS) developed by the HFA national office is the primary repository of program data and outcome measures. HFM began using PIMS in 2001 and since that time the external evaluators have relied on data exports and reports from the PIMS database for the bulk of participant data. During Year 17, HFM was trained and began planning for the transition to the PIMS7 version. Over the past two years, PIMS7 has been fully implemented. The repository for all evaluation data, from program inception to the present, is an SPSS longitudinal dataset created by the evaluators in 1996.

A. Theory of Change

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

B. Target Population

The HFM program targets first-time parents residing in Montgomery County who receive prenatal care through Montgomery County Health Services; potential participants are screened while pregnant or at the time of birth. These parents are identified to be at risk for child abuse and neglect based on a standardized screening and assessment process. Almost all HFM families screened and assessed in Year 19 were identified at one of three Montgomery County Health Centers (Germantown, Silver Spring or Piccard). As initial points of entry for the majority of pregnant women throughout the county who are in need of government health assistance for themselves and their unborn babies, these health centers are ideal screening locations for HFM's target population. Additionally, Baby Steps nurses conduct screens of newborns and mothers in order to determine medical risk, which could lead to eligibility for the HFM program. A

much smaller number of screens are completed on women who utilize other community resources.

During Year 19, there were 122 active participants that are included in the analysis of enrollment data (attrition, retention, duration and service levels), demographic and risk data, and outcome data. All target children (n=120) are included in ASQ analysis if they were old enough to receive one. For some variables, data was not available or was unknown, and therefore the sample size (*n)* varies within the report. Finally, sample sizes are larger when examining goals pertaining to screening and assessment. This is either due to the inclusion of families who participated in these aspects of the program, yet do not meet the criteria for the evaluation sample, or due to staffing limitations are unable to be enrolled in services.

C. Procedure

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

D. Process Evaluation

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

The HFM program database (PIMS7) includes data on enrollment, demographics, dates of home visits and other services, number and types of referrals for outside services, and program management (administration, staffing, and organizational linkages). This data was imported into SPSS by the evaluator and analyzed with outcome measures data. Enrollment has been historically defined as initial contact with the FSW and a signed consent to participate in the program. However, using the new HFA Accreditation Standards, Date of First Home Visit is now used to define when the family is officially enrolled. Likewise, the last home visit date is used to determine retention and duration of enrollment, instead of enrollment and termination dates as previously used to calculate these variables.

E. Outcome Evaluation

A quasi-experimental design with repeated measures has been implemented since program inception. A brief description of the standardized measures and the schedule

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

Table 1. HFM Instrument Administration Matrix

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

The Year 19 outcome evaluation examined the impact of program activities on participants and progress towards meeting stated goals and objectives from July 1, 2014 - June 30, 2015.

F. Program Goals and Objectives

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

I. Promote Preventive Health Care

1. 95% of participating children who are at least 2 months old will have a primary health care provider.
2. 95% of eligible children will be enrolled in MA (includes non-target children)
3. 90% of participating children will receive all immunizations on schedule and completed by the age of two.

4. 90% of mothers will not have an additional birth within two years of target child's birth.
5. 85% of enrolled mothers will complete post-partum care.
6. 90% of mothers enrolled within the first two trimesters will deliver newborns weighing 2500 grams (5.5 lbs.) or more.
7. 95% of mothers will have a health care provider.

II. Reduce Incidence of Child Maltreatment

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

III. Optimize Child Development

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

IV. Promote Positive Parenting

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

V. Promote Family Self-Sufficiency

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

III. RESULTS

A. Process Evaluation

Program Description

Healthy Families Montgomery (HFM) is based on the Healthy Families America (HFA) model, a nationally recognized voluntary program for the prevention of child maltreatment. HFA was first implemented by Prevent Child Abuse America (PCA America) in 1992, building on two decades of research in the field of home visitation. The program connects expectant parents and parents of newborns with health and child development assistance in their homes. Home visitors provide guidance, information and support to promote optimal long-term mental and physical health for the children. The home visitors are highly trained, with an average of seven years (range 1-16 years) home visiting experience and tenure with the HFM program. The most recent HFA Best Practice Standards (2014-2017) require direct service staff to have at least a high school degree or equivalent. All (100%) of HFM's home visitors are high school graduates with some college training, and most (n=3/5) have college or graduate degrees.

The quality of HFM services is assured through adherence to best practice guidelines defined through twelve Critical Elements based on over 20 years of research. An HFA site accreditation is required every four years. HFA recently revised its accreditation standards and process, which HFM underwent during Year 17. The rigorous new accreditation process involves an in-depth examination of each site's operation, as well as the quality of the home visits (see **Appendix J: HFM Critical Elements**). The program maintains high quality practices across program services, from the amount of participant contact and supervision to the content of home visits and supervision. Other key elements of the model include intensive, comprehensive, long-term (3-5 years), flexible and culturally competent services. In this way, the program is able to best serve the community and ensure that it is consistently delivering quality program services to promote healthy growth and development to the parents and children it serves.

Screening and assessment are the processes through which families are identified as either eligible for HFM home visitation services or referred to other community agencies based on family need and willingness. Most families are referred to the program through one of three Montgomery County Health Centers, including Germantown, Silver Spring, and Piccard. HFM receives screens monthly from these sources and based on the risk criteria of the screen, identifies families who will receive a more in-depth assessment.

Since most target families are Spanish speaking, HFM retains a bi-lingual Family Resource Specialist (FRS) to conduct the initial home visit and assessment. The highly trained FRS conducts individual family interviews (assessments) with potential HFM families to identify family assets and challenges. Through the use of the standardized Parent Survey (formerly the Kempe Family Stress Checklist - FSC), the assessment process offers one-on-one time with the family so that they can discuss stressors in their lives and potential concerns for welcoming a new baby into the world, as well as

identify those families most in need of supportive services and offer them home visitation services. If the FRS is unable to enroll families into the HFM program due to full caseloads, the family is presented with the best available service at that time which includes a number of community resources. In addition to referrals, the FRS provides families with a packet of enrichment materials. Due to the voluntary nature of the program, families may decline services if for any reason they do not wish to participate. Furthermore, a family may terminate services at any time during their program participation.

Through the HFA Leveling System (see **Appendix K: HFM Service Levels**), HFM ensures that families are seen regularly and frequently, especially early in their program tenure. During pregnancy, families are seen at least bi-weekly, if not weekly, depending on the family's situation and the trimester in which they enrolled. All families are seen weekly beginning three months before the baby's due date. From this point on, the family is seen weekly until a minimum of six months after the birth of the baby. The program has the flexibility to provide the intensity of services based on the needs of the family. Some may continue with weekly home visits for a year or more. However, once families are meeting certain guidelines regarding self-sufficiency, child development knowledge, and understanding of external support, they will progress through the level system to bi-weekly, monthly, and then quarterly home visits. Home visits terminate only after a family meets graduation criteria, ages out, or voluntarily discontinues program services.

Home visits are the core of the HFM program and can be a balancing act of focusing on the parent, child, and parent-child interaction. The principal aim of the home visits is to ensure that children are healthy and ready for school by conducting developmental activities with children and modeling positive parent-child interaction. In addition, FSWs focus on the parents' needs, goals, stressors, and strengths to empower them to provide the best possible care for their children. In utilizing empowering, strength-based techniques, parents come to see their FSW as an individual who advocates for their best interests. Visits are scheduled based on the level of services for each family.
If a family has received 6 months of intensive weekly home visits (Level I) after the birth of the baby and the family situation is stable, the family may be promoted to Level II, with visits every other week. If the family is promoted to Level III, visits take place once a month. Families promoted to Level IV receive quarterly home visits. If a family's attendance in the program becomes inconsistent, or a family is temporarily unavailable for home visits, the Family Support Worker engages in creative outreach activities in order to support re-engagement. HFM monitors the number of home visits expected and completed based on the FSW's caseload on a monthly basis and consistently exceeds national standards for intensive home visiting compliance.

The HFM program also offers group activities each year to provide opportunities for families to interact, share information and resources, and socialize. During Year 19, eight group activities were held, including the annual picnic, family days at a county pool and the National Zoo, and a trip to the Smithsonian Museum of American History. Also, through FSI and other partnerships, HFM is able to provide access for families to other child development and group activities, including the Family Discovery Center, which offers ESOL and GED classes and children's' activities; and the Kids Spot, which is a drop-in center at the Family Court for children over two years of age.

For the past eight years, the HFM program has used the Parents as Teachers (PAT) nationally recognized child development curriculum with its families. PAT has now been replaced with the Growing Great Kids (GGK) curriculum in Year 19 due to its emphasis on attachment and bonding, as well as its alignment with the HFM program model. Staff were trained in the GGK curriculum in June 2014 and full implementation began at the start of Year 19 in July 2014. HFM is utilizing the *Growing Great Kids Prenatal-36 Months Home Visiting* version of the curricula, which focuses on parenting, attachment, child development, and family strengthening with a strong emphasis on social and emotional development and nurturing self-regulation. The skill-driven curriculum provides home visitors with an approach that is research informed, strength-based and solution-focused. The various modules provide a step-by-step guide that encourages interactive questions in order to actively engage parents with the information and skills being presented.

Additionally, the Ages and Stages Questionnaire (ASQ), a screen administered with all target children of appropriate developmental stages, allows parents the opportunity to increase and solidify their knowledge of developmental milestones and to ensure that they have realistic expectations of child behavior patterns. To provide further support in identifying potential delays, the HFM program has an Early Intervention Consultant (EIC) on a consultant/as-needed basis. The Program Support Specialist (PSS) is responsible for coordinating parent education groups that promote healthy parent-child interaction, completing scheduled developmental screenings in the absence of the assigned FSW, assisting with training on typical and atypical development, and the preparation of materials for developmental activities. The EIC is responsible for attending agency meetings, intake information following referral, case presentations, and assessments on an as needed basis. The EIC also accompanies FSWs on home visits upon request, conducts staff trainings on child development, and coordinates referrals with MCITP for families that have children with a suspected developmental delay.

Family Goal Plans (FGPs) are completed with each family on an ongoing basis throughout their tenure in the HFM program. Initially completed within 30 to 45 days of enrollment, FGPs help the family focus on short-term goals. FSWs encourage families to choose goals that are realistically obtainable within a three to six month timeframe. Goals are reviewed on an ongoing basis, and when achieved, new goals are formulated.

Baby Steps nurses provide staff training and support around medical issues and coordinate medical care if no nurse case manager is assigned to the family. Additionally, one of the HFM program supervisors is a board certified lactation consultant and provides breastfeeding consultation to mothers during home visits as needed.

Additional key features of the HFM program are the attributes of the program staff and the quality and quantity of the supervision and trainings offered. HFM staff members are chosen based on a variety of factors including personal and professional experience, as well as education and personality traits that make them qualified to work with an overburdened population (see **Appendix L: Staff Tenure**). HFM staff retention is high, with most (64%; n=7/11) staying with the program for over eleven years. This allows the HFM program to offer more consistency in the services it provides.

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

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

Screening, Assessment and Enrollment

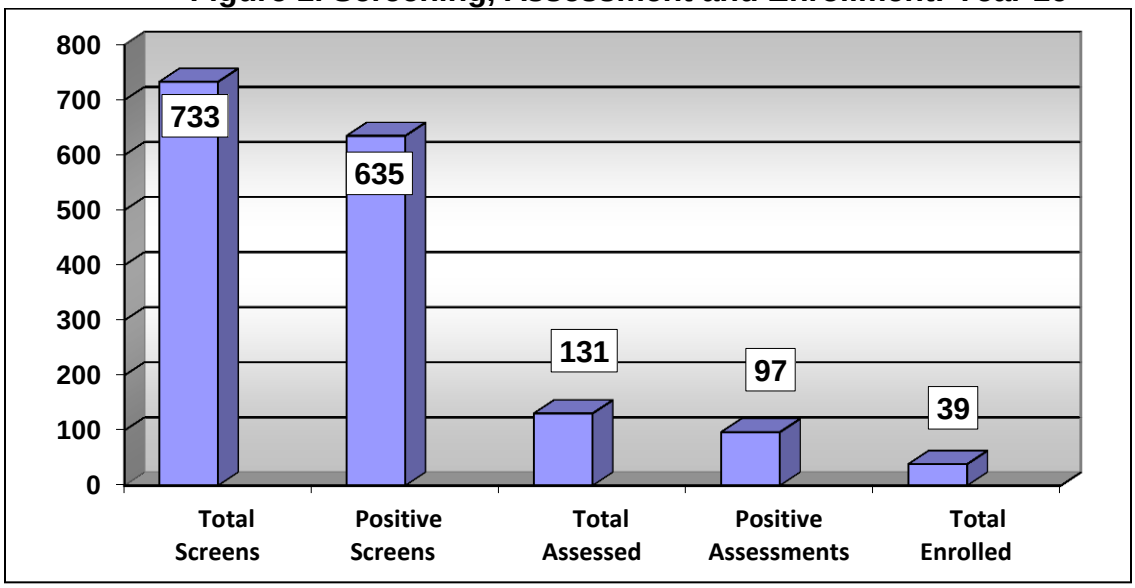
The HFM program has a longstanding partnership with the Montgomery County Department of Health and Human Services. As the major provider of reproductive health and social services to income-eligible families in the County, DHHS conducts universal screenings of all prenatal, perinatal and postnatal female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

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

Figure 1. Screening, Assessment and Enrollment: Year 19 shows the total screening and assessment data for Program Year 19. Almost all screens that were completed resulted in a positive outcome (87%; n=635/733). A total of 131 (21%)

assessments were completed during the fiscal year, which represents an increase from the previous year and continues a trend for an increase in the number of assessments completed despite having only one Family Resource Specialist available to assess families. Of those assessed, 74% (n=97/131) were positive and eligible for the program, but only one-third (39%; n=38/97) were enrolled due to space limitations. One additional family transferred into the program during the fiscal year, bringing the total new enrollments to n=39. When the number of families enrolled based on assessment during FY'15 (n=38) is compared to the total number of positive screens during FY'15 (n=635), only a small fraction (6%) of families determined to be at-risk ultimately receive the intensive home-based services offered by HFM. This reflects the ongoing gap in services for the at-risk population in Montgomery County. For those families who are at-risk but not enrolled, HFM refers them to other services as appropriate.

Figure 1. Screening, Assessment and Enrollment: Year 19



Over the past nineteen years, over 15,000 positive screens for risk of child maltreatment have been referred to HFM, and over 2,560 in-depth assessments have been completed. **Table 2. Screening, Assessment and Enrollment: Years 1-19** displays information for all program years regarding screening, assessment and enrollment.

Table 2. Screening, Assessment and Enrollment: Years 1-19

YEAR*	Total Positive Screens	Total Assessments Completed	Total Positive Assessments	Total Negative Assessments	Total New Enrollments	Total Refusals	Program Capacity
YR 1	-	-	-	-	45	-	50
YR 2	393*	-	-	-	54	-	75
YR 3	787	49	49	0	49	0	75
YR 4	824	110	108	2	104	4	150
YR 5	828	63	60	3	50	3	160
YR 6	854	146	127	19	116	10	150
YR 7	941	259	192	67	66	77	150
YR 8	934	190	136	54	39	15	150
YR 9	934	293	179	114	86	36	150
YR 10	755	298	180	118	60	11	140

YEAR*	Total Positive Screens	Total Assessments Completed	Total Positive Assessments	Total Negative Assessments	Total New Enrollments	Total Refusals	Program Capacity
YR 11	1090	162	110	49	65	28	130
YR 12	1244	165	100	53	43	25	130
YR 13	1144	147	80	62	34	4	130
YR 14	990	124	83	41	44	11	130
YR 15	777	134	82	36	38	22	130
YR 16	784	132	87	42	43	13	130
YR 17	687	57	36	15	15	10	120
YR 18	682	106	88	18	47	12	120
YR 19	635	131	97	34	39	30	120
TOTAL	15,283	2,566	1,794	727	1,037	311	--

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

Enrollment and Attrition

A total of 122 families and 120 children (including two sets of twins) were served in Year 19, and a total of 47 families' cases were closed during the fiscal year. *Of these, 21% (n=10) of families met all of their program goals and graduated from the program.* In addition to these graduating families, a total of 37 families ended services for a variety of other reasons. As shown in **Figure 2. Reasons for Case Closures: Year 19**, the largest percentage of families (47%; n=22) were terminated because they had scheduling conflicts with their job or school. Other reasons for termination included refusing services (9%; n=4), refusing a change of FSW (6%; n=3), and the target child aged out (6%; n=3), the maximum age for the HFM program participation. The remaining families were terminated because they could not be contacted (4%; n=2) or moved (2%; n=1), other family members objected (2%; n=1), or because the target child enrolled in Montgomery County's Preschool Education Program (PEP) (2%; n=1).

Figure 2. Reasons for Case Closures: Year 19 (n=47)

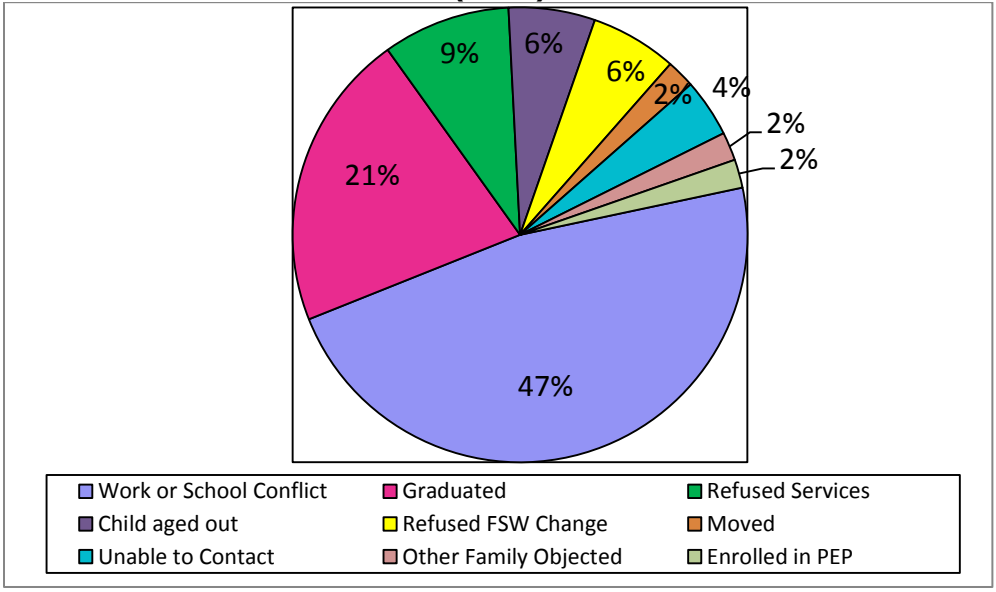


Table 3. HFM Attrition: Years 1-19 shows attrition rates across the nineteen years of the program. The Year 19 attrition rate excludes the families who left due to graduation (n=10) or the child reaching the maximum age for HFM (n=3). Therefore the attrition rate is calculated based on the 34 families who closed for other reasons. The Year 19 attrition rate of 28% (n=34/122) is consistent with the previous year and the program's average attrition rate of 27%.

Table 3. HFM Attrition: Years 1-19

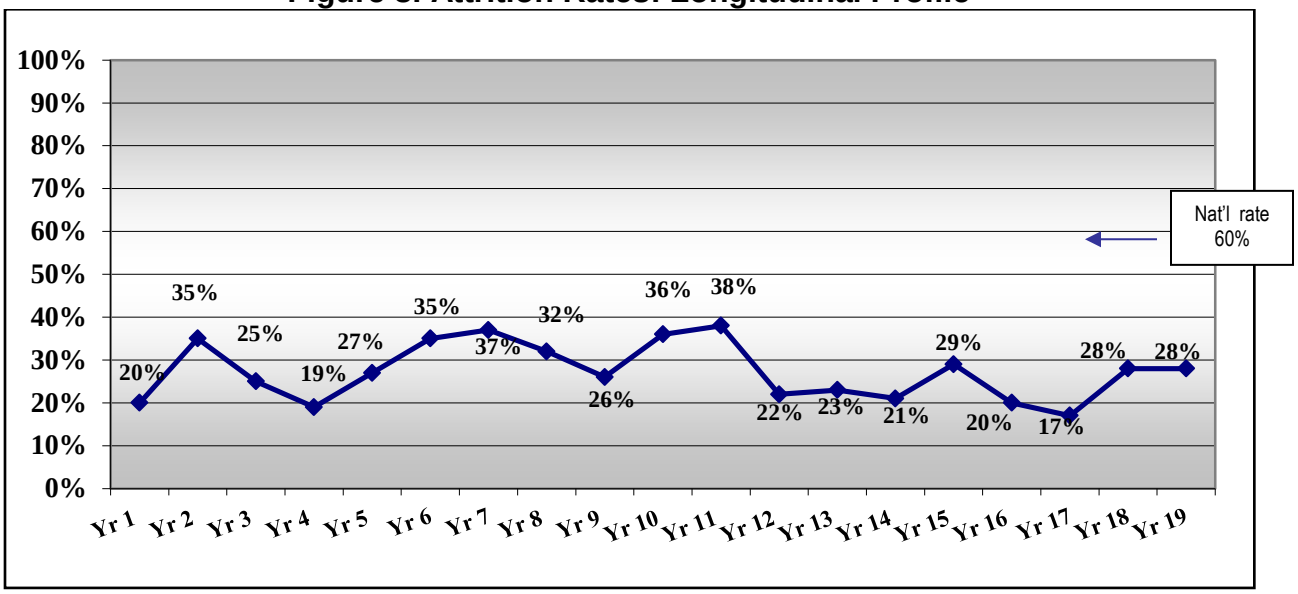
Year	Carryover from previous yr	Enrolled in fiscal year	Total enrolled during fiscal year	Closed* during fiscal year	Graduated / Max Age	Attrition Rate*
Year 1	-	48	48	10	-	20%
Year 2	38	50	88	31	-	35%
Year 3	57	47	104	26	-	25%
Year 4	78	104	182	34	-	19%
Year 5	148	53	201	54	7	27%
Year 6	140	86	226	78	11	35%
Year 7	137	83	220	82	10	37%
Year 8	128	39	167	53	2	32%
Year 9	112	86	198	51	16	26%
Year 10	131	60	191	69	9	36%
Year 11	113	65	178	67	9	38%
Year 12	101	43	144	33	15	22%
Year 13	96	34	130	30	3	23%
Year 14	97	44	141	29	15	21%
Year 15	97	38	135	32	9	29%
Year 16	94	43	137	27	16	20%
Year 17	94	15	109	19	14	17%
Year 18	76	47	123	34	6	28%
Year 19	83	39	122	34	13	28%
Longitudinal						X=27%

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

The attrition rate for Year 19 is 28%. Over the course of nineteen years, attrition rates have ranged from a low of 17% in Year 17 to a high of 38% in Year 11. The average attrition rate of 27% is less than half of the national rate of 60%, as well as the HF New York rates of 50%-70%[2]. See **Figure 3. Attrition Rates: Longitudinal Profile**.

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

Figure 3. Attrition Rates: Longitudinal Profile



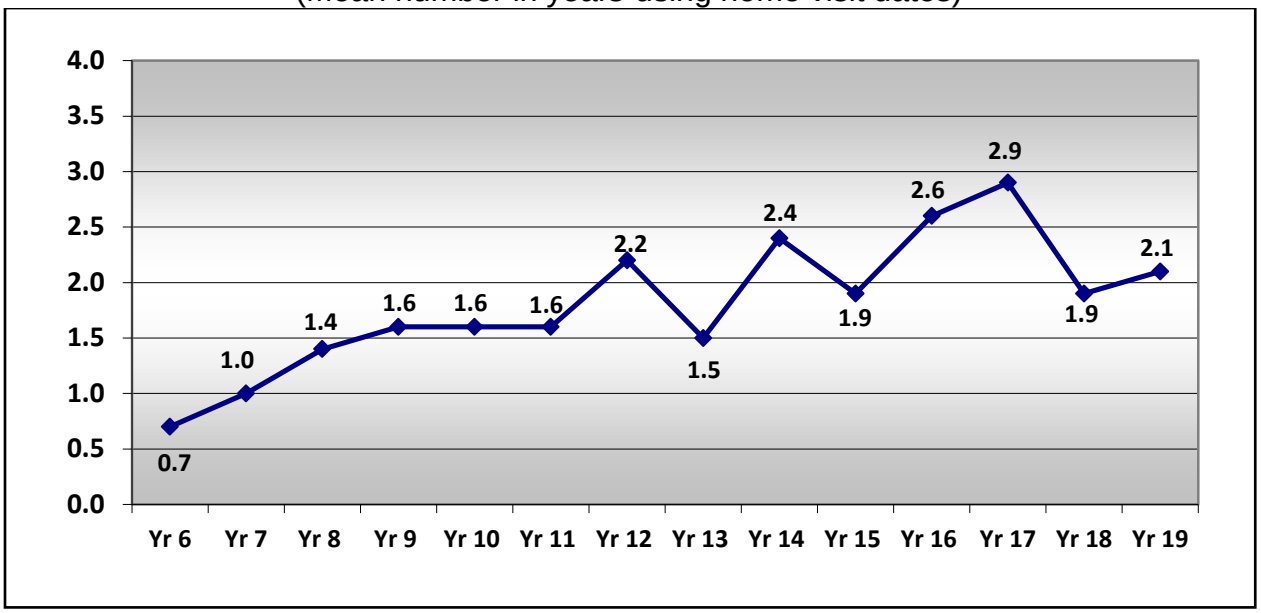
Duration of Enrollment

Low attrition can indicate a longer duration of enrollment for participants. When examining the duration of time between the first and last home visits received by participants who have terminated, there is a clear trend for increased duration of time. Accurate home visit data was available for Years 6 through Year 19. As seen in

Figure 4. Duration of Enrollment-Closed Cases for Years 6-1**9**, the shortest duration was in Year 6 with a mean of less than one year duration, while the longest mean duration of time was achieved in Year 17 with almost three years duration. The duration of enrollment increased slightly in Year 19 after a decrease in Year 18 as a greater number (n=39) of new families were enrolled to replace families that terminated.

The long duration of enrollment (approximately two years) coupled with the higher percentages of families that stay until graduation or the child's 5th birthday indicate that the HFM program is retaining families for the periods of time necessary to achieve success in reaching both the program's and the families' goals.

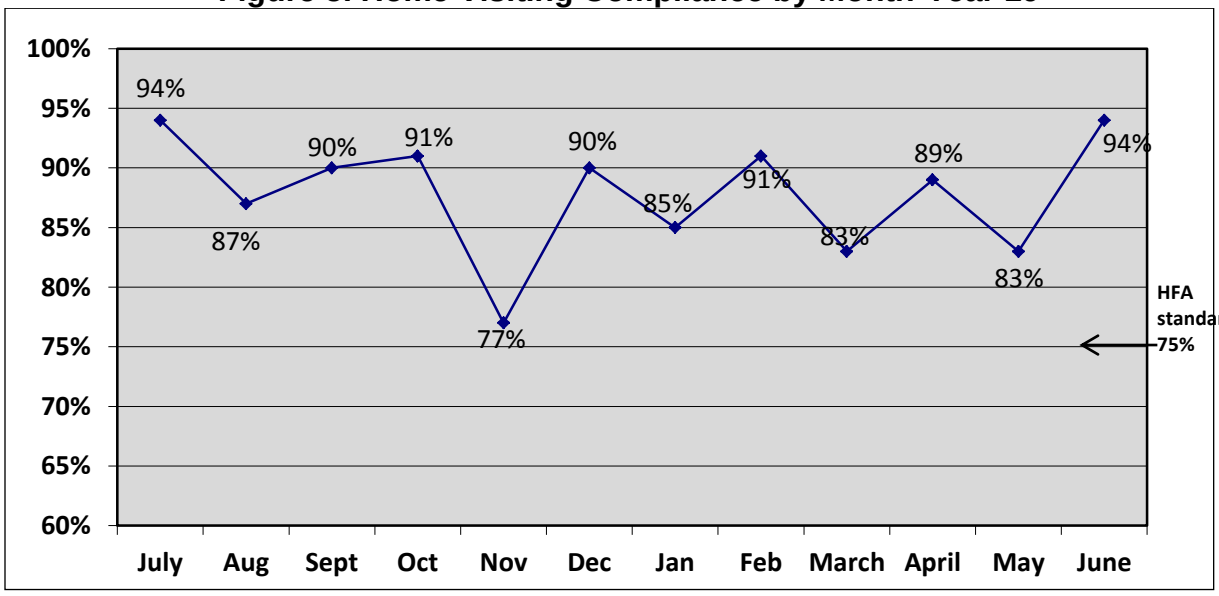
Figure 4. Duration of Enrollment-Closed Cases for Years 6-19
(Mean number in years-using home visit dates)



Home Visit Compliance

The HFM program monitors the number of expected home visits (HV) that are completed each month according to each FSW's caseload. The expected number of home visits per family is determined by their service level. As seen in **Figure 5. Home Visiting Compliance by Month-Year 19**, most of the HV compliance percentages were very high and exceed Healthy Families America standards, which indicate a completion rate of 75% is acceptable for intensive home visiting. The HFM program averaged a completion rate of 88% for Year 19.

Figure 5. Home Visiting Compliance by Month-Year 19



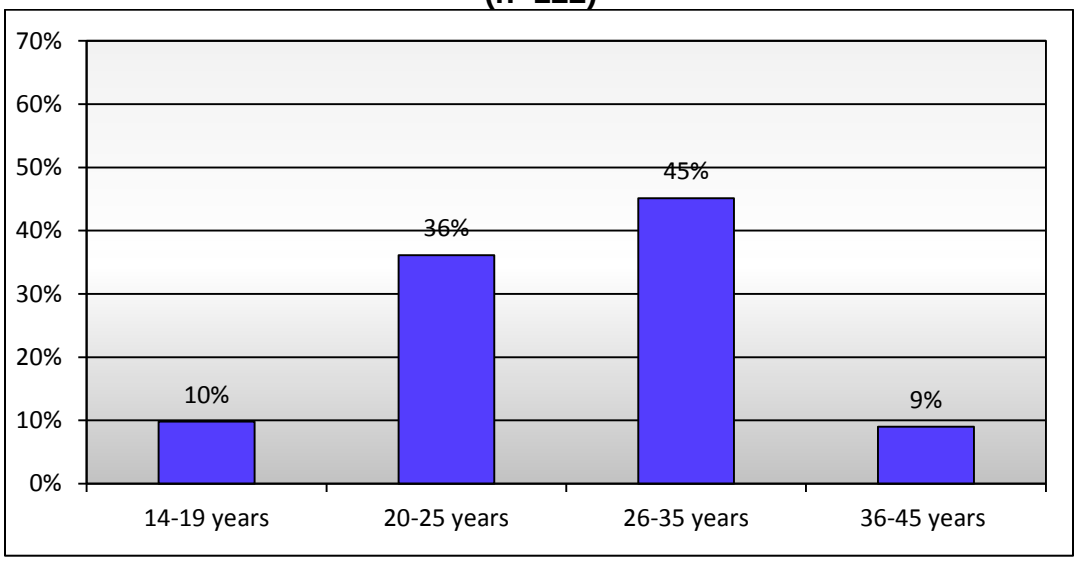
Population Demographics

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

Age

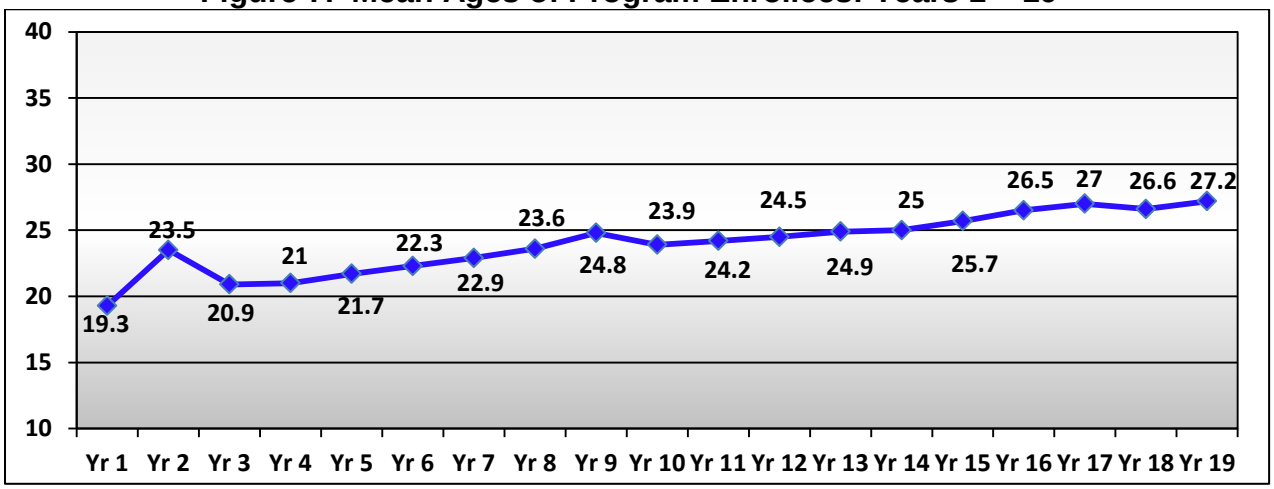
Mother's age is an important factor in determining risk for poor parenting. Teen and young mothers face particular challenges in terms of completing educational goals, achieving self-sufficiency, single parenting, and a lack of emotional maturity necessary for parenting. As seen in **Figure 6. Mothers' Age Groups: Year 19**, the majority of the mothers in Year 19 were between the ages of 26-35 years (45%) at program entry. Most of the remaining mothers were between 20-25 years (36%), while a small percentage were teens, between 14-19 years (10%) or older women 36-45 years (9%).

Figure 6. Mothers' Age Groups: Year 19 (n=122)



Data collected across all program years on mother's age at enrollment is shown in **Figure 7. Mean Ages of Program Enrollees: Years 1 – 19**. There has been a general trend toward increasingly older participants entering the program which is reflected in the steady increase in mean age. Younger mothers are generally referred to FSI's Early Head Start program, which provides the "Keys to Success" program for parenting teens.

Figure 7. Mean Ages of Program Enrollees: Years 1 – 19

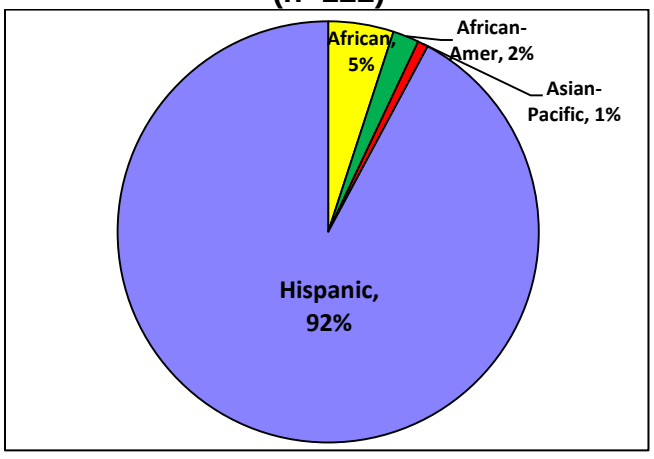


Ethnicity

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

As in previous years, the overwhelming majority of families in the HFM program during Year 19 were Hispanic (92%; n=112), shown in **Figure 8. Mothers' Ethnicity: Year 19**. The remaining mothers were African (5%; n=6), African-American (2%; n=3), Asian-Pacific Islander (1%; n=1)

Figure 8. Mothers' Ethnicity: Year 19 (n=122)

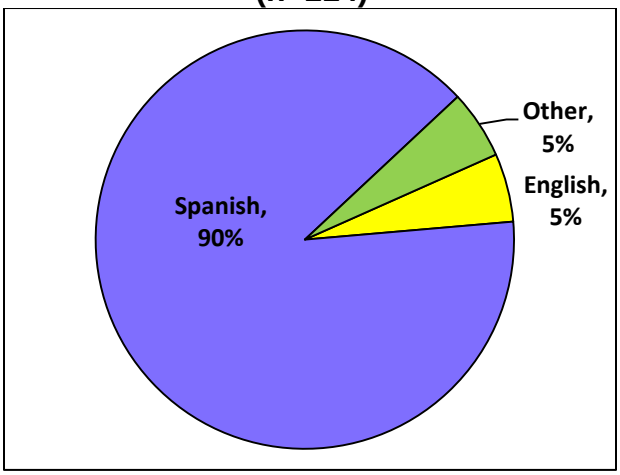


Language

Reflecting the race/ethnicity findings described above, the majority of participants speak Spanish (see **Figure 9. Mothers' Primary Language: Year 19**). In Year 19, most of the participants cited Spanish (90%) as their primary language, while 5% spoke English and 5% 'Other'. Those who cited 'Other' listed French, French-Malagasy, or Konkani/Hindi as their primary language. Of the mothers who report Spanish or another language as

their primary language, many speak some English, but some do not speak any English at all, limiting their ability to access services and community supports, as well as to find employment. HFM provides bilingual staff and linkages to ESOL classes in order to address these communication issues.

Figure 9. Mothers' Primary Language: Year 19 (n=114)

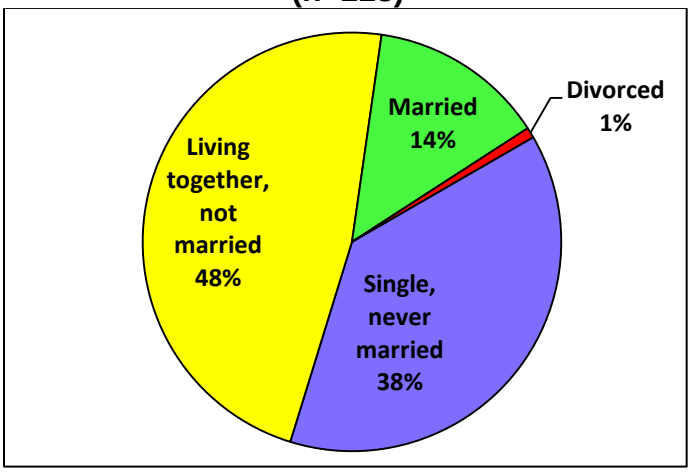


Marital Status

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

As depicted in **Figure 10. Mothers' Marital Status at Program Entry: Year 19** below, most participants in Year 19 were living with their partner (48%; n=56) but not married. Over one-third were single (38%; n=45). A small percentage of mothers were married (14%; n=16), and one mother was divorced. Overall, 86% of mothers were not married at enrollment, which research has indicated is significantly associated with economic risk and instability and places them and their babies at greater risk.

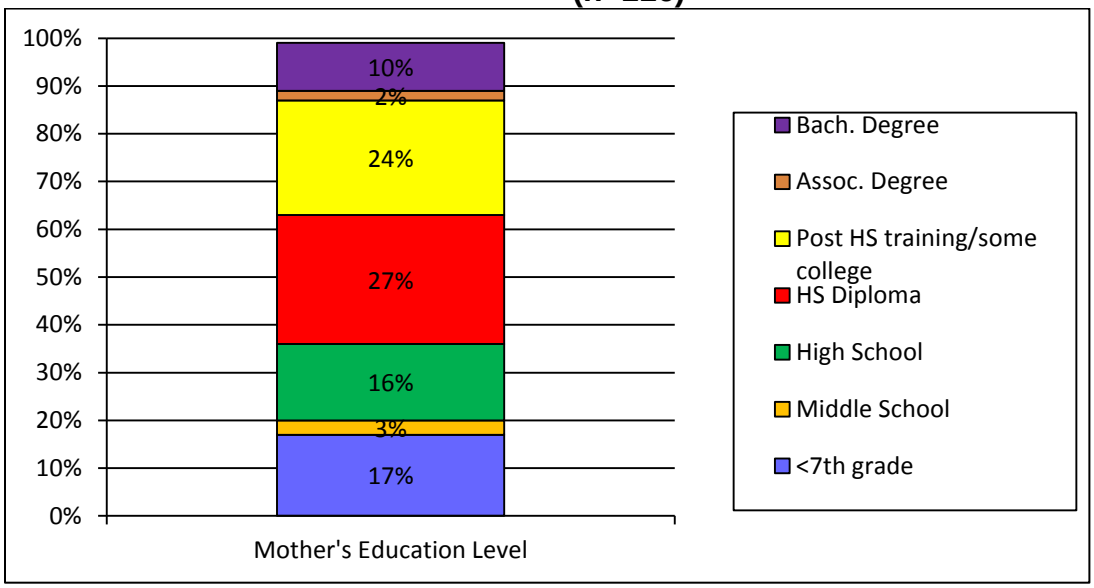
Figure 10. Mothers' Marital Status at Program Entry: Year 19 (n=118)



Education

Mother's level of education is strongly associated with self-sufficiency, literacy, and parenting knowledge. Quality education also helps participants learn parenting skills and foster a love of learning in their children. Our past findings have noted a significant relationship between having a high school degree and increased scores on measures of parenting knowledge. In examining the highest level of education achieved at enrollment, two-thirds (64%; n=74/116) of active participants 18 years of age or older had obtained at least their high school diploma, GED or higher. As seen in **Figure 11. Mothers' Education Status at Program Entry: Year 19**, 27% (n=31) of active participants held a high school diploma, while 25% (n=29) had some post high school training or college, and 12% (n=14) held an Associates or Bachelor's Degree. However, 19% (n=22) had some high school and another 17% (n=20) had less than a 7th grade education. This high percentage of mothers with less than a high school degree is likely attributable to the number of newly immigrated mothers from Latin America and the lack of education offered young women in their native countries. As adults, it is extremely difficult for them to increase their education level, particularly if they are not English speaking, but some do pursue a GED high school equivalency and language classes.

Figure 11. Mothers' Education Status at Program Entry: Year 19 (n=116)

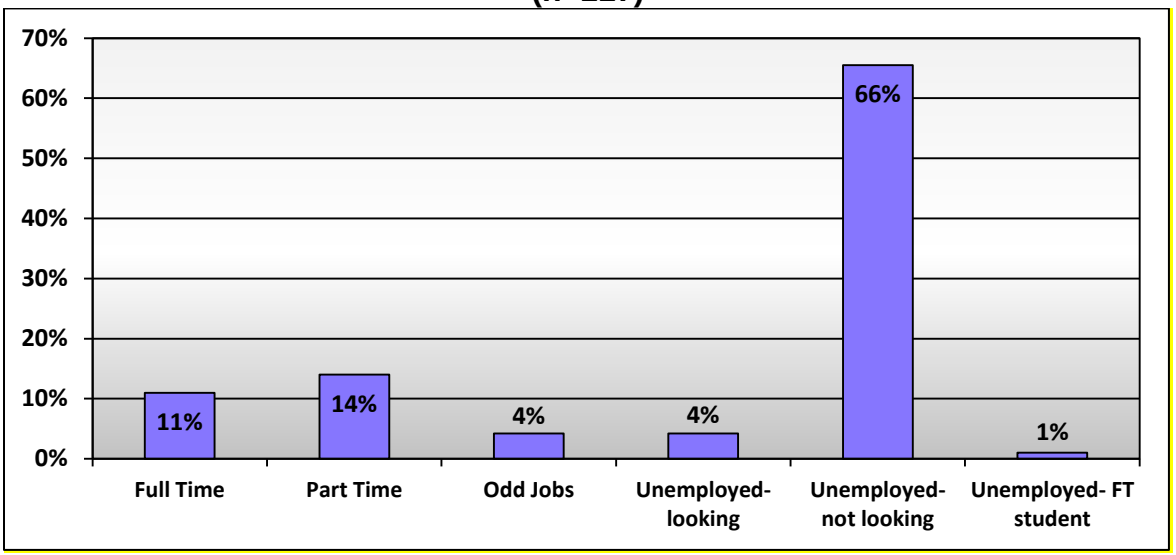


Employment

Mothers' employment status is indicative of economic stability and self-sufficiency. However, mothers often become unemployed around the birth of their baby, or go on maternity leave. The HFM program fosters financial stability by offering assistance with employment-related issues, connecting families to community resources and opportunities, and providing encouragement. As seen in **Figure 12. Mothers' Employment Status at Enrollment: Year 19,** one-quarter of mothers (25%; n=29) were employed either full time or part-time. However, the majority of mothers (71%; n=83) were unemployed at enrollment; 66% were not looking for employment. Of the remaining mothers, several (4%; n=5) were working odd jobs and one mother was a full-time student at the time of enrollment. It is not surprising that such a large percentage of

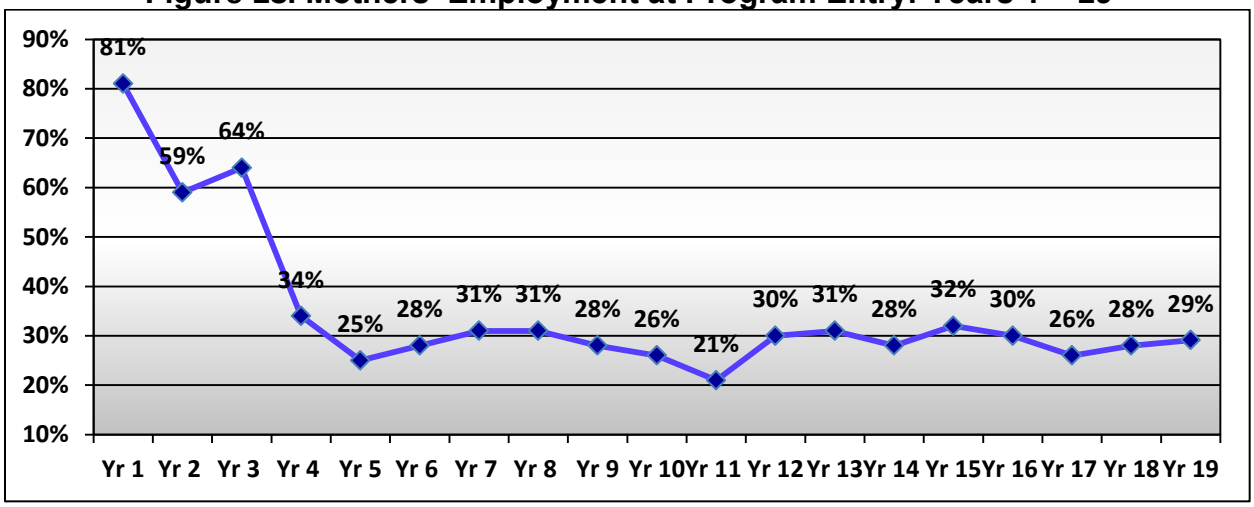
mothers were not employed since they were either perinatal or within 3 months postnatal.

Figure 12. Mothers' Employment Status at Enrollment: Year 19 (n=117)



As seen in **Figure 13. Mothers' Employment at Program Entry: Years 1 – 19**, employment rates were higher in the initial years of the program, but decreased significantly in Year 4. After a significant decrease in percentage of mothers employed in Year 4, employment rates at program entry have remained fairly consistent at approximately 30%, with some lower percentages in Years 10 and 11. In Year 19, 29% of participants were employed full or part-time, including odd jobs and self-employment.

Figure 13. Mothers' Employment at Program Entry: Years 1 – 19



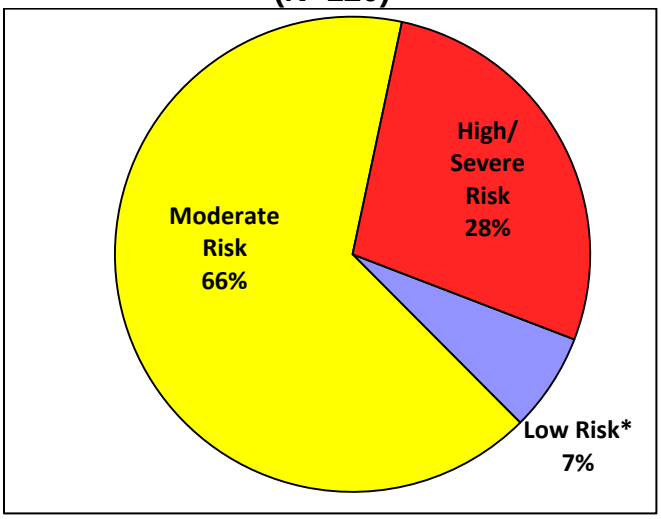
Risk Factors

In addition to examining demographic data, the HFM program assesses participants' initial measured level of risk for child abuse and neglect. Risk factors such as maternal depression, maternal social isolation, and overall parental stress have been associated with heightened risk for child abuse, neglect and poor outcomes. Families are initially

assessed for program eligibility using the Parent Survey, formerly the C.H. Kempe Family Stress Checklist (FSC), in order to identify the level of risk for child maltreatment. The survey assesses mothers' and fathers' current and historical functional status across ten domains including substance abuse, mental illness, criminality, self-esteem, violence potential, developmental expectations, child discipline and bonding/attachment. Scores are grouped into three categories of risk: High/Severe (=>40), Moderate (25-35), and Low (<25). Families with scores of 25 or greater are offered services if the program has availability. Mothers who are enrolled with FSC <25 were found eligible based on the father's FSC score.

While eligibility criteria pre-selects a participant population that is at moderate risk or greater for child abuse and neglect, many families present a constellation of factors that place them at severe risk. FSC scores were available for 120/122 active enrollees in Year 19. As seen in **Figure 14. FSC/Parent Survey Risk Scores: Year 19**, more than one-quarter of mothers (28%) scored in the High/Severe Risk range, while most mothers (66%) scored in moderate risk range.

Figure 14. FSC/Parent Survey Risk Scores: Year 19 (N=120)



** Eligibility based on FOB score or medical risk*

Psychosocial factors play a significant role in assessing the mother's level of risk. Examination of the individual factors addressed on the Parent Survey shows the areas associated with the highest levels of risk for the HFM mothers as they entered the program. The possible scores for each factor, 0 (low risk), 5 (moderate risk), or 10 (severe risk), were averaged across participants and the mean score for each calculated. Results for active participants in Year 19 for the five most significant risk factors based on mean score are displayed in **Table 4. Risk Factors with Highest Mean Score** in rank order. This constellation of severe risk factors places these mothers and their children at very high risk for child maltreatment.

Table 4. Risk Factors with Highest Mean Score (n=120)

Parent Survey Risk Factor	Mean Score
• Being Abused as a Child	7.27
• Social isolation/Depression	7.25

• Multiple Stressors	5.88
• Poor Bonding	4.83
• Unrealistic expectations	4.18

The mean scores for all ten factors on the Parent Survey are shown below in **Table 5. Parent Survey Item Mean Scores by Subscale: Year 19**. These scores assist the HFM program in targeting their interventions to address the overall risk of the participants and to guide the FSW's individual work with the family.

Table 5. Parent Survey Item Mean Scores by Subscale: Year 19 (n=120)

Subscales	Mean Score*
1. Abused as child	7.27
2. Mental Health/Substance Abuse	2.46
3. Previous or Current CWS Involvement	0
4. Self-esteem/Social Isolation/Depression	7.25
5. Multiple Stressors	5.88
6. Violence Potential	.63
7. Unrealistic Expectations	4.18
8. Harsh Punishment	.35
9. Difficult Child	.08
10. Poor Bonding/Attachment	4.83

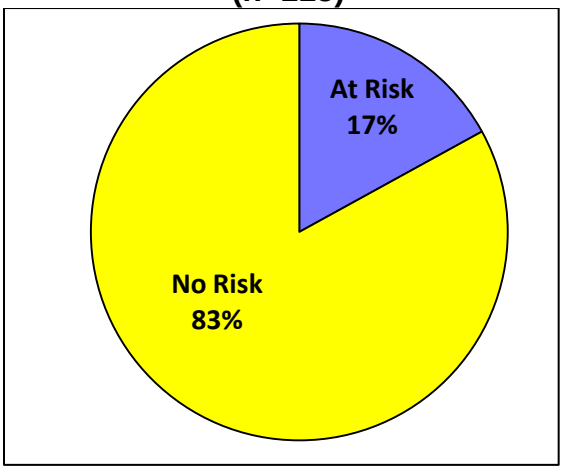
**Range is 0-10 for each subscale with 10=highest risk*

The pattern that emerges from the Year 19 profile of risk factors, including childhood abuse, mental health issues, multiple stressors in their lives, poor bonding and attachment with their child, and unrealistic expectations of their child is one that reflects an increased potential for child maltreatment, particularly neglect. The prevalence of social isolation and depression are more closely associated with potential for neglect. However, the high incidence of mothers that experienced moderate to severe abuse as a child and who have unrealistic expectations of their child places them at much higher risk for harsh discipline with their child and may lead to physical abuse. The identification of these at-risk mothers provides the Healthy Families Montgomery program the opportunity to break the cycle of abuse with these new mothers and their babies.

Maternal Depression

Maternal depression has a direct negative impact on children's development and behavior in that it impedes a mother's ability to bond and effectively discipline her children. Given the projected prevalence of depressive symptomology in the population targeted by HFM, the program strives to identify those participants most at risk and provide appropriate intervention services as soon as possible. The HFM program uses the Center for Epidemiologic Studies-Depression (CES-D), a self-report measure, to determine risk for maternal depression prenatally, post-partum and on an annual basis. Scores of 16 or above indicate risk for maternal depression. As seen in **Figure 15. Maternal Depression at Program Entry: Year 19**, at program entry, 17% (n=19/115) of Year 19 participants scored at risk for depression.

Figure 15. Maternal Depression at Program Entry: Year 19 (n=115)



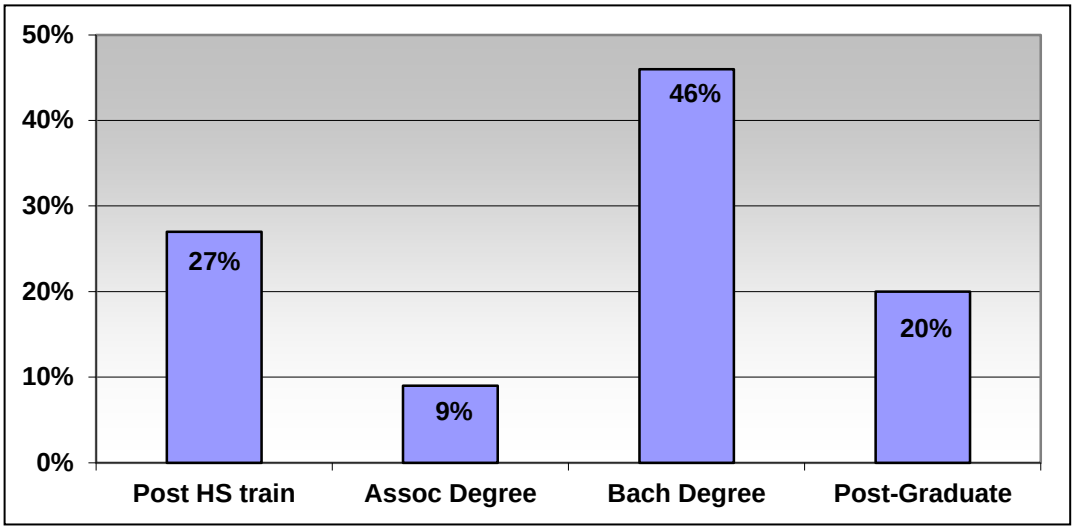
Staffing

During Year 19, one position was added to the existing staffing structure. The HFM program employed 11 individuals in 11 positions (10.45 FTEs). Staff positions included one Program Manager, one Team Leader, one Family Resource Specialist, one Program Support Specialist, 5 Family Support Workers, one part-time Data Specialist, and a part-time Early Intervention Consultant. The program also has two Baby Steps nurses and an RN consultant who are available to the HFM program on as needed basis.

In order to ensure cultural and linguistic competence, the HFM program hires staff that reflect the ethnic and cultural composition of the target population. All staff were female and all direct service staff are bilingual in English and Spanish (n=8), and one speaks Portuguese as well.

The collective educational level of the staff remains high (see Staff Training section below also). As seen in **Figure 16. Staff Education Levels: Year 19**, all (100%) staff members have graduated high school and at a minimum have attended post-high school training or some college (27%; n=3). Additionally, the majority of staff have attained a post-secondary degree, either an Associate's Degree (9%; n=1); a Bachelor's Degree (46%; n=5) or a Graduate Degree (18%; n=2). HFM staff education levels exceed Best Practice Standards requirement of at least a high school degree, and the HFA national percentage of 74% having some college or higher.

Figure 16. Staff Education Levels: Year 19
(n=11)



At hire date, almost one-third of staff were between 20-30 years of age (27%; n=3), while 36% (n=4) were between 31-40 years of age, and the remaining one-third of staff members were between 40-50 years of age (36%; n=4) when hired. Staff ages at hire ranged from 23-47 years, with an average age of 37 years.

Staff Attrition/Retention

The HFM program has an excellent history of retaining good staff. High levels of staff retention reflect a stable program that values its staff and provides opportunities for feedback and growth. Staff retention has also been linked to family retention, particularly retention of the Family Support Workers who engage the families and are directly involved with them on a regular basis. Most staff remained with the program during Year 19 (see **Appendix L: Staff Tenure Dates**). One Family Support Worker left the program in May 2015 to accept a position with another program within Family Services, Inc. Most other current staff members (70%; n=7) have been with the program for over 11 years, while one has been employed for five years, another has been employed for three years, and the remaining two for one year or less. The Program Manager has been employed by HFM since the program began in 1996. The average length of the current staff's tenure is 10 years, with a range of 2 months for the staff members hired in May 2015 to over 19 years for the Program Manager.

Table 6. Profile of Staff Characteristics: Year 19

	N=11
Bilingual English/Spanish*	 73%
Education HS Grad Post HS/Some College Associate Degree Bachelor Degree Post-Graduate	 100% 27% 9% 46% 20%
Mean Age/Range-at Hire	37 years/ 23-47 years
Mean Length of Tenure/Range	10 years/ 2 months-19 years

**One bilingual FSW also speaks Portuguese*

Staff Development

HFM provides rigorous, continuous and varied training as part of its commitment to supporting staff and ensuring that employees feel competent and prepared for their work with families. The required 32-hour Healthy Families "Core Training" and initial training cover topics such as the history and philosophy of home visitation, the core strength-based approach of the Healthy Families model, identification of child abuse and neglect, professional boundaries, and limit setting and confidentiality. Additionally, wrap-around trainings on varied topics are offered on an ongoing basis.

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

Trainings for Year 19 are provided in detail by date and with number of staff who attended (see **Appendix M: HFM Staff Trainings**). The extensive number and type of trainings offered demonstrate the program's dedication to expanding the knowledge and skill set of its staff by providing 94 separate trainings covering 64 different topics. Many of the trainings were individual sessions provided to the new staff member. The average number of trainings per staff member was 22 with a range from 6 to 33 trainings for existing staff, while the newest staff member attended 36 trainings. The trainings can be divided into six general areas: 1) Professional Development, 2) Topics related to Culture; 3) Parenting; 4) Family Mental Health/Well-Being, 5) Family and Child Health Care, and 6) Child Development. Most of the trainings fell within the area of Professional Development, while Family Mental Health/Well-Being trainings were the second most frequently offered. This pattern is indicative of HFM's emphasis on developing highly professional staff that are well-equipped to focus on their family's mental health and helping parents optimize their child's well-being.

- ***Professional Development***

Fifty-six trainings and conferences were offered on 14 topics in this area and are related to program implementation; management, data and evaluation. Among the trainings offered were: Integrated Strategies, PSCO Re-Certification; Recruitment and Retention of Home Visiting Staff; Effective Communication/Motivational Enhancement; Mindfulness Work in the Home Setting; Program Processes; Crisis Training-Mandt Chapters 1-4; HFM Home Visit Record; Confidentiality and HIPPA; Corporate Compliance and Ethics; and Optimizing your Effectiveness.

In addition, nine Orientation sessions were conducted for the new staff member on topics such as FSW Core Training; Administrative Information; Home Visiting Safety; Preparing for the Home Visit; Family Services; Inc.; the HFM Program; Issues of Boundaries; Confidentiality; and the Program's Relationships with the Community Resources.

- ***Topics Related to Culture***

Four trainings were offered to promote cultural competence and understanding of the role of culture in parenting, including: the Silent Trauma of the Immigrant Experience; Immigrant Issues; Cultural Diversity; and the Role of Culture in Parenting.

- ***Parenting***

Five trainings were offered that focused on developing positive parenting skills. These included: Transformational Relationships; Giving Kids What They Need to Succeed; Responding to Relationships; Coaching on Positive Parenting Strategies; Fostering Infant and Child Development.

- ***Family Mental Health and Well-Being***

Sixteen trainings were offered that focused on general family functioning, as well as mental health, substance abuse and domestic violence. Topics included Mental Health First Aid Training; Trauma Informed Supervision; Child Abuse/Neglect; Domestic Violence; Substance Abuse; Promoting Mental Health; Perinatal Depression; Screening for Depression; Safe and Secure Environments; Child Welfare Services; and Child Center and Adult Services.

- ***Family and Child Health Care***

Seven trainings in this area were related to the health care of children and families, including: Basic First Aid; CPR; Infection Prevention; Abusive Head Trauma; Keeping Babies Healthy and Safe; Striving for a Smoke Free Environment; Infection Prevention; and Preparing Moms for Birth and Beyond; and Prenatal Training.

- ***Child Development***

Nine trainings were offered that specifically focused on child development and education, including: DECA Overview; Growing Great Kids Curriculum; Teaching Others to Use ASQ and ASQ On-line; ASQ Third Edition; Right from the Start: Building Brains Birth-Age 5; Growing Great Kids Tier 2; Speed Dial-4/Early Screening Inventory; Brigance Screens; and Curriculum/Materials Overview.

Staff Satisfaction

In July/August 2015, seven staff members completed a questionnaire designed to solicit feedback on HFM staff's perceptions regarding job satisfaction and work-related stress, views on program strengths and areas for improvement, as well as perceptions of support and benefits they have received while working for HFM (see **Appendix N: Staff Satisfaction Survey**). All respondents identified their position within the agency. Four respondents identified themselves as either an FSW or FRS, while two were identified as a manager/team leader and one marked in the 'Other-Administrative' category.

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

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

Table 7. Staff Agreement with Various Program Aspects (n=7)

	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree	No Answer/ NA
I understand the HFA Critical Elements.	5	2				
I understand the goals and objectives of HFM.	6	1				
I receive an adequate amount of supervision to help me get my job done in a quality manner.	4	3				
HFM is designed to optimize child development through comprehensive support to families.	5	2				
The program management is responsive to the needs of staff.	2	4	1			
HFM is a strength-based and family centered program.	6	1				
I have participated in training that adequately prepared me for my position.	5	2				
I have participated in training in the past six months.	5	2				
The agency and program management represent the community.	3	3	1			
The staff is culturally representative of the families served.	5	2				
The program uses materials that are	4	3				

culturally appropriate.						
The program uses bilingual materials as appropriate.	5	2				
I feel comfortable working with the culturally diverse families.	2	5				
HFM helps prepare children to be ready for school.	4	3				

As seen in **Table 8. Staff Work Satisfaction**, most staff enjoy their work, find it worthwhile, and believe they are having a positive impact on families. All agree that they are satisfied with their position and feel appreciated by management for the work they do. However, consistent with previous years, several staff members are “Not Sure” or “Disagree” that they are appropriately compensated for the work they do. Interestingly, almost all staff did not think the work they do is hard.

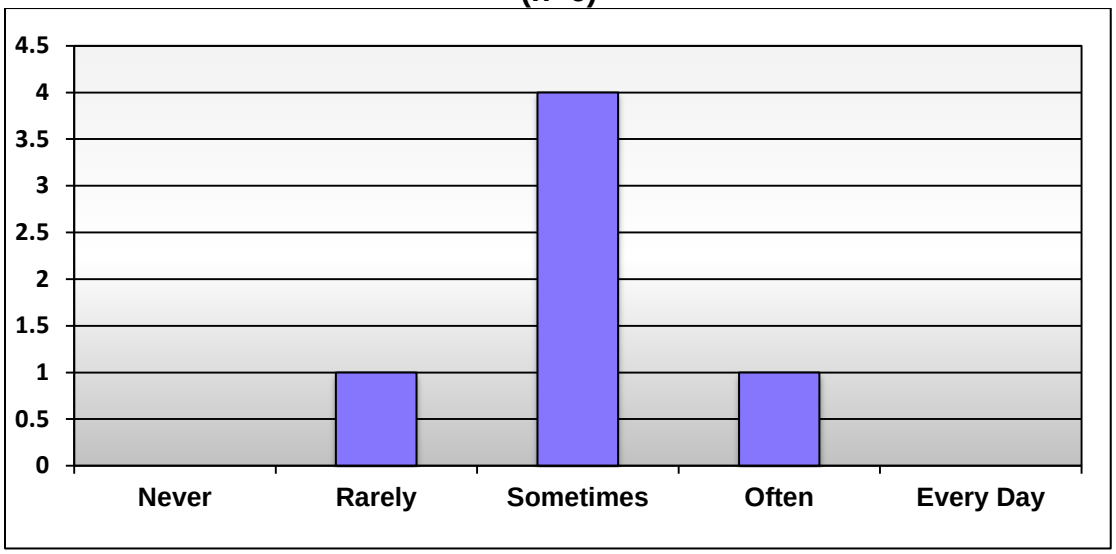
Table 8. Staff Work Satisfaction

	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree	No Answer/ NA
I enjoy my work.	5	2				
I find my work worthwhile.	4	3				
I find the work that I do is hard.		1		6		
I find my work boring.				6	1	
The work I do uses my skills.	2	4				
I am satisfied with my position.	2	5				
I am appropriately compensated for my position.		2	3	2		
I feel appreciated by HFM management for the work I do for the program.		7				
I believe I have made a positive impact on the children and families I work with.	5	2				

Staff members were asked to indicate how often they feel stressed at work. As seen in

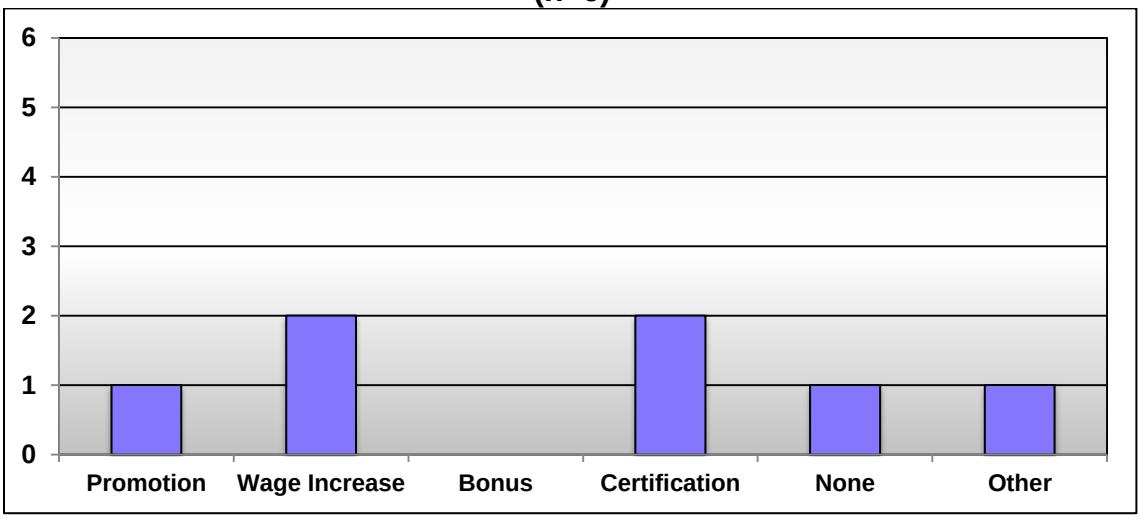
Figure 17. Staff Report of Job Stress: Year 1**9**, most staff (n=4) ‘Sometimes’ feel stress associated with their work, while one respondent (n=1) “Rarely” feels stressed.

Figure 17. Staff Report of Job Stress: Year 19
(n=6)



Staff members were asked what benefits they had received as a result of their participation in work related trainings. Wage increase (n=2) and Certification (n=2) were chosen as the top benefits, while receiving a promotion was reported by one staff member. Another staff chose 'Other', but did not specify the benefit they had received and the remaining respondent indicated that no benefit was received. **Figure 18. Staff Report of Employment Incentives Received: Year 19** shows staff reports of the employment benefits received as a result of their participation in work related trainings. Although only two staff members indicated they received a wage increase, all staff received a cost of living wage increase in Year 19.

Figure 18. Staff Report of Employment Incentives Received: Year 19
(n=6)



In order to assess the staff's perception of the strengths and weaknesses of the program, they were presented with two open-ended questions. When asked what areas of the program are particularly strong, comments focused on several key areas: the dedication and preparedness of staff, the strength-based approach of the program, and the respect for cultural diversity and the ability to connect with families. Respondents

commented on the dedication and strength of staff to connect with families and empower them to be their child's best advocate. They also cited the strength-based program and a curriculum that provides services in a structured way. The training and organization management were also mentioned. **Table 9. Program Strengths Identified by Staff** shows all current strengths cited by the staff in rank order, along with the frequency with which they appeared.

"The staff are fabulous at connecting with the families..."

Table 9. Program Strengths Identified by Staff (n=6)

Strength	Frequency
Staff (well trained, dedicated, respect for cultural diversity, team work; connecting, empowering families)	6
Program's strength-based approach (curriculum, structured model)	3
Training (organization)	1

When asked which areas of the program need improvement, five individuals offered responses. Areas identified as targets for improvement included: 1) Tracking of data to reflect FSW's work; 2) Additional support from supervisor; 3) Improved communication; and 4) Opportunities of fun for staff. Additional comments included, "Understanding that some families don't accept services. Team Leader can instill confidence in her team as well as contribute to analyze situations in the best interest of the well being of the families that the program serves" and "the Family Goal Plan process continues being an area of growth for the program".

Participant Satisfaction

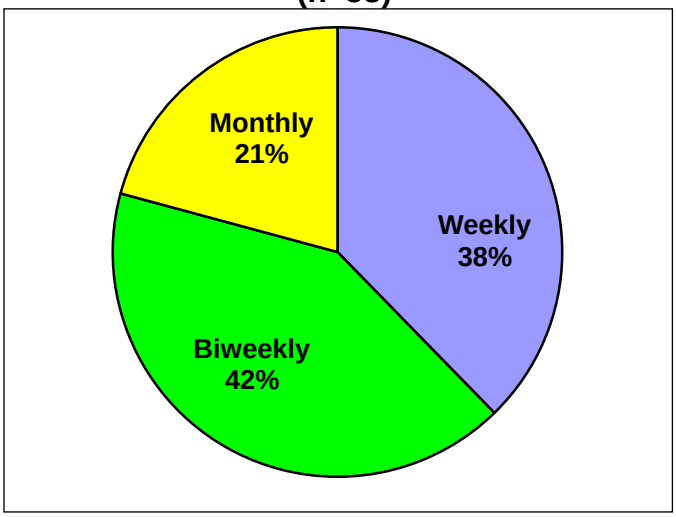
The Healthy Families Montgomery program strongly values fidelity to its model and to providing its families with the best quality support, information, and services. To this end, HFM administers annual participant satisfaction surveys to gather anonymous information from families regarding various program areas (see **Appendix O: HFM ParticiPant Satisfaction Survey**). As in past years, surveys in English and Spanish were distributed to all active participants during home visits. In Year 19, 54 participants returned the survey. The majority of respondents were between 21 and 30 years old (59%; n=32), while 35% (n=19) were over 31 years of age; and 6% (n=3) were 16 years of age or under.

"They support a person when needed and give advice."

"It helps with the development of my baby and connects to community resources."

Survey results show that the majority of participants (42%; n=22/53) are visited on a bi-weekly basis, while 38% (n=20/53) are visited weekly, and 21% (n=11/53) are visited on a monthly basis (see **Figure 19. Frequency of Home Visits).** *Ninety-eight percent (n=50/51) of the respondents reported that they received their first home visit before their babies were 3 months old, an important standard in HFA best practices.* At the time of the survey, most babies were under one year of age at the most recent home visit (37%; n=19/51), and 31% (n=16/51) were 12-24 months old. The remaining babies were 2-years of age (4%; n=2), 3-years of age (20%; n=10) or 4-years of age (8%; n=4).

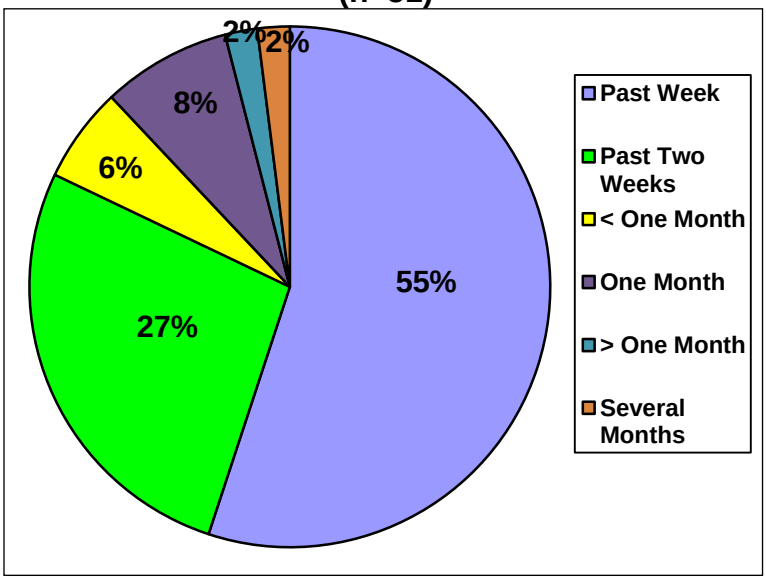
Figure 19. Frequency of Home Visits (n=53)



Participants were also asked when their most recent home visit occurred. Results for Year 19 indicate that more than half of respondents (55%; n=28) were visited within the week prior to survey completion. As seen **in Figure 20. Last Home Visit** below, 27% (n=14) reported being visited within the past two weeks, while 6% (n=3) reported being visited within the past month and 8% (n=4) were visited a month ago. The remaining participants reported being visited more than a month (2%; n=1) and several months ago (2%; n=1). Although only two participants indicated their last home visit was more than one month ago, three participants provided a reason. One noted that the reason they were visited more than a month ago was due to a change in FSW, while the other two noted it was because they were on level 3 or 4.

"I like it a lot and I have learned new thing that are making me a better mom."

Figure 20. Last Home Visit (n=51)



Year 19 participants were asked how effective they thought the program was in various areas by circling "Yes" or "No." **Table 10. Participant Perception of Program Effectiveness** below shows the percentage of "Yes" answers. Respondents unanimously perceived the program to be effective in almost all categories.

Table 10. Participant Perception of Program Effectiveness (n=54)

1. My Family Support Worker visited me as agreed upon.	100%
2. My Family Support Worker gives me information on how to care for my baby.	100%
3. My Family Support Worker is helping me learn about my child's development.	100%
4. My Family Support Worker helps me with my needs and the needs of my baby and family.	100%
5. My Family Support Worker is respectful of my baby, my family and me.	100%
6. My Family Support Worker accepts and respects my culture.	100%
7. My Family Support Worker shows an interest in learning about my culture.	100%
8. My Family Support Worker gives me information that I can understand	100%
9. My Family Support Worker communicates with me in a way that I understand.	98%
10. My Family Support Worker helps me to be more independent by helping me make my own decisions.	100%
11. My Family Support Worker has helped me to become a better parent.	100%
12. Healthy Families has made a positive impact in the life of my baby.	100%

When asked what they liked best about the program, participants responded with 56 positive comments about the program. A large majority of the comments 61% (n=34/56) focused on the support and information they received that helped them better understand their child. Of these, 35% (n=12) focused on the support they received from the staff to help them become better parents, while 9% (n=5) mentioned appreciating the referrals they received to help both their baby and themselves. Twenty-four percent of mothers (n=13/56) provided comments in reference to learning about child development and understanding the stages of their own child. One mother commented on how staff treat her and her child. Another mother noted that she enjoys the group recreation events, as well as the home visits. Finally, five mothers simply said they liked "everything" about the program.

Table 11. Best Aspects of HFM Program

	# Comments
1. Information/Support/Advice	12
2. Parenting/Child Development	13
3. Everything	5
4. Staff	2

Thirty participants responded to a question that asked what they did not like about the program. Nearly two-thirds of mothers (63%; n=19/30) responded that there was

nothing that they did not like and liked everything. Of the 11 respondents who had a comment, three felt the visits should be longer and one felt the program should be offered not only to first time moms. One mother wanted more help at each visit, while another felt that she needed more interaction and activities with her baby. One mother wanted information on how to care for her baby in situations she doesn't understand. Two commented that transportation was difficult. And, finally, two commented on their family support worker; one didn't like that her FSW changed three times and the other didn't feel her FSW was helpful.

> "When my son was younger I wish my visits could have been longer, but I understand there are many families."

Participants were asked if they had any recommendations for improvement of the HFM program. Of the 37 mothers who responded to the question, 76% (n=28/37) re-iterated that the program was excellent and that there was nothing to change. Of the nine mothers who offered suggestions for improvement, 33% (n=3) suggested that the program should offer opportunities for participants to socialize and network with other families, and 22% (n=2) felt more resources and education would be helpful. One mother suggested that the program should offer daycare, while another suggested offering transportation. The remaining two mothers recommended more activities with her baby during the visit and putting in place a good supervisor more understanding of others.

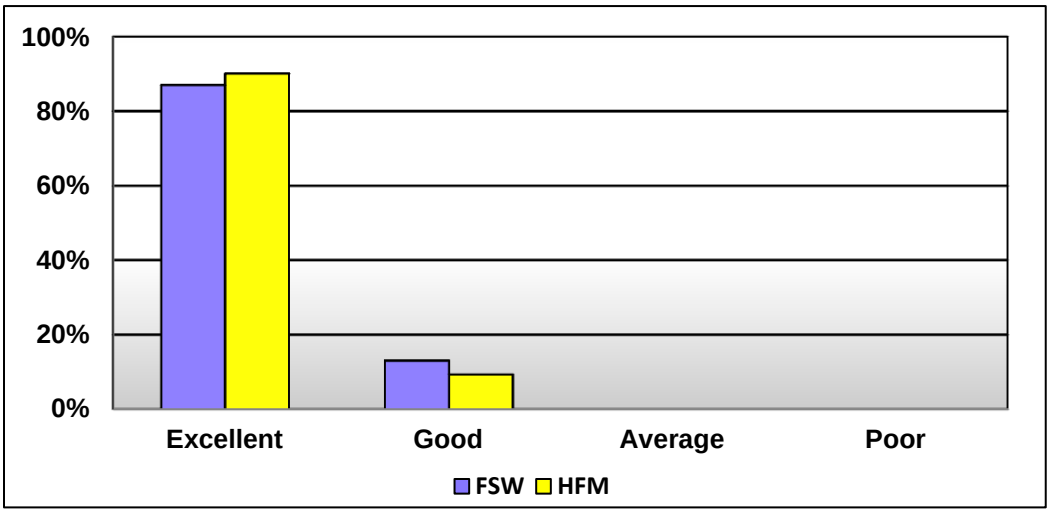
> "Not so much improve, but ..... have more activities in which other moms get to express their experience as mothers."

Table 12. Recommendations for Improvement

Comment	# Respondents
1. Additional education/resources/activities	3
2. More group activities/socialization/network	3
3. Daycare	1
4. Transportation	1
5. Improved supervisor	1

Families were also asked to rate their FSW and the HFM program. All of the respondents reported that both their FSW and the HFM program were either "Excellent" or "Good," as shown in **Figure 21. Participant Ratings of FSWs and HFM.** No participants rated the program or their FSW as "Average" or "Poor".

Figure 21. Participant Ratings of FSWs and HFM (n=54)



All respondents (100%; n=54) agreed that they would recommend the program to a friend or relative, with 89% responding "Strongly Agree."

> "Keep doing what you are doing. You are helping many families."

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

B. Outcome Evaluation

Achievement of Goals and Objectives

Over the past nineteen years, Healthy Families Montgomery has achieved its goals and outcomes annually, and met or exceeded many of its targets for key outcomes. As seen below, current outcomes confirm the program's ability to sustain its successes through its nineteenth year of operation as well (see **Table 14. Summary of Goals, Objectives and Program Outcomes** on page 60 and **Table 15. Summary of Goals, Objectives, Program Outcomes and Comparative Statistics** on page 61).

Goal I: Promote Preventive Health Care

Health Care Provider

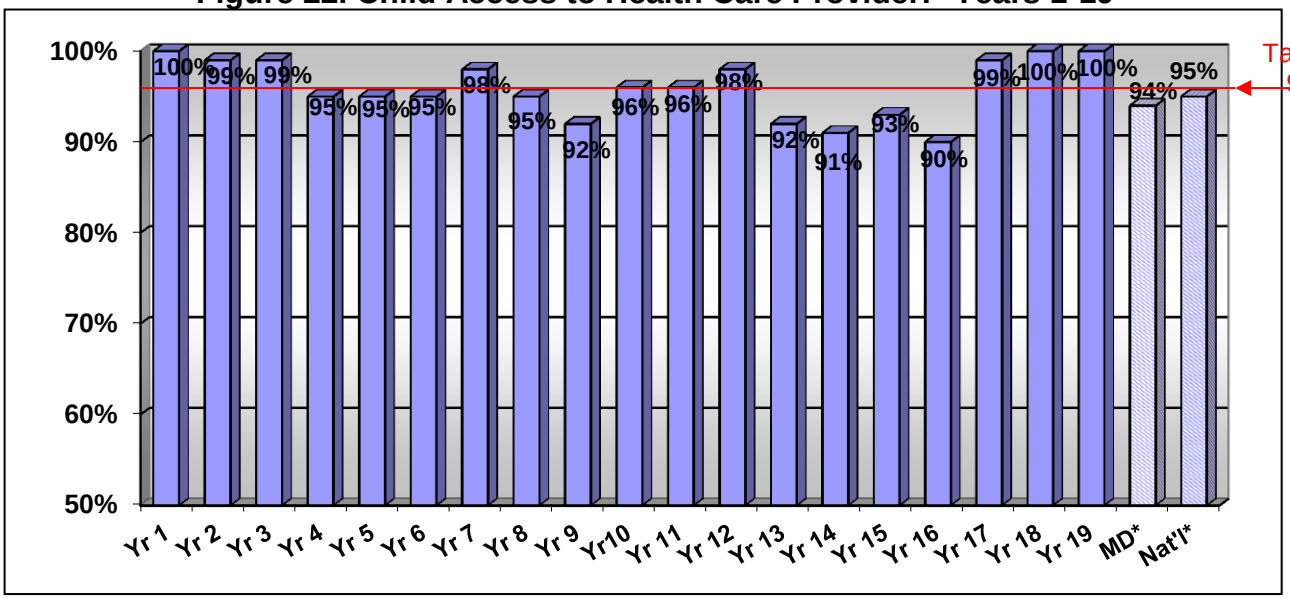
An important goal of the HFM program is ensuring that program participants are linked with primary health care providers and health insurance, specifically Medical Assistance

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

During Year 19, there were 116 children that were at least two months old by the end of the reporting period. ***Of these, 100% (n=116/116) were linked with medical providers by the end of the fiscal year or before termination from the program, exceeding the program's goal of 95%. Additionally, all eligible children were enrolled in Medical Assistance (MA).*** These results increase the likelihood that children will receive timely immunizations and well-child checkups. As seen in **Figure 22. Child Access to Health Care Provider:* Years 1-19,** these results exceed the 2015 National rate for child health insurance for children under 18 years of age at 95%[3], and the 2013 rate for child health insurance for children between 0-5 years in the State of Maryland of 94%**.

Also during Year 19***, all mothers (100%; n=122) were linked to a health care provider.***

Figure 22. Child Access to Health Care Provider:* Years 1-19



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

Current Immunizations

FSWs work with families to ensure that babies are immunized in a timely fashion. This is accomplished through providing information to families on the importance of immunizations for preventing serious medical diseases and by assisting with linkage to

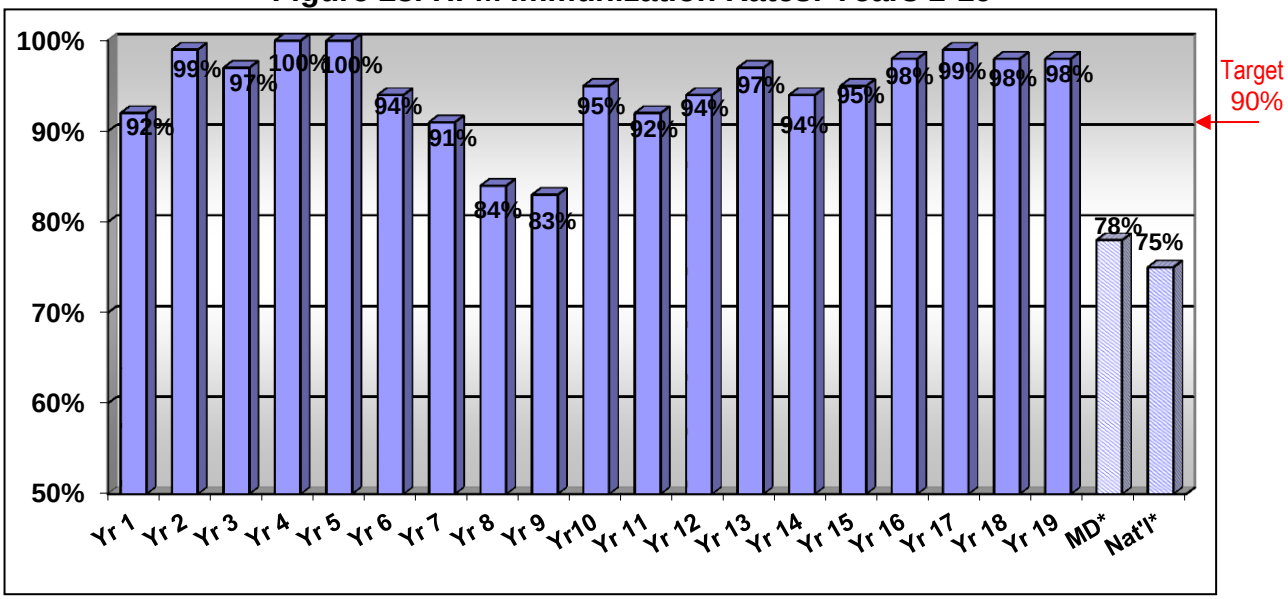
[3] *Center for Disease Control and Prevention: National Center for Health Statistics (2015). Percentage children under 18 years. Available at http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201508.pdf

** Henry J. Kaiser Family Foundation State Health Facts 2013. Health Insurance Coverage of Children (0-18 years)-States (2013). Obtained 10/5/2015 at http://kff.org/other/state-indicator/children-0-18/

healthcare providers, helping to set up appointments when needed, and giving reminders about appointments as necessary. As a result, HFM has achieved impressive success rates with target children receiving their immunizations on schedule. Families are more likely to follow up on immunizing their children if they have both health insurance and a medical provider. Consequently, this goal is closely linked to the previous goal of assisting families in securing medical homes. When examining children who were active during Year 19 and were greater than 4 months of age (n=112), HFM exceeded their goal by having *98% (n=110/112) of all target children current on their immunizations* as recommended by their medical provider.

As seen in
Figure 23. HFM Immunization Rates: Years 1-19, this is especially impressive when compared to the Centers for Disease Control and Prevention (CDC-P) 2014 findings on immunization rates for the Nation (78%). HFM also exceeded the State of Maryland immunization rate of 75%.

Figure 23. HFM Immunization Rates: Years 1-19



**Centers for Disease Control and Prevention (CDC-P). National Immunization Survey: Child ages 19-35 months-National and State data; 2014 Table Data. Comparative percentages are based on the child receiving the 4:3:1:3:3:1 vaccination coverage. Data available at:*
http://www.cdc.gov/vaccines/imz-managers/coverage/nis/child/tables/14/tab03_antigen_state_2014.pdf

Additional Births

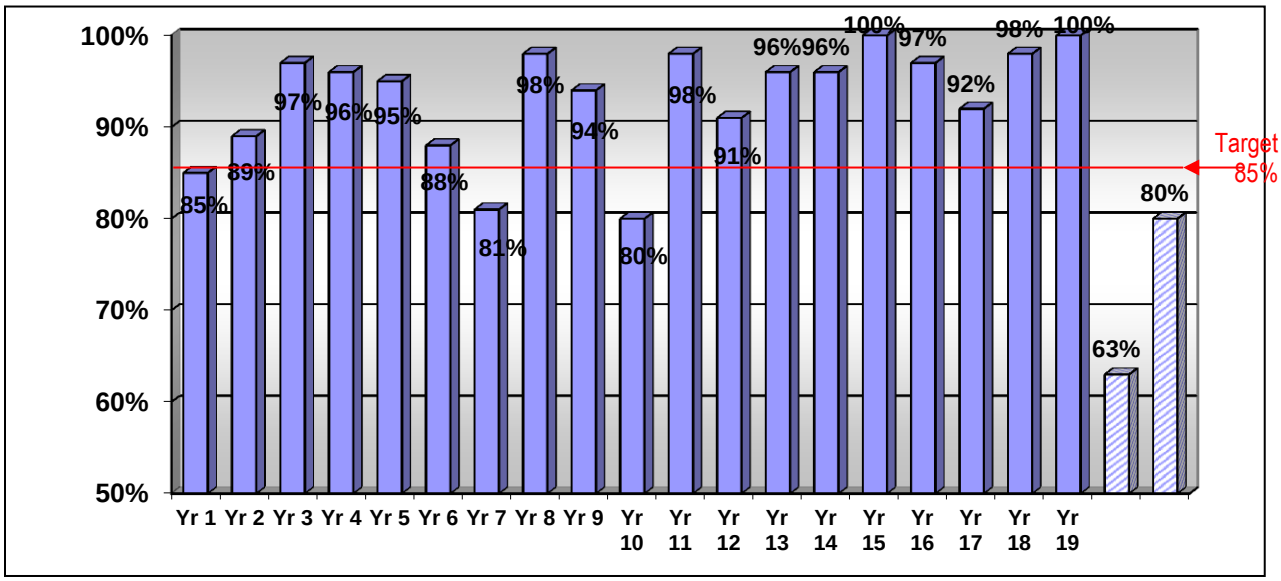
It is recommended that mothers, particularly teenage mothers, wait a period of at least 24 months between pregnancies. The HFM program provides information on family planning to participants immediately upon enrolling in the program. FSWs alert new parents to the fact that additional pregnancies can happen at any time, even when the mother is breastfeeding just after the birth of the baby. The necessity of using family planning methods to prevent unwanted pregnancies is stressed. Related to its success in linking mothers to a health care provider and to health insurance, the HFM program has also been successful in educating mothers about family planning with the goal of decreasing unwanted pregnancies.

In Year 19, 100% (n=122) of all mothers did not have a repeat birth within a 24-month period during their enrollment in the program. This includes twelve mothers who were teens when they enrolled (ages 16-19 years old). HFM's success rate in this area has consistently exceeded its target of 90% and both Maryland State (84%) and National statistics (82%) for teen repeat births.[4]

Post-Partum Care

Post-partum visits provide physicians with the opportunity to evaluate both the physical and emotional status of the mother postnatally and to discuss family planning options. Related to the low percentage of repeat births is the high rate of post-partum visits completed by program mothers. There were 36 mothers who gave birth to a target child during Year 19. Of these, 30 mothers were due for their post-partum visit by the end of June 2015. *All these mothers (100%; n=30/30) completed their post-partum care* (see **Figure 24. Percentage of Mothers Completing Post-Partum Care: Years 1-19.** below). Of the remaining six mothers of target children, four had births late in the fiscal year and were not yet due for their post-partum visit, while the remaining two mothers left the program before they were due for post-partum care. HFM's success on this outcome significantly exceeds the program target of 85% and the 2012 comparative national rate for similar population, 63% for those with Medicaid insurance. It is also important to note that HFM also exceeded the comparative national statistic for mothers with commercial insurance at 80% (NCQA 2013*).

Figure 24. Percentage of Mothers Completing Post-Partum Care: Years 1-19



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

Healthy Birthweight

The HFM program indicator for healthy birthweight targets mothers who enrolled in the first or second trimester. However, almost all HFM participants enroll in the third trimester or immediately after the birth of the baby. During Year 19, more than half of

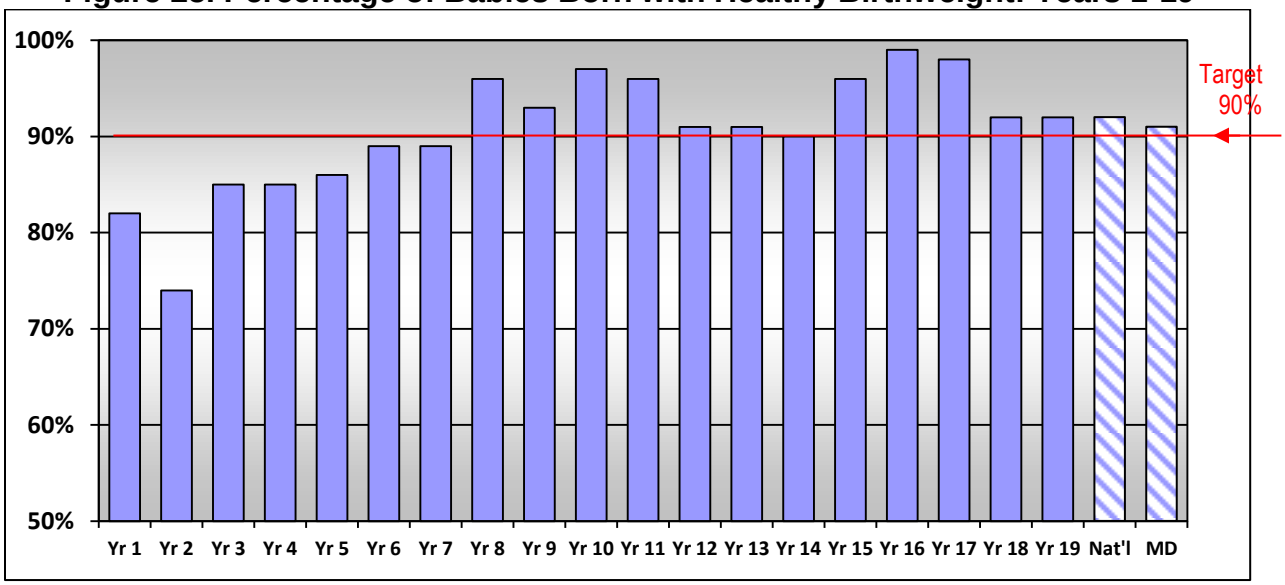
[4] Centers for Disease Control and Prevention: Morbidity and Mortality Weekly Report. Vital Signs: Repeat Births Among Teens – United States, 2007-2010 (April 5, 2013). Available at www.cdc.gov/mmwr/preview/mmwrhtml/mm6213a4.htm?s_cid=mm6213a4_w

mothers (52%; n=63) enrolled postnatally, while an additional 46% (n=56) enrolled in the third trimester. Only one mother enrolled in the first trimester of her pregnancy and the remaining two mothers enrolled in their second trimester. Despite this, the program strives to educate participants about how to ensure the most positive health outcomes for their babies by encouraging all prenatal enrollees to attend their scheduled prenatal care visits and by providing information on healthy eating and lifestyle habits during pregnancy.

Of the 120 target children active during Year 19, birthweight data was available for 118 babies. Of these, *92% (n=109/118) were born at a healthy birthweight (>2500 grams or 5.5 lbs).* It should be noted that the number of target children includes two sets of twins. As seen in **Figure 25. Percentage of Babies Born with Healthy Birthweight: Years 1-19**, this exceeds the 2013 National rate of 92% and the Maryland rate of 91%. Eight babies (7%) were born at low birthweight (<5.5lbs or 2500 grams) and one (1%) was born at very low birthweight (<3.3lbs or 1500 grams). All of the LBW/VLBW babies were born before the mother enrolled in the HFM program. Most of the mothers of LBW/VLBW babies had prenatal care in the first trimester (n=3) or second trimester (n=3). One mother of a LBW baby had no prenatal care, while another began prenatal care in the third trimester.

When birthweight is examined for only those babies who were born during Year 19, the percentage changes to *95% (n=35/37) of babies were born at a healthy birthweight and 5% (n=2) were born at LBW.*

Figure 25. Percentage of Babies Born with Healthy Birthweight: Years 1-19



** National-Centers for Disease Control and Prevention, National Vital Statistics Report-Births: Final Data for 2013. National data (January 15, 2015). Available at*
http://www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_01_tables.pdf#i09

Goal II.

Reduce Incidence of Child Maltreatment

Families will have no indicated reports while enrolled

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

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

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

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

Results for FY'15 indicate that as of June 2015 all HFM Year 19 active families (*100%; n=105/105) of families had no indicated Child Welfare Services (CWS) report.* This finding exceeds the HFM target of 95% and provides solid evidence of the positive impact that prevention can have on reducing the incidence of child maltreatment with high-risk families.

Goal III. Optimize Child Development

Child Trends reported that nationally in 2011/12, only 29% of children nationally were screened for developmental delay. Additionally, results of screening found 11 percent of children ages four months to five years to be at high risk for developmental delays; 15 percent had moderate risk, and 14 percent had low risk for delays. When examined nationally by race/ethnicity, Hispanic children were the most likely to be at high risk for developmental delays, followed by black children, with white children the least likely to have a high risk. In 2011/12, Hispanic and black children were more than twice as likely as white children to have a high risk for delays (17 and 13 percent, respectively, compared with seven percent of white children). [5] These compelling statistics clearly indicate the importance of early screening and referral for developmental delay.

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

Developmental Delay

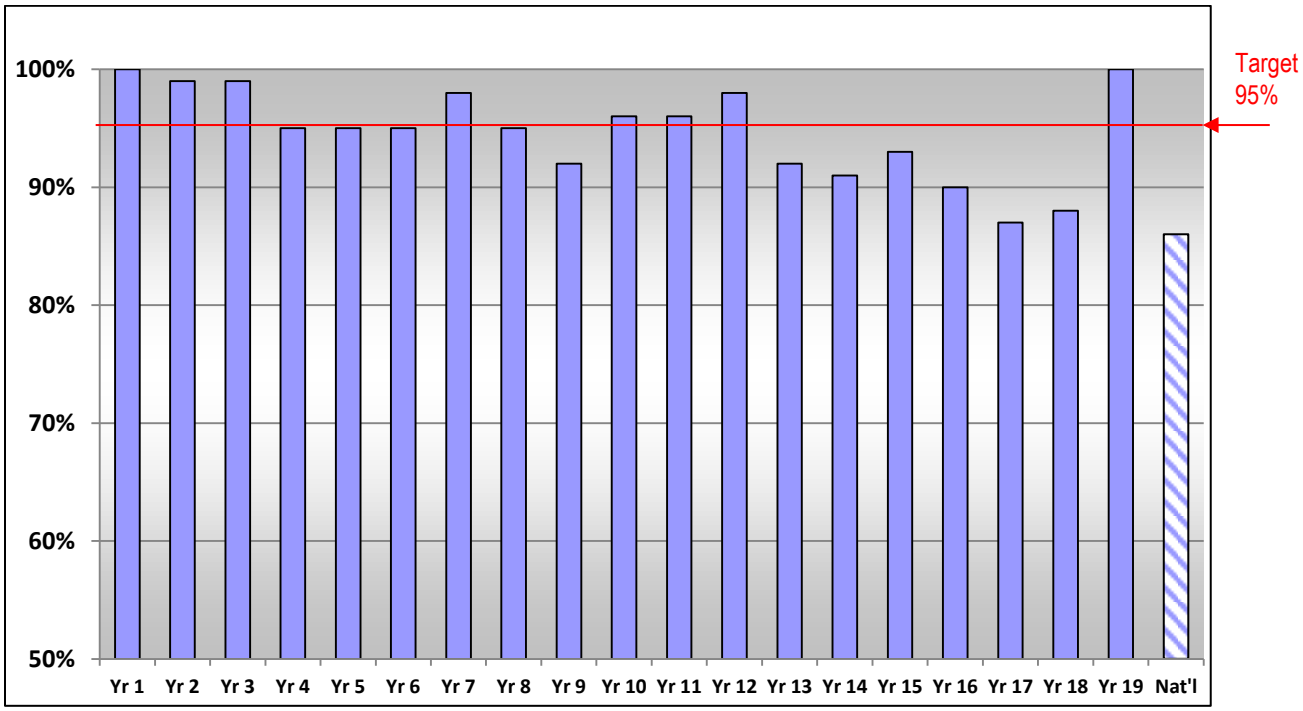
Healthy Families Montgomery uses the Ages and Stages Questionnaire throughout a child's participation in the program to monitor social, emotional, cognitive, language and motor development. Administered at regular four month intervals throughout the child's early years, the tool is designed to identify,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

Of the 120 target children who were in the program in Year 19, 97 were due for an ASQ screening. Of these, ***100% (n=97/97) received a timely ASQ.*** Of the remaining children, nine were not due for a screening during the fiscal year and 14 terminated before the screening was due. The HFM rate for developmental screening of participating children far exceeds the comparable national rate of 29%.

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

At the start of Year 19, HFM redefined its primary goal for child development. The current goal reflects children who are meeting developmental milestones and children who are receiving appropriate services. In total, 17 children were followed by the HFM Early Intervention Consultant (EIC) over the past fiscal year. As seen in **Figure 26. Children Meeting Developmental Milestones or Appropriate Services: Years 1-19**, ***100% (n=120/120) of children demonstrated normal child functioning and were meeting developmental milestones or were receiving appropriate services***. At the end of the fiscal year, 7 children were receiving services: 3 with Child Find, 3 with MCITP, and 1 with the PEP. An additional child ended services due to improved development in speech, and 5 children continued to be monitored by the Early Intervention Consultant. The prevalence of developmental delay for the general population is 13.87%[6]. The HFM results for this objective indicate the positive impact of the program's developmental activities on mitigating the role of environmental factors in developmental delay within a high-risk population.

Figure 26. Children Meeting Developmental Milestones or Appropriate Services: Years 1-19



[6] CDC. 2015. Key Findings: Trends in the Prevalence of Developmental Disabilities in U.S. Children, 1997-2008. Available at http://www.cdc.gov/ncbddd/developmentaldisabilities/features/birthdefects-dd-keyfindings.html

Goal IV. Promote Positive Parenting and Parent-Child Interaction

1. Parents will have adequate knowledge of child development

The Healthy Families Parenting Inventory (HFPI) focuses on behavior, attitudes and perceptions related to parenting within nine domains: Social Support, Problem Solving, Depression, Personal Care, Mobilizing Resources, Role Satisfaction, Parent-Child Interaction, Home Environment, and Parenting Efficacy. **Table 13. HFPI Subscales-Percentage Mothers Score At-Risk** shows the percentages of mothers who scored at-risk for each subscale at three timepoints. It should be noted that the group of mothers at each timepoint is not the same. The number of mothers at each timepoint may be lower for some subscales due to attrition or because if any question within a subscale was not asked/answered, and therefore the subscale score cannot be calculated. There was a decrease in risk percentages for seven of the nine subscales from baseline to 24 months. Two subscales had an increased percentage of mothers at risk, Personal Care and Role Satisfaction, however, these results must be interpreted with caution as the groups of mothers are not the same. A more accurate measure is accomplished with GLM Repeated Measures Analysis below.

Table 13. HFPI Subscales-Percentage Mothers Score At-Risk

Subscale	Baseline (n=90)	12- Months (n=57)	24- Months (n=42)
Social Support	24%	19%	17%
Problem Solving	13%	7%	10%
Depression	20%	21%	19%
Personal Care	14%	9%	19%
Mobilizing Resources	19%	2%	0%
Role Satisfaction	13%	14%	21%
Parent-Child Interaction	17%	5%	5%
Home Environment	19%	5%	2%
Parenting Efficacy	14%	12%	7%

**Results based on all HFPIs administered to active Year 19 participants*

The Home Environment subscale was used to assess participants' knowledge of child development. At baseline, 81% of parents demonstrated adequate knowledge of child development. ***After 12 months of participation this percentage increased to 95% of parents demonstrated adequate knowledge of child development, significantly exceeding the HFM target of 85%.***

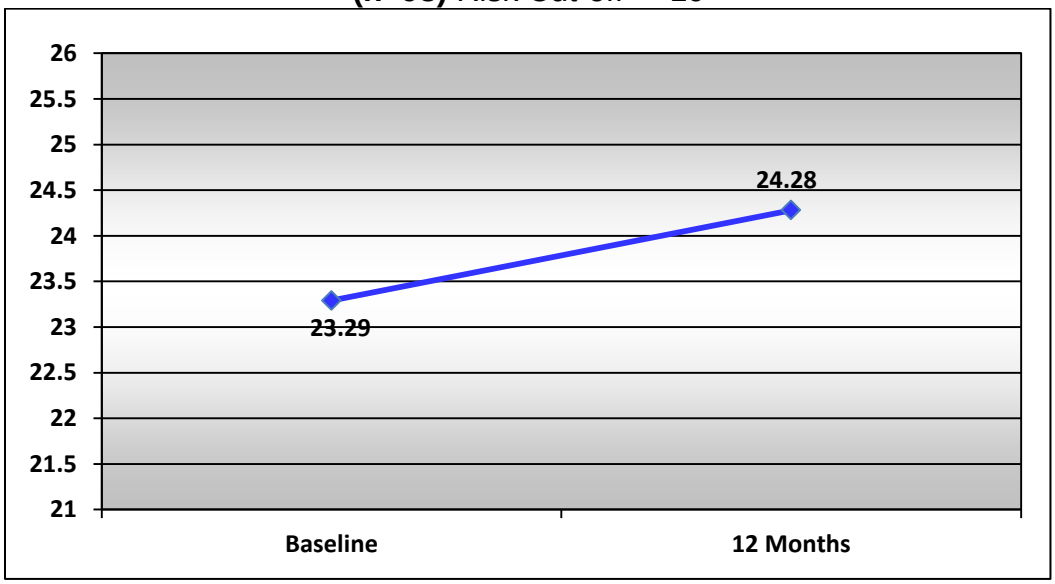
GLM Repeated Measures Analysis was used to compare mean scores of mothers on each subscale at baseline to 12-months follow-up. Using this method, the same group of mothers are compared across timepoints. As a more rigorous measure of change in parenting skills, GLM analysis found a statistically significant improvement in the first year of program participation in six subscales: *Problem Solving, Personal Care, Mobilizing Resources, Parent-Child Interaction, Home Environment,* and *Parenting Efficacy* **(**See **Table 13. HFPI Subscales-Percentage Mothers Score At-Risk**).

Table 13. HFPI Subscale Mean Scores (n=98)

HFPI Subscale	Baseline $\bar{x}$	12-Month $\bar{x}$	Significance
Social Support	19.74	20.55	n.s.
Problem Solving	23.29	24.28	p=.04
Depression	36.81	36.60	n.s.
Personal Care	19.74	20.64	p=.009
Mobilizing Resources	22.29	25.24	p=.000
Role Satisfaction	24.95	24.00	n.s.
Parent-Child Behavior	43.66	45.53	p=.019
Home Environment	38.13	43.52	p=.000
Parenting Efficacy	25.73	27.05	p=.007

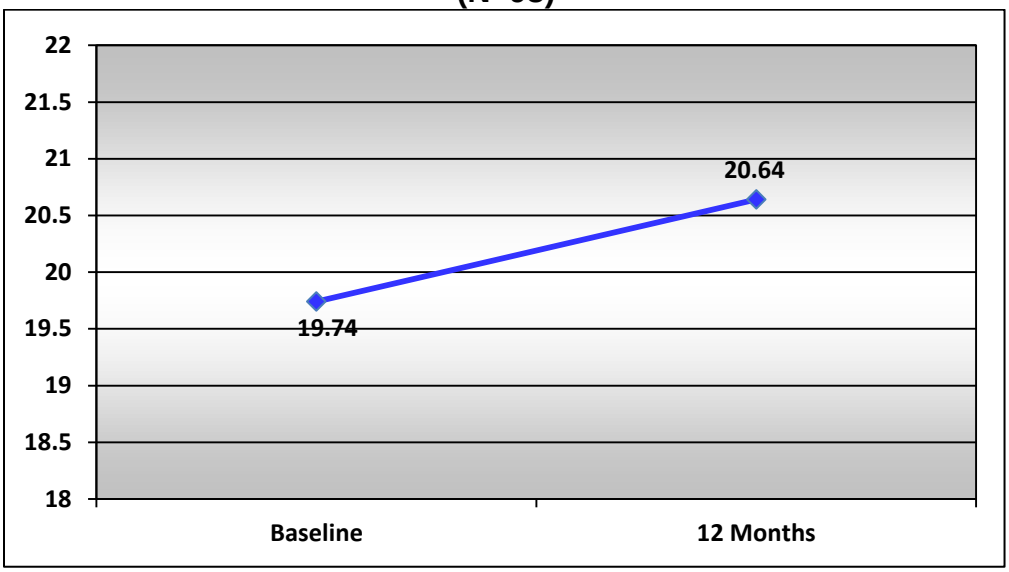
The *Problem Solving* subscale measures the parent's ability to cope with unexpected situations, deal with setbacks, and find solutions when faced with problems. Although the mean score at baseline was already above the risk cutoff, there was significant improvement in the group's score (F=4.314, df (1,97), p=.040) from baseline (x=23.29 to the 12-month follow-up (x=24.28), see **Figure 27. Mothers' Mean Score Improvement: Problem Solving.** Using partial eta squared, an effect size of .043 was calculated and indicated that 4% of the variance in *Problem Solving* mean scores can be accounted for by time in the program.

Figure 27. Mothers' Mean Score Improvement: Problem Solving (n=98) Risk Cut-off =<19



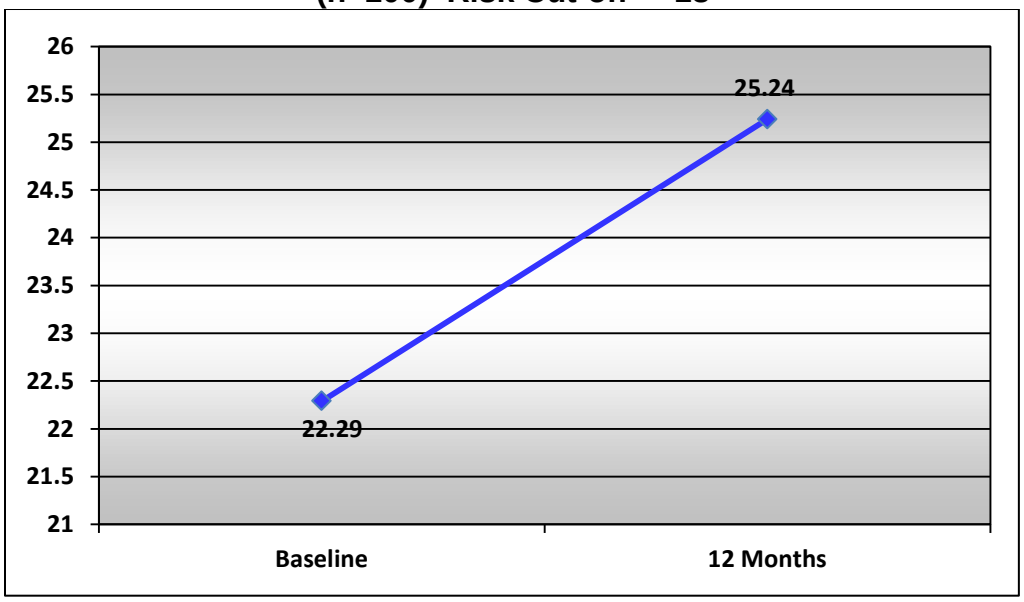
The *Personal Care* Subscale targets the individual parent level regarding whether they are taking care of themselves and, therefore, are well enough to take care of their baby. GLM Repeated Measures results indicate that a significant increase in mean scores was attained after 12 months of program participation, thus significantly reducing risk (F=39.510, df (1,97), p=.009). As seen in **Figure 28. Mothers' Mean Score Improvement-Personal Care**, mean scores increased from baseline (x=19.74) to the 12-month follow-up (x=20.64). Using partial eta squared, an effect size of .067 was calculated and indicated that 7% of the variance in *Personal Care* mean scores can be accounted for by time in the program.

Figure 28. Mothers' Mean Score Improvement-Personal Care (N=98)



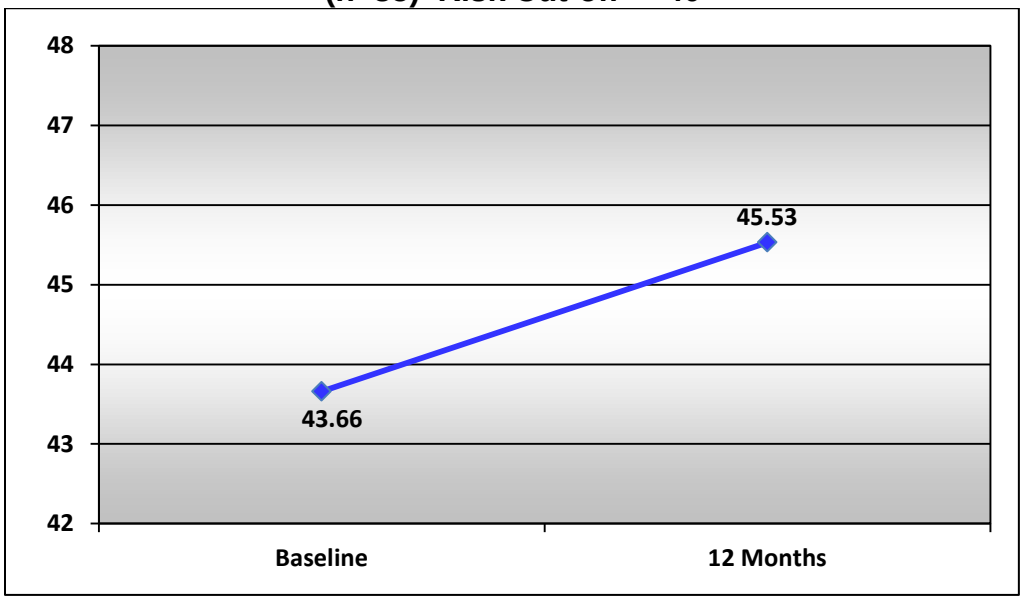
The *Mobilizing Resources* Subscale measures participants' knowledge of available resources in the community, as well as their comfort level in seeking help if needed. GLM Repeated Measures results indicate that a significant increase in mean scores was attained after 12 months of program participation, thus significantly reducing risk (F=28.904,df(1,99),p=.000). As seen in **Figure 29. Mothers' Mean Score Improvement-Mobilizing Resources**, mean scores increased from baseline (x=22.29) to the 12-month follow-up (x=25.24). Using partial eta squared, an effect size of .226 was calculated and indicated that 23% of the variance in *Mobilizing Resources* mean scores can be accounted for by time in the program.

Figure 29. Mothers' Mean Score Improvement-Mobilizing Resources (n=100) Risk Cut-off =<18



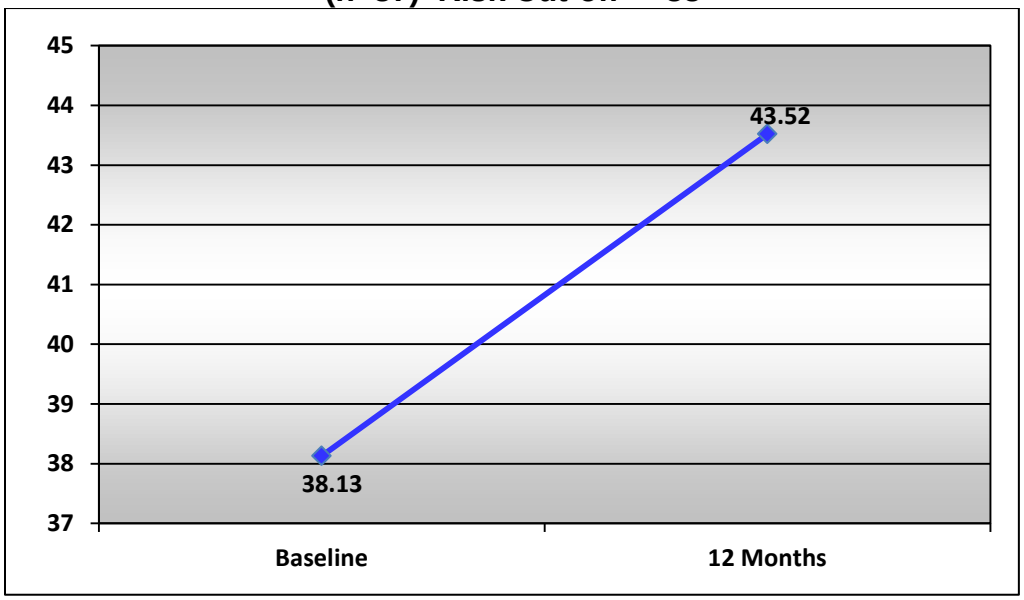
The *Parent-Child Interaction* subscale measures the quality of the parent-child relationship in the context of parental engagement, responsiveness to the child's needs, and the ability to provide positive reinforcement appropriately. Significant improvement was found in the mothers' mean scores (F=5.739, df (1,84), p=.019) from baseline (x=43.66) to the 12-month follow-up (x=45.53), see **Figure 30. Mothers' Mean Score Improvement-Parent-Child Interaction.** Using partial eta squared, an effect size of .064 was calculated and indicated that 6% of the variance in *Parent-Child Interaction* mean scores can be accounted for by time in the program.

Figure 30. Mothers' Mean Score Improvement-Parent-Child Interaction (n=85) Risk Cut-off =<40



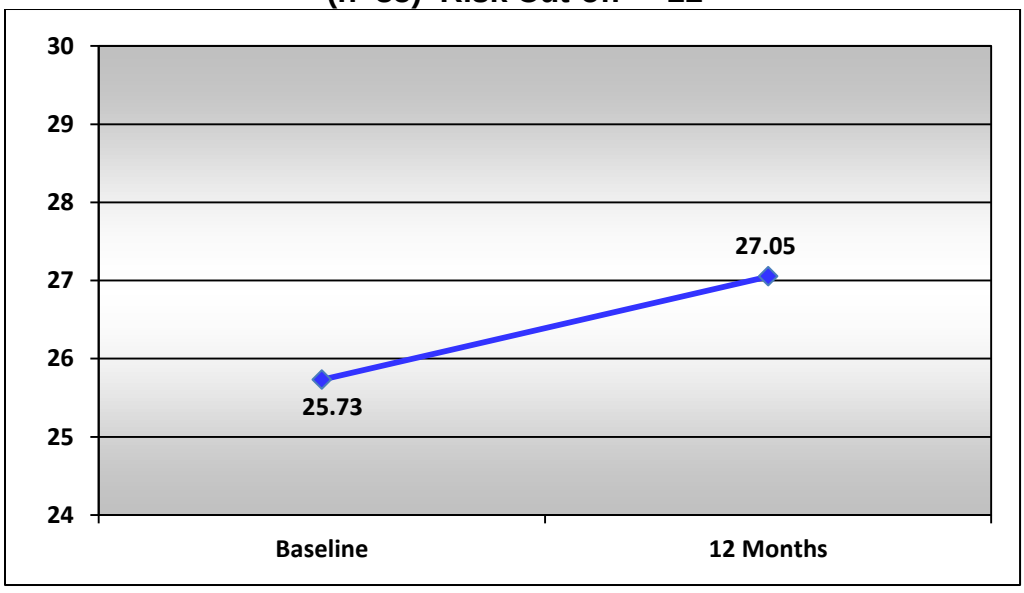
The *Home Environment* subscale measures the safety, organization, availability and quality of stimulating materials and activities in the home. While the mean score at baseline was also above the risk cutoff, there was significant improvement in the group's score) (F=40.712, df (1,86), p=.000) from baseline (x=38.13) to the 12-month follow-up (x=43.52), see **Figure 31. Mothers' Mean Score Improvement-Home Environment.** Using partial eta squared, an effect size of .321 was calculated and indicated that 30% of the variance in *Home Environment* mean scores can be accounted for by time in the program. This is a particularly important finding as the HFM program places emphasis on teaching parents child development activities through the use of ASQ and the Growing Great Kids (GGK) curriculum.

Figure 31. Mothers' Mean Score Improvement-Home Environment (n=87) Risk Cut-off =<33



The *Parenting Efficacy* subscale measures self-image in the parenting role, including their sense of pride and effectiveness, whether they set goals for raising their child, and want to learn new parenting skills. It also measures how parents view themselves as compared to other parents. GLM Repeated Measures results indicate that a significant increase in mean scores was attained after 12 months of program participation, thus significantly reducing risk (F=7.669, df (1,84), p=.007). As seen in **Figure 32. Mothers' Mean Score Improvement-Parenting Efficacy,** mean scores increased from baseline (x=25.73) to the 12-month follow-up (x=27.05). Using partial eta squared, an effect size of .084 was calculated and indicated that 8% of the variance in *Parenting Efficacy* mean scores can be accounted for by time in the program.

Figure 32. Mothers' Mean Score Improvement-Parenting Efficacy (n=85) Risk Cut-off =<22

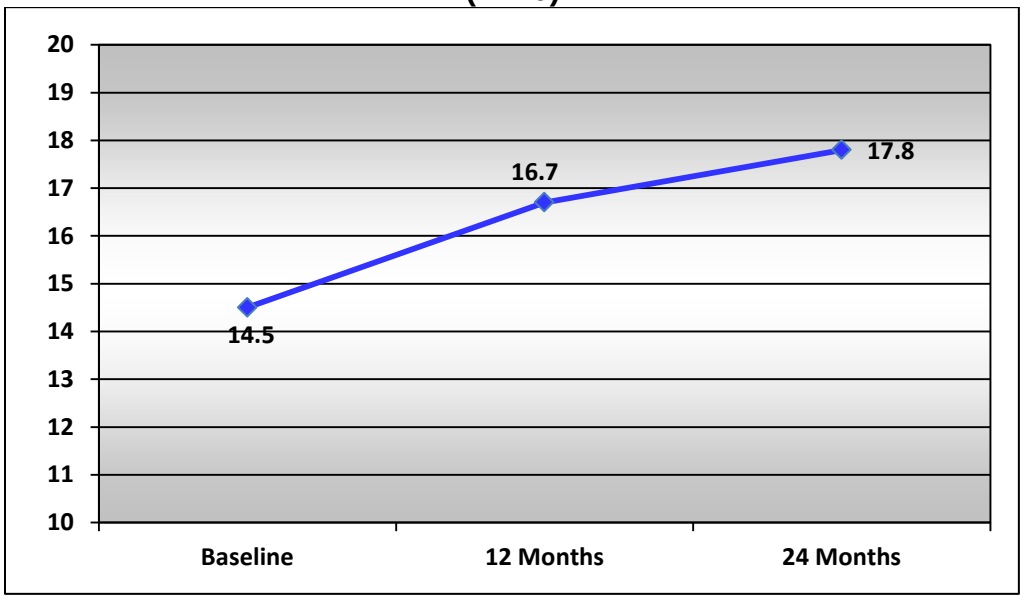


2. Parents have adequate knowledge of child safety

Parents' knowledge of safety in the home is measured through the use of the Safety Checklist. Through interview and observation, the FSW assesses a variety of safety factors, such as knowledge of emergency phone numbers, installation of safety devices, use of automobile safety restraints, monitoring of lead, radon, and CO levels, and the presence of firearms in the home. Of the 122 participants in Year 19, 108 were administered a baseline safety measure. At baseline, 97% (n=105/108) earned scores in the high knowledge ranges. After one year of program participation, 66 parents were administered a follow-up safety measure. Of these, ***97% of parents (n=64/66) had achieved a passing score, demonstrating adequate knowledge of child safety. This percentage exceeds the HFM target of 95%.***

GLM repeated measures analyses were conducted on Safety Checklist scores from Baseline to 12-months and 24-months. There was a significant increase in mean safety scores from Baseline (x=14.92) to 12-months (x=16.82) for the n=61 participants for those participants who had measures at both timepoints (F=12.636; df(1,60); p=.001). Additionally, as seen in **Figure 33. Mothers' Mean Score Improvement-Parent Knowledge of Safety,** mean scores for those participants who had measures at all three time points (n=40) increased significantly from Baseline (x=14.50) to 12-Months (x=16.72) and continued to increase at 24-Months (x=17.80) (F=15.360; df(1,39); p=.000), indicating a significantly higher level of safety knowledge. Partial eta squared showed an effect size of .283, indicating that about 28% of the improvement in safety scores can be attributed to program effects.

Figure 33. Mothers' Mean Score Improvement-Parent Knowledge of Safety (n=40)



3. Psychosocial Factors

The birth of a child can be stressful in its new demands and responsibilities as well as due to hormonal changes and lack of sleep. Mild depressive symptoms include occasional sadness, crying, irritability, and trouble concentrating, are common and transient. However, depression occurs when these symptoms, including depressed

mood and loss of interest in activities, are severe and last for more than two weeks. Other symptoms can include changes in appetite, feelings of worthlessness or guilt, and suicidal thoughts. The US Department of Health and Human Services, Health Resources and Services Administration (HRSA) in their Women's Health USA 2012 report that in 2009, 11.9 percent of recent mothers in a 29-state area reported postpartum depressive symptoms since the birth of their child in the previous 2–9 months. Interestingly, these postpartum depressive symptoms varied significantly by education level. Mothers with higher levels of education (16+ years) had a lower percentage of postpartum depressive symptoms (6.9%) than mothers with less than 12 years of education, 22.2% of whom had depressive symptoms.[7]

Center for Epidemiological Studies – Depression (CES-D)

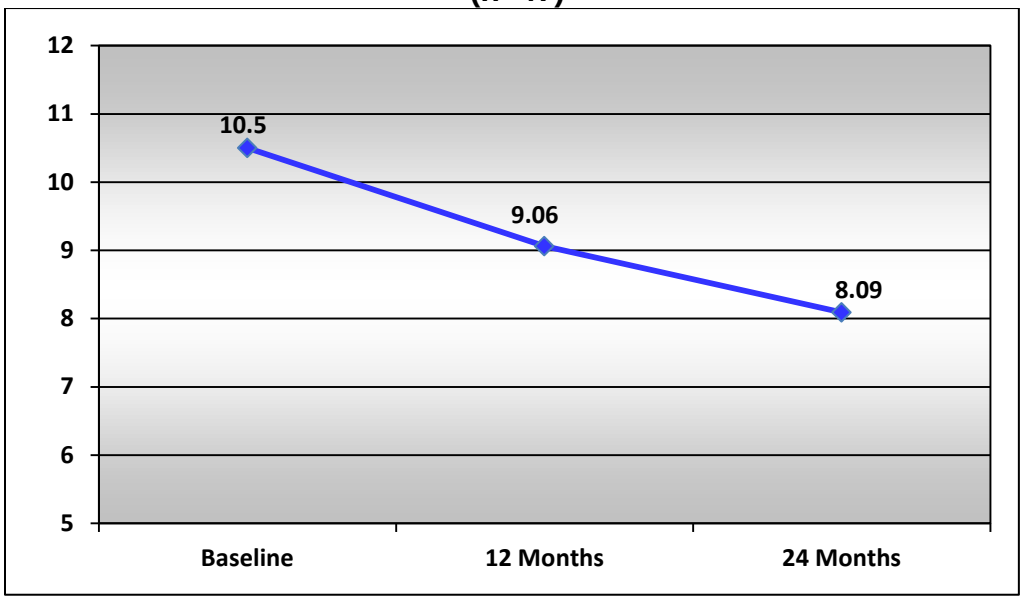
The CES-D measures depressive symptomology in mothers using somatic and psychological symptoms, such as changes in appetite or sleep habits, feelings of sadness, and lack of motivation. At baseline, 17% (n=19/115) of mothers scored at risk for depression. After 12-months of participation in HFM, this percentage decreased to 13% (n=9/72). CES-D results suggest higher prevalence rates of depressive symptomology for HFM mothers than those reported by the CDC (2012) for post-partum women (8% to 19%) non-pregnant women (11%)[8]. As a result of the HFM screening and assessment process, which includes depression as a risk indicator, this is not unexpected.

GLM repeated measures analyses were conducted on CES-D scores from baseline to 12 months. Of the 122 mothers active in Year 19, 72 had CES-D scores for both time points. These mothers entered the program around the time of the birth of their baby and stayed in the program for at least one year. This group's mean baseline score (x=10.54) was already below the cutoff. After 12 months of program participation, this group's mean dropped to x=8.69, however this was not a significant decrease (F=2.434; df(1,71); p=.123). CES-D mean scores were also examined at three timepoints, Baseline, 12-months, and 24-months. There were 47 mothers that had measures at all three timepoints. As illustrated by **Figure 34. Mothers' Mean Scores Decrease-Maternal Risk for Depression,** mean scores continued to decrease up to 24-months after enrollment. Although a non-significant decrease (F=1.436; df(1,46); p=166), scores demonstrate a trend for decrease from baseline to 12-months and 24-months. Results highlight the importance of the HFM program in ongoing screening for depression and linking participants to appropriate mental health professionals.

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

8 CDC: Depression Among Women of Reproductive Age. 2012 Available at http://www.cdc.gov/reproductivehealth/depression/

Figure 34. Mothers' Mean Scores Decrease-Maternal Risk for Depression (n=47)



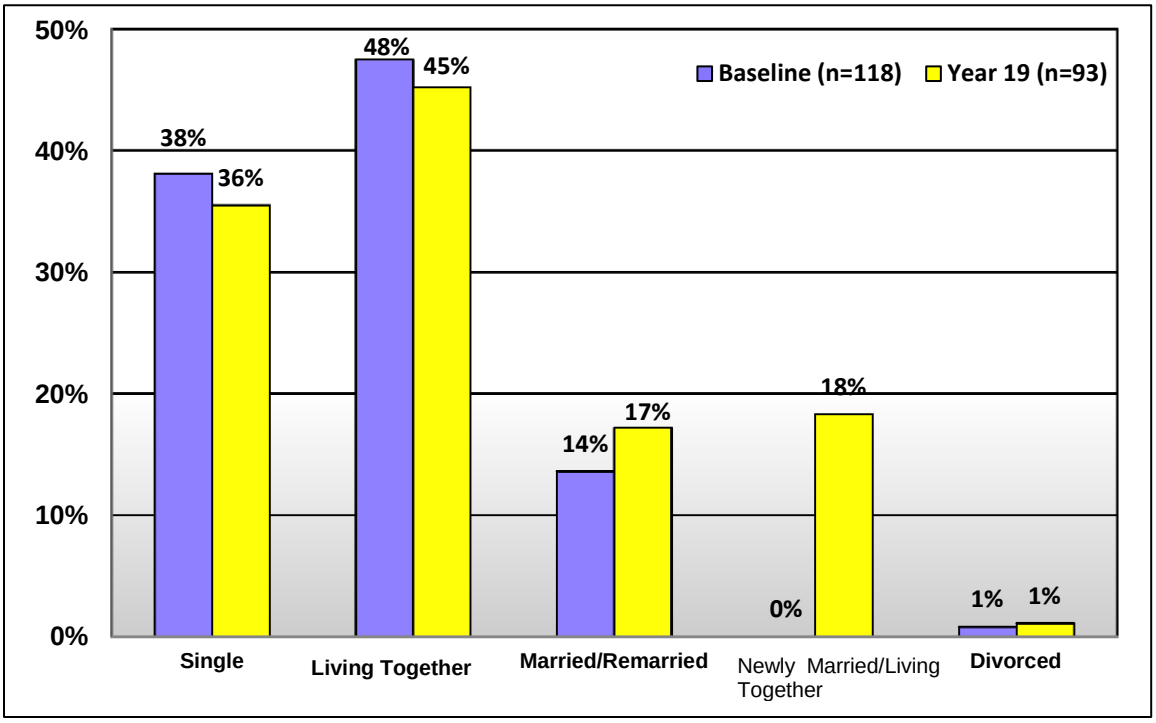
Goal V. Promote Family Self-Sufficiency

Family self-sufficiency is a "composite variable" encompassing factors such as employment, education and housing status that serve as indicators of a participant's autonomy and ability to live without outside aid or support. These factors were examined at entry and again at the close of Program Year 19. Participants who worked either full or part-time or who were enrolled in school are viewed as demonstrating positive self-sufficiency. In addition, participants who had improved or stable housing are also viewed as demonstrating positive self-sufficiency. Conversely, participants who are neither working nor enrolled in school are viewed as having decreased or negative self-sufficiency. Participants who did not have improved or stable housing are also viewed as having decreased or negative self-sufficiency.

Marital Status

Marital status was compared at enrollment and at the end of Year 19 for all active participants. As seen in **Figure 35. Marital Status Follow-up**, at baseline, 61% (n=72/118) were either married or living together with their partner. At the end of Year 19, this percentage increased slightly to 63% (n=59/93) of participants who were either married or living together with their partner. Of those who entered Year 19 living with their partner but never married, 11% (n=5/44) married for the first time by the end of the reporting period. Of those who were single at baseline (n=45), follow-up data was available for n=35 mothers. Of these, one re-married, and eight began living with their partner by the end of Year 19.

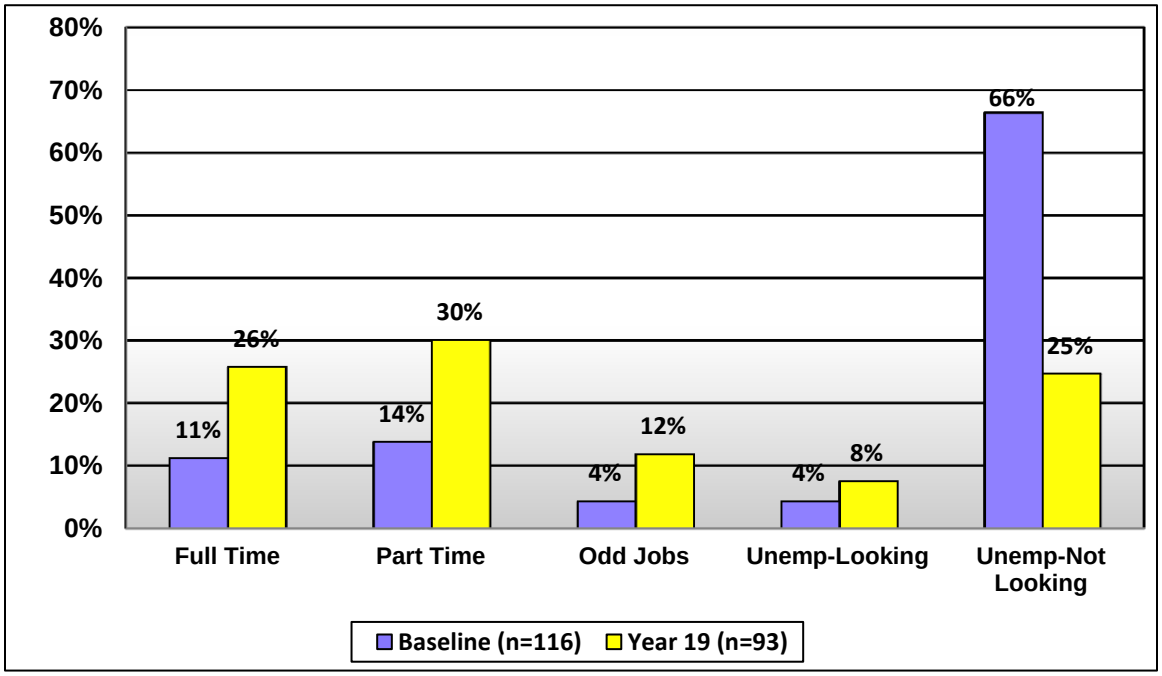
Figure 35. Marital Status Follow-up



Employment and Education

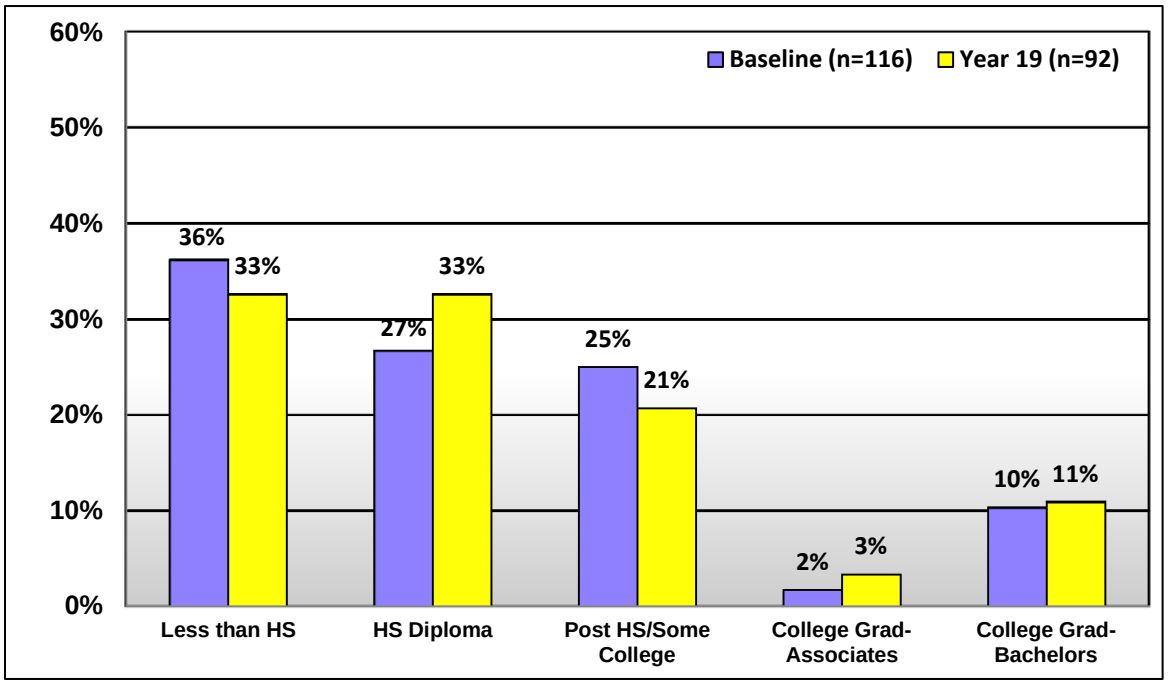
Year 19 baseline and follow-up data was compared for mother's employment status and educational level. These analyses excluded participants who were attending school. As shown in **Figure 36. Employment Status Follow-up**, 29% (n=34/117) were employed full or part-time at baseline. ***At the conclusion of Year 19, this percentage more than doubled to 68% (n=63/93) of mothers employed full or part-time (including those who were self-employed or had odd jobs).***

Figure 36. Employment Status Follow-up



At enrollment, 64% (n=74/116) of Year 19 mothers over the age of 18 years had a high school degree or higher (see **Figure 37. Education Status Follow-up**). At the end of Year 19, the percentage increased to 67% (n=62/92) of participants who had a HS degree or higher.

Figure 37. Education Status Follow-up



When both employment and education factors are considered together and assessed for either remaining positive or improving, ***89% of mothers (n=82/92) had improved or maintained positive educational or employment status.*** This percentage exceeds the HFM target of 65%.

- Positive or improved educational *and* employment status n=49
- Positive or improved educational status only n=17
- Positive or improved employment status only n=16

Housing

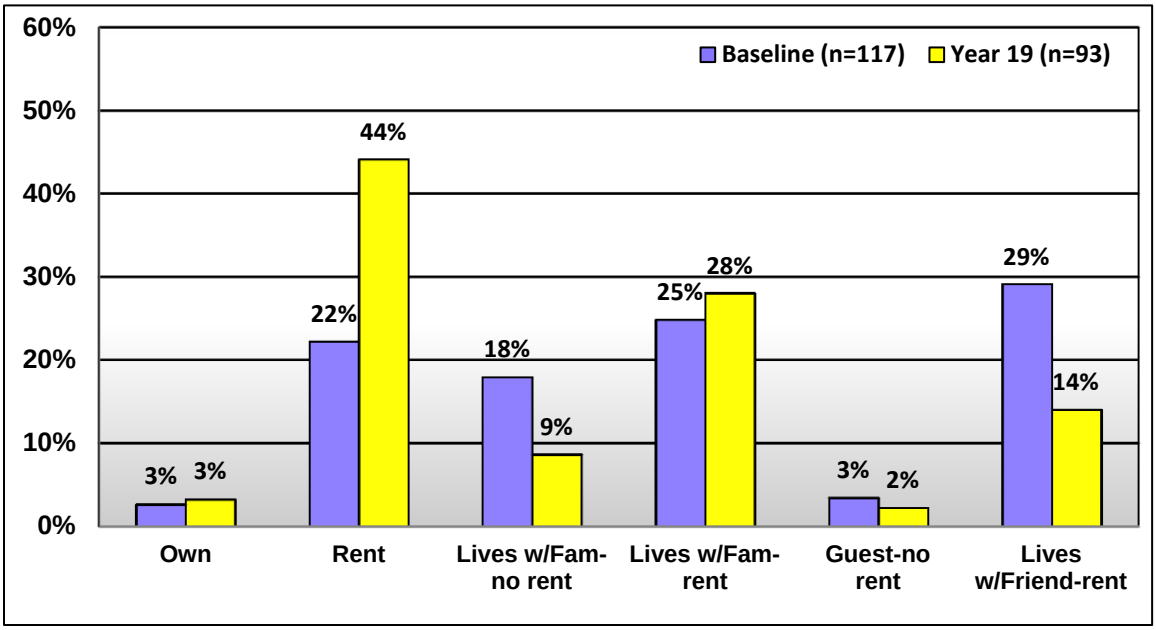
Housing instability is defined as including persons who are literally homeless (i.e., living on streets; shelter), imminently losing their housing (i.e., eviction; hospital discharge), or unstably housed and at-risk of losing housing (i.e., temporary housing; guest in other's home).[9] As shown in **Figure 38. Housing Status Follow-up**, at enrollment, 97% (n=113/117) of participants had stable housing. Four mothers were living as a guest in another's home and did not have stable housing. The majority of participants were renting (76%, n=89/117). Of that group, most live with friends (29%; n=34), or family (25%; n=29) and pay rent, while an additional 22% (n=26) were renting a house,

[9] See http://www.hudhre.info/documents/HomelessDefinition_RecordkeepingRequirementsandCriteria.pdf for

apartment or trailer. A small percentage of participants (18%; n=21) live with family and pay no rent, while 3% (n=3) reported owning their own home.

Follow-up data on housing status was available for 93 participants. ***At the end of Year 19, 97% (n=90/93) either maintained stable housing or improved their housing status.*** Eighteen participants who had been living with friends or family and paying rent at enrollment were renting their own house, apartment, or trailer by the end of Year 19. Four participants who had been living with family and not paying rent, started renting their own apartment, house or trailer during Year 19, while another four remained living with their family, but started to pay rent. One participant, who had unstable housing at enrollment, was renting a house or apartment by the end of the fiscal year. Year 19 results exceed the HFM target of 95% of families will have stable housing.

Figure 38. Housing Status Follow-up



Overall, the current outcomes confirm the HFM program's ability to sustain its successes through its nineteenth year of operation as well. These outcomes are summarized below across all program years and compared with local, state and national comparative statistics where possible (see **Table 14. Summary of Goals, Objectives and Program Outcomes** and **Table 15. Summary of Goals, Objectives, Program Outcomes and Comparative Statistics** on the following pages).

Table 14. Summary of Goals, Objectives and Program Outcomes

Healthy Families Montgomery Years 1-19

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

Notes for Table 14. Summary of Goals, Objectives and Program Outcomes:
[1]Each year that the percentage is less than 100%, the percentage represents one case of founded neglect for that year. [2]This goal was changed in Year 5 to include only mothers enrolled in 1st or 2nd trimester. However, beginning in Year 12, most mothers enrolled in the 3rd trimester or postnatally, so percentages reflect 1st & 2nd trimester of prenatal care. *HFM changes to long version of KIDI ** HFM changes to parenting measure- HFPI ***Re-normed HFPI. Percentage reflects Home Environment subscale.
[3]This goal was changed in Year 19 to reflect children meeting developmental milestones and children who are receiving appropriate services.

Table 15. Summary of Goals, Objectives, Program Outcomes and Comparative Statistics
Healthy Families Montgomery: Year 19

Goals and Objectives	HFM TARGET	HFM Year 19	Montgomery County	State of Maryland	National
Goal I: Promote Preventive Health Care Children will have a health care provider	95%	100%	96.5% [4]	94% [3]	95% [2]
Eligible families will be enrolled in MA	95%	100%	77% [7]	91% [2]	88% [2]
Children immunized on schedule*	90%	98%	98% [3]	78% [5]	75%[5]
Mothers will not have an additional birth within two years of the target child's birth. (Teens <20 Yrs)	90%	100%	Teens-86% [11]	Teens 84% [6]	Teens-82% [6]
Babies Born with Healthy Birthweight	90%	93%	92.5% [10]	91% [8]	92% [8]
Mothers will complete post-partum care.	85%	100%	-	-	63% Medicaid 80% Private Ins [12]
Goal II: Reduce Incidence of Child Maltreatment Enrolled families will not have substantiated CWS reports	95%	100%	Rate of 4.8 per thousand [5]	Rate of 9.2 per thousand [1]	Rate of 9.1 per thousand [1]
Goal III: Optimize Child Development Children will demonstrate normal child functioning or receiving appropriate services	95%	100%	-	88% [13]	88% [13]

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

Data Sources:

Child Maltreatment-

[1] US Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2014). *Child Maltreatment 2013*. Available http://www.acf.hhs.gov/sites/default/files/cb/cm2013.pdf

[5] Montgomery County Department of Health and Human Services. SHIP Biennial Report 2012-2014. http://hsia.dhmh.maryland.gov/Documents/Biennial%20SHIP%20Progress%20Report%202012-2014.pdf

Health Care Provider-

[2] Center for Disease Control and Prevention: National Center for Health Statistics (2015). Percentage children under 18 years. Available at http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201508.pdf

Percent eligible children enrolled in Medicaid/CHIP: Maryland (2013). Available at http://www.insurekidsnow.gov/professionals/reports/index.html

[3] Henry J. Kaiser Family Foundation State Health Facts 2013. Health Insurance Coverage of Children (0-18 years)-States (2013). Obtained 10/5/2015 at http://kff.org/other/state-indicator/children-0-18/

[4] Maryland State Health Improvement Process (SHIP)-Montgomery County. Healthy Montgomery 2012. Rates are for individuals under 18 years of age. Obtained 10/5/15 at *http://www.healthymontgomery.org/modules.php?op=modload&name=NS-Indicator&file=indicator&iid=8268047*

[7] Montgomery County, MD: CountyStat-Performance Measurement and Management 2014. Available at https://reports.data.montgomerycountymd.gov/countystat/objective/communities

Immunizations-

[5] Centers for Disease Control and Prevention (CDC-P). National Immunization Survey: Children ages 19-35 months-State data; 2014 Table Data. Comparative percentages are based on the child receiving the *4:3:1:3:3:1 vaccination coverage. Data a*vailable at:
http://www.cdc.gov/vaccines/imz-managers/coverage/nis/child/tables/14/tab03_antigen_state_2014.pdf

[3] Maryland State Health Improvement Process (SHIP)-Montgomery County. Healthy Montgomery 2012. *http://www.healthymontgomery.org/modules.php?op=modload&name=NS-Indicator&file=indicator&iid=8268047*
Immunization rate is for children entering school not 19-36 months.

Repeat Births-

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

Healthy Birthweight

[8] * National-Centers for Disease Control and Prevention, National Vital Statistics Report-Births: Final Data for 2013. National data (January 15, 2015). Available at *http://www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_01_tables.pdf#i09*

[10] Maryland Department of Health and Mental Health. Maryland Vital Statistics Report 2014 Preliminary *http://dhmh.maryland.gov/vsa/Documents/prelim14.pdf* and updated at Healthy Montgomery Core Measures 2014. Available at http://www.healthymontgomery.org/index.php?module=Trackers&func=display&tid=1006

[11] Maryland Department of Health and Mental Health. Maryland Vital Statistics Report 2013. Annual Report *http://dhmh.maryland.gov/vsa/AnalyticsReports/Montgomery.pdf*

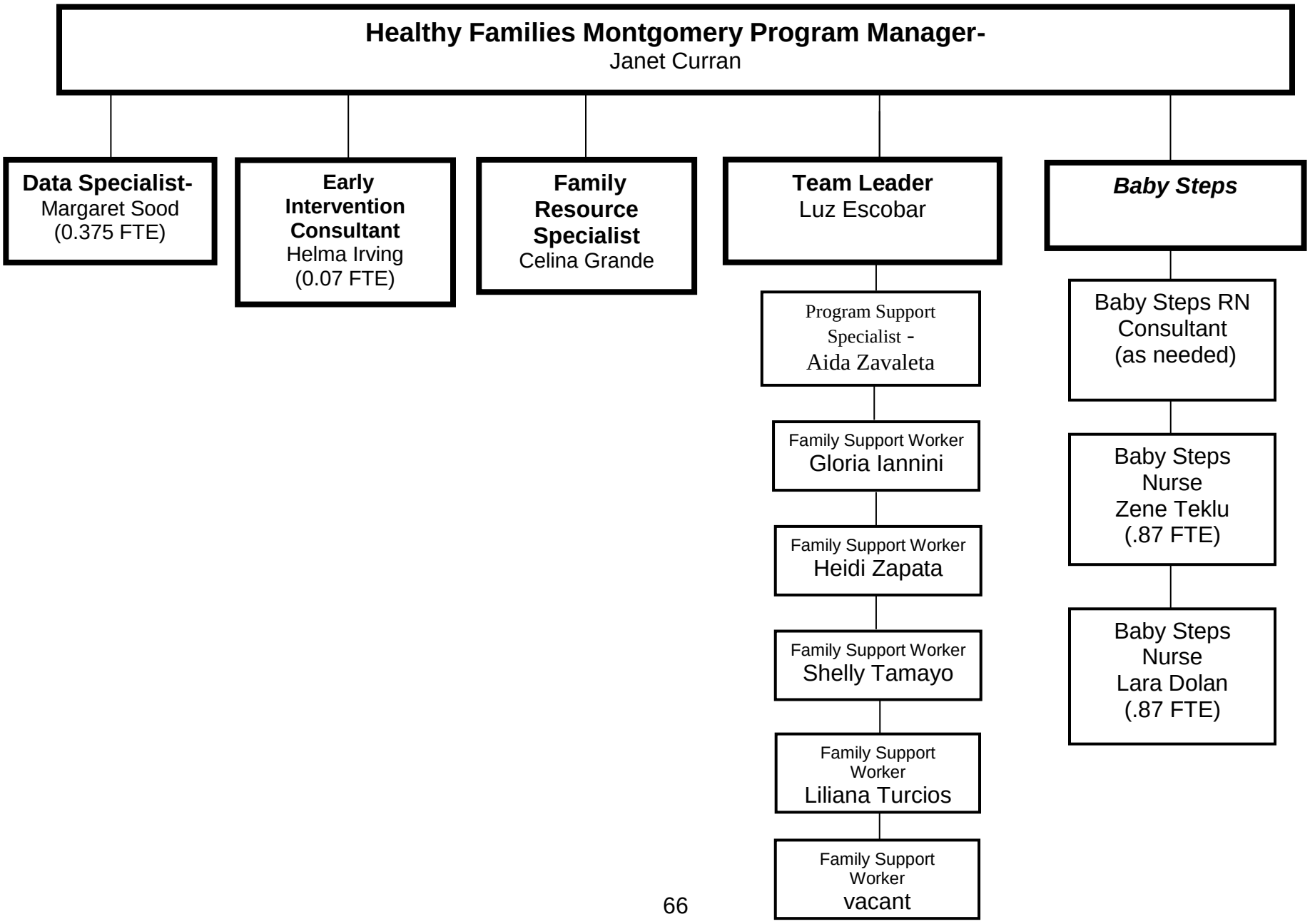
Post-Partum Care

[12] National Center on Quality Assurance (NCQA).The State of Health Care Quality 2013. *Improving Quality and Patient Experience.* Available at: https://www.ncqa.org/Portals/0/Newsroom/SOHC/2013/SOHC-web_version_report.pdf

Developmental Delay

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

APPENDIX A. HFM ORGANIZATIONAL CHART



APPENDIX B. HFM FUNDING SOURCES & EXPENDITURES

Funding Sources
July 2014– June 2015

Private Foundations

Morris and Gwendolyn Cafritz Foundation
Clark Winchcole Foundation
Gratis Foundation
O'Neill Foundation
Rite Aid Foundation

Public Funding

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

Individual Donors and Other

Individual Donors

In-Kind Donations

Barnes and Noble, Washingtonian Center
Christ Child Society
First Books – Montgomery County
Friendship Star Quilters
Woodworkers for Charity

Program Expenditures
July 2014– June 2015

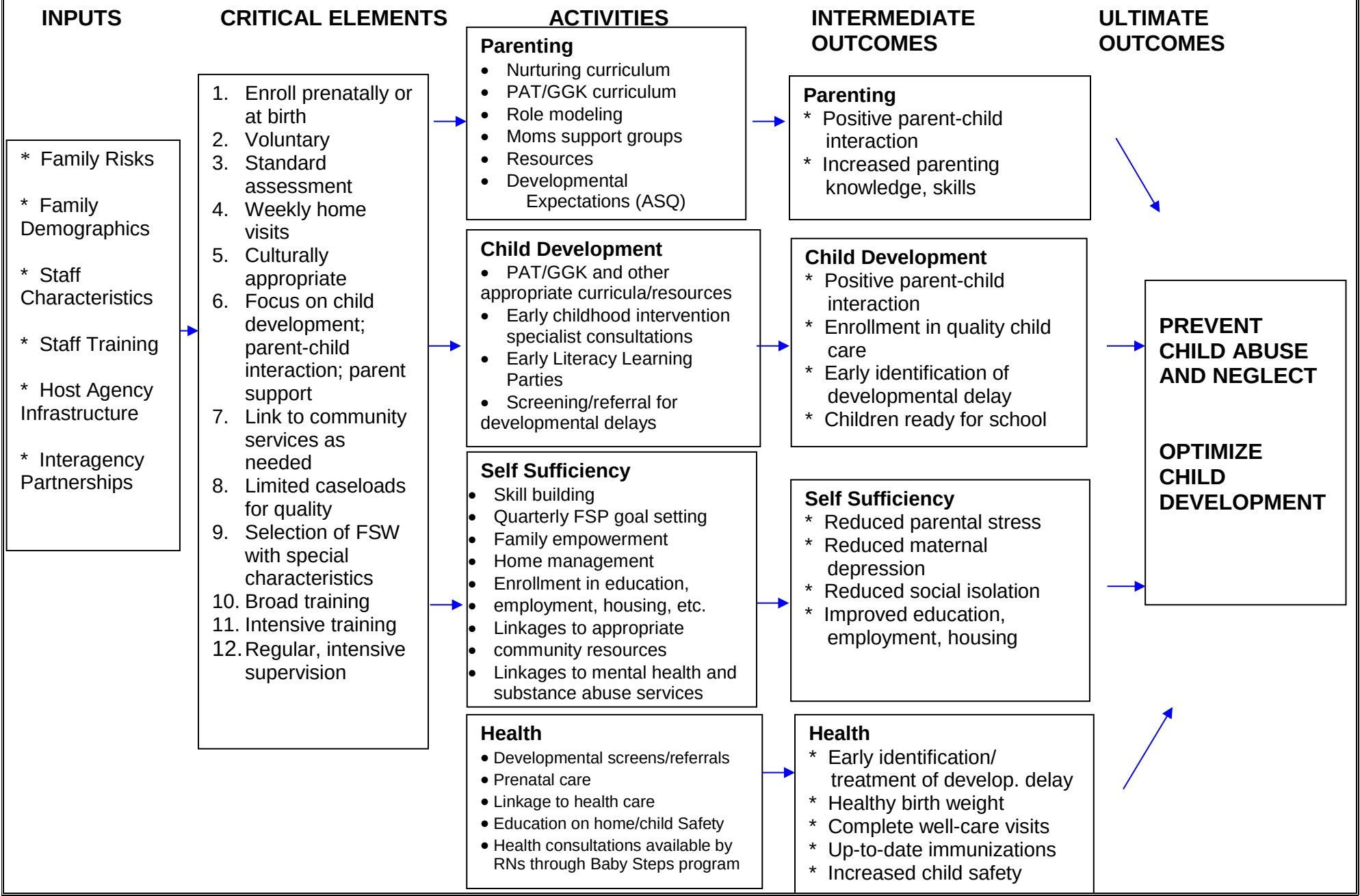
Program Funding	
Montgomery County DHHS	$533,333
Montgomery County Collaboration Council	$170,286
City of Rockville	15,000
Morris and Gwendolyn Cafritz Foundation	38,346
Foundation support and training fees	35,725
Total Funding	**$792,690**
Program Expenses	
Personnel salaries	$421,572
Personnel fringe benefits	124,650
Building occupancy	60,943
Professional services and evaluation	15,972
Transportation, local travel	15,539
Telephone	4,989
Training/conferences	8,679
Program activities/supplies/equipment	13,914
Subtotal Expenses	**$666,258**
General and administration	$94,291
Total Expenses	**$760,549**
Excess/Deficit	$ 32,141

APPENDIX C. HEALTHY FAMILIES MONTGOMERY ADVISORY BOARD

July 2014– June 2015

Member	Organization/Title
Barbara Andrews (*Ex-Officio Member*)	MC DHHS Early Childhood Services
Beth Arcarese	Saint Rose of Lima
Robin Chernoff, MD	Retired Pediatrician, Montgomery County Collaboration Council Board Member
George Cohen, MD	Retired Pediatrician, Mobile Med
Janet Curran (*Ex-Officio Member*)	FSI/HFM Program Manager
Ruth Hayn	League of Women Voters
April Kaplan (*Ex-Officio Member*)	Montgomery County Collaboration Council
Joan Liversidge	Community Member
Meredith Myers (*Ex-Officio Member*)	FSI/FCS Director
Margaret Sood (*Ex-Officio Member*)	HFM Data Specialist

APPENDIX D. HEALTHY FAMILIES MONTGOMERY LOGIC MODEL



APPENDIX E. PARENTAL CONSENT FOR PARTICIPATION

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

PARENTAL CONSENT FOR PARTICIPATION

I, _____,

residing at _____,

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

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

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

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

_____ _____
Parent's Signature Date Witness' Signature Date

_____ _____
Printed Name of Parent Printed Name of Witness

_____
Relationship to Target Child

_____ _____
Parent's Signature Date Witness' Signature Date

_____ _____
Printed Name of Parent Printed Name of Witness

_____
Relationship to Target Child

Consent Withdrawn

_____ _____

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

Consentimiento para Participación

Yo, _____, residiendo en _____

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

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

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

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

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

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

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

_____
Parentesco con el niño(a)

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

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

_____
Parentesco con el niño(a)

Consentimiento Revocado

_____
Firma Fecha

APPENDIX F. PARENTAL CONSENT FOR PARTICIPATION OF A MINOR

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

PARENTAL CONSENT FOR PARTICIPATION OF A MINOR

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

hereby consent for _____
(Minor Mother of the Baby)

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

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

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

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

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

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

_____
Relationship to Target Child

Consent Withdrawn

_____ _____
Signature Date

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

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

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

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

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

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

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

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

_____ _____
Nombre de imprenta Fecha

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

_____ _____
Nombre de imprenta Fecha

_____ _____
Firma del testigo(a) Fecha

_____
Nombre de imprenta

Consentimiento Revocado

_____ _____
Firma Fecha

APPENDIX G. PARENTAL CONSENT TO PARTICIPATE IN PROGRAM EVALUATION

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

Parental Consent to Participate in Program Evaluation

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

Please be aware of the following:

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

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

Donna D. Klagholz, Ph.D.
Program Evaluator

_____ _____
Participant's Signature Date Print Name

_____ _____
Witness' Signature Date Print Name

_____ _____
Parent or Guardian of Participant Date Print Name

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

Consentimiento para Participar en el Proyecto de Evaluación

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

Por favor tome nota de lo siguiente:

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

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

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

_____		_____
Firma del Participante	Fecha	Nombre de Imprenta
_____		_____
Firma del Testigo(a)	Fecha	Nombre de Imprenta
_____		_____
Padre o Tutor Legal del participante	Fecha	Nombre de Imprenta

APPENDIX H. HFM DESCRIPTION OF EVALUATION MEASURES

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

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

Center for Epidemiologic Studies – Depression (CES-D)
Author: The Center for Epidemiologic Studies, National Institute of Mental Health
Description: The CES-D is used to measure maternal depression. This 20-item self-reporting instrument focuses on depression symptomology rather than diagnosing clinical depression. It consists of four separate factors: depressive affect, somatic symptoms, positive affect, and interpersonal relations. The evidence that shows a causal link between symptoms of depression and children's well-being provides the rationale for including this construct in the Parent Interview. It has been used in many rural and urban populations and cross-cultural studies of depression. The reliability of the CES-D is supported by a correlation with the NIMH Depressed Mood subscale of

the General Well-Being Scale with a correlation coefficient of .71, a high test-retest correlation, and a sensitivity of .89 and specificity of .70 when related to psychiatric instruments such as the Diagnostic Interview Scale (DIS). Demonstrated associations with related constructs support its construct validity and CES-D has been shown to have good discriminant validity.

Healthy Families Parenting Inventory (HFPI)

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

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

APPENDIX I. HFM EVALUATION ADMINISTRATION SCHEDULE

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

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

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

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

APPENDIX J. HFA CRITICAL ELEMENTS OF SUCCESSFUL HOME VISITATION PROGRAMS

1. Initiate services at birth or prenatally.

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

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

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

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

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

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

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

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

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

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

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

GOVERNANCE AND ADMINISTRATION

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

APPENDIX K. HFM SERVICE LEVEL SYSTEM DESCRIPTIONS

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

APPENDIX L. HFM STAFF TENURE DATES

1996 – 2015

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

NAME	TITLE	% TIME	START DATE	EXIT DATE
	EIS/Team Leader	75	01/09/09	
Maritza Buitrago	FRS II	100	08/06/01	06/10/05
Patricia Paredes	Nurse	50	09/04/01	11/15/04
Helma Irving	Early Intervention	50	09/10/01	07/31/02
Leigh-Ann Nauser	FSW I	100	12/03/01	06/30/04
Melodye Berry	FSW I	100	12/03/01	01/01/03
Silvia Hurtarte	FSW I	100	09/03/02	02/00/04
Celina Grande	FRS II	100	10/01/02	
Ana Caba	FSW I	100	10/07/02	08/31/04
Crystal Carr	Program Director	100	11/04/02	12/31/05
Diana Hawley	Early Intervention Specialist	50	02/11/03	11/00/03
Aleta (Pedreira) Winters	Program Assistant	100	06/02/03	04/27/07
Meredith Jossi	FSW I	100	12/15/03	08/15/05
Helma Irving	Early Intervention	50	02/00/04	02/01/08
Bridget Kish	FSW I	100	02/02/04	04/15/04
Megan Broadbent	FSW I	100	02/23/04	08/15/04
Maria Pilar Sepulveda	FSW I	100	04/21/04	07/14/2012
Adriana Parra	FSW I	100	07/12/04	08/12/04
Latteefa Salaam	FSW I	100	07/12/04	08/13/04
Mery Aguirre	FSWI	100	07/26/04	01/26/07
Latika Wilson	Data Entry Specialist	100	07/26/04	09/15/05
Gloria Gonzalez	FSW I	100	08/16/04	05/08/2015
Aida Zavaleta	FSW I	100	08/16/04	
Nancy Patino	FSW I	100	09/27/04	02/15/05
Elaine Zagami	FSW Team Leader	100	11/03/04	05/26/06
Samantha LaBelle	FSW I	100	03/28/05	04/06/06
Asia Conley	FSW I	100	04/25/05	08/16/05
Ruth Rivas	FRS I	100	06/13/05	01/25/08
Marian Bolton	FSW II	100	08/11/05	02/15/07
Amita Binger	Early Intervention	50	10/03/05	05/31/06
Meredith Myers	Director, ECS	25	04/23/06	
Lourdes L. Castro	FSW I	100	06/12/06	12/07/2011
Zelma Sciaudone	FSW II	100	01/02/07	10/01/09
Sandra Peltier	FSW I	100	02/08/07	07/05/07
Joylyn Bishop	FSW I	100	04/02/07	09/09/08
Sue Chen	FSW III	50	09/13/07	09/30/10
Supreet Kaur	Program Assistant	50	10/08/07	11/15/2013
Liana Vega-Hernandez	Team Leader	100	04/07/08	01/09/09
Erin Yoon	Data Specialist	On call	04/07/08	01/01/09
Ana Del Negro	FSW I	100	11/30/2009	06/15/2010
Heidi Zapata	FSW I	100	11/30/2009	
Sandra Buitrago	FSW	100	01/23/2012	09/10/2012
Helma Irving	Early Intervention	As needed	12/07/2012	
Cinthia Guzman	FSW	100	04/1/2013	3/11/2014

NAME	TITLE	% TIME	START DATE	EXIT DATE
Jamuna Sundrum	FSW	100	04/01/2013	4/30/2014
Margaret Sood	Data Specialist	38%	11/15/2013	
Shelly Tamayo	FSW	100	04/14/2014	
Liliana Turcios	FSW	100	04/13/2015	

APPENDIX M. HFM STAFF TRAININGS

Year 19

DATE	TOPIC	# HFM STAFF ATTENDED
Professional Development		
8/12/2014	New Hire Orientation	1
3/16/2015	Integrated Strategies	5
3/23/2015	PSCO Re-Certification	1
3/24/2015	Recruitment & Retention of Home Visiting Staff	1
3/25/2015	Effective Communication/ Motivational Enhancement	2
3/25/2015	Mindfulness Work in Home Visiting	3
4/13/2015	Orientation to Family Services, Inc	1
4/13/2015	Orientation to Healthy Families Montgomery	1
4/13/2015	Orientation to Issues of Confidentiality	1
4/14/2015	FSI New Staff Orientation	1
4/15/2015	Orientation to Administrative Info	1
4/16/2015	Orientation to Program's Relationships with Community	1
4/20/2015	Orientation to Home Visiting Safety	1
4/20/2015	Orientation to Issues of Boundaries	1
4/20/2015	Preparing for Visit (10-2.C)	1
4/22/2015	Program Processes	1
5/6/2015	Crisis Training - Mandt Chapters 1-4	1
5/8/2015	Mandt Training, Chapter 4	8
6/12/2015	HFM Home Visit Record	8
Multiple Dates	Confidentiality & HIPAA	3
Multiple Dates	Corporate Compliance & Ethics	4
Multiple Dates	Optimizing Your Effectiveness	5
Multiple Dates	Sexual Harassment/Discrimination Prevention	4
Topics Related to Culture		
3/4/2015	Silent Trauma of the Immigrant Experience	1
6/16/2015	Immigration Issues Update	4
Multiple Dates	Cultural Diversity	4
Multiple Dates	The Role of Culture in Parenting	4
Parenting		
9/30/2014	Transformational Relationships	1
3/25/2015	Giving Kids What They Need to Succeed	2
Multiple Dates	Responding to Relationships	5
Multiple Dates	Coaching on Positive Parenting Strategies	4
Multiple Dates	Fostering Infant & Child Development	5

Family Mental Health and Well Being		
7/28/2014	Nat. Council for Behavioral Health	1
8/21/2014	Moving Beyond Depression	1
8/22/2014	Child Abuse Training	1
8/22/2014	Child Center & Adult Services	1
8/25/2014	Trauma Informed Supervision	1
10/24/2014	Child Welfare Services - CAN Indicators	8
10/27/2014	Safe & Secure Environments (TIC)	1
4/20/2015	Orientation to Child Abuse/Neglect	1
5/1/2015	Youth Mental Health First Aid Training	1
5/4/2015	Program Evaluation Including Screening for Depression	1
6/12/2015	Domestic Violence 101	5
Multiple Dates	Addressing Domestic Violence	5
Multiple Dates	Promoting Mental Health	5
Multiple Dates	Preventing Child Abuse	5
Multiple Dates	Recognizing Perinatal Depression	5
Multiple Dates	Recognizing Substance Abuse	5
Family and Child Health Care		
8/22/2014	Abusive Head Trauma	1
4/23/2015	Prenatal Training	1
Multiple Dates	CPR, AED, Basic First Aid	6
Multiple Dates	Infection Prevention	4
Multiple Dates	Keeping Babies Healthy & Safe	5
Multiple Dates	Preparing Moms for Birth & Beyond	5
Multiple Dates	Striving for a Smoke-Free Environment	5
Child Development		
10/31/2014	DECA Overview	7
11/6/2014	Tier 2 GGK Curriculum	8
1/4/2015	Teaching Others to Use ASQ-# and ASQ on line	1
1/14/2015	ASQ Third Edition	1
3/25/2015	Right from the Start: Building Brains Birth-Age 5	6
3/27/2015	GGK Tier 2 Training	7
4/14/2015	Speed Dial-4/Early Screening Inventory	1
4/22/2015	Brigance Screens 0-36 mo & 3-5 yrs	1
5/20/2015	Curriculum/Materials Overview	1

APPENDIX N. HFM STAFF SATISFACTION SURVEY

Version-June 2014

Healthy Families Montgomery Staff Satisfaction Survey

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

1. In what capacity do you work with HFM?

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

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

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

school.					

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

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

4. Which areas of the program are particularly strong?

_____
_____
_____

5. Which areas of the program need improvement?

_____
_____
_____

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

□ Always stressful □ Usually □Sometimes □ Rarely □ Never

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

□ None □ Promotion □Wage Increase □ Bonus

□ Certification □ Other (please specify) _____

Thank you for sharing your thoughts and suggestions today.

APPENDIX O. HFM PARTICIPANT SATISFACTION SURVEY

Healthy Families Montgomery
Participant Satisfaction Survey

Today's Date:_____

Please share the following information:

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

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

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

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

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

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

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

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

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

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

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

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

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

7. My Family Support Worker gives me information that I can understand.

YES **NO**

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

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

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

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

Please give us your opinion on the following questions.

What do you like most about Healthy Families?

_____
_____
_____

What do you not like about Healthy Families?

_____
_____
_____

How do you think we could improve our program?

_____
_____
_____

How would you rate your Family Support Worker?

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

How would you rate Healthy Families?

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

I would recommend Healthy Families to a friend or relative.

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

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

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

HEALTHY FAMILIES MONTGOMERY
Encuesta de satisfacción de los participantes

Fecha de hoy: _____

Por favor comparta con nosotros la siguiente información:

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

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

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

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

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

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

Por favor conteste SI o NO a las siguientes declaraciones.

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

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

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

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

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

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

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

8. Mi trabajadora de apoyo familiar me da información fácil de comprender.

SI **NO**

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

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

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

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

Por favor denos su opinión en las siguientes preguntas.

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

_____
_____
_____

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

_____
_____
_____

¿Cómo cree que podemos mejorar el programa?

_____
_____
_____

¿Cómo calificaría a su trabajadora de apoyo familiar?

☐**Excelente** ☐**Muy Buena** ☐**Buena** ☐**No muy Buena**

¿Cómo calificaría al programa de Healthy Families?

☐**Excelente** ☐**Muy bueno** ☐**Bueno** ☐**No muy bueno**

Yo recomendaría este programa a un familiar o un amigo.

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

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

_____

Muchísimas gracias por participar en esta encuesta.