

100 Years of Service



Family Services, Inc.

An affiliate of Sheppard & Enoch Pratt Foundation

HEALTHY FAMILIES MONTGOMERY

YEAR 15 REPORT JULY 2010 – JUNE 2011

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

For More Information Contact:

**Family Services, Inc.
Healthy Families Montgomery
610 East Diamond Avenue, Suite 100
Gaithersburg, MD 20877
Janet Curran: 301-840-3232**

Prepared by
Donna D. Klagholz, Ph.D. & Associates, LLC
12098 Kinsley Place
Reston, VA 20190

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EXECUTIVE SUMMARY

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

To date, over 12,000 positive screens for risk of child maltreatment have been made by HFM. Most of the 866 screens that were conducted in Year 15 were positive (90%, n=777); however, of those positive screens, only 134 (17%) were assessed, as there was only one Family Resource Specialist available to assess families. Furthermore, due to capacity limitations, the program was only able to enroll 38 families, less than half of those found eligible through assessment. This Year 15 enrollment number represents only 5% of the original positive screens and continues to underscore the significant gap in services for the at-risk population in Montgomery County. However, HFM's efforts to refer unserved families to other appropriate resources in the area highlight a strong commitment to helping overburdened families, as well as its value as a community resource.

In Year 15, the program served 135 families. Demographic data reveals a population that continues the trend of increasingly older mothers; the mean age of Year 15 participants is 25.7 years, the oldest to date. Most (89%) were single, but about half reported that they lived with their partners. Overall, at time of enrollment, 62% (n=83/135) were either married or living with a partner. As in the past, most mothers are Hispanic (88%) and speak Spanish as their primary language. At enrollment, 37% of mothers over the age of 18 had less than a HS education and most were unemployed (68%). By the end of Year 15, marital status had improved slightly, with 63% either married or living with a partner. Improvements were also seen in the education and employment status of program participants. Whereas only 63% of mothers over the age of 18 years had a high school degree or higher at enrollment, 67% had attained degrees by the end of Year 15. Additionally, the percentage of mothers who were working full-time, part-time, self-employed, or at odd jobs doubled by the end of the reporting period from 32% (n=43/135) to 60% (n=64/106).

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

In the area of health, HFM continues to exceed its goals. In Year 15, almost all children were linked with medical providers (98%) and were enrolled in Medical Assistance (MA) (99%). In addition, 95% of all target children were current with their immunizations. This is especially impressive when compared to the Centers for Disease Control 2010 findings on immunization rates for the nation (75%). It also exceeds the State of Maryland immunization rate of 73% (CDC, 2010). Of the mothers who gave birth during Year 15, 100% received 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 rate of 70%. Additionally, 100% (n=135) of mothers did not have a repeat birth within a 24-month period during their enrollment in the program. HFM's success rate in this area has consistently exceeded both Maryland State (82%) and national statistics (81%). During Year 15, 129 target babies were born to active participants in the program. Of these, 96% (n=124) were born at a healthy birthweight. Of the five babies who were born at low birthweights, all enrolled in the program postnatally, but had received prenatal care in their first or second trimester. When birthweight is examined for only those babies who were born during Year 15, the percentage of those born at a healthy birthweight increased to 100% (n=20/20), and exceeded both national (92%) and Maryland (91%) rates.

In order to monitor the social, emotional, cognitive, language and motor development of each participating child, the HFM program administers the Ages and Stages Questionnaire (ASQ) at regular intervals throughout a family's participation. During Year 15, 95% (n=87/92) of target children who were due for an ASQ received one. Of these, 93% demonstrated normal child functioning and are meeting developmental milestones. When comparing this percentage to prevalence rates at the national and state level, this data provides strong evidence of the impact of the program's developmental activities on mitigating the role of environmental factors in developmental delays. At both the national level and in Maryland the prevalence for developmental delays that would qualify a child for Part C is approximately 12% (NECTAC, 2010). By the end of Year 15, a total of 9 children were identified with a developmental delay and were receiving services from MCITP (n=4) or MCPS/Child Find (n=5).

The goal of positive parenting includes the areas of home safety, parent-child interaction, and parenting knowledge. Measurement of parents' knowledge of safety in the home focuses on a variety of factors, such as knowledge of emergency phone numbers, installation of safety devices, and use of automobile safety restraints. Statistically significant increases (p=.000) were measured in parents' knowledge of child safety, with 96% of parents demonstrating adequate safety knowledge after one year of program participation. Results from the Healthy Families Parenting Inventory (HFPI) revealed statistically significant improvement in three areas: *Home Environment* (safety, organization, availability and quality of stimulating materials/activities in the home), *Mobilizing Resources* (knowledge of available resources in the community and comfort level in seeking help), and *Parenting Efficacy* (knowledge and skills related to childrearing). Additionally, results from the Center for Epidemiological Studies-Depression (CES-D) indicate that there were significant decreases in parents' risk for depression, a potent factor in reducing risk for child maltreatment.

HFM participants continue to report high levels of satisfaction with the program. Respondents perceive the program to be highly effective and feel the program has helped them to be better parents. Specifically, they recognize their FSW's efforts in teaching them about child development and strategies for helping their children learn. Parents also value the support and guidance they receive from their FSWs when the family is in need, as well as the information they give them about community resources.

INTRODUCTION

In June 2011, Healthy Families Montgomery (HFM) concluded its fifteenth year of service to high-risk families in Montgomery County, Maryland. The comprehensive services offered by the HFM program are designed to reduce family risk factors and enhance protective factors in order to prevent child abuse and neglect and promote optimal child development. Over the past fifteen years, HFM has demonstrated its ability to maintain high quality standards and consistently achieve positive maternal and child health outcomes despite funding challenges, relocating and renovating office space, and a changing political landscape pertaining to early childhood and home visitation at the state level. This was affirmed in December 2008 (Year 13) when HFM received an expedited four-year credential from Healthy Families America. The reviewers indicated that HFM is an extremely strong site – among the top 2% nationwide. FSI's HFM program was first accredited in November 1999, when it became the first nationally credentialed Healthy Family America site in the State of Maryland. The HFM program was built on research-based best practices and has drawn upon these practices as it has grown over the years. Additionally, HFM has twice received awards from the Montgomery County Council for the excellence of its services to families, once with a special mention with regard to cultural competence.

This purpose of this report is to describe the HFM program implementation during Year 15 and the outcomes achieved by the end of the fiscal year.

Family Services, Inc. (FSI)

Established in 1908, Family Services, Inc. is the oldest private nonprofit social service and behavioral health organization in Montgomery County, Maryland. An affiliate of the Sheppard and Enoch Pratt Foundation, FSI provides innovative early childhood, educational, and behavioral health programs that foster health and wellbeing in the home, school and community. FSI offers basic emergency assistance to those with the most critical needs in the Montgomery County community. Through the behavioral health program, FSI provides a comprehensive range of treatment for adults, children and families, including psychiatric, rehabilitation and vocational services in both residential and outpatient settings to help persons with mental illness integrate into their community. Educational programs focus on school readiness for children, for families whose children are already in school, trained staff link parents to the resources they need and help them become actively involved in their children's education. Early childhood programs provide parents with a variety of educational and informational resources to produce the best outcomes for children. Through Early Childhood Services Programs, families are linked with the community resources they need to achieve self-sufficiency, while at the same time providing them with parenting education and support.

The Healthy Families Montgomery Program falls within the Early Childhood division of FSI. In addition to HFM, specific programs within each service area include:

EARLY CHILDHOOD

Baby Steps nurses provide universal hospital-based health screenings to over 4,800 new mothers and babies at Shady Grove Adventist and Holy Cross Hospitals. Baby Steps nurses link new parents to community health services and provide appropriate follow up as needed through telephone consultations and/or home visits.

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

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

EDUCATION

B.R.O.T.H.E.R.S. is a year round program for young men at Gaithersburg High School in Gaithersburg, MD, who come together to support each other in their academic, social and emotional growth. The BROTHERS program introduces positive role models to young men to help them tackle life's daily challenges. College students mentor high school students, who in turn mentor middle and elementary students.

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

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

DARE to be you is a substance abuse prevention education program that provides a 10-week program to preschoolers and their families which is designed to improve parent and child interaction in the areas of self-concept, self-responsibility,

communication and decision-making. They provide family meals, techniques to enhance family resilience, and financial incentives for successful completion of the program.

BEHAVIORAL HEALTH

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

Montgomery Station is a Psychiatric Rehabilitation Program. Staff work with adults with serious mental illnesses in a variety of settings to reach their full potential in all aspects of their lives. Montgomery Station's philosophy is based on the Mental Health Recovery Model. The Recovery Model emphasizes that people can make progress and positive changes in their lives, despite having mental illness. Montgomery Station and the Recovery Model take a holistic view that focuses on the person, not just the symptoms. They work closely with the individual, their family and friends, and their doctors and therapists.

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

CRITICAL COMMUNITY SERVICES

The **Betty Anne Kranke Center** (BAK), founded in 2000, is the only domestic violence shelter serving Montgomery County, Maryland. With a 54-bed capacity, BAK provides safety for women and their children, support in trauma recovery and empowerment to increase their personal safety within the community. With the assistance of individual therapists and case managers, women are empowered to create a new future for themselves and their children that is free of abuse, coercion and fear.

The **Housing Counselor** provides relocation assistance, renter assistance and assistance 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 with area foreclosure counseling agencies. These programs are available to the residents of the City of Gaithersburg.

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

As the host agency, FSI provides HFM with support through its strong infrastructure, in-kind services and information sharing among its other programs. Its expertise in advocacy and resource development is also an asset to HFM. FSI is located within a complex of other nonprofit providers, including Community Clinic, Inc., the Dwelling Place, Guide Youth Services, Teen and Young Adult Health Connection (TAYA), and WIC. Referrals are made to these providers by FSI staff as needed in order to provide additional services to consumers who would benefit from their assistance.

See Appendix A: HFM Organizational Chart

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

Funders

During Year 15, the HFM program maintained its diversified funding streams, but was forced to reduce its budget by 140K due to decreases in funding from public sources including -96K from the State of Maryland (through the Montgomery County Collaboration Council) and -36K from the Montgomery County Department of Health and Human Services. HFM received a final grant from the Freddie Mac Foundation, which no longer funds early childhood programs. FSI was successful in obtaining support from private sources including the William S. Abell Foundation, Bank of America, Morris and Gwendolyn Cafritz Foundation, CSG Foundation, TD Charitable Foundation, and PNC Bank Foundation. The HFM program also received private donations and in-kind funding from Barnes and Noble at the Washingtonian Center,

Christ Child Society, First Books of Montgomery County, Friendship Star Quilters, Mom's Club of Germantown/Kingsview, Payless Shoe Source, Weichert Realty in Gaithersburg and North Potomac, and Woodworkers for Charity. (see Appendix B: Healthy Families Montgomery Funding Sources: July 2010-June 2011 and Healthy Families Montgomery Program Expenditures: July 2010-June 2011).

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 15, the HFM Advisory Board was comprised of 11 local private and public stakeholders who serve a 2-year term and meet regularly. The Board is comprised of individuals representing diverse ethnic and professionals sectors, which bring a range of expertise and cultural perspectives. Members are able to provide support to ensure that the program serves the community to the best of its ability. Over the course of the year, the HFM program solicited feedback and encouraged members to attend a participant group meeting in order to increase engagement and participation of the board. See Appendix C: List of Advisory Board Members 2010-2011.

National Accreditation

The HFM program was built on research-based best practices and has drawn upon these practices as it has grown over the years. All Healthy Families programs must participate in the accreditation process in order to be considered an official Healthy Families site. During this intensive process, sites prepare a lengthy written self-assessment that is submitted to a team of peer reviewers for evaluation prior to a two to three-day site visit. It is through the self-assessment and site visit that the trained reviewers are able to assess the program's adherence to the 12 research-based critical elements, a set of guidelines for best practices in a home visitation program. Accreditation ensures that programs implement evidence-based effective practices and adhere to quality standards on a regular basis over time.

The program has been accredited since November 1999 (Year 4), when it received the first national credential of all the Healthy Family America sites in the State of Maryland. In Year 8 of the program, HFM received a rare expedited credential with no follow-up work required, based on exemplary scores on the Preliminary Credentialing Report. In Year 13, HFM underwent the new accreditation process, during which revised standards and criteria were applied. Upon completion of the site visit in September 2008, HFM once again received an expedited accreditation. The HFM program will undergo the accreditation process again in the fall of 2012.

METHODS

Donna D. Klagholz, Ph.D. & Associates, LLC designed the HFM program evaluation over 15 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 fifteen years has enhanced quality and increased the credibility of longitudinal outcomes.

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

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

A. Theory of Change

The logic model provides a useful framework for conceptualizing the program model and evaluation. It clearly links the key program components and activities to targeted change in the participants and to intermediate and long-term outcomes. Appendix D: HFM Logic Model provides a graphic illustration of the theory of change for the HFM program. Although modified slightly over the past fifteen 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. All HFM families screened and assessed in Year 15 were identified at one of three Montgomery County Health Centers (Germantown, Silver Spring or Piccard). As initial points of entry for the majority of pregnant women throughout the county who are in need of government health assistance for themselves and their unborn babies, these health centers are ideal screening locations for HFM's target population. A much smaller number of screens are completed on women who utilize other community services and are referred to the program. Potential participants represent a wide range of racial and ethnic backgrounds.

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

C. Research Sample

All Year 15 participants (n=135) are included in the analysis of enrollment data (attrition, retention, duration and service levels) and all target children (n=129) are included in ASQ analysis. However, in order to accurately represent the impact of program participation on outcomes, a subset of participants (research sample) is created based on a minimum amount of documented program participation. To be included in the research sample, participants must have been enrolled by the end of the Year 15 fiscal year (June 30, 2010), and must have completed a minimum of eight home visits. Thus, the Year 15 research sample includes 120 families.

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

D. Procedure

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

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

E. Process Evaluation

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

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

F. Outcome Evaluation

A quasi-experimental design with repeated measures has been implemented since program inception. A brief description of the standardized measures and the schedule of assessment are provided in Appendix H: HFM Description of Evaluation Measures and Appendix I: HFM Evaluation Administration Schedule. In addition, the Instrument Administration Matrix (**Table 1**) outlines the data collection measures, domain, administration and data points. The schedule is determined by the date of enrollment for most measures but by the age of the baby for the ASQ and ASQ:SE. 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 15 outcome evaluation examined the impact of program activities on participants and progress towards meeting stated goals and objectives from July 1, 2010 - June 30, 2011.

G. Program Goals and Objectives

Derived from the Healthy Families America program model, the HFM goals and objectives have remained fairly consistent over the past twelve years, focusing on parenting, child health and development, family self-sufficiency, and the reduction of child maltreatment. At the conclusion of Year 15, the target for children demonstrating normal developmental functioning was reduced from 95% to 93%*. This change was due to the increased comparative percentages of congenital delay at the national level, as well as the program's trend for lowered percentages of normal functioning over the past 15 years.

I. Reduce Incidence of Child Maltreatment

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

II. Promote Preventive Health Care

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

III. Optimize Child Development

1. 93%* of children will demonstrate normal child functioning through ASQ developmental screening.
2. 100% of children actively enrolled will be screened for developmental delays in accordance with an ASQ schedule.
3. 100% of children who screen at risk for developmental delays will be informed of the Montgomery County Infant and Toddlers Program (MCITP) for assessment/services (referrals only made with parent's consent).

IV. Promote Family Self-Sufficiency

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

V. Promote Positive Parenting

1. 85% of participants will score at or above normal range for knowledge of child development after one year and annually thereafter as measured on the HFPI.
2. 90% of participants will score at or above program-determined level for knowledge of child safety after one year and annually thereafter as measured on the Safety Checklist (version 5).

RESULTS

A. PROCESS EVALUATION

Program Description

Healthy Families Montgomery (HFM) is based on the Healthy Families America (HFA) model, a nationally recognized voluntary program for the prevention of child maltreatment. HFA was first implemented by Prevent Child Abuse America (PCA America) in 1992, building on two decades of research in the field of home visitation. The program connects expectant parents and parents of newborns with health and child development assistance in their homes. 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 four years home visiting experience and three years tenure with their HFA program. Nationally, 76% of HFA home visitors have some college experience or college degrees.

The quality of HFM services is assured through adherence to best practice guidelines defined through twelve Critical Elements based on 20 years of research. An HFA site accreditation is required every three to four years. The accreditation process involves an in-depth examination of each site's operation, as well as the quality of the home visits (see Appendix J: HFM Critical Elements). 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 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 local clinics and outreach efforts. Families who may be in the "high risk" category are identified based on their score on the initial screen and assessment workers make a strong effort to contact these families.

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/survey process offers one-on-one time with the family so that they can discuss stressors in their lives and potential concerns for welcoming a new baby into the world, 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 Parent Packet filled with enrichment materials. Due to the voluntary nature of the program, families may decline services if for any reason they do not wish to participate. Furthermore, a family may terminate services at any time during their program participation.

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

Home visits are 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 enters the program at the end of the month, they will probably only receive one visit during the month. When families are temporarily unavailable for services and do not want to terminate from the program, they may discontinue home visitation services for up to 3 months. HFM monitors the number of home visits expected and completed based on the FSWs caseload on a monthly basis and consistently exceeds national standards for intensive home visiting compliance.

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

Intervention Specialist (EIS) on staff. The EIS also serves as one of the program's Team Leaders and is responsible for accompanying FSWs on home visits upon request, staff trainings on child development, and referral coordination with MCITP for families that have children with a suspected developmental delay. Changes to the implementation of the PAT curriculum are forthcoming and will require staff to undergo the new foundational and subsequent refresher trainings.

Family Support Plans (FSPs) are completed with each family on an ongoing basis throughout their tenure in the HFM program. Initially completed within 30 to 45 days of enrollment, FSPs help the family focus on short-term goals. FSWs encourage families to choose goals that are realistically obtainable within a three to six month timeframe. Every three to six months goal plans are reviewed, achievement of goals is assessed, and new goals are formulated.

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

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 staying with the program for multiple years. This allows the HFM program to offer more consistency in the services it provides.

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

The HFM program also supports its staff members by assigning each a limited caseload. Each full-time FSW has a maximum caseload capacity of 15-25 families. A weighted system is used to determine the amount of time the FSW spends with a family

based on their level. This helps the FSWs to devote time and attention to each family without feeling overwhelmed or rushed.

During Year 15, program implementation was consistent with previous years, but several changes are noteworthy. In July 2010, the program began administering the Life Skills Progression (LSP) to participants before services were initiated. The LSP is a field tested tool that measures a variety of family competencies in key categories, including relationships with family and friends, relationships with children, physical health care, basic needs, education and employment, mental health and substance abuse, and infant/toddler development and temperament. FSWs can use the results to plan interventions and track progress.

Also during Year 15, the HFM program offered literacy groups, which provided activities on 'singing books' from the local library. Other group activities included a Family Picnic in August 2010 and a Cultural Sharing in June 2011, which was very well attended. One of the supervisors ran a discipline group, which was also well-attended. Unfortunately, a Financial Literacy group that was offered had a low turnout.

Screening, Assessment and Enrollment

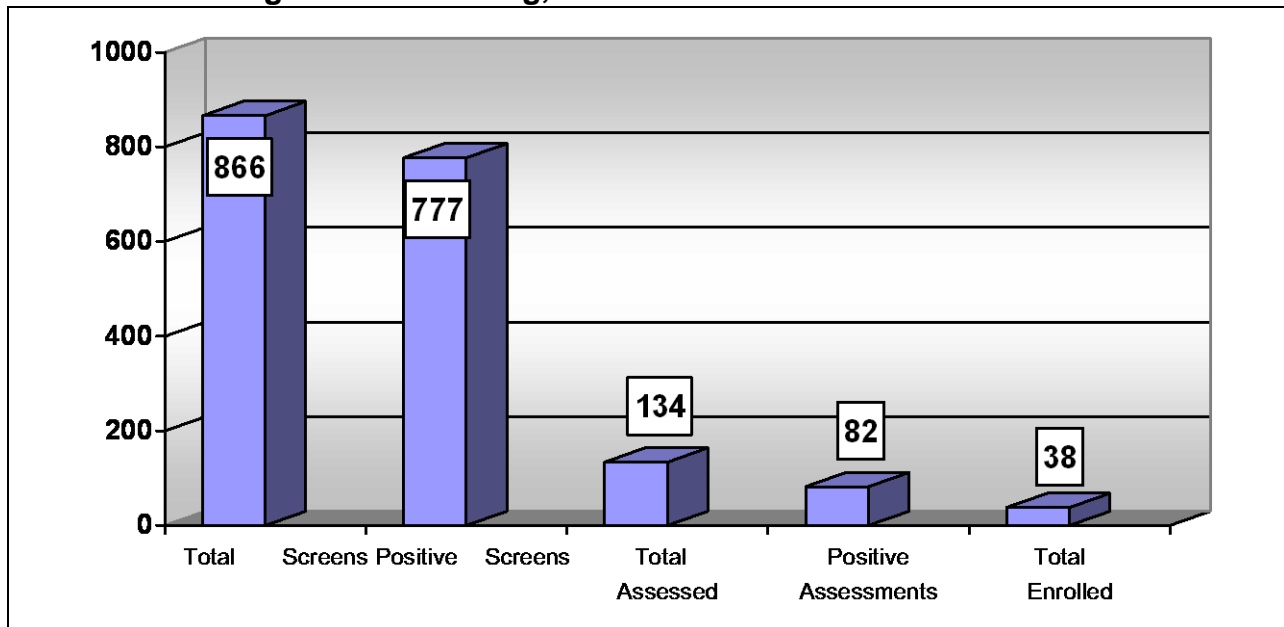
The HFM program has a longstanding partnership with the Montgomery County Department of Health and Human Services. As the major provider of reproductive health and social services to income-eligible families in the County, DHHS conducts universal screenings of all prenatal, perinatal and postnatal female 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. All positive and negative screens are sent to the HFM program for tracking. Positive screens are reviewed by the Family Resource Specialist (FRS), who completes assessments on families in the order of their due date.

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

Figure 1 below shows the total screening and assessment data for Program Year 15. Almost all screens that were completed resulted in a positive outcome, 90% (n=866). Of

these, only 17% (n=134) were assessed because there was only one Family Resource Specialist available to assess families. Of those assessed, 61% (n=82) were eligible for the program, only half of which (46%; n=38) were able to be enrolled due to capacity limitations. Finally, when the number of families enrolled (n=38) is compared to the total number of positive screens (n=777), only a small fraction (5%) of families determined to be at-risk ultimately receive the intensive home-based services offered by HFM. This shows a large gap in services for the at-risk population in Montgomery County. However, HFM makes every attempt to refer families to other services as appropriate.

Figure 1. Screening, Assessment and Enrollment: Year 15



Over the past fifteen years, over 12,000 positive screens for risk of child maltreatment have been made by HFM. **Table 2** displays information for all program years regarding screening, assessment and enrollment. In Year 15, only twenty-two eligible families declined enrollment, which provides evidence of the program’s ability to engage families. The refusal rate (those who were offered services but refused participation) has ranged from 0% in Year 3 to 27% in Year 15, with an average refusal of 17% over the lifetime of the program.

Table 2. Screening, Assessment and Enrollment: Years 1-15

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

YEAR*	Total Positive Screens	Total Assessments Completed	Total Positive Assessments	Total Negative Assessments	Total New Enrollments	Total Refusals	Program Capacity
YR 9	934	293	179	114	86	36	150
YR 10	755	298	180	118	60	11	140
YR 11	1090	162	110	49	65	28	130
YR 12	1244	165	100	53	43	25	130
Yr 13	1144	147	80	62	34	4	130
Yr 14	990	124	83	41	44	11	130
Yr 15	777	134	82	36	38	22	130
TOTAL	12,495	2,140	1,486	618	893	246	--

* Screening and Assessment Data from DHHS incomplete for Years 1 and 2 of the program

Enrollment and Attrition

A total of 135 families and 129 children were served in Year 15 and a total of 49 families were terminated during the fiscal year. Of these, 18% (n=9) families met all of their program goals and graduated from the program. In addition to these graduating families, a total of 40 families terminated services for a variety of reasons. As shown in **Figure 2**, the largest percentage of families (27%; n=13) was terminated because they refused services or were unable to be located. An additional 25% (n=12) were due to the family moving out of the service area. An equivalent percentage of families (22%; n=11) were terminated due to scheduling conflicts with their job or school. The remaining four cases (8%) were closed due to other reasons, such as the target child reaching the age of five years or the family never engaging.

Figure 2. Reasons for Case Closures: Year 15 (n=41)

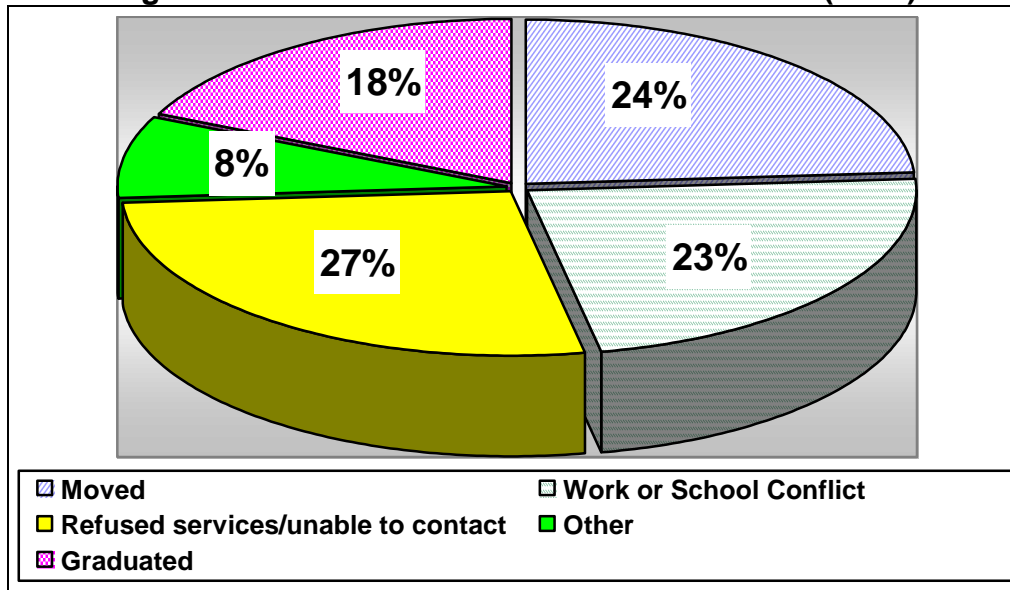


Table 3 shows attrition rates across the fifteen years of the program. The Year 15 attrition rate excludes the families who left due to graduation or the child reaching five years of age (n=10). Therefore the attrition rate is calculated based on the 39 families who closed for other reasons. The Year 15 attrition rate of 29% is an increase from several years prior. However, it is closer to the average attrition rate over the course of

the program (28%). Often the attrition rates are impacted by funding reductions. This is reflected in Year 15 attrition as the HFM program lost 1.5 FSW positions, reducing its capacity to serve the same number of families.

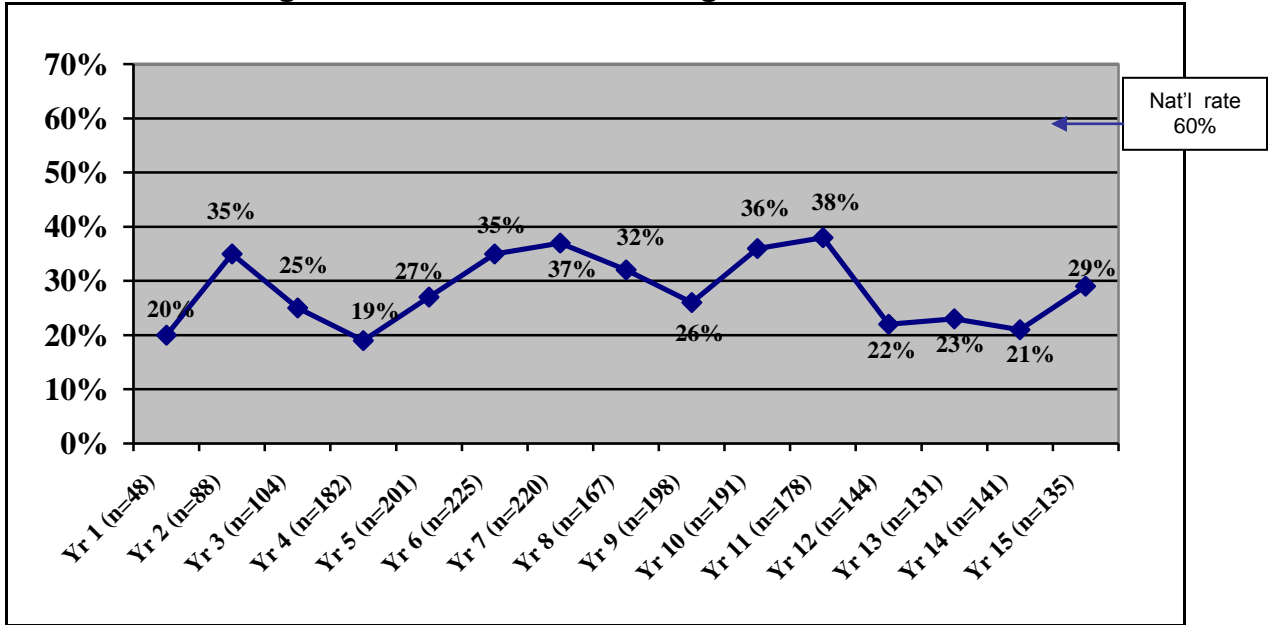
Table 3. HFM Attrition: Years 1-15

Year	Carryover from previous yr	Enrolled in fiscal year	Total enrolled during fiscal year	Closed* during fiscal year	Graduated / Age > 5 years	Attrition Rate*
Year 1	-	48	48	10	-	20%
Year 2	38	50	88	31	-	35%
Year 3	57	47	104	26	-	25%
Year 4	78	104	182	34	-	19%
Year 5	148	53	201	54	7	27%
Year 6	140	86	226	78	11	35%
Year 7	137	83	220	82	10	37%
Year 8	128	39	167	53	2	32%
Year 9	112	86	198	51	16	26%
Year 10	131	60	191	69	9	36%
Year 11	113	65	178	67	9	38%
Year 12	101	43	144	33	15	22%
Year 13	96	34	130	30	3	23%
Year 14	97	44	141	29	15	21%
Year 15	97	38	135	49	10	29%
Longitudinal						X=28%

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

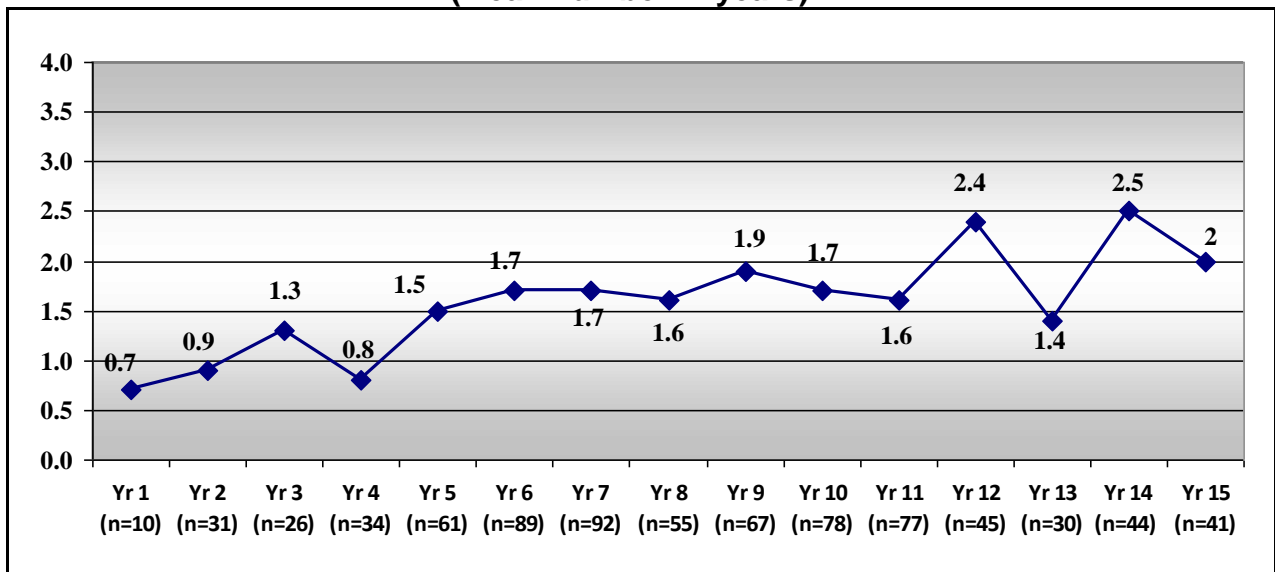
Over the course of 15 years, attrition rates ranged from a low of 19% in Year 4 to a high of 38% in Year 11. The average attrition rate of 28% is less than half of the national rate of 60%. See **Figure 3**.

Figure 3. Attrition Rates: Longitudinal Profile



Low attrition typically indicates a longer duration of enrollment for participants. When examining how long families remain in the program before termination, it can be seen that the higher attrition rate in Year 15 corresponds with a shorter mean length of enrollment for that year as compared to previous years. **Figure 4** displays the duration of enrollment for closed cases over the past 15 years.

Figure 4. Duration of Enrollment/Closed Cases for Years 1- 15 (Mean number in years)



Attrition and retention analyses were completed on Year 15 participants to ascertain if there were any trends or mediating variables that influenced program retention. When

length of enrollment was analyzed by attrition status and reason for termination, it is evident that program graduates remain in the program for the longest average time (5 years). As seen in **Table 4**, duration of enrollment for open cases was almost twice as long as the duration for cases that closed by the end of Year 15.

Table 4. Enrollment Mean and Range: Year 15

Enrollment Status	Mean Length of Enrollment (<i>in years</i>)	Enrollment Range (<i>in years</i>)
<i>Open</i>	2.0	.03 to 4.7
<i>Closed (non-Graduates)</i>	1.3	.08 to 5.1
<i>Closed (Graduates)</i>	4.9	4.4 to 5.2
<i>Total Year 15</i>	2.0	.03 to 5.2

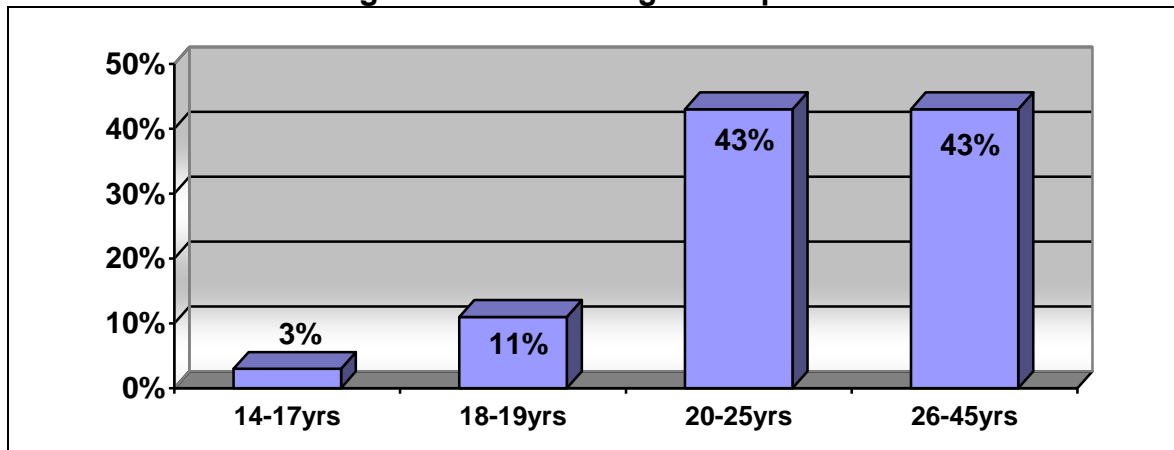
Population Demographics

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

Age

As seen in **Figure 5**, an equal percentage of the mothers in Year 15 were between the ages of 20-25 years (43%) and 26-45 years (43%) at the time of enrollment. Only a small percentage of mothers (14%) were teenagers at enrollment, however, it is notable that 3% (n=3) were 17 and under, significantly increasing their risk status.

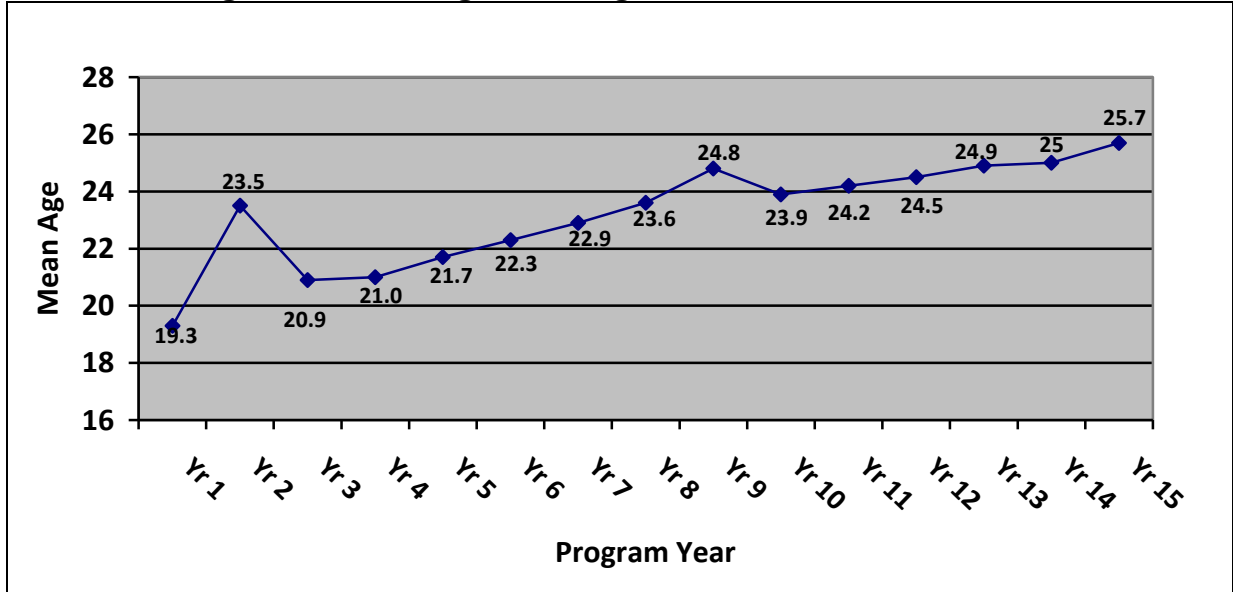
Figure 5. Mothers’ Age Groups: Year 15



Data collected across all program years on mother’s age at enrollment is shown in **Figure 6**. There has been a general trend toward increasingly older participants entering the program. The sudden rise and drop in mean age in Year 2 reflects the

creation of a separate “Teen Mothers Program” by the County. However, it is unclear if the trend from Year 3 to Year 15 is indicative of a decline in teen pregnancy over the past decade or if there are other programs that are specifically targeting teens.

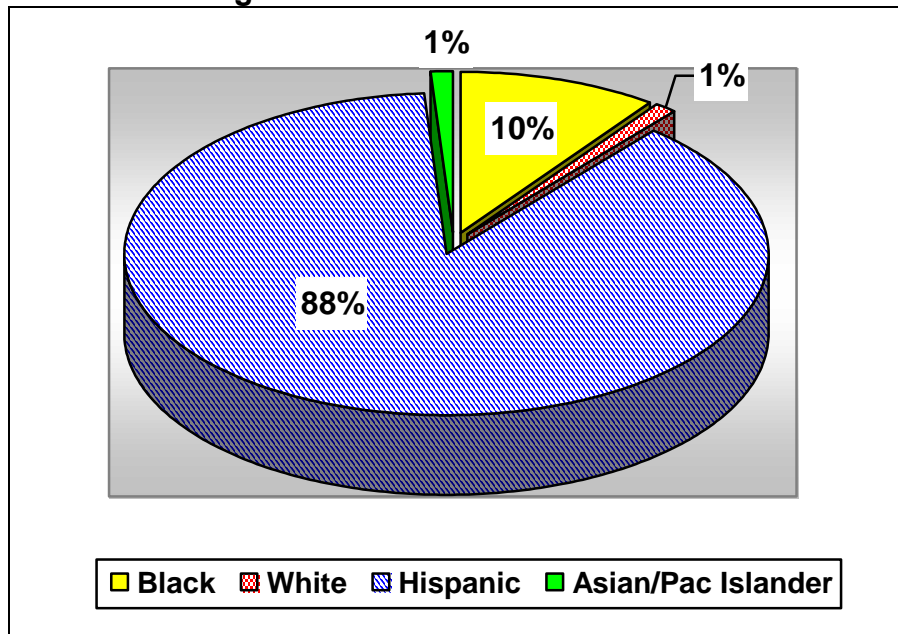
Figure 6. Mean Ages of Program Enrollees: Years 1 – 15



Race

As seen in **Figure 7**, the majority of families in the HFM program during Year 15 were Hispanic (88%), although this represents a slight decrease from last year. The remaining mothers were Black (10%), White (1%), and Asian/Pacific Islander (1%).

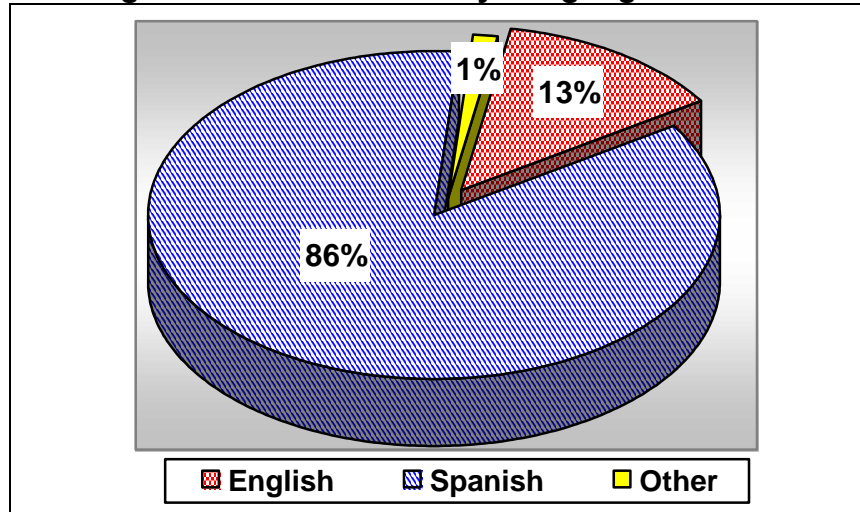
Figure 7. Mothers’ Race: Year 15



Language

It is not surprising that the majority of participants speak Spanish. In Year 15, most of the participants cited Spanish (86%) as their primary language, while 10% spoke English and 1% spoke another language. (see **Figure 8** below)

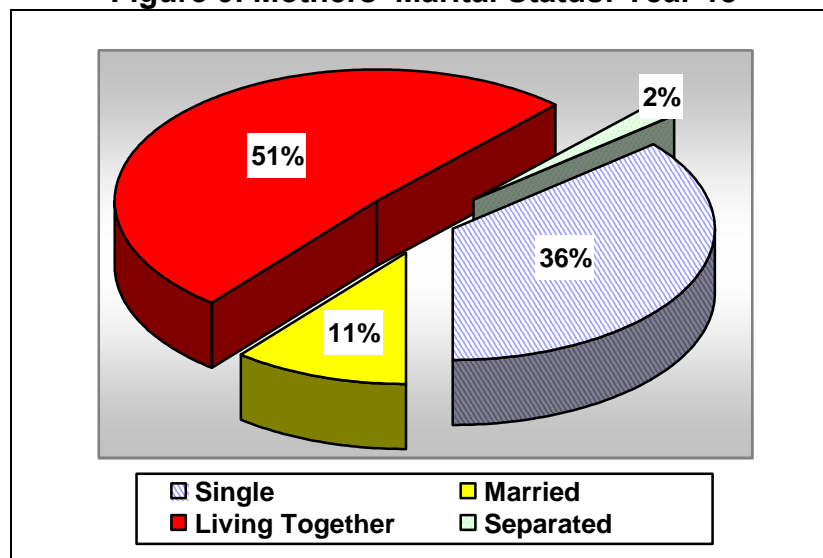
Figure 8. Mothers' Primary Language: Year 15



Marital Status

As depicted in **Figure 9** below, the majority (51%) of HFM participants in Year 15 were living together, but not married. This has been an increasing trend in marital status with a corollary decrease in single status (36%). The remaining mothers were married (11%) or separated (2%). Overall, 89% 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.

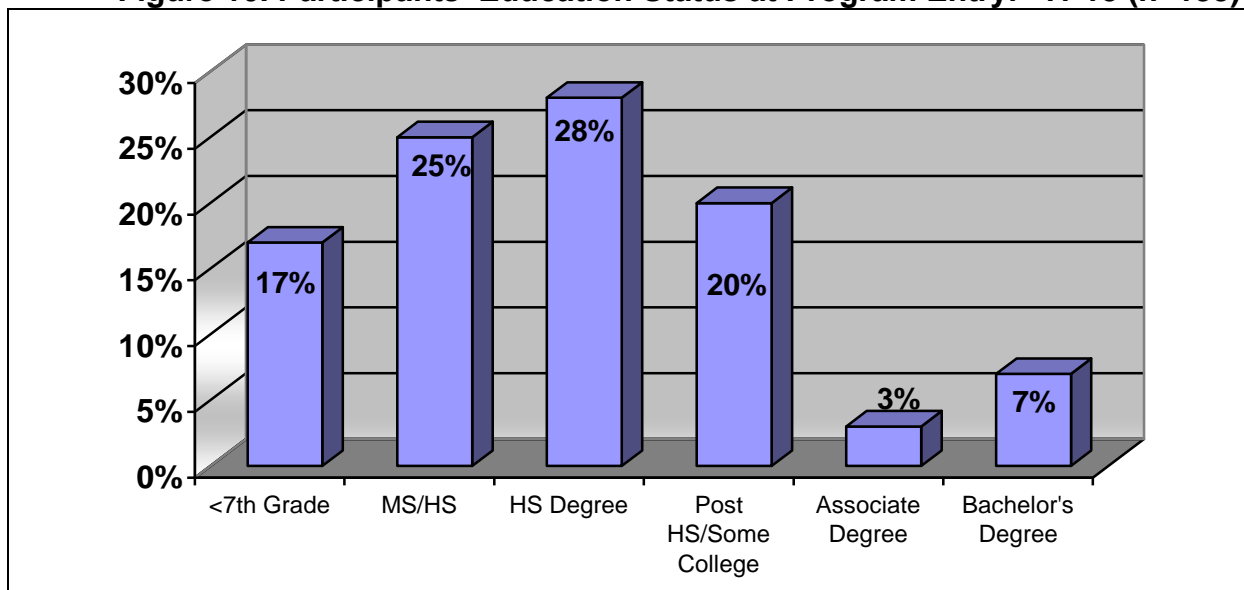
Figure 9. Mothers' Marital Status: Year 15



Education

Education is strongly encouraged in the HFM program because it plays an essential part in the development of self-sufficiency, resiliency and economic independence. Quality education also helps participants learn parenting skills and foster a love of learning in their children. Our past findings have noted a significant relationship between having a high school degree and increased scores on measures of parenting knowledge. In examining the highest level of education achieved at enrollment, almost two-thirds (63%; n=77/123) of active participants 18 years of age or older had obtained their high school diploma, GED or higher. As seen in **Figure 10**, 21% (n=26) of active participants had also attended at least some post high school training as well, and 11% (n=13) obtained an Associates or Bachelor's Degree. However, a large percentage of mothers had less than a 12th grade education (42%) and 17% 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 many do pursue a GED.

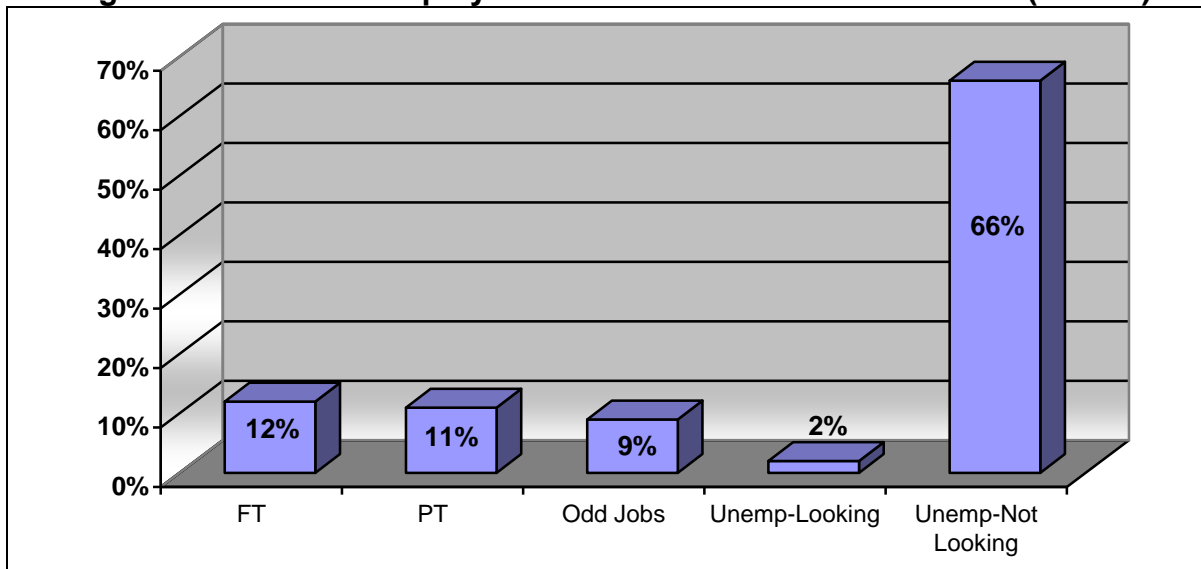
Figure 10. Participants' Education Status at Program Entry:* Yr 15 (n=133)



Employment

Financial stability is also integral to self-sufficiency and plays a role in participant resiliency. The HFM program fosters financial stability by offering assistance with employment-related issues, connecting families to community resources and opportunities, and providing encouragement. Data from Year 15 on participants' employment status at enrollment was examined for participants who were not enrolled in school (n=125). As seen in **Figure 11**, more than two-thirds (68%) of participants were unemployed and not looking for a job at enrollment, while one-third (32%) were working full/part-time or working odd jobs. It is not surprising that such a large percentage of mothers were not employed since they were either perinatal or within 3 months postnatal. Ten mothers were in school at enrollment.

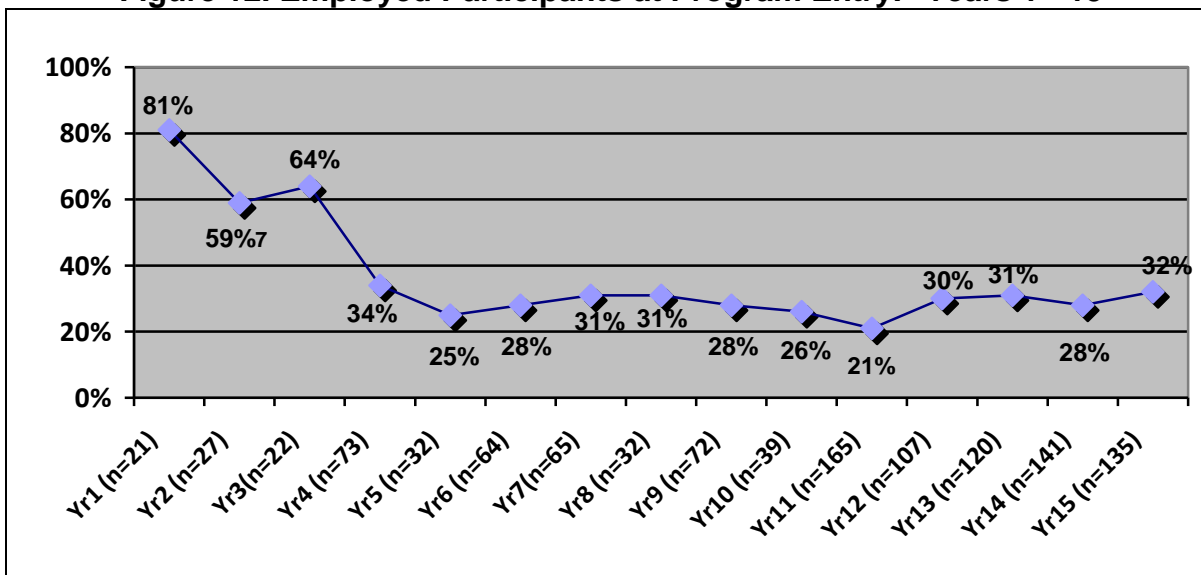
Figure 11. Mothers' Employment Status at Enrollment: Year 15 (n=125*)



*does not include ten mothers who were in school at enrollment.

As seen in **Figure 12**, employment rates were higher in the initial years of the program, but decreased significantly in Year 4. Mothers' employment rates at program entry have remained approximately 29% over the years. In Year 15, 32% (n=43/135) of participants were employed full or part-time, including odd jobs and self-employment.

Figure 12. Employed Participants at Program Entry:* Years 1 - 15



*Excludes enrollees that are full-time students

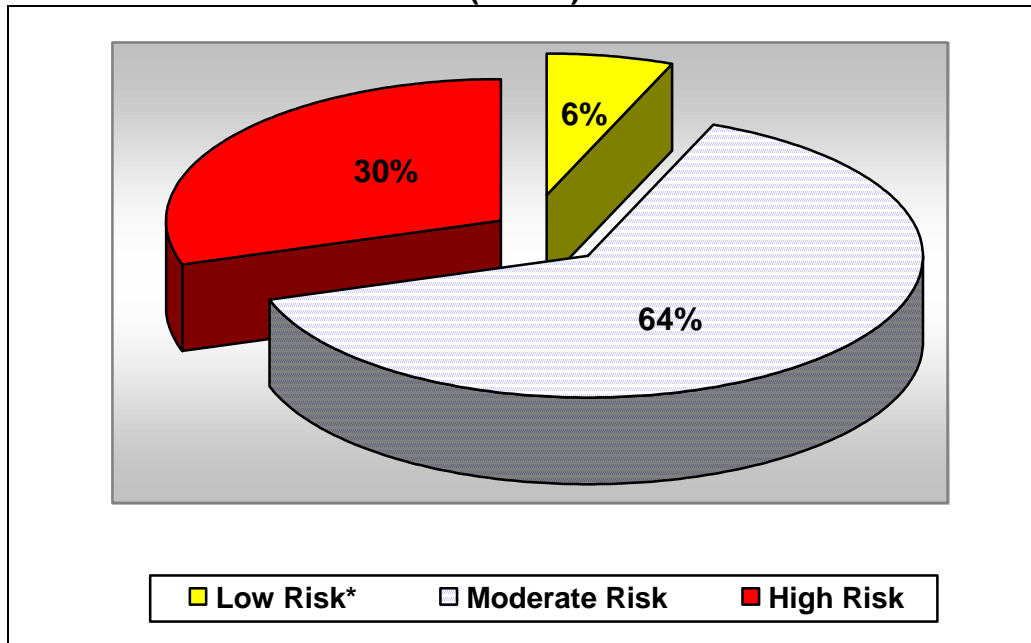
Risk Factors

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

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

While eligibility criteria pre-selects a participant population that is at moderate risk or greater for child abuse and neglect, many families present a constellation of factors that place them at severe risk. **Figure 13** below shows the categorization of the FSC/Parent Survey scores of 134 active enrollees during Year 15. For those mothers who scored in the low range, they were found eligible for the program based on the father's FSC risk score. Almost one-third of mothers (30%) scored in the High/Severe Risk range, while most mothers (64%) scored in moderate risk range.

Figure 13. FSC/Parent Survey Risk Scores at Program Entry: Year 15 (n=134)



* Eligibility based on FOB score

It has been found that psychosocial factors play a significant role in assessing the mother's level of risk. Examination of the individual factors addressed on the Parent Survey shows the areas associated with the highest levels of risk for the HFM mothers as they entered the program. The possible scores for each factor, 0 (low risk), 5 (moderate risk), or 10 (severe risk), were averaged across participants and the mean score for each calculated. Results for active participants in Year 15 indicate that the four most significant risk factors based on mean score are displayed in **Table 5** in rank

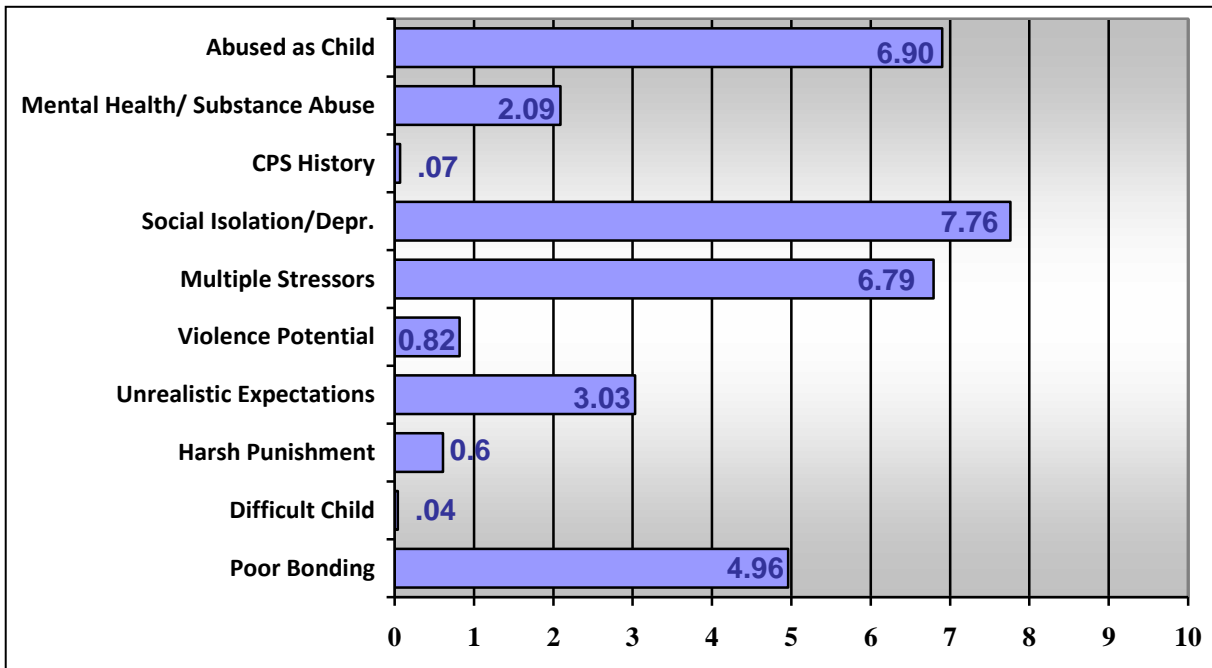
order. This constellation of severe risk factors places these mothers and their children at very high risk for child maltreatment.

Table 5. Risk Factors with Highest Mean Score (n=134)

Parent Survey Risk Factor	Mean Score
• Social Isolation/Depression	7.76
• Being Abused as a Child	6.90
• Multiple Stressors	6.79
• Poor Bonding	4.96

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

Figure 14. Parent Survey Item Mean Scores by Subscale: Year 15 (n=134)

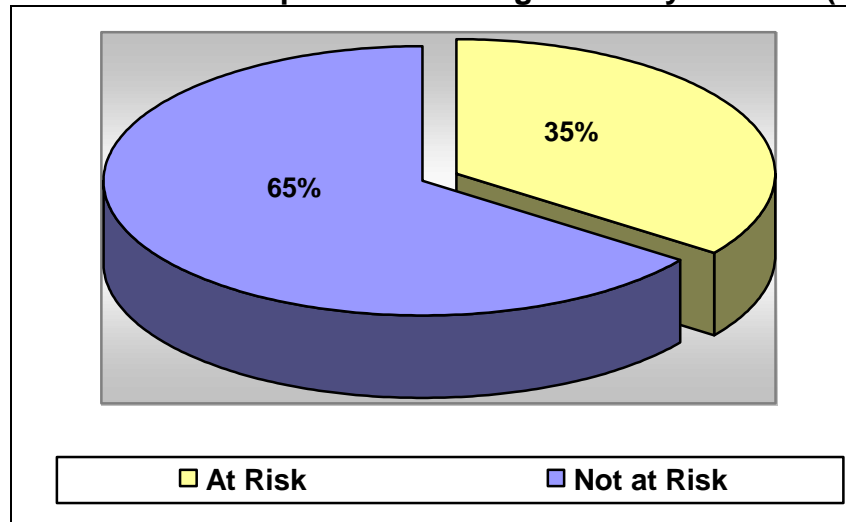


The pattern that emerges from the Year 15 profile of risk factors that represent childhood abuse, mental health issues, multiple stressors in their lives, and poor bonding and attachment with their child, is one that reflects an increased potential for child maltreatment, particularly neglect. The prevalence 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 places them at much higher risk for abuse. The identification of these at-risk mothers provides the Healthy Families Montgomery program the opportunity to break the cycle of abuse with these new mothers and their babies.

Maternal Depression

Depression is a potent correlate of child abuse and neglect, thus it is important to screen for depression and provide linkages to intervention services. The HFM program has used the Center for Epidemiologic Studies-Depression (CES-D), a self-report measure, to determine risk for maternal depression prenatally, post-partum and on an annual basis. Scores of 16 or above indicate risk for maternal depression. As seen in **Figure 15**, at program entry, *over one-third (35%; n=41) of Year 15 participants scored at risk for depression.*

Figure 15. Maternal Depression at Program Entry: Year 15 (n=117)

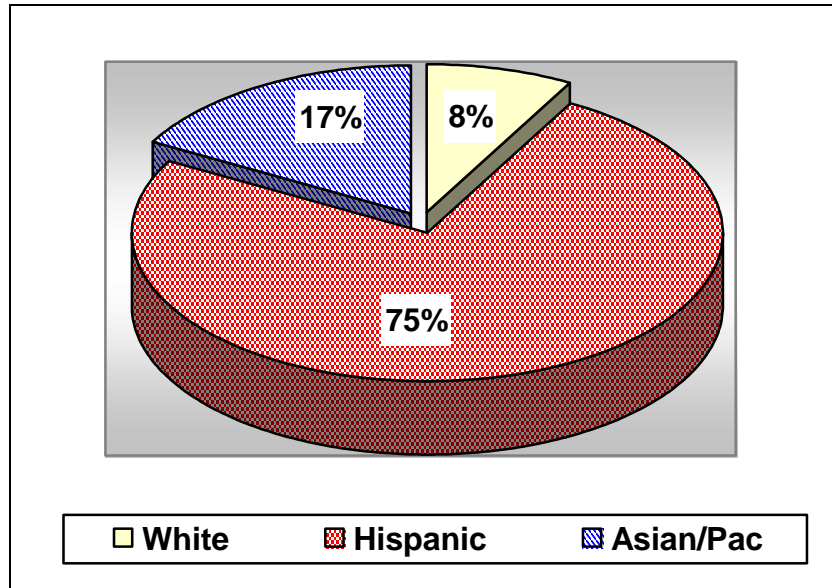


Staffing

During Year 15, the HFM program employed 12 individuals (10.25 FTEs). Staff positions included one Program Manager, two Team Leaders (one of whom also acts as the part-time Early Intervention Specialist), one Family Resource Specialist, 6 Family Support Workers, and one half-time Program Assistant. Two Baby Steps nurses are also employed within the HFM program, but their work mostly involves hospital screening at two local hospitals. However, budget reductions at the end of Year 14 affected staffing in Year 15 as the Program Assistant was reduced to half-time, and 1.5 FSW positions were eliminated.

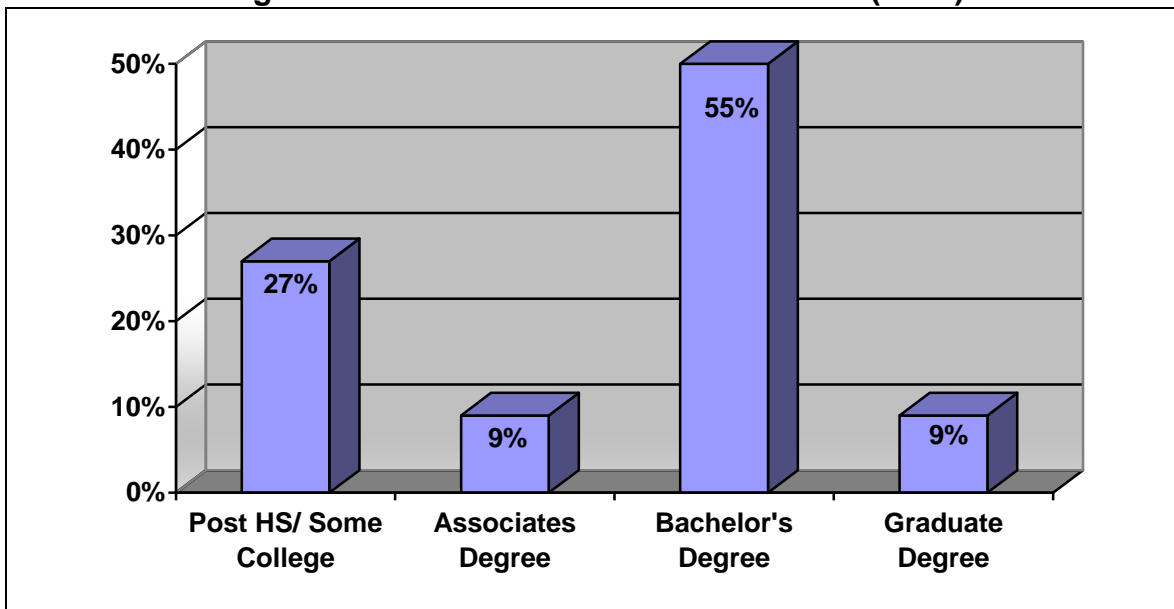
In order to ensure cultural and linguistic competence, the HFM program hires staff that reflects the ethnic and cultural composition of the target population. All staff were female and most were Hispanic (75%; n=9), while the remaining staff were white (8%; n=1) or Asian Pacific Islander (17%; n=2), see **Figure 16**. Almost all staff (92%; n=11/12) were bilingual in English and another language. Most in Spanish (75%; n=9) but one spoke English and Hindi/Punjabi (8%; n=1), and one spoke English and Chinese (8%; n=1).

Figure 16. Staff Ethnicity: Year 15 (n=12)



The collective educational level of the staff remains high. The staff employed during Year 15 is well-educated and highly trained, as evidenced by education levels and the extensive trainings completed (see Staff Training section below). As seen in **Figure 17**, all staff members have obtained a high school degree and have some post-high school training or college. Additionally, the majority of staff have attained a post-secondary degree, either an Associate's Degree (9%; n=1), a Bachelor's Degree (55%; n=6) or a Graduate Degree (9%; n=1).

Figure 17. Staff Education Levels: Year 15 (n=11)



Staff Attrition/Retention

The HFM program has retained many of its staff over the past fifteen years. High levels of staff retention reflect a stable program that values its staff and provides opportunities for feedback and growth. Staff retention has also been linked to family retention, particularly retention of the Family Support Workers who engage the families and are directly involved with them on a regular basis. All staff members have been with the program for at least one year and several staff have been with the program for over ten years, one of whom has been employed by HFM since the program began in 1996. During Year 15, one FSW left the program, which represents a 92% (n=11/12) staff retention rate (see Appendix L. Staff Tenure Dates: Years 1-15).

Staff Development

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

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

Trainings for Year 15 are provided in detail by date (see Appendix M: HFM Year 15 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 48 trainings covering over 44 different topics. In addition, staff attended a variety of other external trainings and professional conferences, such as the Healthy Families Maryland Spring Training Day. The trainings can be divided into four topic areas: Professional Development, Family Mental Health/Well-Being, Family and Child Health Care, and Child Development. Most trainings fell within 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 who are well-equipped to focus on their family’s mental health and helping parents optimize their child’s well-being.

- ***Professional Development***

Twenty-four trainings and conferences were offered in this area and are related to program implementation, management, data and evaluation. These included: Parent Survey Trainer recertification, Personal Safety, Child Abuse and Neglect Indicators and

Reporting, Mobilizing Support for Home Visiting Programs, Applying SEFEL in Home Visits, Professional Boundaries, Optimizing Effectiveness, Confidentiality and HIPPA, Conflict Resolution, Designing and Using an Effective Database, Culture and Communication, HFMD Spring Training Day, and Excel. A variety of local, national and federal conferences, as well as the HFA core training, was also provided.

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

Fourteen trainings were offered in this area and focused on general family functioning and parenting, as well as mental health, substance abuse and domestic violence. Topics included Abusive Head Trauma, Autism, Preventing Child Abuse, Addressing Domestic Violence, Promoting Mental Health, Recognizing Substance Abuse, Healthy Lifestyles, Green & Healthy Home, Striving for a Smoke-free Environment, Working with Families with Mood Disorders, Recognizing Perinatal Depression, Responding to Relationships, Diagnosis and Treatment of OCD, CBT for Panic and Other Anxiety Disorders.

- **Family and Child Health Care**

Eight trainings in this area covered topics related to the health care of children and families, including First Aid, CPR, Infection Prevention, Family Planning and STDs.

- **Child Development**

Two trainings were offered in this area that focused on child development and education. Topics included Supporting Infants and Toddlers Mental Health and From Trash to Toys.

Staff Satisfaction

In September 2011, ten 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). Respondents were asked to identify their position. Three respondents identified themselves as manager/team leader; six identified themselves as FSW/FRS category; and one marked the 'Other-Administrative' category.

The questionnaire consisted of 13 statements accompanied by a 5-point Likert scale. Respondents were asked to indicate if they *strongly agree*, *agree*, *are not sure*, *disagree* or *strongly disagree* for each item. As seen in **Table 6**, most staff members agree or strongly agree with the positive statements about the program. However, consistent with previous years, some staff does not feel that they are adequately compensated for the work they do. Compared to last year's responses, staff members appear more positive about their supervisors being responsive and more supportive of their needs, but they still feel there could be improvement in compensation.

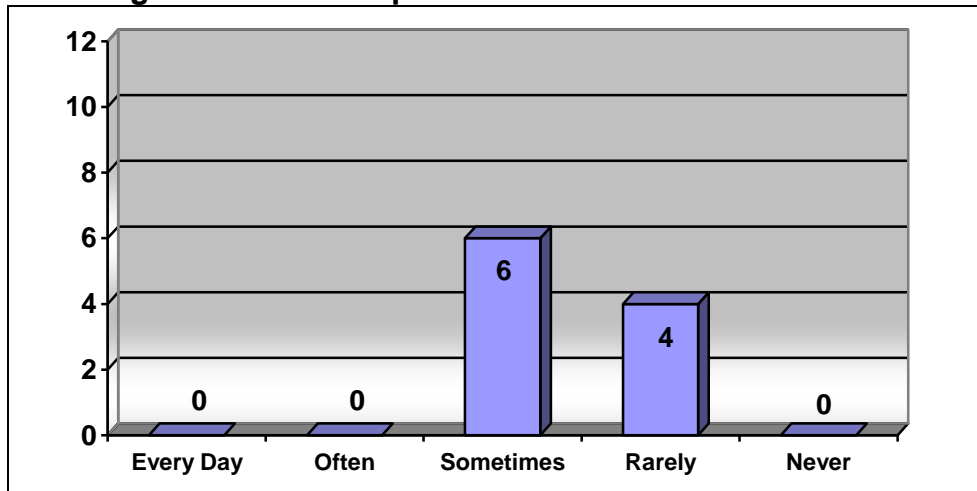
Table 6. Staff Agreement with Various Program Aspects

	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree
I understand the goals and objectives of HFM.	9	1			
HFM is a strength-based and family centered program. (One did not answer)	8	1			
HFM trainings adequately prepared me for my position.	7	3			
My supervisor is responsive and supportive of my needs.	4	6			
The program uses materials that are culturally and linguistically appropriate.	6	4			
The program uses bilingual materials as appropriate.	6	4			
I feel comfortable working with the culturally diverse families served by HFM.	7	3			
I enjoy being part of the HFM team.	8	2			
My work is worthwhile and has a positive impact on children and families.	9	1			
The work I do uses my skills, knowledge and experience.	8	2			
I generally feel safe in the communities I visit *	1	4	3		
HFM management shows appreciation for the work I do for the program.	3	6	1		
I am adequately compensated for my position.		3	4	3	

*2 staff answered N/A

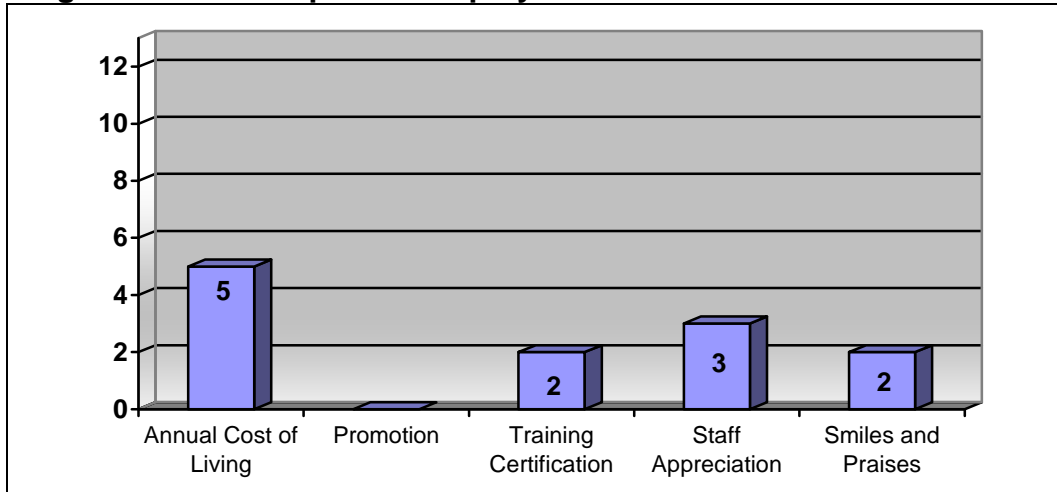
Staff members were asked to indicate how often they feel stressed at work. In contrast to previous years, most staff (n=6) feel occasional stress associated with their work, as indicated by the number who responded “Sometimes”, while the remainder (n=4) “Rarely” feel stressed.

Figure 18. Staff Report of Job Stress: Year 15



Staff members were asked whether they had received or taken part in any employment incentives during the past year. Consistent with last year, the majority of staff (n=5) reported receiving a pay increase (annual cost of living increase), while one third of staff members participated in a staff appreciation event (n=3), received a Training Certification (n=2) or “Smiles and Praises”, FSI’s internal staff recognition program (n=2). No staff received promotions. **Figure 19** shows staff reports of the employment incentives received within the past year.

Figure 19. Staff Report of Employment Incentives Received: Year 15



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, the three areas mentioned the most were: 1) strength-based approach; 2) program focus on prevention and child development; and 3) the quality of the staff, staff retention, and the organization. **Table 7** shows all current strengths cited by the staff in rank order, along with the frequency with which they appeared.

“...the high staff retention results in ongoing expertise of staff.”

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

Strength	Frequency
Program Curricula, goals, and procedures for level changes	3
Staff Retention, Quality, Bilingual/ Organization	4
Program’s strength-based approach	2

When asked which areas of the program need improvement, six individuals offered responses. There were no additional recommendations provided in the “comments” section. Two key areas emerged as targets for improvement: 1) Training: additional training resources and broader understanding of family support plans; 2) Professional Development: having administrative support, salary increases, and more possibilities to

grow in the program professionally. One staff member indicated there were no areas in need of improvement.

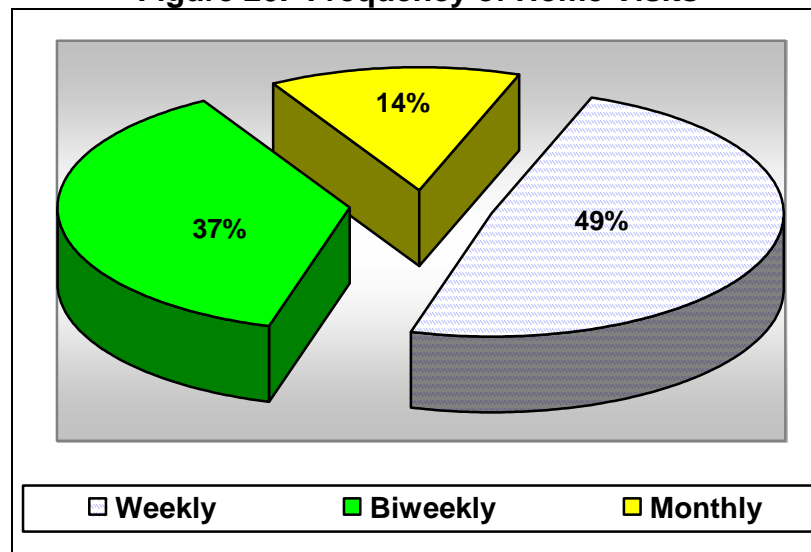
Participant Satisfaction

The Healthy Families Montgomery program strongly values fidelity to its model and to providing its families with the best quality support, information, and services. To this end, HFM administers annual participant satisfaction surveys to gather anonymous information from families regarding various program areas (see Appendix O: Participant Satisfaction Survey). As in past years, surveys in English and Spanish were distributed to all active participants during home visits. In Year 15, 94 surveys were distributed to families who were active at the conclusion of Year 15. Of these, 54% (n=51) returned the survey. The majority of respondents were between 21 and 30 years old (68%; n=34), while 30% (n=15) were 31 years old or older and 2% (n=1) was a teen between 16 and 20 years old.

“I became a good mother and understand more about my baby’s needs.”

Home visits are a core component of the HFM program. Survey results show that the majority of participants were receiving the most intensive level of services, as indicated by frequent home visits, reflecting that they were at the highest level of risk. A majority of the respondents reported that they received home visits once a week (49%; n=25), as depicted in **Figure 20**. An additional 37% (n=19) reported that they were visited twice a month and 14% (n=7) indicated that they were visited once a month. *Ninety-six percent (n=49) of the respondents reported that they received their first home visit before their babies were 3 months old.*

Figure 20. Frequency of Home Visits

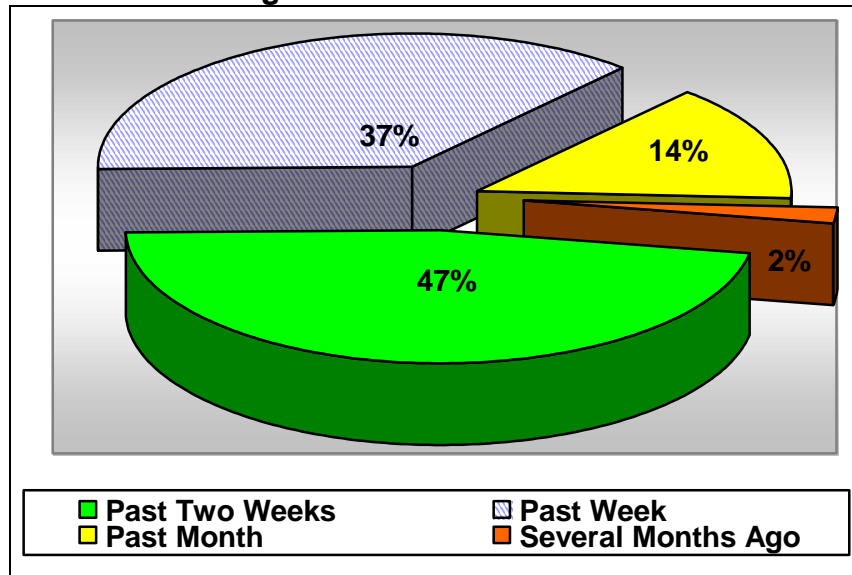


Participants were also asked when their most recent home visit occurred. Results for Year 15 indicate a smaller percentage of participants were visited in the week prior to the survey collection (37%; n=19) as compared to last year (70% in Year 14). As

depicted in **Figure 21** below, the highest percentage of respondents reported being visited within the past two weeks (47%; n=24), which is a large increase from last year (19% in Year 14). The remainder of participants reported being visited within the past month (14%; n=5), also an increase from last year (8% in Year 14), while one participant (2%) reported they had been visited several months prior.

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

Figure 21. Last Home Visit



Participants were asked how effective they thought the program was in various areas by circling “Yes” or “No.” **Table 8** shows the percentage of “Yes” answers. Respondents unanimously perceived the program to be effective in all categories, with the exception of question #8, on which one person responded ‘NO’ to whether their FSW had helped them to be more independent by helping them make their own decisions. However, most respondents (98%; n=50/51) answered this in the affirmative.

Table 8. Participant Perception of Program Effectiveness (n=51)

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

9. My Family Support Worker has helped me to become a better parent.	100%
10. My Family Support Worker has made a positive impact.	100%

When asked what they liked best about the program, 48 participants responded with 52 positive comments about the program. Most of the comments 60% (n=31/52) focused on how the HFM program has helped them to be a better parent by teaching them about child development and strategies for helping their child learn. Parents also value the support and guidance they receive from their FSWs when the family is in need, as well as the information they give them about community resources.

“They have helped me as a woman and a mother.”

Table 9. Best Aspects of HFM Program

Comment	# Respondents
1. Parenting/Child Development	31
2. Everything/Support/Information	10
3. FSW	6
4. Self-Sufficiency/Problem Solving	5

When asked what they did not like about the program and if they had recommendations for improvement, almost all (92%; n=34/37) responded that there was nothing that they did not like and that they thought the program was excellent. Of the three respondents who had a suggestion, one thought there were not enough social gatherings or outdoor excursions, one felt the program should have transportation to parent activities, and one wanted their FSW to be able to participate in her family’s social events.

“I learned how to discipline my son without being harsh.”

Participants were asked if they had any recommendations for improvement of the HFM program. Of the 35 participants who responded, most (51%) re-iterated that the program was excellent and that there was nothing to

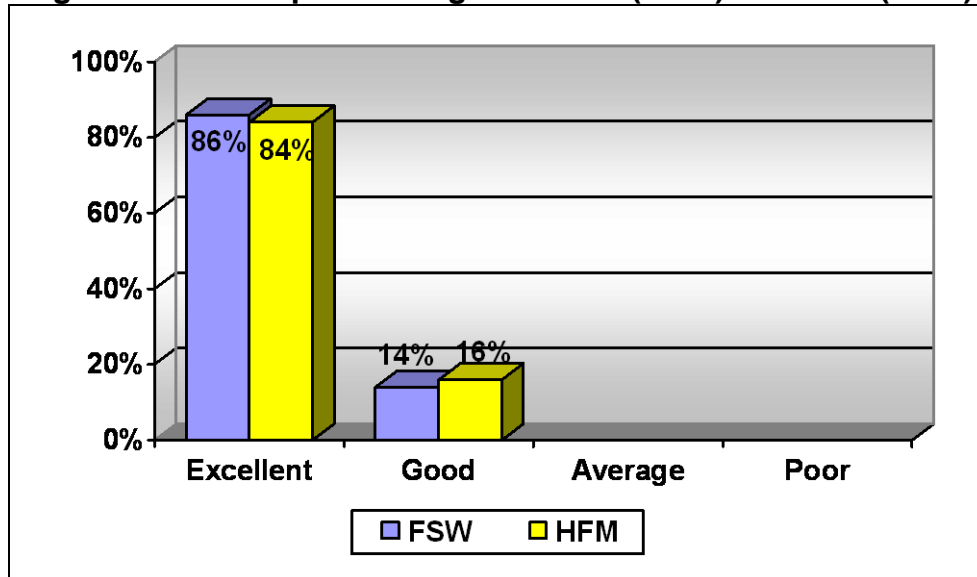
change. Of the 18 participants who made recommendations for improvements, most (n=6) wanted more group activities for mothers to get to know each other, provide support and socialize. Several (n=4) recommended transportation be provided for parents to attend program activities and others (n=3) wanted additional child development activities and classes only for children. Two participants expressed a desire for family counseling and for their FSW to be their counselor, while the remaining participant suggested using multi-media programs for both parents and children.

Table 10. Recommendations for Improvement

Comment	# Respondents
1. More Group Activities for mothers	6
2. Transportation	4
3. English classes for mothers	2
4. More Child Development activities/groups	3
5. Counseling	2
6. Multi-media programs	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 22**. No participants rated the program or their FSW as “Average” or “Poor”.

Figure 22. Participant Ratings of FSWs (n=50) and HFM (n=51)



All respondents (100%; n=51) agreed that they would recommend the program to a friend or relative, with 88% responding “Strongly Agree.”

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

B. OUTCOME EVALUATION

Achievement of Goals and Objectives

In the past fifteen years, Healthy Families Montgomery has continually met its goals and outcomes successfully, as well as exceeded many of its targets for key outcomes. As seen below, current outcomes confirm the program's ability to sustain its successes through its fifteenth year of operation as well (see Table 10: Summary of Goals, Objectives, and Program Outcomes: Years 1-15 and Table 11: Summary of Goals, Objectives, Program Outcomes and Comparative Statistics: Year 15).

Goal I: Reduce Incidence of Child Maltreatment

Families will have no founded reports while enrolled

The overarching goal of the Healthy Families program is to prevent or reduce child abuse and neglect. Families found eligible for the HFM program are identified as experiencing multiple stressors and risk factors that place them at moderate to high risk for child maltreatment. In addition to monitoring this outcome through direct contacts with families and home visit records, HFM receives aggregated reports from Child Welfare Services semiannually. During Year 15, *100% of families had no founded Child Welfare Services (CWS) cases*. This finding provides solid evidence of the positive impact that prevention can have on reducing the incidence of child maltreatment with high-risk families. Over the fifteen years of program implementation, there have only been six cases of founded child maltreatment, all of which were cases of neglect.

Goal II. Promote Preventive Health Care

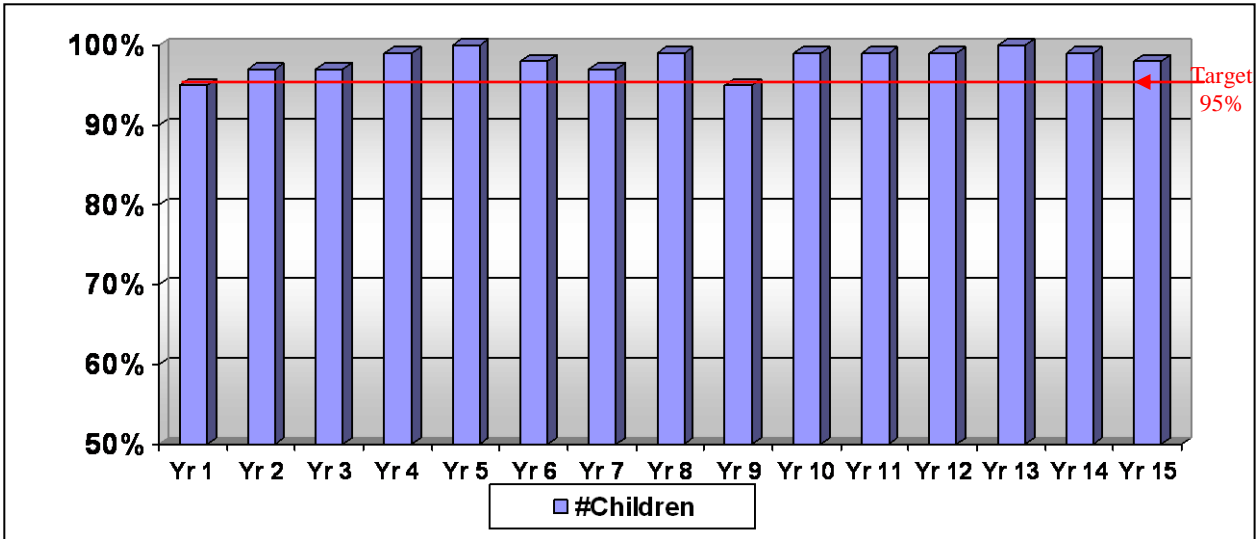
Health Care Provider

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

As seen in **Figure 23**, of the 129 target children at the end of Year 15, 122 were at least two months old by the end of the reporting period. Of these *98% (n=120/122) were linked with medical providers, exceeding the program's goal*. In addition, *99% (n=128) of non-target children were enrolled in MA*. These results increase the likelihood that

children will receive timely immunizations and well-child checkups. These results exceed the national rate for child health insurance coverage of 92% (CDC, 2009).

Figure 23: Child Access to Health Care Provider:* Years 1-15

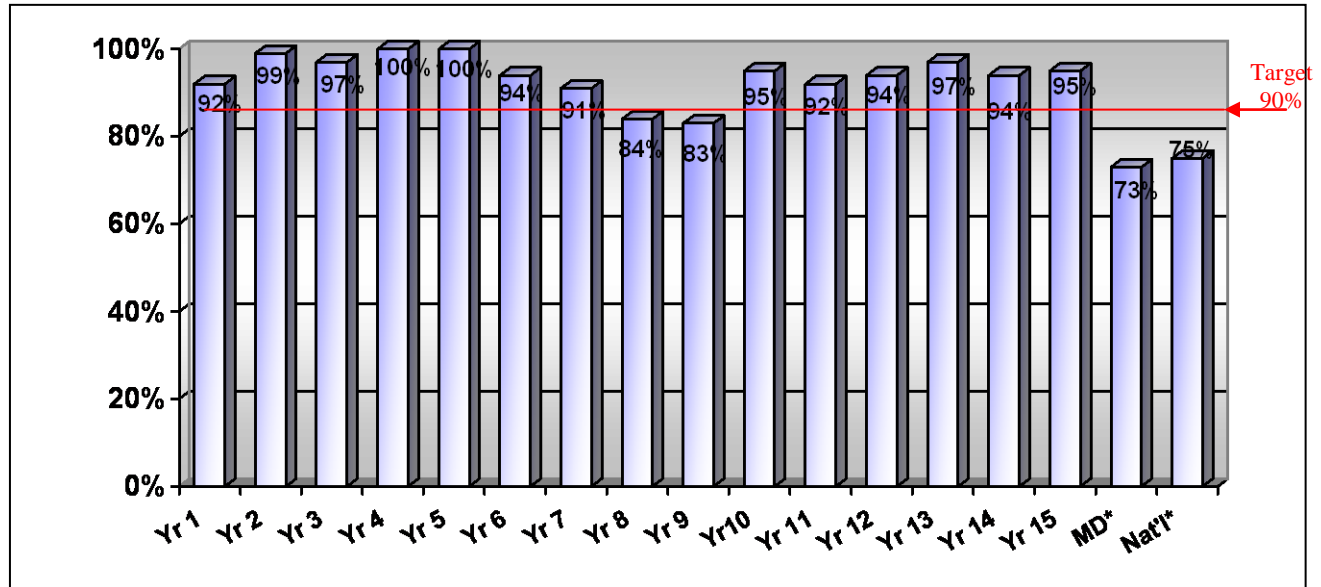


*Access is defined as having health insurance and/or linked to a provider.

Current Immunizations

FSWs work with families to ensure that babies are immunized in a timely fashion. This is done through providing information to families on the importance of immunizations for preventing serious medical diseases and by assisting with linkage to healthcare providers, helping to set up appointments when needed, and giving reminders about appointments as necessary. As a result, HFM has achieved impressive success rates with infants receiving their immunizations on schedule. Families are more likely to follow up on immunizing their children if they have both health insurance and a medical provider. Consequently, this goal is closely linked to the previous goal of assisting families in securing medical homes. When examining children who were active during Year 15 and were old enough to be immunized, HFM exceeded their goal by having 95% of all target children ($n=111/123$) current on their immunizations as recommended by their medical provider. As seen in **Figure 24**, this is especially impressive when compared to the Centers for Disease Control 2010 findings on immunization rates for the nation (75%). It also exceeds the State of Maryland immunization rate of 73% (CDC, 2010).

Figure 24. HFM Immunization Rates: Years 1-15



*National and State percentage taken from the CDC immunization 4:3:1:3:3:1 series 2010 report http://www.cdc.gov/vaccines/stats-surv/nis/data/tables_2010.htm

Additional Births

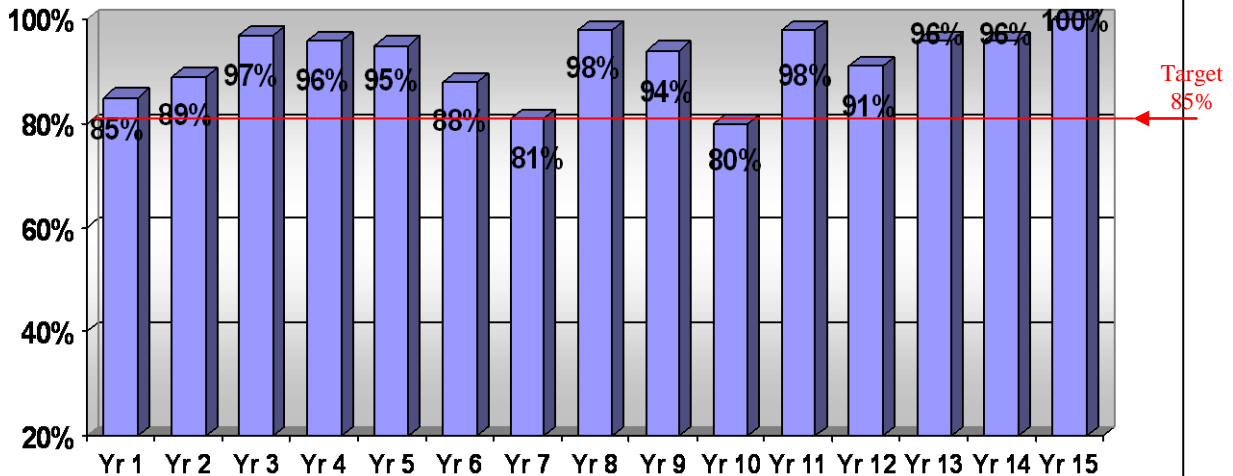
It is recommended that mothers, particularly teenage mothers, wait a period of at least 24 months between pregnancies. The HFM program provides information on family planning to participants immediately upon enrolling in the program. FSWs alert new parents to the fact that additional pregnancies can 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 15, 100% (n=135) of mothers did not have a repeat birth within a 24-month period during their enrollment in the HFM program. HFM's success rate in this area has consistently exceeded both Maryland State (82%) and national statistics (81%).

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. Of the 45 mothers who were due for their post-partum visit by the end of June 2011, 100% completed their post-partum care (see **Figure 25** below). This significantly exceeds the national rate of 70%.

Figure 25. Percentage of Mothers Completing Post-Partum Care: Years 1-15



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. Despite this, the program strives to educate participants about how to ensure the most positive health outcomes for their babies by encouraging all prenatal enrollees to attend their scheduled prenatal care visits and by providing information on healthy eating and lifestyle habits during pregnancy. During Program Year 15, 129 target babies were born to active participants in the program. Of these, 96% ($n=124$) were born at a healthy birthweight (>2500 grams or 5.5 lbs). Of the five babies who were born at low birthweights, all enrolled in the program postnatally, but had received prenatal care in their first or second trimester. When birthweight is examined for only those babies who were born during Year 15, the percentage changes to 100% ($n=20/20$) of babies born at a healthy birthweight.

National and Maryland statistics indicate that when birthweight is examined by ethnicity, African-Americans are twice as likely to have babies with low birthweight. As seen in the comparative statistics below, HFM has exceeded National and State percentages overall and for each ethnicity (CDC, 2010). Most striking is the 100% healthy birth weight for African-Americans.

- **HFM Year 15: Total=96%, Latino= 96% (n=108), African-American=100% (n=14)**
- **2009 National: Total=92%, Latino=93%, African-American=87%**
- **2009 Maryland: Total=91%, Latino=93%, African-American=87%**

Goal III. Optimize Child Development

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

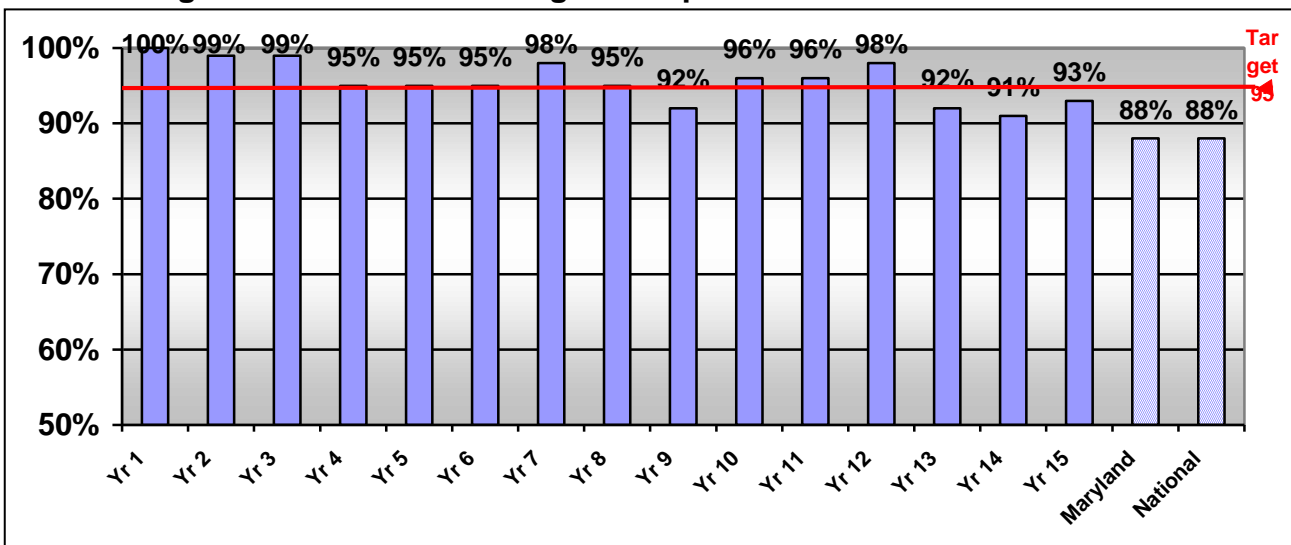
Developmental Delay

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

During Program Year 15, there were 129 target children who participated in the program and 92 target children who should have been screened at least once. Of these, **95% (n=87/92) received an ASQ during the past year**. There were only 5 children who were scheduled to receive an ASQ but did not get one during Year 15.

By the end of Year 15, a total of 9 children were identified with a developmental delay and were receiving services from MCITP (n=4) or MCPS/Child Find (n=5). Therefore, **93% (n=120/129) of children demonstrated normal child functioning and were meeting developmental milestones**. When comparing this percentage to the prevalence rates at the National and State level, this data provides strong evidence of the impact of the program's developmental activities on mitigating the role of environmental factors in developmental delay. At both the national level and in Maryland the prevalence for developmental delay that would qualify a child for Part C is approximately 12% (NECTAC, 2010).

Figure 26. Children Meeting Developmental Milestones: Years 1-15



Goal IV. Promote Family Self-Sufficiency

Family self-sufficiency is a “composite variable” encompassing factors such as employment, education and housing status that serve as indicators of a participant’s autonomy and ability to live without outside aid or support. These factors were examined at entry and again at the close of Program Year 15. 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 15 for all active participants. At baseline, 62% (n=83/135) were either married or living together with their partner. At the end of Year 15, this percentage increased slightly to 63% (n=81/128) of participants who were either married or living together with their partner. Of those who entered Year 15 living with their partner but never married, five (8%) married by the conclusion of the reporting period. Of those who were single at baseline, five (10%) were married for the first time by the end of Year 15.

Employment and Education

Year 15 baseline and follow-up data was compared for mother’s employment status and educational level. At baseline, 31% (n=42/134) were employed full or part-time. At the conclusion of Year 15, this percentage doubled to 60% (n=64/106) of mothers employed full or part-time (including those who were self-employed or had odd jobs).

At enrollment, there were ten mothers who were under the age of 18 years, four of whom were in school. These ten mothers were excluded from percentages calculated for a HS diploma or higher. At enrollment, 63% (n=77/123) of Year 15 mothers over the age of 18 years had a high school degree or higher. At the end of Year 15, 67% (n=74/111) improved their education level and had a HS degree or higher.

When both employment and education factors are considered together and assessed for either remaining positive or improving, *88% of mothers (n=92/105) had improved or maintained positive educational or employment status.*

- Positive or improved educational *and* employment status n=38
- Positive or improved educational status only n=30
- Positive or improved employment status only n=24

Housing

Data on housing status at enrollment was available on all 135 program participants from the sample. Records indicate that at program entry, 98% of participants had stable housing. Of those that did not, one was living in a shelter and two were guests in another’s home. The majority of participants were renting (85%, n=115). Of that group,

36% (n=48) lived with family and paid rent, while an additional 18% (n=24) were renting a house, apartment or trailer, and the remaining 32% (n=43) lived with friends and paid rent. Eleven percent (n=15) reported living with family and paying no rent, while 2% (n=2) reported owning their own home.

Follow-up data on housing status was available for 118 participants. **At the end of Year 15, 98% (n=115/118) either maintained stable housing or improved their housing status.** Four participants who had been living with friends and paying rent at enrollment were renting their own house, apartment, or trailer by the end of Year 15, while one participant who had been renting at enrollment had purchased a home during Year 15. The three participants who had unstable housing at the end of the year, also had unstable housing at enrollment.

Goal V. Promote Positive Parenting and Parent-Child Interaction

1. Parents will have adequate knowledge of child development

The Healthy Families Parenting Inventory (HFPI) focuses on behavior, attitudes and perceptions related to parenting within nine domains: Social Support, Problem Solving, Depression, Personal Care, Mobilizing Resources, Role Satisfaction, Parent-Child Interaction, Home Environment, and Parenting Efficacy. **Table 11** shows the percentages of mothers who scored at-risk in each of the nine domains at three time points. Subscales with consistent decreases in the percentage of mothers at-risk are highlighted in yellow. These include Problem Solving, Personal Care, Mobilizing Resources, and Home Environment.

Table 11. HFPI Risk Status-Percent Mothers At Risk

Subscale	Baseline	12- Months	24- Months
Social Support	27% (n=26/98)	28% (n=16/57)	31% (n=15/48)
Problem Solving	24% (n=23/97)	14% (n=8/58)	8% (n=4/48)
Depression	31% (n=30/97)	40% (n=23/58)	38% (n=18/48)
Personal Care	16% (n=15/97)	14% (n=8/58)	10% (n=5/48)
Mobilizing Resources	27% (n=26/97)	9% (n=5/58)	4% (n=2/48)
Role Satisfaction	23% (n=18/80)	25% (n=14/56)	35% (n=17/48)
Parent-Child Interaction	27% (n=21/78)	17% (n=10/58)	21% (n=10/48)
Home Environment	29% (n=22/77)	2% (n=1/57)	0% (n=0/48)
Parenting Efficacy	20% (n=15/75)	4% (n=2/56)	9% (n=4/47)

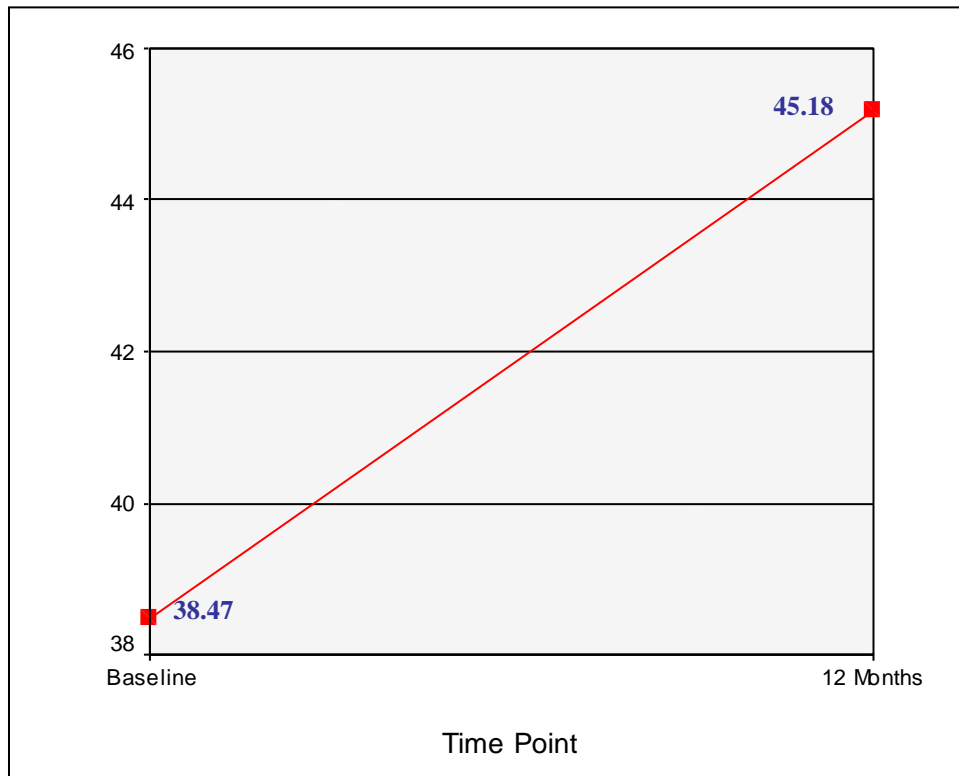
*Results based on all HFPIs administered to Year 15 participants

**the N may be lower for some subscales because if any question within a subscale was not asked/answered, the subscale score cannot be calculated.

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

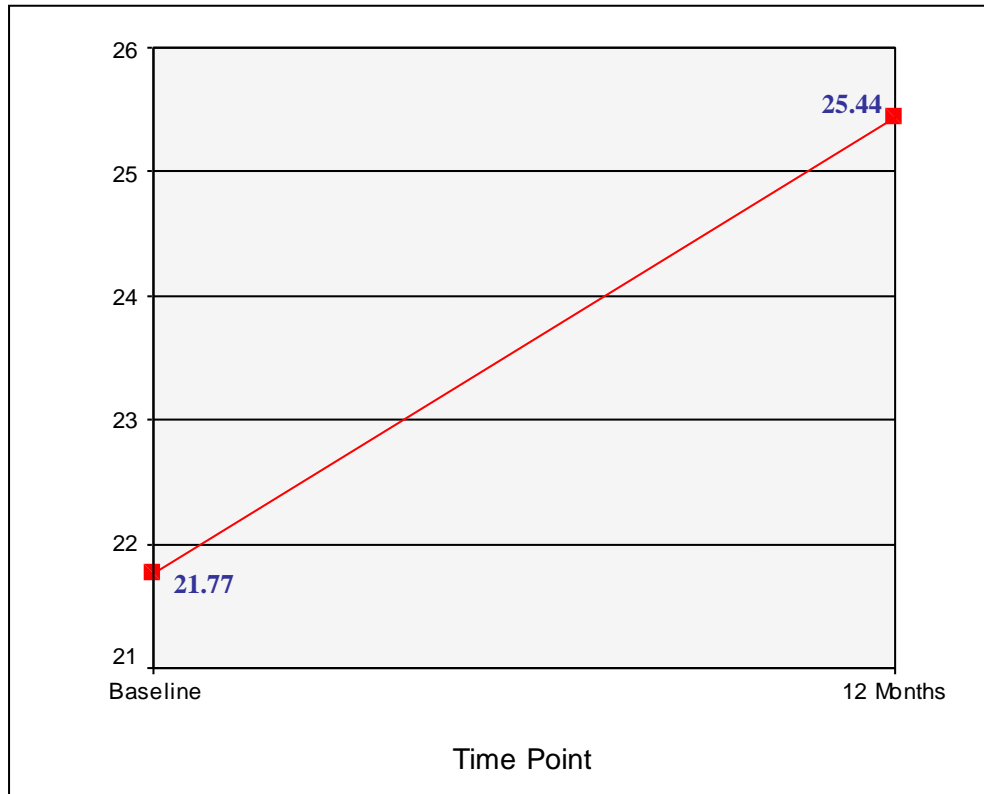
The Home Environment subscale measures the safety, organization, availability and quality of stimulating materials and activities in the home. Although the mean score at baseline was already above the risk cutoff, there was significant improvement in the group's score ($F=33.258$, $df (1,33)$, $p=.000$) from baseline ($\bar{x}=38.47$) to the 12-month follow-up ($\bar{x}=45.18$), see **Figure 27**. Using partial eta squared, an effect size of .502 was calculated, indicating that 50% of the variance in Home Environment mean scores can be accounted for by time in the program. This is a particularly important finding as the HFM program places emphasis on teaching parents child development activities through the use of ASQ and Parents as Teachers (PAT) curriculum.

**Figure 27. Home Environment Subscale (n=34)
Risk Cut-off =<33**



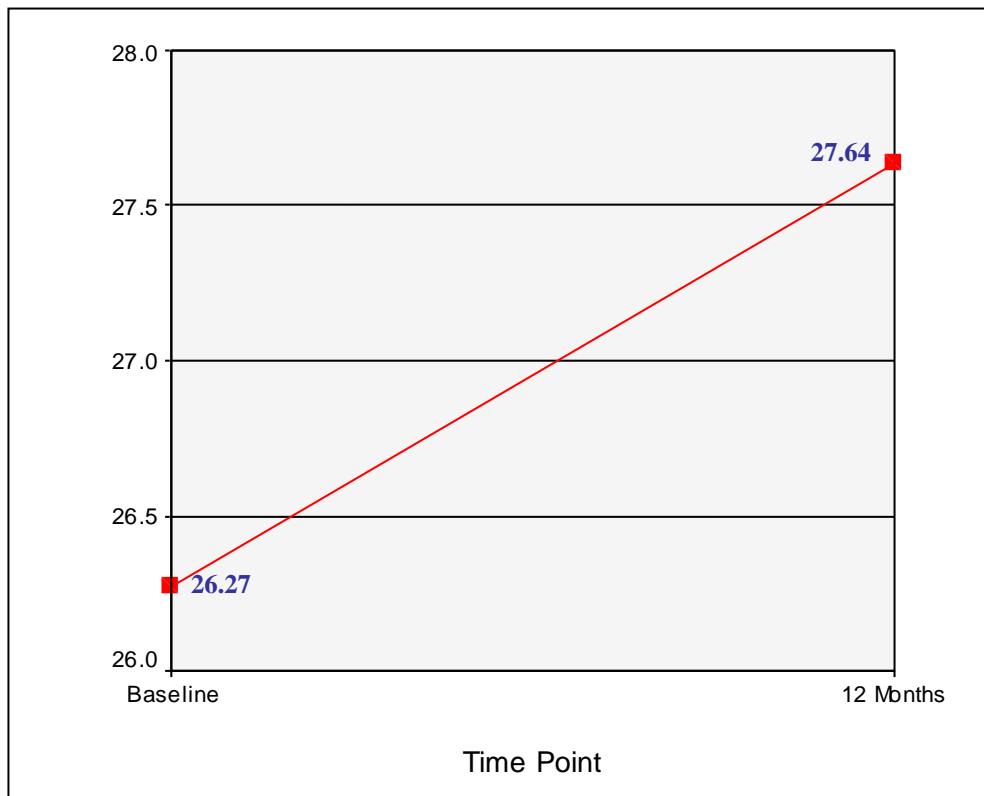
The Mobilizing Resources Subscale measures participants' knowledge of available resources in the community, as well as their comfort level in seeking help if needed. GLM Repeated Measures results indicate that a significant increase in mean scores was attained after 12 months of program participation, thus significantly reducing risk ($F=15.676$, $df(1,42)$, $p=.000$). As seen in **Figure 28**, mean scores increased from baseline ($x=21.77$) to the 12-month follow-up ($x=25.44$). Using partial eta squared, an effect size of .272 was calculated, indicating that 27% of the variance in Mobilizing Resources mean scores can be accounted for by time in the program.

**Figure 28. Mobilizing Resources Subscale Mean Score (n=43)
Risk Cut-off =<18**



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 ($F=5.993$, $df(1,32)$, $p=.020$). As seen in Figure 29, mean scores increased from baseline ($x=26.27$) to the 12-month follow-up ($x=27.64$). Using partial eta squared, an effect size of .158 was calculated, indicating that 16% of the variance in Parenting Efficacy mean scores can be accounted for by time in the program.

**Figure 29. Parenting Efficacy Subscale Mean Score (n=33)
Risk Cut-off =<22**

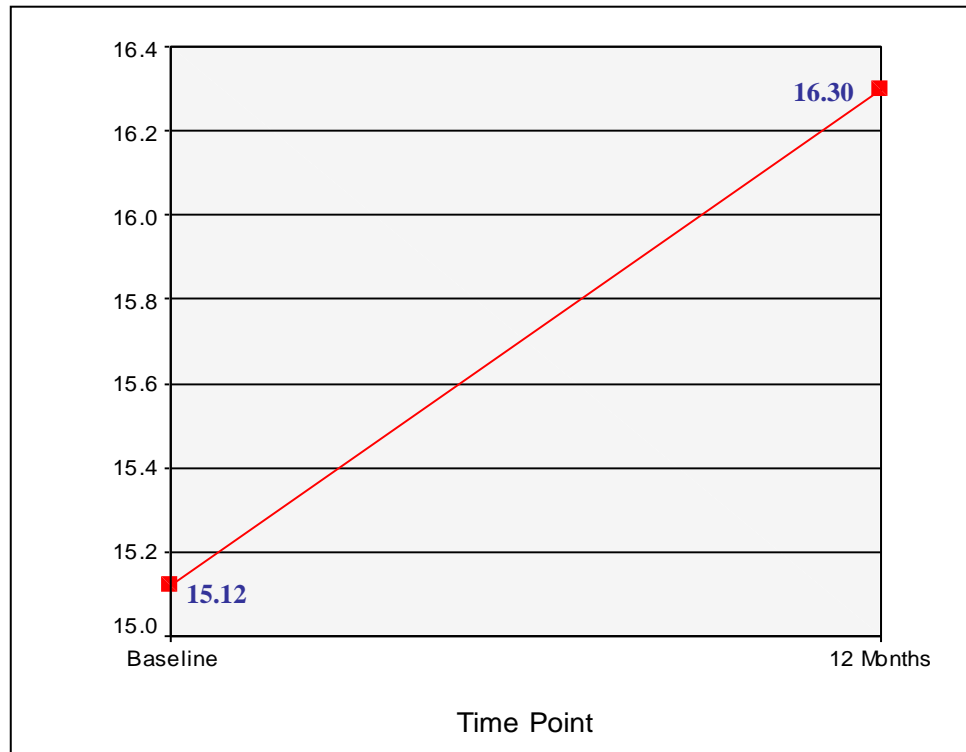


2. Parents have adequate knowledge of child safety

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 135 participants in Year 15, 116 were administered a baseline safety measure. At baseline, 95% (n=110) earned scores in the high knowledge ranges, while after one year of program participation, 55 parents were administered a follow-up safety measure. Of these, 96% of parents (n=53) had done the same, demonstrating adequate knowledge of child safety.

GLM repeated measures analyses were conducted on Safety Checklist scores from Baseline to 12 months. As seen in **Figure 30**, mean scores for those participants who had measures at both timepoints (n=40) increased significantly from 15.12 to 16.30 (F=4.278; df(1,49); p=.044), indicating a higher level of safety knowledge.

Figure 30. Parent Knowledge of Safety: Baseline and 12 Months (n=50)

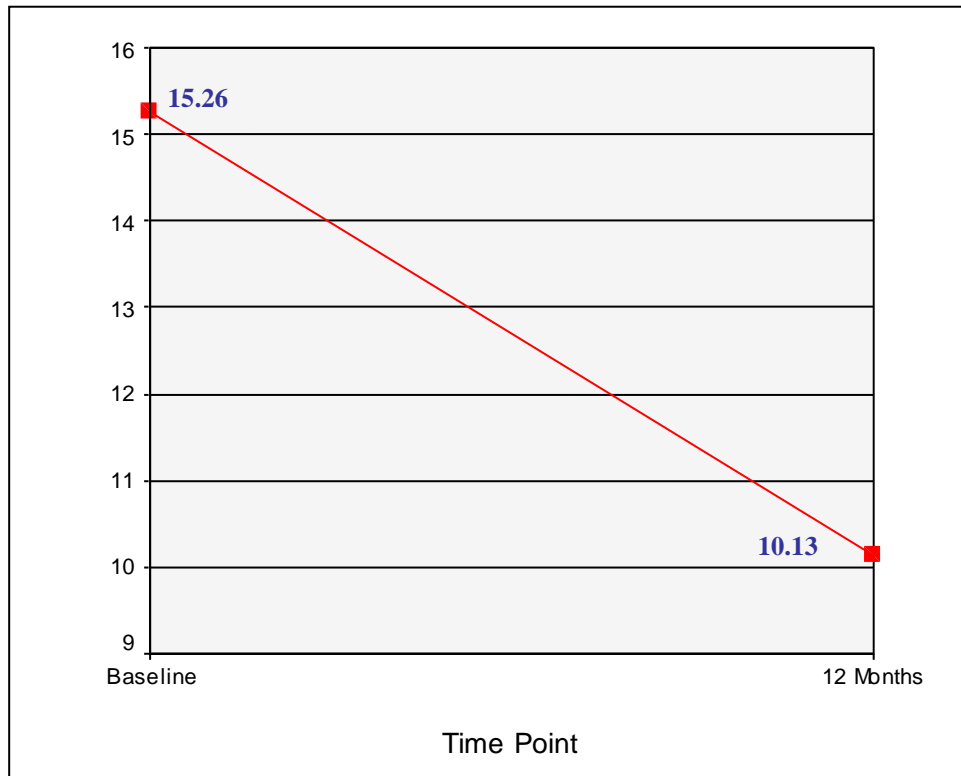


3. Psychosocial Factors

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. Results of the CES-D parallel those on the Depression subscale of the HFPI, however the CES-D indicates significant change occurred after 12-months of participation. GLM repeated measures analyses were conducted on CES-D scores from baseline to 12 months. Of the 135 HFM sample, 39 had CES-D scores for both time points. These mothers entered the program around the time of the birth of their baby and stayed in the program for at least one year. As illustrated by **Figure 31**, this group's mean baseline score ($\bar{x}=15.26$) was already slightly below the cutoff. However, after 12 months of program participation, this group's mean dropped significantly ($F=8.906$; $df(1,38)$; $p=.005$) to $\bar{x}=10.13$, well below the risk cutoff. These results highlight the success of the program in providing mental health services and linking participants to appropriate mental health professionals, resulting in decreases in depressive symptomology after one year of enrollment.

Figure 31. Repeated Measures: Maternal Risk for Depression (n=39)



SUMMARY

Outcome Evaluation results for HFM Years 1 -15 are summarized in **Table 12**. Outcome highlights are presented in **Table 13** with local, state and national comparative statistics. As seen in the tables, there were no founded CWS reports among families in the HFM program in Year 15. This was achieved despite the initial risk status of families enrolled in Year 15. In the area of health, 98% of children were linked with medical providers and 99% were enrolled in Medical Assistance (MA), exceeding the program's goal. In addition, 95% of all target children were current with their immunizations. This is especially impressive when compared to the national (75%) and Maryland (73%) immunization rates (CDC, 2010). The high percentage of mothers who completed post-partum care (100%) was no doubt linked to the fact that all mothers (100%) did not have a repeat birth within a 24-month period. In addition, 96% of all babies born in Year 15 had a healthy birthweight.

During Year 15, 93% of children demonstrated normal child functioning and are meeting developmental milestones. In the area of positive parenting, significant increases were measured in parents' knowledge of child safety, parents' knowledge and ability to mobilize community resources, parenting efficacy, and in providing a stimulating and safe home environment for their baby. Additionally, there were significant decreases in parents' risk for depression, a potent factor in reducing risk for child maltreatment.

**Table 12. Healthy Families Montgomery Years 1-15
Summary of Goals, Objectives and Program Outcomes**

Goals and Target Objectives	Yr 1 N=38	Yr 2 N=71	Yr 3 N=73	Yr 4 N=145	Yr 5 N=159	Yr 6 N=196	Yr 7 N=191	Yr 8 N=146	Yr 9 N=162	Yr 10 N=170	Yr 11 N=179	Yr 12 N=144	Yr 13 N=131	Yr 14 N=141	Yr 15 N=135
<i>Goal I: Reduce Incidence of Child Maltreatment</i> 95% No founded CWS reports ¹	95%	100%	99%	100%	98%	99%	99.6%	100%	100%	99%	100%	100%	100%	100%	100%
<i>Goal II: Promote Preventive Health</i> 95% Children have health care provider	97%	97%	99%	100%	99%	98%	97%	99%	95%	99%	99%	99%	99%	99%	98%
95% Eligible families enrolled in MA	100%	99%	99%	99%	97%	99%	97%	100%	98%	98%	99%	99%	99%	99%	99%
90% Children immunized on schedule	92%	99%	97%	100%	100%	94%	91%	84%	83%	95%	92%	94%	97%	94%	95%
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%
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%
85% Mothers will complete post-partum care.	85%	89%	97%	96%	95%	88%	81%	98%	94%	80%	98%	91%	96%	96%	100%
<i>Goal III: Optimize Child Development</i> 95% Children demonstrate normal child functioning	100%	99%	99%	95%	95%	95%	98%	95%	92%	96%	97%	98%	92%	91%	93%
<i>Goal IV: Improved Self-Sufficiency</i> Families have improved housing, educ, employment	Housing 100% Ed/Emp 68%	Housing 100% Ed/Emp 73%	Housing 99% Ed/Emp 86%	Housing 95% Ed/Emp 88%	Housing 96% Ed/Emp 90%	Housing 97%	Housing 100%	Housing 99% Ed/Emp 63%	Housing 99% Ed/Emp 53%	Housing 98% Ed/Emp 56%	Housing 96% Ed/Emp 49%	Housing 96% Ed/Emp 85%	Housing 96% Ed/Emp 81%	Housing 96% Ed/Emp 86%	Housing 98% Ed/Emp 88%
<i>Goal V: Positive Parenting</i> Parents have adequate knowledge of child development.	78%	90%	97%	95%	96%	96%	97%	85%*	83%	74%	74%	99%**	94%***	95%	98%
Parents have adequate knowledge of child safety.	79%	100%	100%	93%	97%	92%	96%	100%	100%	86%	86%	100%	98%	100	96%
Parents demonstrate positive parent-child interaction	77%	100%	100%	100%	99%	96%	95%	97%	N/A	N/A	N/A	100%	76%***	78%	83%

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

**Table 13. Healthy Families Montgomery: Year 15
Summary of Goals, Objectives, Program Outcomes and Comparative Statistics**

Goals and Objectives	HFM TARGET	Year 15	Montgomery County	State of Maryland	National
<i>Goal I: Reduce Incidence of Child Maltreatment</i> Enrolled families will not have founded CWS reports	95%	100%	Rate of 1.8 per thousand [5]	Rate of 12.4 per thousand [1]	Rate of 10.1 per thousand [1]
<i>Goal II: Promote Preventive Health Care</i> Children will have a health care provider	95%	98%		89% [6]	92% [2]
Eligible families will be enrolled in MA	95%	99%	88% [10]	90% [8]	23 million total Medicaid 84% [2]
Children immunized on schedule	90%	95%	91%	73% [3]	75%*[3]
Mothers will not have an additional birth within two years of the target child's birth. (Teens <20 Yrs)	90%	100% Teens 100%		Teens 82% [7]	Adults - 55% [4] Teens-81%** [7]
Babies Born with Healthy Birthweight	90%	96%*	94% [5]	91% [4]	92% [4]
Mothers will complete post-partum care.	85%	100%			70% [13]
<i>Goal III: Optimize Child Development</i> Children will demonstrate normal child functioning	95%	93%	-	88% [12]	88% [12]

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

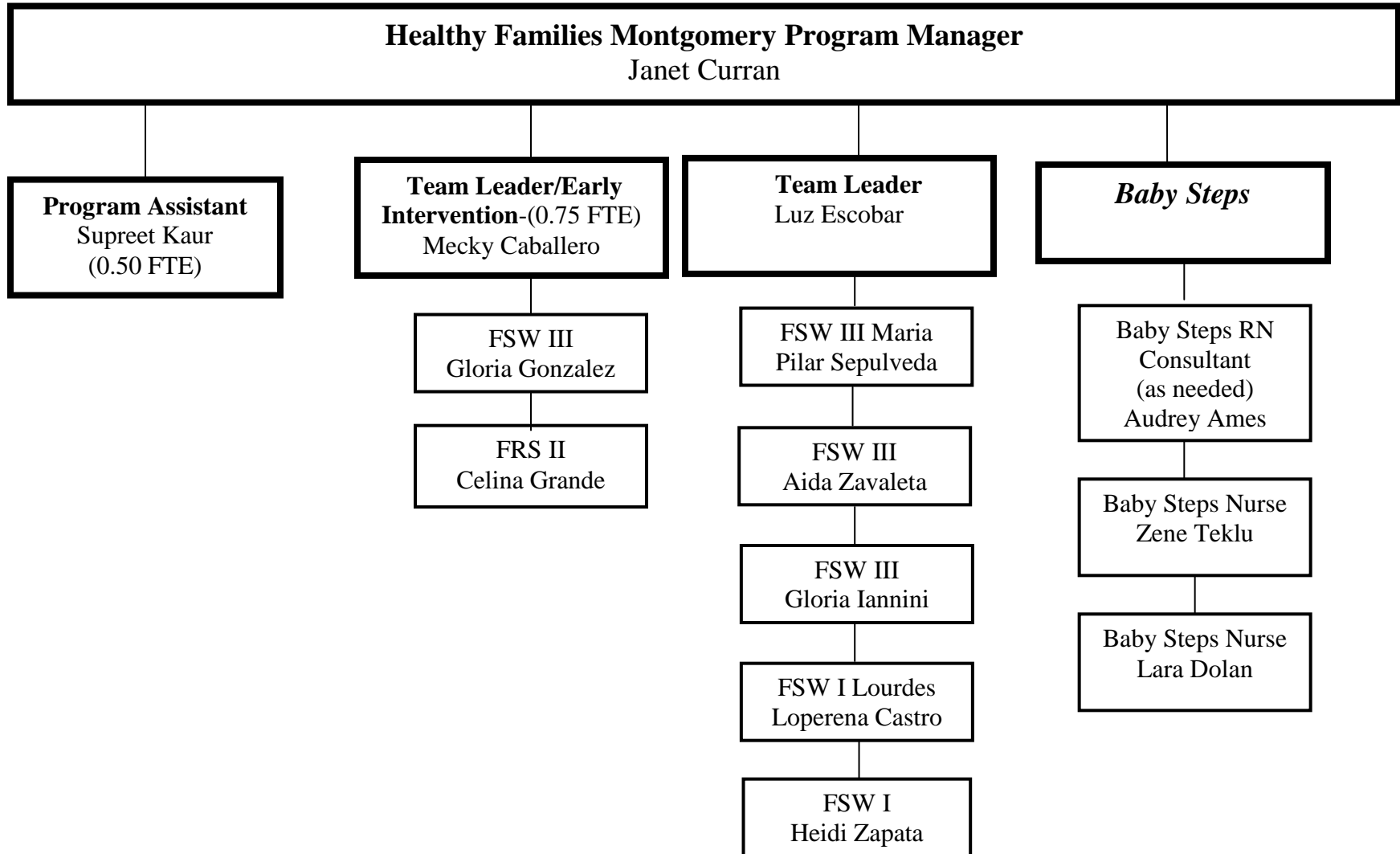
**Comparative National Percentages for African-American (64%) and Hispanic (62%) teens with no repeat births are much lower.

Data Sources:

- [1] US Department of Health & Human Services, Administration for Children and Families (ACF). Child Maltreatment 2009 (published 2010). Available at <http://www.acf.hhs.gov/programs/cb/pubs/cm09/cm09.pdf>
- [2] Center for Disease Control and Prevention: National Center for Health Statistics (2010). Available at <http://www.cdc.gov/nchs/fastats/children.htm>
- [3] Center for Disease Control and Prevention: Vaccines and Immunizations Data Table, 2010 (4:3:1:3:3:1 series). Available at http://www.cdc.gov/vaccines/stats-surv/nis/data/tables_2010.htm
- [4] Center for Disease Control and Prevention, National Vital Statistics Report 2010: Live Births and Percentage Low Birthweight. Available at http://www.cdc.gov/nchs/data/nvsr/nvsr60/nvsr60_02.pdf
- [5] Montgomery County Department of Health and Human Services: 2009 Annual Report-Child Welfare Services. Available at <http://www.montgomerycountymd.gov/content/hhs/pdf/annualreport2009.html>
- [6] National Center for Children in Poverty: State Profiles-Maryland 2007. Available at http://www.nccp.org/profiles/MD_profile_32.html
- [7] Child Trends Facts at a Glance-Trends in Teen Childbearing (2011). Available at http://www.childtrends.org/Files/Child_Trends-2011_04_14_FG_2011.pdf
- [8] Annie E Casey Foundation. Kids Count Online 2008. Available at <http://datacenter.kidscount.org/data/bystate/stateprofile.aspx?state=MD&cat=910&group=Category&loc=22&dt=1%2c3%2c2%2c4>
- [9] Centers for Disease Control and Prevention: MMWR-National, State, and Urban Area Vaccination Levels Among Children Aged 19-35 Months (2009) Available at http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5833a3.htm?s_cid=mm5833a3_e#tab2
- [10] Annie E Casey Foundation. Kids Count Online 2008. Available at <http://datacenter.kidscount.org/data/bystate/stateprofile.aspx?state=MD&cat=910&group=Category&loc=3315&dt=1%2c3%2c2%2c4>
- [11] Individuals with Disabilities Act 2008 Data: Number/Percentage of children receiving services under IDEA. Available at https://www.ideadata.org/tables32nd/AR_C-13.xls
- [12] National Early Childhood Technical Assistance Center (NECTAC). Webinar series March 2010-*Early Identification and Part C Eligibility* (Steven Rosenberg, Ph.D. and Duan Zang, Ph.D.)
- [13] National Center on Quality Assurance (NCQA).The State of Health Care Quality 2011. *Continuous Improvement and the Expansion of Quality Measurement*. Available at: <http://www.ncqa.org/LinkClick.aspx?fileticket=FpMqgpADPo8%3d&tabid=836>

APPENDIX A

HFM Organizational Chart



APPENDIX B

Healthy Families Montgomery Funding Sources July 2010 – June 2011

Private Foundations

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

Public Funding

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

Individual Donors and Other

Individual Donors

In-Kind Donations

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

APPENDIX B

Healthy Families Montgomery Program Expenditures July 2010 – June 2011

Program Funding

Fees/Grants: Montgomery County	\$485,766
Fees/Grants: State and County	\$170,286
Fees/Grants: City and Local	11,000
Foundation Support	107,395
Total Funding	\$774,447

Program Expenses

Personnel (salaries, benefits, taxes)	\$576,849
Occupancy	61,982
Professional services and evaluation	16,342
Transportation, travel	17,756
Telephone	5,481
Training/conferences	3,727
Program activities/supplies/equipment	9,897

Subtotal Expenses **\$692,034**

Management and General \$82,474

Total Expenses **\$774,508**

Excess/Deficit -\$61

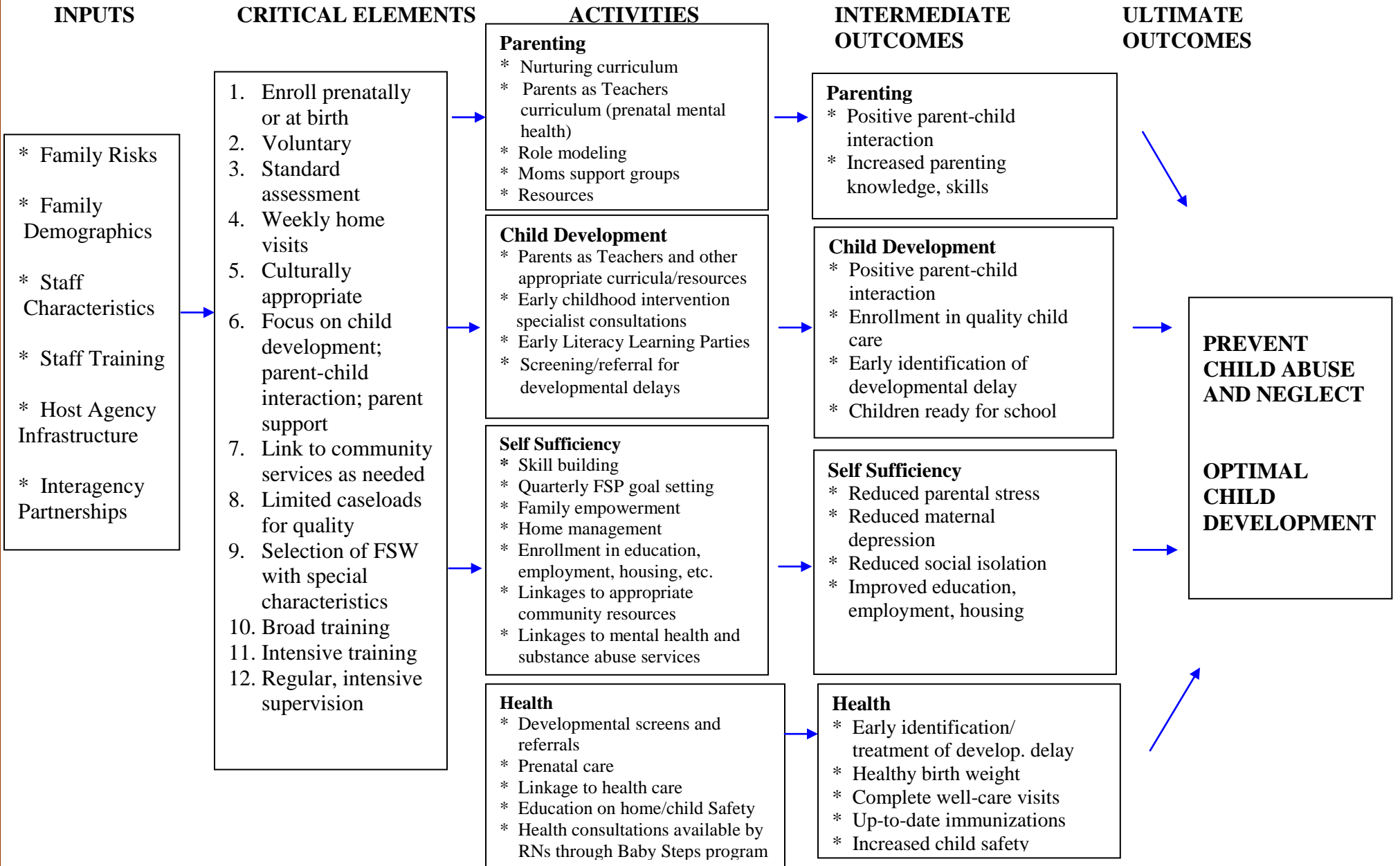
APPENDIX C

Healthy Families Montgomery Advisory Board July 2010 – June 2011

Member	Organization/Title
Janet Curran (<i>Ex-Officio Member</i>)	FSI/HFM Program Manager
Beth Molesworth (<i>Ex-Officio Member</i>)	MC DHHS Early Childhood Services
Janet Ceasar	HFA Credentialing Consultant
Joan Liversidge	Community Member
George Cohen, MD	Retired Pediatrician, Mobile Med
Carol Walsh (<i>Ex-Officio Member</i>)	Montgomery County Collaboration Council
Jamie Ambrosi	Community Member
Meredith Myers (<i>Ex-Officio Member</i>)	FSI/FCP Director
Beth Arcarese	Saint Rose of Lima
Ruth Hayn	League of Women Voters
Supreet Kaur (<i>Ex-Officio Member</i>)	HFM Program Assistant

APPENDIX D

Healthy Families Montgomery Logic Model



**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

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

PARENTAL CONSENT FOR PARTICIPATION OF A MINOR

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

residing at _____,

hereby consent for _____
(Minor Mother of the Baby)

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

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

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

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

Parent's/Guardian's Signature Date

Witness' Signature Date

Printed Name of Parent/Guardian

Printed Name of Witness

Relationship to Target Child

Consent Withdrawn

Signature

Date

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

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

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

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

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

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

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

Firma de la madre / tutora

Parentesco con el niño(a)

Nombre de imprenta

Fecha

Firma del padre / tutor

Parentesco con el niño(a)

Nombre de imprenta

Fecha

Firma del testigo(a)

Fecha

Nombre de imprenta

Consentimiento Revocado

Firma

Fecha

APPENDIX G

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

Parental Consent to Participate in Program Evaluation

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

Please be aware of the following:

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

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

Donna D. Klagholz, Ph.D.
Program Evaluator

Participant's Signature

Date

Print Name

Witness' Signature

Date

Print Name

Parent or Guardian of Participant

Date

Print Name

Healthy Families Montgomery

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

Consentimiento para Participar en el Proyecto de Evaluación

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

Por favor tome nota de lo siguiente:

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

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

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

Firma del Participante Fecha Nombre de Imprinta

Firma del Testigo(a) Fecha Nombre de Imprinta

Padre o Tutor Legal del participante Fecha Nombre de Imprinta

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 casual link between symptoms of depression and children’s well-being provides the rationale for including this construct in the Parent Interview. It has been used in many rural and urban populations and cross-cultural studies of depression. The reliability of the CES-D is supported by a correlation with the NIMH Depressed Mood subscale of the General Well-Being Scale with a correlation coefficient of .71, a high test-retest correlation, and a sensitivity of .89 and specificity of .70 when related to psychiatric instruments such as the Diagnostic Interview Scale (DIS). Demonstrated associations with related constructs support its construct validity and CES-D has been shown to have good discriminant validity.

Healthy Families Parenting Inventory (HFPI)

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

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

Safety Checklist-version 5

Authors: adapted from the Early Head Start Safety checklist by Healthy Families Maryland

Description: The Safety Items included on the HFMD Safety Checklist measure a parent's knowledge and use of safety practices within the home and car. It focuses on parents' awareness of potential safety hazards in the child's environment. The 9-item instrument measures such hazards as access to poisons, stairs, windows, and electrical outlets. Parents are also asked about presence of smoke alarms and age-appropriate automobile safety restraints. The safety items are administered in an interview format and can be done during a home visit. It takes approximately 5 minutes to complete.

APPENDIX I

HEALTHY FAMILIES MONTGOMERY Evaluation Administration Schedule

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

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

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

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

APPENDIX J

HFA Critical Elements of Successful Home Visitation Programs

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

APPENDIX K

HFM Service Level System Descriptions

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

**APPENDIX L
HEALTHY FAMILIES MONTGOMERY STAFF TENURE DATES
1996 – 2011**

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

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

APPENDIX M**Healthy Families Montgomery
Year 15 Staff Trainings**

DATE	TOPIC	# HFM STAFF ATTENDED
07/21/2010	First Aid	2
08/2-6/2010	Parent Survey Trainer recertification in Minneapolis, MN	1
08/20/2010	Abusive Head Trauma	1
09/08/2010	Life Skills Progression – Tool Training	1
09/10/2010	Autism	7
09/27/2010	Preventing Child Abuse	1
09/28/2010	CPR	1
10/05/2010	Addressing Domestic Violence	1
10/22/2010	Working with New African Immigrants	1
11/01/2010	Promoting Mental Health	1
11/01/2010	Recognizing Substance Abuse	1
11/05/2010	Personal Safety	8
11/12/2010	Child Abuse & Neglect Indicators and Reporting	9
11/17/2010	Healthy Lifestyles	4
11/17/2010	Progress on Federal Home Visiting Grant	1
11/17/2010	Mobilizing Support for Home Visiting Programs	1
11/17/2010	From Trash to Toys	1
11/17/2010	Green & Healthy Home	2
11/17/2010	Applying SEFEL in Home Visits	2
11/17/2010	Professional Boundaries	1
11/17/2010	Striving for a Smoke-free Environment	1
11/19/2010	ECS Resource Library-Community Resources	8
11/23/2010	Optimizing Your Effectiveness	1
11/24/2010	Responding to Relationships	1
11/28/2010	Recognizing Perinatal Depression	1
12/03/2010	Working with Families with Mood Disorders	6
12/06/2010	Confidentiality and HIPPA	1
12/15/2010	Infection Prevention	1
12/21/2010	SEFEL	1
01/04/2011	Infection Prevention	1
01/04/2011	Confidentiality & HIPPA	1
01/07/2011	Family Planning and STD's	8
01/10/2011	ECS Supervisory Procedures	3
01/19/2011	Reflective Supervision	3
01/25/2011	Conflict Resolution	3
01/25/2011	The Functional Neuroanatomy of Grief	1
02/24/2011	Designing and Using an Effective Database	1
03/24/2011	Culture and Communication	10
04/27/2011	Diagnosis & Treatment of OCD	1
04/29/2011	CBT for Panic and Other Anxiety Disorders	1
05/02/2011	Mental Health First Aid, part 1	2
05/09/2011	Mental Health First Aid, part 2	2
05/09/2011	Excel	1
05/18/2011	CPR	4
05/19/2011	Integrated Strategies for Home Visitors	2
06/08/2011	HFMd Spring Training Day	10
06/10/2011	Supporting Infants & Toddlers Mental Health	8
06/14/2011	Performance Planning and Evaluation	2

***Healthy Families Montgomery
Staff Satisfaction Survey***

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

1. What is your job with HFM?

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

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

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

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

- Never Rarely Sometimes Often Every day

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

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

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

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

7. **Additional Comments and Suggestions:**

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

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** **Disagree** **Strongly Disagree**

THANK YOU!

HEALTHY FAMILIES MONTGOMERY
Encuesta de satisfacción de los participantes

Fecha de hoy: _____

Por favor comparta con nosotros la siguiente información:

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

¿Qué tan frecuente la visita su trabajadora de apoyo familiar?

Una vez por semana Dos veces al mes Una vez al mes No me acuerdo

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

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

¿Cuándo fue su ultima visita? Hace una semana Hace dos semanas Hace un mes

Más de un mes Hace varios meses Me Salí del programa

Si la ultima visita fue hace más de un mes, ¿por qué razón no fue más reciente? **SI** **NO**

Si la respuesta es sí, por favor díganos la razón:

Por favor conteste SI o NO a las siguientes declaraciones.

1. Mi trabajadora de apoyo familiar me visita como acordamos.

SI **NO**

2. Mi trabajadora de apoyo familiar me informa de cómo cuidar de mi bebé.

SI **NO**

3. Mi trabajadora de apoyo familiar me enseña acerca del desarrollo de mi bebé.

SI **NO**

4. Mi trabajadora de apoyo familiar me ayuda con mis necesidades, las de mi bebé y de mi familia.

SI **NO**

5. Mi trabajadora de apoyo familia respeta a mi bebé, a mi familia y a mí.

SI **NO**

6. Mi trabajadora de apoyo familiar acepta y respeta mi cultura.

SI **NO**

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

SI **NO**

8. Mi trabajadora de apoyo familiar conversa conmigo con un lenguaje que yo le pueda entender.

SI **NO**

9. Mi trabajadora de apoyo familiar me ayuda a ser independiente y me ayuda a tomar mis propias decisiones.

SI **NO**

10. Mi trabajadora de apoyo familiar me ha ayudado a ser un mejor padre de familia.

SI **NO**

11. El programa de Healthy Families ha hecho un impacto positivo en la vida de mi bebé.

SI **NO**

Por favor denos su opinión en las siguientes preguntas.

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

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

¿Cómo cree que podemos mejorar el programa?

¿Cómo calificaría a su trabajadora de apoyo familiar?

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

¿Cómo calificaría al programa de Healthy Families?

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

Yo recomendaría este programa a un familiar o un amigo.

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

Muchísimas gracias por participar en esta encuesta.