Affordable Care Act Maternal, Infant and EarlyChildhood Home Visiting Program

Maryland's Statewide Needs Assessment

September 20, 2010

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Affordable Care Act Maternal, Infant and Early Childhood Home Visiting Program Response to Supplemental Information Request #1 for the Submission Maryland Statewide Home Visiting Needs Assessment
September 20, 2010

I. INTRODUCTION

Maryland is home to 5.6 million residents including 380,606 children ages 0-4, 370,292 children ages 5-9, and 1.2 million women of childbearing age. Maryland is a racially and ethnically diverse State with 42% of its population representing racial and ethnic population groups in 2008. There were more than 77,000 births in 2008, the majority (54%) of them to racial/ethnic minority mothers. Although one of the wealthiest States in the nation, Maryland's ranking on a number of key health related indicators vary from best (e.g., income and education) to among the worse (e.g., infant mortality and related risk factors). There are significant pockets of poverty in the State, namely in Baltimore City, on the Eastern Shore and in Western Maryland. Health disparities continue as a widespread problem across Maryland (e.g., the African American infant mortality rate is two to three times the White rate), exacting a significant toll on the State's overall health. The disparity gap reflects not only a lack of access to care for some Marylanders, but other factors including the social determinants of health.

Last school year, one in three Maryland kindergarteners entered school unhealthy and unprepared to learn. Early childhood stakeholders in Maryland have a history of commitment to the process of creating an early childhood comprehensive system that delivers integrated, family focused early childhood services including home visiting programs in areas of greatest need throughout the State. Maryland addresses early childhood systems building through unified partnerships and planning efforts.

At the State level, there is a Maryland Children' Cabinet designated by the Governor to coordinate Maryland's child and family service delivery system with emphasis placed on the provision of prevention, early intervention and community based services for children and families. The Cabinet is comprised of the Secretaries of major child and family serving agencies including Health and Mental Hygiene (DHMH), Education (MSDE), Humans Resources (DHR), Juvenile Services (DJS) and Disabilities (DOC). The Governor's Office for Children (GOC) provides administrative support to the Cabinet and oversees implementation of the State's Children's Plan. The GOC's Executive Director chairs the Cabinet. The Children's Cabinet and the GOC are overseeing the development and implementation of the ACA funded home visiting program. Governor Martin O'Malley has designated the Department of Health and Mental Hygiene, Center for Maternal and Child Health as applicant/administering agency on behalf of the Children's Cabinet. The Children's Cabinet will serve as an advisory body for selecting high risk communities in which evidence-based models in these communities will be funded.

Other collaborative efforts include a State Early Childhood Advisory Council (ECAC) that oversees implementation of a State Plan to improve school readiness. The State's ECCS Plan has been integrated into the Council's State Plan for Early Childhood. This Plan has identified mental health, maternal substance abuse, health disparities and perinatal health issues as priority areas of need.

Ensuring that children are born healthy and maintain good physical and mental health is a critical first step in all early childhood efforts. However, until recently, the important role of health during the early childhood period was sometimes overlooked and under-funded. In August 2009, Governor O'Malley identified the need to improve the health of Maryland's infants as one of his top 15 strategic policy goals under an initiative termed the Governor's Delivery Unit (GDU) Plan. State funds appropriated under a *Babies Born Healthy Initiative* are being used to implement a life course approach to improving the health of women and infants prior to, during and following pregnancy. New home visiting funds combined with existing services will help to strengthen this approach.

Under the new ACA Home Visiting Initiative, Maryland will continue to build upon previous programs as well as continue to blend new strategies from the Home Visiting State Plan as it is developed. As described below, Maryland plans to mobilize new and existing partners to implement strategic planning and collaborative processes using new home visiting funds to promote healthy child/family development and school readiness Statewide. The sections below describe Maryland's approach to conducting the preliminary home visiting needs assessment to identify communities at risk through analysis of data and assessment of capacity.

II. MARYLAND NEEDS ASSESSMENT PROCESS

For the Needs Assessment, Maryland has looked at 15 indicators that put children and families at-risk including: infant mortality, premature birth, unemployment, poverty, and crime rates. Maryland collected information about current home visiting programs and substance abuse services throughout the State. Maryland has used a systematic approach for looking at data and capacity in our State and communities. The Center for Maternal and Child Health along with partners will use the information gathered to support the highest risk communities and guide them in their decisions on the types of resources needed for their communities. In addition, the information gathered will inform the State on policy and further the coordination of a home visitation system of care in Maryland. Steps in the needs assessment process have included:

1. Reviewing data and findings from related needs assessments as required in the guidance;
2. Collecting Statewide and community level data to assist in determining and prioritizing "communities at risk;"
3. Conducting surveys to assess capacity; and

4. Engaging stakeholders through key informant meetings, data sharing and an August 2010 Stakeholder Meeting.

Ongoing assessment of community needs and strengths is crucial to developing a useful and well-considered strategic plan. To this end, Local Management Boards (whose job is to plan, implement, and monitor child and family services) (LMBs) in Maryland jurisdictions, initiated a comprehensive assessment process beginning in May 2009 utilizing multiple components, including: analysis of available secondary data, community forums and focus groups of key informants, service provider surveys, and community surveys. In addition to providing the LMB and its partners with a demographic profile of the community, this process yielded useful community feedback related to the current delivery of services as well as information about critical gaps in services to families and children, levels of developmental assets among children and youth, patterns of risk-taking behavior among adolescents, and suggestions for improving results for our county's children. Although data was not available for use in each county identified at risk, Maryland was able to compare findings from the Home visiting Needs Assessment and the LMB needs assessment in the following counties: Dorchester County, Washington County and Wicomico County to ensure a comprehensive and detailed look into specific needs.

1. Reviewing Findings from Related Needs Assessment: Title V, Head Start, and CAPTA II

Maryland has a rich history of collaboration and partnerships. Through the home visiting needs assessment, we have made additional inroads in data sharing and reporting on our most vulnerable populations. Below is a brief summary of the three needs assessments/annual reports from our partnering organizations. The required letters of support from each of the partnering agencies are contained in Appendix C.

Title V Needs Assessment

CMCH is responsible for preparing the MCH Block grant needs assessment and data gathered for Title V significantly supported the home visiting needs assessment. The Leadership Team for the Title V Needs Assessment also coordinated the home visiting needs assessment. Statewide data from the Title V needs assessment was used to measure several of the indicators in the Statewide Data Report (Appendix A).

Maryland identified 8 MCH priorities for the 2010 Title V needs assessment, including one focused on improving access to home visiting services for at risk children and families: **Promote early and middle childhood health, healthy child development and parent-child connectedness by increasing access to evidence based home visiting programs.**

Similar to findings from the 2005 needs assessment, for the 2010 needs assessment, Title V heard about the need to support and strengthen families to assure that children remain healthy and thrive. This need for support is cross-cutting and required for

all Maryland families, but especially needed for socio-economically disadvantaged families. The Title V Program also recognized that families with young children are especially vulnerable and in need of services to enhance their ability to address their health needs, to meet their developmental needs, and to promote school readiness.

Many Maryland families were anecdotally described as "in crisis or in peril." Maryland heard that families are disconnected; parents are stressed and overwhelmed with the process of parenting as well as accomplishing the tasks of daily living; parents are placing demands on their children to be "successful;" children are being abused and neglected; and parental substance use is a growing problem. The current recession has led to higher unemployment and many parents are struggling to make ends meet on a daily, weekly or monthly basis. Additional family support is needed.

Family support can take many forms including parenting classes; affordable quality child care; mental health counseling programs; and substance abuse treatment programs. Over the next five years, the Title V Program will promote healthy children by improving access to home visiting programs in areas of greatest risk. Evidence based home visiting programs are a primary prevention strategy for poor birth and child health outcomes, reducing child abuse and neglect prevention, and improving family/parent functioning.

A new State performance measure has been developed to focus on the number of children served in evidence based home visiting programs in Maryland. This is a developmental performance measure. As the State completes its required State Home Visiting Plan, then another more meaningful performance measure may be identified.

Head Start Needs Assessment

In Maryland, approximately $78 million in federal grant funds support 19 grantees and 24 delegate agencies. This reflects the addition of one new Early Head Start grantee during recent expansion initiatives. These programs operate over 250 program sites Statewide. In addition, the Collaboration Office is funded through a federal Head Start grant. Direct services are provided through 15 Early Head Start programs, which serve pregnant women and children under three years old; and 28 Head Start programs, which serve child aged three to 5 years old. Four agencies have both Head Start and Early Head Start programs and three grantees do not provide direct services, but have delegate agencies that provide services. Head Start Programs serve children in all 24 counties within the State. However, Early Head Start is only found in 10 counties and Baltimore City.

CMCH partners with the Maryland State Department of Education (MSDE)'s Division of Early Childhood Development (DECD) on many issues including child care, and with the DECD Head Start Collaboration Office on many projects including the Early Childhood Advisory Council. The Head Start Collaboration Office provided CMCH with a copy of it most recent needs assessment/strategic plan for 2009-2010. The needs assessment report identified twenty improvement objectives which are reflected in the State Strategic Plan. These objectives include increasing access to oral health and

mental health services for Early Head Start and Head Start children, and promoting improved parent and staff knowledge on health services. The Head Start/Early Head Start needs assessment report/strategic plan contained little data of use to the home visiting needs assessment, however, data from the annual Program Information Report for 2007-2008 (most recent data available) proved to be very useful. Data from this Report was used to the complete the Statewide Reporting Matrix in Appendix A.

Annual data from the Program Information Report from 2007-8 indicate that just over 12,000 low-income children and over 180 pregnant women received services from Head Start and Early Head Start programs in Maryland. Nearly 6,000 children were enrolled in full-day, five-days per week Head Start programs in Maryland; while an additional 3,848 children were in part-day programs. Other children were served in home-based settings and nearly all programs were operating at their full capacity. Most of the children served were 3 and 4 year olds, and the majority of the families were determined to be eligible based upon their income being below 100% of the federal poverty level. Nearly two-thirds of the families served in Head Start programs in Maryland were African American.

CAPTA II Needs Assessment

The Department of Human Resources (DHR) has provided with child abuse and neglect data that included counts of indicated and unsubstantiated child abuse and neglect investigations by census tract. Maryland does not use the term substantiated, but rather uses indicated (meaning they can prove there has been abuse and neglect). We are also using unsubstantiated (meaning indications of occurrence but no proof) data to look at the most detail possible. Although the CAPTA II data on the Family Support Index has not been received yet, we used the Community-Based Child Abuse Prevention (CBCAP) annual report submitted to the Administration on Children, Youth and Families. This report was compiled by the designated agency to deliver services, the Maryland Family Network.

DHR is Maryland's single State agency for administering the Child Abuse Prevention and Treatment Act (CAPTA). In Maryland, CAPTA program funds are provided to the Maryland Family Network to support direct services for CBCAP. These child abuse prevention programs are currently supported through these funds. The CBCAP annual report is summarized and a complete list of the service delivery programs is provided in Appendix J. CMCH has a long-standing relationship with the Maryland Family Network (MFN), the State's designated CAPTA Title II agency. MFN currently provides support to the Home Visiting Consortium convened by the Maryland State Department of Education (MSDE). MFN has also provided CMCH with their 0-3 Business Plan outlining needs and gaps in service coordination.

The process for identifying unmet needs in communities involves collecting data and community needs assessments from the partners in 23 Maryland communities and CBCAP funds are awarded based in part on the local determination of needs. These

Statements of need are incorporated into contracts with Family Support Center sponsoring agencies.

With support from the State of Maryland Office on Planning, Maryland Family Network developed a Family Support Index to help determine the need for a family support program within a specific jurisdiction of Maryland. The Family Support Index (FSI) is a weighted composite of the following measures for each Maryland census tract: ratio of births to never married females 15-24 years of age; percent of children 0-5 years of age below the poverty level; median household income; percent of households with public assistance income; and percent of civilian population 16-19 years old not in school and not a high school graduate. These measures are considered to be high risk factors that correlate to child abuse and neglect, and long-term welfare dependency. CMCH has requested, but not yet received, a copy of the FSI, methodology and findings.

2. Identifying At Risk Communities

In addition to relying on existing data and assessments to identify at risk communities, Maryland sought input with State and local stakeholders and came up with 15 indicators of risk. At risk communities were defined using the methodology described below.

3. Conducting Surveys to Determine Current Home Visiting Capacity

Several surveys were completed to ascertain current home visiting capacity in Maryland. This is still a work in progress for some areas of the State and a completed capacity assessment will be submitted with SIR #2. First, State level program administrators of known federal or State funded "evidence based" home visiting programs in Maryland were surveyed. These programs included: Parents as Teachers, Nurse Family Partnership, local health departments, Healthy Families Maryland and Early Head Start. The following questions were asked to assess capacity as identified in the guidance:
What county (ies) does your program serve?
What home visiting model or approach is used?
Name the specific service(s) you provide.
List the intended recipients of the service (e.g., pregnant women, infants).
What are the targeted goals/outcomes of the intervention (e.g., child maltreatment reduction, maternal and child health, early literacy, reduction of domestic violence)?
What are the demographic characteristics of individuals or families served?
How is the demographic data collected (e.g., intake sheet, questionnaire done by staff, self report…)
What is the number of individuals or families served per month?
What is the geographic area served (e.g., entire county, certain neighborhoods, or zip codes)?

Maryland has 15 Early Head Start Programs, 14 Healthy Families Programs, 2 Parents as Teachers Programs and one Nurse Family Partnership. St. Mary's County is

the only county in our State that does not currently have a home visiting program. Through out looking at the evidence based programs in our State we found the following:

- Although some programs only serve infants, or pregnant mothers, or children 0-3, there was overlap in the programs so that Mothers and children up to age 5 may be served in each community.
- In most cases, funds come from federal and State dollars.
- Demographics could vary greatly by community, but all served low income, low education and young moms.

A detailed summary of each of the four evidence based programs can be found in Appendix E.

Second, local health departments were surveyed to determine their home visiting capacity. Seventeen of the 24 Maryland jurisdictions replied to the survey. Several of the local health departments have multiple programs for families and children including programs for children with special health care needs and programs for substance abusing Moms. A detailed summary of the results can be found in Appendix F.

Finally, a survey of all Maryland home visiting programs was conducted in August. Maryland currently has no mechanism in place to identify the quality of home visiting programs offered in the State. Each evidence based program responds to its federal funder and all local health departments report to CMCH. The purpose of the survey was to broadly reach home visiting programs Statewide and gather further detail about the programs offered. This survey was the first attempt to gather information that was wide enough in scope to help inform the needs assessment and develop a plan to track all home visiting programs Statewide.

Eighty-eight respondents from State, federal and local agencies provided information on demographics, program capacity, funding and program evaluation. The questions asked were to gather detail on types of programs, zip codes served and numbers of people served in each program. Some of the findings included:

- Home visits average 1-2 hours in length and occur weekly to monthly.
- The duration of stay in a program ranged from 6 months to 3 years.
- Some programs, most of which were associated with the school system, lasted from 5 to 13 years (following the student through the system).
- Home visiting services normally ended due to aging out of the program, end of a pregnancy, entering school, volunteering to leave the program, or moving out of the jurisdiction.
- Monthly client capacity ranged between approximately 10-100 clients per program.
- Annual client capacity ranged between approximately 20-300 clients per year. Those that surpassed this range were usually associated with a school system.
- Most programs conducted evaluations at the end of the year, or FY.
- Most programs used a specific program model (i.e., PAT, etc.). Those that did not seemed to be connected to a Head Start program.

During State Plan development, this information will be asked again and combined with the evidence based capacity charts to further determine gaps in service and needs in our identified at risk communities. The results were used to complete under section III below.

4. Engaging Stakeholders

Following passage of the new federal law, CMCH immediately began receiving inquiries from various stakeholders about the new federal funds and the process for acquiring them. CMCH and GOC let stakeholders know that a meeting was being planned for early August and that a web site would soon be developed to keep stakeholders abreast of activities. CMCH and GOC hosted the Home Visiting Stakeholder Meeting on August 9, 2010 to acquire input to assist with identifying communities at risk and determining current capacity. Background meeting materials including the agenda, meeting summary and evaluation and stakeholder attendees are contained in Appendix G and the presentations and materials can be found on: http://fha.maryland.gov/mch/stakeholders.cfm.

Preliminary data from both the analysis of at risk communities and a survey to determine home visiting capacity were presented. Speakers included Jill Antonishak, Research Manager, Pew Charitable Trusts, Center on the States. The University of Maryland School of Medicine Maryland Child and Adolescent Innovations Institute facilitated the meeting and provided a meeting summary. Invitees included representatives from Children's Cabinet agencies, ADAA, MHA, OMHDD, Maryland Family Network (the CAPTA Title II agency), the Maryland Head Start Office, local health officers/designees departments, local management board directors/designees, and currently State-funded home visiting programs. There were a total of 75 attendees (not including MCH, GOC, Innovations Institute staff and/or speakers). All jurisdictions, with the exception of two, Cecil and St. Mary's counties, were represented.

Based on feedback from the Stakeholder's meeting, Maryland added three additional indicators to the federally required indicators – WIC and Medicaid participation and school-readiness. Race/ethnicity was another suggested indicator. Attendees also expressed a strong preference for not weighting the indicators. Additionally, stakeholders provided additional information about home visiting programs within their region/community and shared candid thoughts about what is working.

Additionally, feedback was given to remind us going forward to capture data on the needs of undocumented families, data on families who deliver out of county (i.e. high risk pregnancy delivering in DC or Baltimore) and to include consumers in surveying. Finally, stakeholders shared the need to develop a State Plan that is inclusive of:

1. Home visiting programs that are effective with families with various levels of need (i.e. a home visiting system of care)
2. Support, funding, and time needed to develop and implement a sustainable program

III. MARYLAND HOME VISITING NEEDS ASSESSMENT FINDINGS AND REPORT

1. Findings from the Statewide Data Report

A Statewide data report and a report for each at risk community has been completed using the reporting matrix located in Appendix A. Maryland's Statewide data serves as the baseline against which indicators for at risk communities are to be compared. A geocoded map of Maryland can be found in Appendix C and provides a visual description of the identified pocket of need throughout our State.

Maryland's indicators of prenatal, maternal, newborn, and child risk are mostly lower than the national average. The percentage of women receiving late (initiated in the third trimester) or no prenatal care was 4.2% in Maryland in 2008 compared with 7.1% nationally in 2007. In 2008, Maryland's prevalence for premature birth (those born less than 37 weeks gestational age) was 11.0% compared with 12.7% nationally in 2007. (Note however that Maryland's and U.S. rates are not directly comparable because Maryland computes gestational age via the clinical estimate of gestation, whereas the National Vital Statistics System uses the last menstrual period). The Maryland adolescent (15-19 years) birth rate was 32.7 per 1,000 population in 2008 compared with the higher national rate of 42.5 per 1,000 in 2007.

However, in two key indicators of maternal and child health, Maryland's indicators are elevated above the national average. The percentage of low birth-weight infants (less than 2500 g) was 9.3% in 2008, compared with 8.2% in the U.S. in 2007. Most importantly, the infant mortality rate in Maryland in 2008 was 8.0 per 1,000 live births compared to 6.75% nationally in 2007.

Indicators of poverty in Maryland are lower than national averages. Maryland's percent of residents living below the poverty level was 8.7% in 2008, compared with 13.2% nationally. However, among needy subpopulations, the Maryland rate of unemployment among families enrolled in Head Start was higher, 15.0% of 2 parent families were both unemployed, and 40.9% of single parent families were unemployed in 2008 through 2009, compared with the national unemployment rate of 9.3% in 2009 among all members of the workforce.

In 2008, Maryland's crime rate was 41.5 per 1,000 residents which was close to the national rate of 36.7 per 1,000 residents for violent and property crimes.

SAMSHA's National Survey on Drug Use and Health for 2008 reported that Maryland's prevalence for various types of substance abuse was roughly similar to national rates. Maryland was reported as having 21.7% of persons age 12 and older having binged on alcohol during the past month compared with 23.3% nationally. Approximately 4.9% of Marylanders reported marijuana use in the past month compared to 6.1% nationally. The rate of nonmedical use of pain relievers was higher in Maryland

at 3.9% compared to 1.9% in the U.S. The prevalence of illicit drug use excluding marijuana was 3.1% in Maryland and 3.4% nationally.

2. Identification of the Unit Selected as "Community"- Methodology for Identifying Communities At-Risk

Defining "Community." In Maryland, there is no definition for community that is used across all jurisdictions. There are 23 counties, which vary in size and in composition from rural to suburban. There is also one large city, Baltimore. The goal of the needs assessment was to use the finest geographic granularity available for each metric in order to identify pockets of need. For many metrics, the smallest geographic unit of measurement was the census tract. However, census tracts are not generally useful to people providing community services. Baltimore City had previously defined community statistical areas (CSAs) as aggregates of census tracts to define 55 distinct neighborhoods for the purposes of data analysis and program development. These CSAs are used to define communities within Baltimore City for this assessment. For the remaining 23 jurisdictions, we chose to use ZIP codes as proxies for communities. This unit was selected because we have found that many service providers are comfortable specifying which ZIP codes they provide services to, i.e. using ZIP codes to identify their catchment area. The full chart of communities at risk can be found in Appendix B.

Selection of Indicators. The Affordable Care Act (ACA) specified areas to be measured in order to identify communities with concentrations of:

- Premature birth
- Low-birth weight infants
- Infant Mortality (including death due to neglect)
- Or other indicators of prenatal, maternal, newborn, or child health risk
- Poverty
- Crime
- Domestic Violence
- High School Dropout Rate
- Substance Abuse
- Unemployment
- Child Maltreatment

In the process of selecting specific indicators, we strove to find metrics which would meet three key criteria: 1) the data needed to be available Statewide, i.e. measured in the same way in all 24 jurisdictions, 2) utilize the finest granularity data available (preferably census tract), 3) utilize the most recent data available. We then proceeded to select indicators for each area specified in the ACA legislation. All data were available Statewide, and many were available at the census tract level. For those that weren't, we attempted to utilize indicators available at the ZIP Code level. Unfortunately there were still a few indicators for which data were only available at the jurisdiction level.

Maryland shared a preliminary analysis of indicators at a Home Visiting Stakeholders meeting and requested feedback on whether additional indicators would be

useful. Two additional indicators were added as a result of these recommendations. A full description of each indicator, the justification for selection, data source, granularity, rate definition, years covered, and limitations is included in Appendix B1.

Defining Elevated Risk. Elevated risk was defined, for the purpose of this needs assessment, as a unit (census tract, ZIP code, or jurisdiction) with a rate that was substantially greater than the State average for that indicator. Maryland decided that rates that were greater than one standard deviation from the mean would be considered elevated.

The process for computing this elevated risk follows: For each indicator, once a rate or percentage was computed for each unit (census tract, ZIP code, or jurisdiction) the average rate was computed based on all the units. (Note that this average may differ slightly from rates computed at the unit of the entire State because some data is lost due to geocoding errors when census tract or ZIP code units are used.) The standard deviation, based on all units, was also computed. The Z Score for each unit was then computed, and all units that had Z Scores ≥ 1 were mapped using ArcGIS. For elevated risk units at the census tract level, CSAs (Baltimore City) and ZIP codes (other jurisdictions) were overlaid on the map. If a CSA or ZIP code contained at least one elevated census tract, then the CSA or ZIP code was marked as being at elevated risk. For elevated risk units at the ZIP code level, CSAs were overlaid in Baltimore City and the same process was followed to identify neighborhoods at elevated risk. For elevated risk units at the jurisdiction level, all ZIP codes or CSAs in that jurisdiction were marked as being at elevated risk.

Computing an Elevated Risk Index. Once the above described process was performed for all indicators, the elevated CSAs and ZIP codes for each indicator were exported from ArcGIS to a spreadsheet. Each unit was assigned a 1 for an elevated indicator and a 0 for indicators that were not elevated. Then the total number of elevated indicators for each CSA and ZIP code were summed. This total elevated risk index was used to rank the CSAs and ZIP codes.

Defining Communities At-Risk. Although a community with any elevated metrics indicates need in some areas, it was decided that we would focus on those communities in greatest need. We decided to define communities at-risk as those with 10 or more elevated indicators. This resulted in a total of 46 communities at-risk, representing 6 jurisdictions (Baltimore City, Dorchester County, Washington County, Wicomico County, Prince George's County, and Somerset County).

3. Findings from Data Report – "At Risk Communities in Maryland"

Maryland's ZIP code/CSA analysis as discussed above identified 368 potential communities at risk (having at least one elevated indicator). Using the process described above, Maryland identified 46 communities with higher than average concentrations of: premature, low-birth-weight, late or no prenatal care, teen birth and infant mortality rates; poverty; crime; domestic violence; high-school drop-outs; low school readiness rates; substance abuse treatment; unemployment; WIC and Medicaid participation; and/or

child maltreatment. Communities at-risk were defined as those with 10 or more elevated indicators out of the 15 described above. This resulted in a total of 46 communities at-risk, representing six jurisdictions: Baltimore City, Dorchester County, Washington County, Wicomico County, Prince George's County, and Somerset County as summarized in Appendix B.

Baltimore City

Baltimore City is the State's fourth largest jurisdiction with a total population of 637,418 in 2009 including 45,379 young children ages 0-4 and 149,266 women of childbearing age. By race, the majority of the population is Black (65.5%), followed by Whites (32.0%) and Asians (2.1%). Hispanics represent 2.7% of the population. The City has some of the highest poverty, infant mortality, and unemployment rates in the State. Data from the U. S. Census Bureau's American Community Survey for 2006-2008 estimates that 20% of individuals lived below the poverty level including 16% of all families, 27% of related children under age 18, and 27% of families with a female headed householder. In 2009, the City's infant mortality rate of 13.5 per 1,000 live births was 87.5% higher than the State rate of 7.2 per 1,000 live births.

In the recently published County Health Rankings Report released by the University of Wisconsin Public Health Institute in collaboration with the Robert Wood Johnson Foundation, Baltimore City ranked 24th (out of 24) as the jurisdiction with the worst health outcomes and health factors in the State. The County Health Rankings, a collection of 50 reports - one per state - ranks all counties within each state on their overall health.

The majority of at-risk communities (39 of the 46) are located in Baltimore City. Seventy one percent of the City's fifty-five CSAs/neighborhoods have been designated as at-risk. Appendix H contains a map displaying the 39 at risk communities in Baltimore City. The City was the only jurisdiction where communities had a total of 14 elevated indicators out of the 15 described above. There were nine such communities with seven located in the western section of the City, one in the East (Greenmount), and one in the southern section (Cherry Hill). There are ten City neighborhoods that scored 13, nine scoring 12, seven scoring 11 and four scoring 10.

Among the 15 indicators, many neighborhoods in Baltimore City had the highest rates among the communities at-risk. Three neighborhoods in the city had the highest percentage of preterm births at 25.0%, more than twice the state average at 11.2%. Two neighborhoods had the highest percentage of low birth-weight births at 25.6%, which was over 2.7 times higher than the state average. The communities with the highest levels of families with children living below the poverty level were in Baltimore City. Two communities had 71.8% of their families in poverty. Baltimore had the highest rate of high school dropouts and the lowest level of children entering kindergarten ready to learn. Seven neighborhoods in the city had the highest level of substance abuse treatment at 52.6 per 1,000 women of childbearing age. Baltimore City also had the highest rate of births to adolescents (15-19 years) at 200.0 per 1,000 population which was six times

higher than the state average of 33.0 per 1,000 population. WIC participation rates were highest in eight neighborhoods in the city at 67.2 per 1,000 total population, compared to 16.8 per 1,000 statewide. Medicaid enrollment rates were also highest in Baltimore with nine communities at 496.4 per 1,000 total population, over 4 times higher than the state average.

Substance Abuse Annual Report

In fiscal year 2009, in Baltimore City, females represented 54 percent of program participants while 46 percent of the participants countywide were male. During fiscal year 2009, approximately 59 percent of all individuals participating in prevention programs were adolescents. Parents or primary care givers represented 22 percent of the distribution in Baltimore City. African Americans accounted for 84 percent of the racial distribution receiving prevention services in Baltimore City while Caucasians comprised 12 percent during fiscal year 2009. Hispanics (2%) and Other (2%) accounted for the remainder of the distribution (4%). The total number of individuals receiving prevention services in Baltimore City was 26,005 in fiscal year 2009.

In a 2008 report from University of Maryland entitled, "Need For Substance Abuse Treatment In Maryland -- Final Report," William E. McAuliffe, PhD, created a composite of validated substance abuse indicators. The study used the Substance Need Index (SNI) as the independent variable in a statistical equation to estimate relative gaps in treatment services among the State's counties. Baltimore City's SNI score (91) was the highest by far. Treatment needs in Maryland were highest in Baltimore City by a wide margin. Interestingly, the author's study of indicators in counties nationwide found that Baltimore City's drug and alcohol problems were among the most severe in the country, especially its drug problems. Baltimore City had the highest rate of treatment admissions, but it nevertheless did not meet the level of admissions to be expected based on its SNI score.

Home Visiting Capacity Assessment

Baltimore City's local health department had completed it's own capacity assessment and the results summarized in Appendix I show provider, target area, service capacity, types of home visitors, eligibility, primary focus, partnerships, current families served, client details including when clients enter service, annual case load and unduplicated numbers, curriculum for home visiting, provision of services based on need, training and licenses for new staff, method of recruitment, discharge criteria and sources of referrals. Up to 1,762 clients are served annually reaching approximately 20% of the population in need.

Assessment of the evidence based home visiting programs, showed Early Head Start serving South East Baltimore City, and Health Families programs located in West Baltimore, Druid Heights, Upton, Mondawmin, Reservoir Hill and parts of Rosemont. An additional 350 children and families are receiving serves through these programs.

Dorchester County

Dorchester County located on the Eastern Shore is the State's 21st largest jurisdiction with a total population of 32,043 in 2009 including 1,965 young children ages 0-4 and 5,802 women of childbearing age. By race, the majority of the population is White (70.6%), followed by Blacks (28.2%) and Asians (1.0%). Hispanics represent 2.5% of the population. Data from the U. S. Census Bureau's American Community Survey for 2006-2008 estimates that 12.7% of individuals lived below the poverty level including 9.4% of all families, 17.9% of related children under age 18, and 35.7% of families with a female headed householder. In 2009, the County's infant mortality rate of 21.9 per 1,000 live births was 204.2% higher than the State rate of 7.2 per 1,000 live births. In the County Health Rankings Report, Dorchester County ranked 22nd (out of 24) as a jurisdiction with some of the worst health outcomes and health factors in the State.

Dorchester had the highest unemployment rate among the at-risk communities at 10.7%. It also had a community with a substantially elevated infant mortality rate at 31.0 per 1,000 live births, nearly 4 times higher than the state average.

Substance Abuse Annual Report

In fiscal year 2009 in Dorchester County, females represented 61 percent of program participants while 39 percent of the participants countywide were male. During fiscal year 2009, approximately one half (47%) of those receiving prevention services in Dorchester County were adolescents. Parents or primary care givers accounted for 41 percent of the distribution. African Americans accounted for 56 percent of the racial distribution receiving prevention services in Dorchester County. Caucasians (39%), Hispanics (3%) and "Other" (2%) comprised the remaining racial distribution during fiscal year 2009. The total number of individuals receiving prevention services in Dorchester County was 3,408 in fiscal year 2009. Dorchester County's SNI was (42) and the report found it surprising that the results indicated relatively high rates of treatment needs on the Eastern Shore, including Dorchester (34). Like SNI scores, the substance abuse treatment admission rates from privately- and publicly-funded treatment programs were high in Dorchester County (2,158 per 100,000).

Home Visiting Capacity Assessment

The Dorchester County local health department home visiting programs serve the entire county. The county serves 35-45 families monthly depending upon their service level, including 8 children receiving a home visit every 1 – 3 months, and each woman and/or child getting at least two visits a year. Their current funding allows them a caseload of 20. The LHD uses the Healthy Families program and PAT curriculum. There is an Early Head Start program in the county as well serving an additional 45 families and children 0-3.

Washington County

Washington County located in Western Maryland is the State's 10th largest jurisdiction with a total population of 145,910 in 2009 including 9,298 young children ages 0-4 and 27,023 women of childbearing age. By race, the majority of the population is White (87.9%), followed by Blacks (10.3%) and Asians (1.6%). Hispanics represent 2.9% of the population. Data from the U. S. Census Bureau's American Community Survey for 2006-2008 estimates that 9.1% of individuals lived below the poverty level including 7.2% of all families, 11.0% of related children under age 18, and 28.8% of families with a female headed householder. In 2009, the County's infant mortality rate of 7.4 per 1,000 live births was 2.8% higher than the State rate of 7.2 per live births. In the County Health Rankings Report, Washington County ranked 13th (out of 24) on health outcomes and 15th on health factors in the State.

Washington County had the community with the highest rate of protective and peace order filings (a measure of domestic violence) at 115.2 per 10,000 population, compared with 77.8 per 10,000 statewide. The rate of child abuse and neglect investigations was also highest in this community at 11.5 per 1,000 children, over seven times the state average.

Substance Abuse Annual Report

In fiscal year 2009, in Washington County, females represented 51 percent of program participants while 49 percent of the participants countywide were male. During fiscal year 2009, about one half (43%) of those receiving prevention services were adolescents. Parents and primary care accounted for 25 percent of individuals receiving prevention services in Washington County. Caucasians (80%) and African Americans (14%) accounted for 94 percent of the racial distribution receiving prevention services. Hispanics (4%) and Asians (2%) represented the remaining 6 percent of the total racial distribution during fiscal year 2009. The total number of individuals receiving prevention services in Washington County was 3,995 in fiscal year 2009. Washington County made the list of largest relative treatment admissions gaps per 100,000 at (18). Most of the western counties had relatively low levels of drug treatment need: only Washington County (13) was above the median. Washington County had a treatment gap of (17). In Western Maryland, Allegany, Fredrick, Garrett, and Washington Counties had treatment gaps.

Home Visiting Capacity Assessment

Washington County is home to Healthy Families, Maternal and Child Home Visiting from the LHD, Early Head Start, the Washington County Family Center, the Parent-Child Center and the Judy Center. Each of these programs has traditional home visiting components including Healthy Families and PAT curriculums. It is estimated that 95 children and families are served through these programs.

Wicomico County

Wicomico County located on the Eastern Shore is the State's 14th largest jurisdiction with a total population of 94,222 in 2009 including 6,495 young children ages 0-4 and 20,012 women of childbearing age. By race, the majority of the population is White (73.2%), followed by Blacks (24.6%) and Asians (2.0%). Hispanics represent 3.8% of the population. Data from the U. S. Census Bureau's American Community Survey for 2006-2008 estimates that 12.4% of individuals lived below the poverty level including 7.6% of all families, 15.2% of related children under age 18, and 27.0% of families with a female headed householder. In 2009, the County's infant mortality rate of 9.1 per 1,000 live births was 26.4% higher than the State rate of 7.2 per 1,000 live births. In the County Health Rankings Report, Wicomico County ranked 19th on health outcomes and 17th on health factors in the State. Wicomico had the community with the highest crime rate among the communities at-risk at 10,730.7 offenses reported per 100,000 population.

Substance Abuse Annual Report

In fiscal year 2009, in Wicomico County, females represented 52 percent of program participants while 48 percent of the participants countywide were male. Parents (11%) and preschoolers (89%) participating in Wicomico County's preschool program accounted for approximately one third of the individuals receiving prevention services in fiscal year 2009. Over one half (57%) of those receiving prevention services were adolescents. African Americans accounted for 52 percent receiving prevention services while Caucasians comprised 45 percent of the racial distribution. Hispanics (2%) accounted for the remaining distribution. The total number of individuals receiving prevention services in Wicomico County was 1,888 in fiscal year 2009. Wicomico SNI was (26). Perhaps Report results indicated relatively high rates of treatment needs on the Eastern Shore, including Wicomico (26). The highest total substance abuse treatment admission rates per 100,000 residents were in several counties including Wicomico (2,184).

Home Visiting Capacity Assessment

The LHD in Wicomico County serves 40 families per month and targets low income (Medicaid or Medicaid eligible) women under age 25 who receive a positive score upon full assessment that indicates that they are at risk for child abuse/neglect. The focus of their prevention services aim to prevent child abuse and neglect, to assure children enter school ready to learn, parents complete GED and have employment and/or further education, promote positive parenting skills, assure children have a medical home and are current with well baby visits and immunizations.

Two additional Healthy Families programs are also offered in Wicomico County and they estimate an additional 30 families and children are served annually.

Prince George's County

Prince George's County, a suburban jurisdiction bordering the District of Columbia, is the State's second largest jurisdiction with a total population of 834,560 in 2009 including 60,333 young children ages 0-4 and 183,750 women of childbearing age. By race, the majority of the population is Black (66.7%), followed by Whites (28.4%) and Asians (4.3%). Hispanics represent 13.5% of the population. Data from the U. S. Census Bureau's American Community Survey for 2006-2008 estimates that 7.4% of individuals lived below the poverty level including 4.7% of all families, 8.7% of related children under age 18, and 10.2% of families with a female headed householder. In 2009, the County's infant mortality rate of 8.7 per 1,000 live births was 20.8% higher than the State rate of 7.2 per 1,000 live births. In County Health Rankings Report, Prince George's County ranked 17th (out of 24) on health outcomes and 14th on health factors in the State.

Prince George's had two communities that held the highest infant mortality rate, 38.0 per 1,000 live births, among the communities at-risk, which was nearly 5 times the state average. The highest rate of women receiving late or no prenatal care occurred in two communities in Prince George's County at 22.1% of births. This was over 5 times higher than the statewide average.
Substance Abuse Annual Report

In fiscal year 2009, in Prince George's County, females represented 65 percent of program participants while 35 percent of the participants countywide were male. During fiscal year 2009, adolescents accounted for 58 percent of those individuals receiving prevention services. African Americans accounted for 62 percent of the racial distribution in Prince George's County. Caucasians (24%) and Hispanics (14%) accounted for the remainder of the distribution for fiscal year 2009. The total number of individuals receiving prevention services in Prince George's County was 4,460 in fiscal year 2009. The ATOD Center at Bowie State University served 3,387 individuals in fiscal year 2009. Prince George's County's SNI of 15 was lower than some observers expected, but its low score mainly reflected low alcohol indicators. Prince George's County was among the seven counties with the largest treatment gaps. The largest relative treatment admissions gaps per 100,000 were in several counties including Prince George's County (493). However, the lowest primary alcohol treatment admission rate was in Prince George's County (217.9 per 100,000).

Home Visiting Capacity Assessment

Prince George's County LHD provides: nursing home visits to high-risk pregnant women to assure adequate pregnancy follow-up for prenatal care, WIC etc. as well as teaching and support about pregnancy; assessment and early intervention at the birth hospital bedside; follow-up inter-conceptual and infant nursing home visits to provide parenting support and education to assess infant health and safety in the home and to assure connection to needed services; visits to at-risk pregnant women, postpartum/interconception women and at-risk infants to age 2 who live in the county.

The home visits average 200 per month. The county also has two Even Start programs using the PAT curriculum and an Early Head Start program serving over 109 children.

Somerset County

Somerset County located on the Eastern Shore is the State's 23rd largest jurisdiction with a total population of 25,959 in 2009 including 1,314 young children ages 0-4 and 4,898 women of childbearing age. By race, the majority of the population is White (56.6%), followed by Blacks (42.1%) and Asians (0.9%). Hispanics represent 2.7% of the population. Data from the U. S. Census Bureau's American Community Survey for 2006-2008 estimates that 19.6% of individuals lived below the poverty level including 13.3% of all families, 30.3% of related children under age 18, and 36.1% of families with a female headed householder. In 2009, there were fewer than 5 infant deaths so an infant mortality rate was not computed. In the County Health Rankings Report, Dorchester ranked 23rd (out of 24) as the jurisdiction with second worst health outcomes and health factors in the State.

Somerset County had one community with ten elevated indicators. None of these indicators was among the highest rates of the at-risk communities, but all were significantly elevated above the state averages.

Substance Abuse Annual Report

In fiscal year 2009, in Somerset County, females represented 53 percent of program participants while 47 percent of the participants countywide were male. During fiscal year 2009, approximately 67 percent of individuals participating in prevention programs were adolescents. The majority of those individuals receiving prevention services in Somerset County were African American (70%). Caucasians (28%) and Hispanics (2%) accounted for the remaining racial distribution. The total number of individuals receiving prevention services through the Somerset County prevention office was 579 in fiscal year 2009. The ATOD Center at the University of Maryland Eastern Shore served 2,643 individuals in fiscal year 2009. The SNI study took into consideration the small population size of the county (24,747). Drug mortality was the only indicator for which there were no cases in the five-year period studied. Somerset County has one of the highest total substance abuse treatment admission rates per 100,000 residents (1,885 per 100,000).

Home Visiting Capacity Assessment

Somerset County's LHD home visits are based on an educational model that includes anticipatory guidance provided by community health nurses and provides linkage to resources and other community services. The goal is to improve maternal health and birth outcomes, reduce infant mortality, and establish a medical home for infants. The health department averages 40 home visits per month to pregnant women and additional 31visits per month to infants and their mothers.

In Somerset is one of 2 stand-alone PAT programs in our State. 100 families were served in FY '10 reporting 13-38 year old mothers with a demographic breakdown of: 66% African American, 4% Hispanic, and 30% Caucasian. There is no Early Head Start or Judy Center.

4. Findings from the Quality and Capacity Assessment of Programs/Initiatives for Early Childhood Home Visitation in Identified "At Risk Communities"

Maryland has identified the quality and capacity of existing programs/initiatives for early childhood home visiting in the State, including the number and types of programs and the numbers of individuals and families who are receiving services under such programs or initiatives; the gaps in early childhood home visiting in the State, including descriptions of underserved communities where possible; and the extent to which such programs or initiatives are meeting the needs of eligible families.

Statewide, there is one Nurse Family partnership program in Garrett County, 14 Healthy Families America programs, 15 Early Head Start programs and 2 stand-alone Parents as Teachers programs as described below. Table 1 below also summarizes federal and State supported home visiting models currently used in Maryland by jurisdiction and type.

Nurse-Family Partnership: Only one program is operating in Maryland (Garrett County) with funding from the local health department, local management board, and Community Health Resources Commission. NFP serves low-income, first-time mothers with the aim of preventing low birth weight, prematurity, infant mortality, second births to teen mothers, promotion of school readiness and reductions in (long-term) high-school drop-out and juvenile delinquency rates.

Healthy Families America: There are 14 State funded programs currently operating in Maryland with administrative/programmatic support provided by MSDE and local child management boards. Services may begin prenatally or at birth and continue for three to five years. Not restricted to first parents; aimed at promoting positive parenting, enhancing child health and development, and preventing child abuse and neglect. Trained professionals with supervision from either nurses or social workers link families with a medical home and ensure homes are safe. Families are selected through a standardized assessment that identifies health and abuse risk factors.

Early Head Start: There are 15 programs in Maryland supported with direct federal funding. The program offers a combined program of center-based classes and weekly home visits for low-income families with infants and toddlers (zero to three years old) and pregnant women; linked to Family Support Centers and/or schools.

Parents as Teachers programs across the State, serving families from pregnancy through a child's school entry. Parents learn what to expect at different levels of development to help become their child's first teacher. The model includes monthly, biweekly or weekly

home visits by a parent educator, group meetings, developmental screenings and referrals. There are two stand alone programs in Maryland and 38 blended programs.

Home Instruction for Parents of Preschool Youngsters (HIPPY): Evidence supported. Works with parents of children ages three to five. Linked to schools, HIPPY uses home visitors from the local community to work with low-income families in home visits and group social meetings. There are 4 programs in Maryland.

Other Programs. .Some local health departments also offer a case management program called *Healthy Start*, which may include home visits. There are many local models in place as well. For example, there are at least eight local home visiting models operating in Baltimore City, including the federally funded **Baltimore City Healthy Start, Inc.,** in addition to the national models discussed above. Baltimore City Healthy Start, Inc. uses community health workers to identify at-risk women and connect them with health care and other services

Table 1
Federal and State Supported Home Visiting Programs in Maryland by Jurisdiction and Type

Jurisdiction	Healthy Families	Early Head Start	HIPPY	PAT*	NFP	Other
Allegany County	X	X		X		
Anne Arundel Co.		X				
Baltimore City	X	X	X			Baltimore City Healthy Start
Baltimore County	X	X	X			
Calvert County	X		X	X		
Caroline County		X		X		
Carroll County				X		
Cecil County		X				
Charles County	X			X		
Dorchester County	X	X				
Frederick County	X					
Garrett County	X	X		**X**	X	
Harford County		X				
Howard County	X					
Kent County				X		
Montgomery Co.	X	X				
Prince George's Co.	X					
Queen Anne's Co.	X			X		
Somerset County	X			**X**		
Talbot County	X	X				
Washington County	X	X		X		
Wicomico County	X					
Worcester County	X		X	X		

* Note that there are only 2 stand alone PAT programs (Garrett and Somerset Counties as indicated by a red X). All remaining PAT is used as curriculum as part of another home visiting program.

5. Narrative Description of the State's Capacity for Providing Substance Abuse Treatment and Counseling Services to Individuals/Families in Need in "At Risk Communities"

What is currently known about the State's capacity for providing substance abuse treatment and counseling services to individuals and families in need of such treatment or services is described below. The Alcohol and Drug Abuse Administration (ADAA), is charged with providing access to a quality and effective substance abuse prevention, intervention and treatment service system in Maryland.

ADAA periodically assesses the need for substance abuse treatment services in Maryland, most recently, in 2008, in response to legislation passed by the Maryland General Assembly. ADAA was directed to conduct a needs assessment "for prevention, diagnosis, and treatment of drug misuse and alcohol misuse in the State and to "identify the financial and treatment needs of each jurisdiction and of each drug treatment program operated by the State." The ADAA subsequently contracted with the Center for Substance Abuse Research (CESAR) at the University of Maryland, College Park, to conduct the treatment needs assessment. CESAR subcontracted with Harvard University researchers to complete the study. The results of from this work are used as a preliminary Statement of need for substance abuse treatment and counseling in Maryland for purposes of the home visiting needs assessment.[1]

The study's researchers created a Substance Need Index (SNI) as the independent variable in a statistical equation to estimate relative gaps in treatment services among the State's counties. The components of the need indexes were mean rates of drug and alcohol mortality, hospital discharges, and arrests. The study used five years of data from 2001 to 2005.

The need index scores were highest for Baltimore City (91, followed by two Eastern Shore Counties, Worcester (55) and Dorchester (42). The authors noted that national studies indicate that Baltimore City's drug and alcohol problems were among the most severe in the country, especially its drug problems." Substance abuse treatment needs were lowest in suburban areas surrounding the District of Columbia (e.g., the SNI in Montgomery County was 11), in counties west of Baltimore County (Howard 14, Carroll 18, and Fredrick 18), and in Western Maryland (Garrett County 20).

The researchers also found:

- The areas of greatest unmet need were the suburban counties outside of the District of Columbia, Baltimore County and its surrounding counties (Anne Arundel, Harford, and Carroll), Baltimore City, the western counties, and Cecil County.
- Among the seven counties with the largest treatment gaps were four (Prince George's, Montgomery, Howard, and Harford) with SNI scores below the median, but they also had especially low levels of treatment admissions.

[1] William E. McAuliffe, et al. Need for Substance Abuse Treatment in Maryland: Final Report, Revised, December 15, 2008. Report prepared for the Maryland Department of Health and Mental Hygiene, Alcohol and Drug Abuse Administration to the Center for Substance Abuse Research at the University of Maryland, College Park under DHMH Agreement Number DHMH-OCPMP 08-9720G.

- The largest relative treatment admissions gaps per 100,000 were in Allegany County (550), Prince George's County (493), Baltimore County (434), Howard County (397), Cecil County (259), Montgomery County (254), Harford County (249), Worcester County (160), Fredrick County (120), Baltimore City (116), Anne Arundel County (101), Carroll County (76), Garrett County (43), St. Mary's County (24) and Washington County (18).
- If all of the gaps were completely eliminated so that these counties had treatment admissions rates consistent with estimated need, an additional 13,807 admissions per annum would be required.

Preliminary findings on substance abuse treatment needs by jurisdiction are summarized above. The next step in the planning process is to convene a meeting with the ADAA as well as local substance abuse agencies to address additional data and capacity needs. This will assist the State in determining the specific needs of our identified at risk communities and further clarify gaps in needs.

6. Narrative Summary of Needs Assessment Results including Discussion of How the State will Address Unmet Needs

Because of the needs assessment, Maryland has a clearer understanding of the existing home visiting needs, programs and capacity. In our State:

- There are 46 identified communities at risk.
- Every local health department except St. Mary's and Harford County provide home visiting services to mothers and children.
- Head Start provides services to 1,247 children and families in 15 programs serving Baltimore City, Baltimore County, Allegany, Anne Arundel, Caroline, Cecil, Talbot, Dorchester, Garrett, Harford, Montgomery, and Washington Counties.
- There are two stand alone Parents As Teachers programs, but PAT curriculum can be found in over 50 programs Statewide.
- There are 18 counties with Healthy Families programs serving over 757 families.

Now that Maryland has taken a preliminary assessment of programs and home visiting capacity in our State and reviewed the data from the communities identified at risk, there are several next steps needed to develop the State plan. Maryland will begin the self assessment process. We have begun to assess detailed home visiting capacity and we have prioritized the 15 indicators as areas for improvement. In order to most completely address gaps in service and unmet needs, Maryland has taken steps to assure a solid infrastructure and organized supports that should guarantee a wide reach across State agencies and firm foundation on which to build a coordinated system of care for women and children in need of home visiting services. Below is an outline of next steps:

1. Hire Staff

Through the initial funding allocation, Maryland is currently in the process of hiring several key staff to support the infrastructure of home visiting in our State. The project leader will be the same person who administers the ECCS grant. This ensures the integrity of the project and keeps the continuity and coordination of activities in early childhood throughout State agencies. The Project Director is responsible for providing coordination of State level efforts through work with other State agencies, supervising project staff while working closely with the epidemiologist, community coordinator, and a research assistant. The Project Director will oversee the development and implementation of a State Plan and assure coordination of activities across agencies.

To continue the infrastructure needed to build a sound program, the additional positions to be filled are as follows:

Epidemiologist: This position will have chief responsibility for collecting and analyzing data on child and family needs, service use and capacity. She/he will work closely with the Program Director and the senior epidemiologist to complete the needs assessment as well as collect and analyze data for the required benchmarking and monitoring of State Plan outcomes.

Health Policy Analyst: This position will serve as the policy analyst and staff the Home Visiting Consortium which will move to GOC. This individual will work for the Executive Director of the GOC to coordinate work with the State and local agencies, provide support to the Maryland Children's Cabinet on home visiting issues, liaison with other State agencies, and work with Innovations Institute on evaluation of the program.

Community Development Coordinator: This position will oversee the development and implementation of local-level components of the comprehensive strategic plan for developing, implementing and sustaining infrastructure and programs in the identified at risk communities. Duties will include: outreach and education to community groups in targeted at-risk communities with low capacity, and providing leadership with local agencies, including the establishment of interagency collaborations with other community based, child and family serving public agencies.

Program Consultant: A consultant will provide technical expertise in home visiting and early childhood education and will assist in the development and implementation of the State plan.

Research Assistant: A research student will be hired to provide staff support to the MCH home visiting needs assessment, strategic planning and policy development; assist epidemiologist in conducting analyses and preparing reports using State data; design and conduct surveys and focus groups, then analyze results, to ascertain various needs of maternal and child health populations in collaboration with staff; participate in policy discussions and development of policy alternatives; and contribute to policy

recommendations and intervention strategies for identifying at-risk communities and developing the State Plan for home visiting the maternal and child health population. These positions are currently being filled through the contractual State hiring process.

2. Convene Work Groups to Conduct Local Planning

Maryland will convene four work groups, one in each priority jurisdictions/region: Baltimore City, Western Maryland, Eastern Shore and Prince George's County. The goal of each work group is to develop a mission and vision for home visiting in their community and work with the State to determine the next steps needed. The four groups will contribute to the State plan process and be an integral part of the decisions made.

3. Develop a State Plan

A State plan will be coordinated and developed over the next several months. This will be accomplished through a number of existing groups including ECAC, and the Home Visiting Consortium annual conference. Because we have gathered detailed information, and we have multiple home visiting models, we will use the current charts and tables to inform our executive group and conduct workgroups to address the mission, vision, gaps, and needs.

Our State needs to ask tough questions. When we begin to convene our workgroups, in order to plan for the sustainability of programs, the following questions will be addressed:

a. How will Maryland centralize intake and assessment mechanisms and/or establish criteria that determine how families are assigned to particular program models?
b. How will we centralize data systems and collect information on key home visiting indicators and statistics?
c. What additional gaps remain in service delivery of home visiting, substance abuse and child abuse prevention?
d. How shall we determine a process for program expansion into the State plan?
e. What (if any) mechanisms are in place to provide funding, technical assistance, and support to new program sites?

Since Baltimore City has demonstrated such great need (39 of the 46 at risk communities identified) we will potentially work to fund a project in the City – the greatest area of need. Baltimore City already has a "Targeted Plan" for infant mortality that sets a strong foundation for receiving the additional funding support to bring it to scale. It is Maryland's intent to work with the remaining areas to get them ready for funding in subsequent years.

4. Convene an Advisory Group

The needs assessment will be presented to the Children's Cabinet for final approval and a decision on at risk areas. Our State will hold additional stakeholder

meetings to get buy-in and feedback on gaps and needs. We will utilize a smaller group of the original 75 stakeholders to be the Maryland Home Visiting Advisory Group. This group will meet regularly and complete the needed steps of developing the State plan. One of the key elements in coordinating this Advisory Group will be to bring the home visiting indicators and benchmarks that are developed- to other State plans. This will ensure that there is coordination and blending of resources and champions of home visiting throughout other agencies.

5. Request TA from MCHB

When the Advisory Group begins to develop the benchmarks that support the chosen indicators, it is Maryland's intention to request technical assistance from MCHB. At that time we will request support/TA on development activities in the jurisdictions at risk, but not yet funded (i.e., Prince George's County, Western Maryland and the Eastern Shore).

Maryland's Next Steps

Maryland will continue to seek information to complete more detailed substance abuse and child abuse capacity assessments. In addition, we will further examine other home visiting capacity data to determine trends and missing information. After this is conducted, we will engage our Advisory Group to assist in determining areas of high need and low capacity across the State. This will give us clear direction on the needs of the communities and drive the course of the State Plan. Maryland plans to position itself to be competitive for funding by meeting the requirements of all supplemental information requests.

END NARRATIVE

APPENDICES

A. **Statewide Reporting Matrix**

B. **Communities At Risk**

B1. **Indicator Descriptions**

C. **State Map**

D. **Letters of Support**

E. **EBP Capacity Chart**

F. **Local Health Department Capacity Chart**

G. **Stakeholder Meeting Materials**

H. **Baltimore City Map- At Risk Communities**

I. **Baltimore City Capacity Assessment**

J. **CBCAP Summary and Programs**

Appendix A

Public Burden Statement: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0915-0333. Public reporting burden for this collection of information is estimated to average 24 hours per respondent, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 10-33, Rockville, Maryland, 20857

Indicator	Title V	CAPTA[1]	Head Start[2]	SAMHSA Sub-State Treatment Planning Data Reports	Other	Comments
Premature birth -Percent: # live births before 37 weeks/total # live births	11.0	--	--	--		2008, MD DHMH, Vital Statistics Administration (VSA)
Low-birth-weight infants -Percent: # resident live births less than 2500 grams/# resident live births	9.3	--	--	--		2008, MD DHMH, VSA
Infant mortality (includes death due to neglect) -# infant deaths ages 0-1/1,000 live births	8.0	--	--	--		2008, MD DHMH, VSA
Poverty -# residents below 100% FPL/total # residents	8.7	--	Not available	--		2008, U.S. Census Bureau
Crime - # reported crimes/1000 residents - # crime arrests ages 0-19/100,000 juveniles age 0-19	-- 3582.8	--	--	--	41.5	2008, MD State Police
Domestic violence -Percent of Head Start participants receiving Domestic Violence Services	--	--	4.8	--		2008-2009 Head Start Prog Info Rep

<u>School Drop-out Rates</u> -Percent high school drop-outs grades 9-12	2.8	--	--	--		2008 MSDE
<u>Substance abuse</u> -Prevalence rate: Binge alcohol use in past month[3]	--	--		21.7		2006-2008 SAMHSA National Survey on Drug Use and Health
-Prevalence rate: Marijuana use in past month				4.9		
-Prevalence rate: Nonmedical use of pain relievers in past month				3.9		
- Prevalence rate: Use of illicit drugs, excluding Marijuana, in past month				3.1		
-Percent of Head Start participants receiving substance abuse prevention or treatment			7.9			2008-2009 Head Start Prog Info Rep
<u>Unemployment</u> -Percent of 2 parent families enrolled in Head Start not working	--	--	15.0	--		2008-2009 Head Start Prog Info Rep
-Percent of single parent families enrolled in Head Start not working			40.9			
<u>Child maltreatment</u> -Rate of indicated maltreatment (Total per 1,000 Population <18 yrs) (substantiated/indicated/alt response victim)[4]	--	4.3		--		2008 DHR, Child Protective Services (MD uses 'Indicated' instead of substantiated)
-Rate of indicated maltreatment by type						
- Indicated – Physical Abuse		1.0				
- Indicated – Sexual Abuse		0.8				
- Indicated – Mental Injury/Abuse		0.0				
- Indicated – Neglect		2.5				
- Indicated – Mental Injury/Neglect		0.0				
-Percent of Head Start participants receiving Child Abuse and Neglect Services			25.5			2008-2009 Head Start Prog Info Rep

Other indicators of at risk prenatal, maternal, newborn, or child health						
- Teen (15-19 years) birth rate per 1,000 population	--	--	--	--	32.7	2008, MD DHMH, VSA
- % of births to women receiving late or no prenatal care	--	--	--	--	4.2	2008, MD DHMH, VSA

Appendix B. **Communities At-Risk**

Jurisdiction	CSA/ Zipcode	Area Name	Percent Preterm[a]	Percent LBW[b]	Infant Mortality Rate[c]	Percent Families in Poverty[d]	Crime Rate[e]	Rate of Protective Orders[f]	Percent HS Drop-outs[g]	Percent Ready to Enter School[h]	Subst Abuse Trtmnt Rate[i]	Percent Unem-ployed[j]	Abuse & Neglect Investig-ation Rate[k]	Percent Late or No PNC[l]	Teen Birth Rate[m]	WIC Partici-pation Rate[n]	Medicaid Enrollment Rate[o]	Total Number of Elevated Indicators[p]
Maryland Avg			**11.2**	**9.3**	**7.9**	**9.5**	**4316.5**	**77.8**	**3.0**	**81.6**	**7.1**	**7.0**	**1.6**	**4.3**	**33.0**	**16.8**	**112.0**	
Baltimore City	1	Irvington	17.7	18.9	30.6	51.1	*	107.7	7.1	64.0	52.6	10.2	8.7	9.8	119.4	51.7	483.8	14
Baltimore City	7	Cherry Hill	20.7	20.7	37.7	59.7	*	107.7	7.1	64.0	37.9	10.2	7.8	8.9	141.7	53.7	396.3	14
Baltimore City	21	Mondawmin	18.9	20.0	23.0	44.1	*	107.7	7.1	64.0	45.4	10.2	5.4	9.9	135.5	48.6	436.6	14
Baltimore City	23	Rosemont	18.8	20.0	27.6	45.7	*	107.7	7.1	64.0	52.6	10.2	5.7	10.6	135.5	51.7	483.8	14
Baltimore City	24	Greenmount	23.8	20.4	20.8	65.9	*	107.7	7.1	64.0	51.6	10.2	10.1	9.1	133.3	67.2	496.5	14
Baltimore City	33	Madison	18.5	16.8	28.7	57.2	*	107.7	7.1	64.0	51.6	10.2	10.1	8.0	137.8	67.2	487.8	14
Baltimore City	45	Pimlico	21.5	18.8	18.2	44.0	*	107.7	7.1	64.0	33.3	10.2	5.3	8.6	99.5	43.3	362.1	14
Baltimore City	47	Sandtown	21.9	20.0	27.6	56.5	*	107.7	7.1	64.0	52.6	10.2	6.2	8.2	200.0	51.7	483.8	14
Baltimore City	51	Southwest	21.2	19.7	32.6	58.8	*	107.7	7.1	64.0	52.6	10.2	9.1	9.3	125.0	51.7	483.8	14
Baltimore City	10	Clifton	23.8	20.4	*	57.2	*	107.7	7.1	64.0	51.6	10.2	10.1	11.5	137.8	67.2	496.5	13
Baltimore City	17	Walbrook	18.6	18.3	29.7	39.9	*	107.7	7.1	64.0	33.3	10.2	*	11.1	124.4	45.0	374.6	13
Baltimore City	30	Oldtown	23.3	25.6	*	68.0	*	107.7	7.1	64.0	51.6	10.2	8.8	8.1	200.0	67.2	487.8	13
Baltimore City	35	Midtown	20.0	20.4	*	65.9	*	107.7	7.1	64.0	45.4	10.2	8.8	7.7	133.3	48.6	436.6	13
Baltimore City	36	Midway	23.8	20.4	29.2	48.8	*	107.7	7.1	64.0	38.1	10.2	6.7	8.5	88.5	*	496.5	13
Baltimore City	42	Patterson Park	18.6	16.8	28.7	48.8	*	107.7	7.1	64.0	51.6	10.2	9.6	*	144.1	67.2	487.8	13
Baltimore City	46	Hollins Market	25.0	19.7	*	61.4	*	107.7	7.1	64.0	52.6	10.2	7.4	7.7	200.0	51.7	483.8	13
Baltimore City	49	Southeastern	18.6	15.9	13.2	71.8	*	107.7	7.1	64.0	23.3	10.2	5.0	*	129.0	44.4	277.6	13
Baltimore City	50	Park Heights	19.4	17.7	18.2	43.8	*	107.7	7.1	64.0	45.4	10.2	5.3	*	99.5	48.6	436.6	13
Baltimore City	53	Upton	21.9	18.3	26.0	65.6	*	107.7	7.1	64.0	52.6	10.2	7.0	*	200.0	51.7	483.8	13
Dorchester	21613	Cambridge	17.6	13.8	31.0	30.4	7124.7	*	*	66.0	28.9	10.7	6.5	9.2	123.9	45.0	315.6	13
Baltimore City	3	Edison	23.8	20.0	29.2	*	*	107.7	7.1	64.0	38.1	10.2	5.6	*	131.1	45.3	496.5	12
Baltimore City	4	Brooklyn	*	13.9	*	50.0	*	107.7	7.1	64.0	37.9	10.2	8.2	10.2	137.3	53.7	396.3	12
Baltimore City	9	Claremont	18.4	*	*	56.9	*	107.7	7.1	64.0	51.6	10.2	5.6	11.5	137.0	67.2	496.5	12
Baltimore City	13	Dorchester	18.6	17.7	*	43.8	*	107.7	7.1	64.0	33.3	10.2	*	14.1	99.5	45.0	374.6	12
Baltimore City	19	Charles Village	20.0	20.4	*	48.8	*	107.7	7.1	64.0	32.9	10.2	6.7	8.0	103.6	*	391.7	12
Baltimore City	43	Penn North	19.4	20.6	*	44.1	*	107.7	7.1	64.0	45.4	10.2	5.4	*	97.6	48.6	436.6	12
Baltimore City	44	Perkins	23.3	25.6	*	68.0	*	107.7	7.1	64.0	51.6	10.2	10.1	*	200.0	67.2	496.5	12
Baltimore City	54	Washington Village	25.0	20.7	*	47.9	*	107.7	7.1	64.0	52.6	10.2	8.7	*	141.7	51.7	483.8	12
Baltimore City	55	Westport	*	20.7	37.7	59.7	*	107.7	7.1	64.0	37.9	10.2	7.8	*	141.7	53.7	396.3	12
Washington	21740	Hagerstown	15.0	13.8	*	46.2	*	115.2	*	73.0	19.1	9.7	11.5	7.9	145.2	42.6	257.5	12
Wicomico	21801	Salisbury	16.6	15.5	16.1	42.3	10730.7	*	5.5	*	30.7	*	5.0	8.4	133.3	42.7	265.7	12
Baltimore City	6	Cedonia	18.0	16.9	22.8	41.3	*	107.7	7.1	64.0	*	10.2	*	*	89.9	45.3	496.5	11
Baltimore City	15	Edmonson Village	20.9	18.3	*	*	*	107.7	7.1	64.0	29.8	10.2	5.0	*	124.4	45.0	374.6	11
Baltimore City	27	Highlandtown	18.6	*	*	39.1	*	107.7	7.1	64.0	23.3	10.2	*	8.7	144.1	44.4	277.6	11
Baltimore City	31	Lauraville	20.6	19.0	26.7	*	*	107.7	7.1	64.0	*	10.2	*	7.3	89.9	45.3	496.5	11
Baltimore City	34	Hampden	20.0	*	*	43.8	*	107.7	7.1	64.0	45.4	10.2	5.1	*	99.5	48.6	436.6	11
Baltimore City	41	Highlandtown	*	*	*	71.8	*	107.7	7.1	64.0	51.6	10.2	7.4	7.7	144.1	67.2	496.5	11
Baltimore City	52	Waverlies	19.1	18.3	*	48.8	*	107.7	7.1	64.0	25.6	10.2	6.7	*	86.2	*	303.6	11
Prince Georges	20785	Hyattsville	17.7	16.5	38.0	33.8	*	109.6	*	68.0	*	*	3.6	22.1	111.9	35.2	259.9	11
Baltimore City	2	Beechfield	20.9	17.4	30.6	*	*	107.7	7.1	64.0	19.0	10.2	*	*	*	39.3	287.8	10
Baltimore City	14	Downtown	25.0	*	*	65.9	*	107.7	7.1	64.0	32.9	10.2	8.8	*	200.0	*	391.7	10
Baltimore City	16	Fells Point	*	*	24.0	*	*	107.7	7.1	64.0	32.9	10.2	*	15.4	200.0	44.4	287.7	10
Baltimore City	20	Govans	*	15.8	*	*	*	107.7	7.1	64.0	25.6	10.2	4.2	7.8	93.1	*	303.6	10
Prince Georges	20706	Lanham	16.3	*	18.4	28.6	6870.1	109.6	*	68.0	*	*	3.6	22.1	70.7	39.5	*	10
Prince Georges	20743	Capitol Heights	17.7	17.4	38.0	25.2	8584.0	109.6	*	68.0	*	*	3.2	14.2	75.2	*	*	10
Somerset	21817	Crisfield	16.3	14.0	19.9	34.6	*	*	*	*	22.8	9.4	6.3	*	74.1	41.1	314.5	10

* Indicates rate < 1 standard deviation above mean

Appendix C. Indicator Descriptions (by ACA specified area)

Premature birth, Low birth weight infants, Infant Mortality (including death due to neglect), or other indicators of prenatal, maternal, newborn, or child health risk

- **Percent Preterm Births:**
  - Justification for selection: This is a standard, well understood indicator of poor birth outcomes.
  - Defined as: (# of births <37 weeks gestational age / total births) * 100
  - Years represented: 2004-2008
  - Measured at census tract level
  - Source: MD Department of Health and Mental Hygiene (DHMH), Vital Statistics Administration (VSA)
  - Limitations: Some addresses listed on the birth record could not be geocoded to a census tract, and were therefore not included in the analysis. Rates were not computed for census tracts with fewer than 5 preterm births over the 5 year period.

- **Percent low birth weight infants**:
  - Justification for selection: This is a standard, well understood indicator of poor birth outcomes.
  - Defined as: (# of births <2500 grams / total births) * 100
  - Years represented: 2004-2008
  - Measured at census tract level
  - Source: MD DHMH, VSA
  - Limitations: Some addresses listed on the birth record could not be geocoded to a census tract, and were therefore not included in the analysis. Rates were not computed for census tracts with fewer than 5 low birth weight infants over the 5 year period.

- **Infant Mortality Rate:**
  - Justification for selection: This is a standard, well understood indicator of community need.
  - Defined as: (# of infant (<1 yr) deaths / total births) * 1,000
  - Years represented: 2004-2008
  - Measured at census tract level
  - Source: MD DHMH, VSA
  - Limitations: Some addresses listed on the birth or death record could not be geocoded to a census tract, and were therefore not included in the analysis. Rates were not computed for census tracts with fewer than 5 infant deaths over the 5 year period. There were no census tracts with more than 4 infant deaths due to neglect over the 5 year period, and it was therefore not possible to include a separate indicator for infant deaths due to neglect.
- **Percent Late or No Prenatal Care:**
  - Justification for selection: This is a standard, well understood indicator of community need.
  - Defined as: (# of births to women receiving late (3rd trimester) or no prenatal care / total births) * 100

  - Years represented: 2004-2008
  - Measured at census tract level
  - Source: MD DHMH, VSA
  - Limitations: Some addresses listed on the birth record could not be geocoded to a census tract, and were therefore not included in the analysis. Rates were not computed for census tracts with fewer than 5 births to women receiving late or no prenatal care over the 5 year period.

- **Teen Birth Rate:**
  - Justification for selection: This is a standard, well understood indicator of community need.
  - Defined as: (# of births to adolescents (15-19 yrs) / female population (15-19 yrs)) * 1,000
  - Years represented: Births: 2004-2008, Population: 2000
  - Measured at census tract level
  - Sources: Births: MD DHMH, VSA, Population: US Census Bureau
  - Limitations: Some addresses listed on the birth record could not be geocoded to a census tract, and were therefore not included in the analysis. Rates were not computed for census tracts with fewer than 5 teen births to over the 5 year period. Population data at the census tract level is only available from the U.S. Decennial Census, and there are likely to have been substantial changes to the population in Maryland over the last 10 years.

Poverty and Unemployment

- **Percent of Families in Poverty:**
  - Justification for selection: This indicator seemed to more closely measure the poverty level of families likely to benefit from home visiting programs than the broader total resident poverty level metric specified in the Home Visiting Program Supplemental Information Request.
  - Defined as: (# of families with children (<18 yrs) with incomes below the poverty level / total # of families with children (<18 yrs)) * 100
  - Year represented: 2000
  - Measured at census tract level
  - Source: MD Department of Planning (MDP), US Decennial Census
  - Limitations: Rates were not computed for census tracts with fewer than 5 families with children under 18 years of age living below the poverty level. Population data at the census tract level is only available from the U.S. Decennial Census, and there are likely to have been substantial changes to the population in Maryland over the last 10 years. The number of families living in poverty is likely to have increased due to the current recession.

- **Percent Unemployed:**
  - Justification for selection: This is a standard, well understood indicator of community need.
  - Defined as: (# of adults seeking employment / # of adults in labor force) * 100
  - Year Represented: 2009
  - Measured at jurisdiction level

- Source: MD Department of Labor, Licensing and Regulation (DLLR)
- Limitations: This metric is only computed by MD DLLR at the census tract level immediately following a Decennial Census. MD DLLR felt that the unemployment rates had increased across the state to such a great degree since the 2000 Census that it would be unwise to use the 2000 data.

- **WIC Participation Rate:**
  - Justification for selection: Participants at the Home Visiting Stakeholder Conference that was held to review the Needs Assessment strongly recommended adding this metric as a good way of identifying communities with women and children in need.
  - Defined as: (# of people enrolled in WIC / total population) * 1,000
  - Years represented: WIC: 2005-2009, population: 2000
  - Measured at ZIP code level
  - Sources: WIC enrollment: MD DHMH, Family Health Administration, WIC Program, Population: MDP US Decennial Census
  - Limitations: This metric was not available at the census tract level, but was available by ZIP code. Rates were not computed for ZIP codes with fewer than 5 WIC participants over the 5 year period. Population data at the ZIP code level is only available from the U.S. Decennial Census.

- **Medicaid Enrollment Rate:**
  - Justification for selection: This indicator was added because it serves as an additional metric of poverty but has more recent data than the Census poverty information (at least for the numerator).
  - Defined as: (# of people enrolled in Medicaid / total population) * 1,000
  - Years represented: Medicaid: 2005-2009, population: 2000
  - Measured at ZIP code level
  - Sources: MD DHMH, Medical Assistance Programs, MDP US Decennial Census
  - Limitations: This metric was not available at the census tract level, but was available by ZIP code. Rates were not computed for ZIP codes with fewer than 5 Medicaid enrollees over the 5 year period. Population data at the ZIP code level is only available from the U.S. Decennial Census.

Crime

- **Crime Rate:**
  - Justification for selection: This is a standard indicator of a community in need.
  - Defined as: (total offenses / total population) * 100,000
  - Years represented: 2007-2008
  - Measured at municipality and jurisdiction level
  - Source: Crime: MD State Police, Uniform Crime Report, population: MDP Census estimates
  - Limitations: Rates were not computed for municipalities with less than 50 reported offenses per year. The rates for Ocean City, and its containing jurisdiction, Wicomico County, were adjusted to account for the seasonal tourist population influx.

Domestic Violence and Child Maltreatment

- **Rate of Protective/Peace Orders:**
  - Justification for selection: Maryland does not currently have any direct measures of domestic violence. The Governor's Office of Crime Control and Prevention recommended this metric as the best proxy indicator for domestic violence.
  - Defined as: (# of protective and peace order filings / total population) * 10,000
  - Years represented: 2008-2009
  - Measured at jurisdiction level
  - Source: Protective/Peace Orders: MD Judiciary, population: MDP population estimates
  - Limitations: This measure is only available at the jurisdiction level. A new system is being developed which will allow police departments to indicate when offenses are related to domestic violence. Data from this system may be available for future assessments.

- **Child Abuse & Neglect Investigation Rate:**
  - Justification for selection: Based on information from the MD Department of Human Resources (DHR), it was decided to combine indicated and unsubstantiated child investigations in order to compute more stable rates at the census tract level. DHR reported that both categories were indicative of child abuse and neglect. Maryland does not use the term 'substantiated'.
  - Defined as: (# of indicated and unsubstantiated child abuse and neglect investigations / total population) * 1,000
  - Years Represented: Abuse/neglect: 2006-2009, population: 2000
  - Measured at census tract level
  - Sources: MD DHR, US Census Bureau
  - Limitations: Some addresses in the DHR database could not be geocoded to a census tract, and were therefore not included in the analysis. Rates were not computed for census tracts with fewer than 5 investigations over the 4 year period. It was not feasible to subdivide the investigations by allegation type due to small cell sizes at the census tract level. Population data at the census tract level is only available from the U.S. Decennial Census.

High School Dropout Rate

- **Percent HS Dropouts:**
  - Justification for selection: This is a standard indicator of communities in need.
  - Defined as: (# of high school dropouts / total # of high school students) * 100
  - Years Represented: 2008-2009
  - Measured at jurisdiction level
  - Source: MD State Department of Education (MSDE)
  - Limitations: This measure is published by MSDE per high school, however because they were unable to identify the geographic areas that feed enrollment to each school, it was not possible to map the rates at this level. Therefore, jurisdictional rates were used for this metric.

- **Percent Ready to Enter School:**

- Justification for selection: School readiness was another metric that was widely recommended for inclusion in the needs assessment by the participants of the Home Visiting Stakeholders Conference. It was felt that this was an important measure of need in the early childhood area.
- Defined as: (# of children entering kindergarten ready to learn / total # of children entering kindergarten) * 100
- Year Represented: 2009-2010 School Year
- Measured at jurisdiction level
- Source: MSDE
- Limitations: This measure is published by MSDE per elementary school, however because they were unable to identify the geographic areas that feed enrollment to each school, it was not possible to map the rates at this level. Therefore, jurisdictional rates were used for this metric.

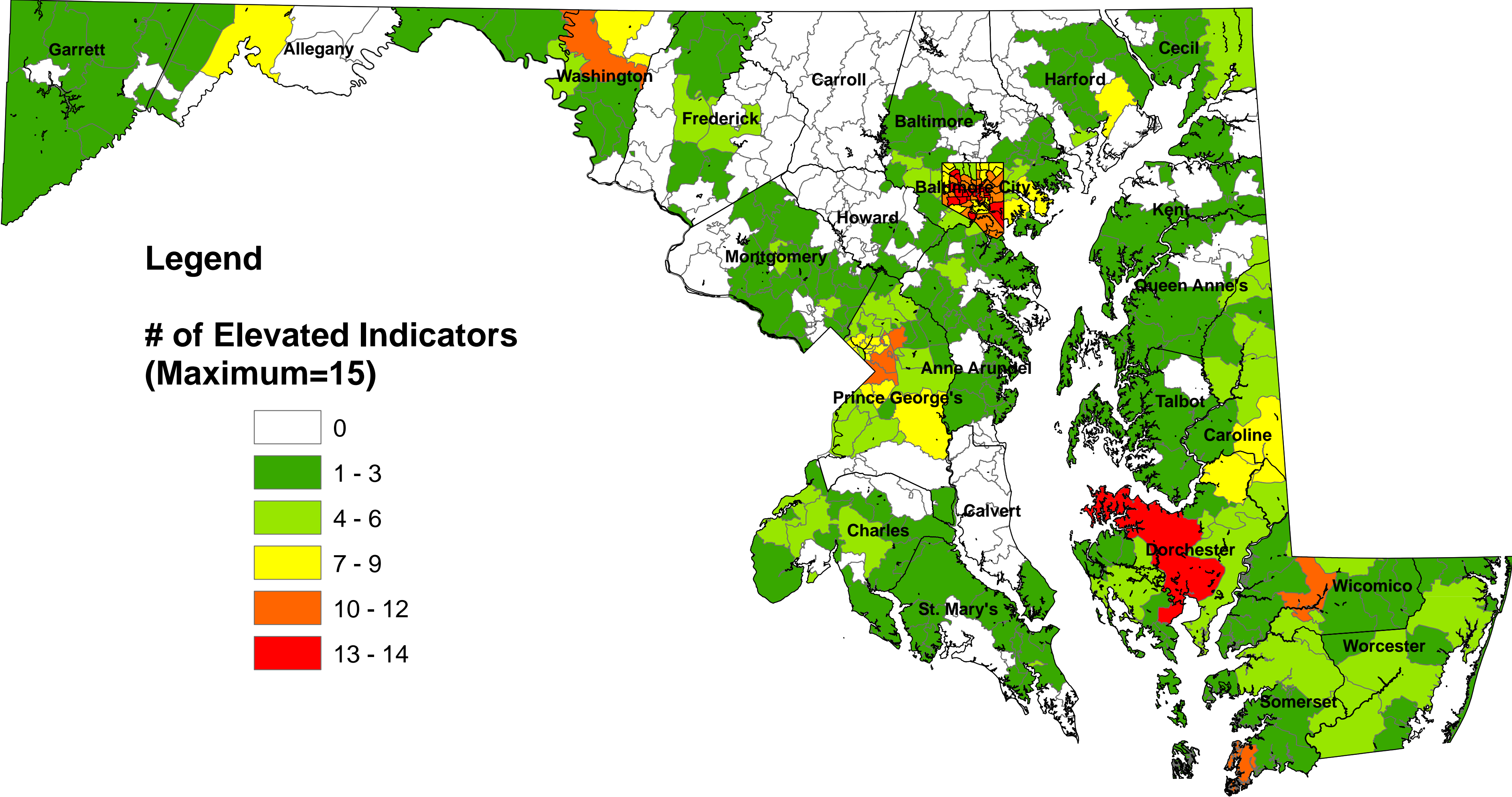
Substance Abuse

- **Substance Abuse Treatment Rate:**
  - Justification for selection: Maryland does not have a good measure of substance abuse prevalence available at a community level. We therefore decided to use substance abuse treatment rates as a proxy. We focused on women of childbearing age because we are working to get women into treatment before they become pregnant in an effort to improve pregnancy outcomes.
  - (# of women (15-44 yrs) receiving ADAA-funded treatment for substance abuse / total # of women (15-44 yrs)) * 1,000
  - Years Represented: Treatment: 2004-2008, population: 2000
  - Measured at ZIP Code level
  - Sources: MD DHMH, Alcohol and Drug Abuse Administration, MDP US Decennial Census

Limitations: Rates of substance abuse treatment are only a proxy measure for substance abuse prevalence and may reflect better access to treatment in some areas. These data were not available at the census tract level. Population counts at the ZIP code level are only available from the Decennial Census.

Appendix C.

Number of Elevated Indicators by CSA (Baltimore City) or ZIP Code, Maryland



Prepared by MD DHMH, Center for Maternal and Child Health

STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – John M. Colmers, Secretary

Family Health Administration
Russell W. Moy, M.D., M.P.H., Director

September 20, 2010

Audrey M. Yowell, Ph.D., MSSS
Health Resources and Services Administration
Maternal and Child Health Bureau
5600 Fishers Lane, 18A-39
Rockville, MD 20857

RE: CFDA No. 93.505- Affordable Care Act (ACA) Maternal, Infant and Early Childhood Home Visiting Program

Dear Dr. Yowell:

I am very pleased to submit the Department of Health and Mental Hygiene's letter of concurrence and support for Part 2 of the Maryland's response to Federal Opportunity Announcement HRSA-10-275, *Affordable Care Act (ACA) Maternal, Infant, and Early Childhood Home Visiting Program.* As you know, the Governor has designated the Department as the administering state agency for this new program. Within the Department, the Center for Maternal and Child Health (CMCH) is the State Title V agency, with responsibility for administering the federal MCH Block Grant as well as a number of related federal and state MCH programs.

Since our initial submission (Part 1), we have been working closely with our key partners – the Alcohol and Drug Abuse Administration here in the Department (State Single Agency for Substance Abuse), the Governor's Office for Children (Maryland's Children's Cabinet), the Maryland Family Network (CAPTA Title II), and Headstart – on the federally required needs assessment for this new program. Separate letters from these partners are included with this submission.

We are very enthusiastic about this opportunity to work with our State agency and local partners to strengthen early childhood and home visiting systems that are critical for improving the health of families. We also look forward to working with you, your colleagues at the Administration for Children and Families, and with federal project staff at the central and regional offices. Please contact me at 410-767-6717 or birkelb@dhmh.state.md.us if you have any questions about this submission.

Sincerely,

Bonnie S. Birkel, RN, CRNP, MPH
Director
Center for Maternal and Child Health

Nancy S. Grasmick
State Superintendent of Schools

200 West Baltimore Street • Baltimore, MD 21201 • 410-767-0100 • 410-333-6442 TTY/TDD

Bonnie S. Birkel, C.R.N.P., M.P.H.
Director, Center for Maternal and Child Health
Maryland Department of Health and Mental Hygiene
201 West Preston Street, Room 306
Baltimore, MD 21201

Dear Ms. Birkel:

I am glad to support the Department of Health and Mental Hygiene's proposal, prepared on behalf of the Children's Cabinet, in response to the Funding Opportunity Announcement HRSA-10-275, *Affordable Care Act (ACA) Maternal, Infant, and Early Childhood Home Visiting Program*. This new funding will improve results for children and families through the evidenced-based home visiting programs in at risk communities, including outcomes for maternal, infant and early childhood health; school readiness; child abuse and neglect; and parenting skills.

The Head Start State Collaboration Office is located in the Division of Early Childhood Development. As Director of the Office, I fully endorse this project. All home visiting programs will benefit from collaborating with the federally regulated Early Head Start and Head Start programs and their long-established home visiting components.

MSDE and the Collaboration Office commit to assisting the State Title V Agency and/or the Children's Cabinet with the planned home visiting initiative. Also, I commit to serving on committees or workgroups to advance the home visiting agenda and to bring information regarding the initiative to many relevant group meetings, including the Early Childhood Mental Heath Steering Committee, the Oral Health for Maryland Kids Committee, the Head Start Collaboration and Judy Center Partnership Advisory Council, and the State Council on Early Childhood Education and Care. Connections can be established with Early Head Start and Head Start programs and other MSDE Divisions to help in the implementation of project goals and objectives.

I look forward to working collaboratively with the Children's Cabinet and the Title V Agency to strengthen early childhood and home visiting systems for pregnant women, parents and caregivers, and children through this new initiative. I can be reached at 410-767-0140 or lzang@msde.state.md.us.

Sincerely,

Linda Zang

Linda Zang, Branch Chief
Collaboration and Program Improvement
Division of Early Childhood Development

cc: Rolf Grafwallner
Marcella Franczkowski

STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene
55 Wade Avenue • Catonsville, Maryland 21228
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – John M. Colmers, Secretary

Alcohol and Drug Abuse Administration
Thomas Cargiulo, Pharm.D.
Director

September 17, 2010

Ms. Bonnie Birkel, C.R.N.P., M.P.H.
Director, Center for Maternal and Child Health
Maryland Department of Health and Mental Hygiene
201 West Preston Street, Room 306
Baltimore, MD 21201

Dear Ms. Birkel:

The Maryland Alcohol and Drug Abuse Administration has an enthusiastic partnership with the Center for Maternal and Child Health. As the Single State Agency for substance abuse prevention, intervention, and treatment services, we have collaborated with Maternal and Child Health on several initiatives. We recognize that in order to have healthy families we need all the individuals within the family to be healthy. The Administration fully supports the Needs Assessment Process that has been undertaken by the Maryland Department of Health and Mental Hygiene – Center for Maternal and Child Health and will make available all substance abuse data necessary to present a comprehensive analysis of substance use disorders in Maryland. Staff from the ADAA fully participated in the Home Visiting Stakeholder meeting and agree to continue to work on any strategic planning and needs assessment.

We believe that this innovative opportunity will help provide services for all Marylanders especially those communities that have low birth weight, premature births, and infant mortality.

Sincerely,

Thomas P. Cargiulo, Pharm.D.
Director

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September 9, 2010

Bonnie S. Birkel, C.R.N.P., M.P.H.
Director, Center for Maternal and Child Health
Maryland Department of Health and Mental Hygiene
201 West Preston Street, Room 306
Baltimore, MD 21201

Dear Ms. Birkel:

Thanks so much for including us in the Home Visiting Stakeholder Meeting last month. Several Maryland Family Network senior staff members were present and delighted to have had the opportunity to contribute to a common understanding of the State's needs and conducting a needs assessment related to the home visiting proposal to the U. S. Department of Health and Human Services. I thought it was an informative and productive meeting.

Maryland Family Network (a merger of Maryland Committee for Children and Friends of the Family, Inc.) has been Maryland's lead agency for the federally-funded Community-Based Child Abuse Prevention program since the inception of the legislation as the Family Resource and Support program in 1992. As the Executive Director of legacy Friends of the Family and the current Maryland Family Network, the State's agency for Title II of CAPTA, I fully support this application.

We are pleased to be able to provide you with any reports and data we collect as part of our prevention and early-intervention work in communities throughout Maryland. We are more than happy to run special reports that you may like from the Management Information Systems we maintain for both the Family Support Center and Child Care Resource and Referral Center networks.

We are ready and willing to continue to work with DHMH as part of the planning and implementation process for the Home Visiting and look forward to doing so.

Sincerely yours,

Margaret E. Williams
Executive Director

Appendix E. Evidence Based Capacity

CAPACITY ASSESSMENT: Maryland Early Head Start

What county (ies) does your program serve?	Baltimore City, Baltimore County, Allegany, Anne Arundel, Caroline, Cecil, Talbot, Dorchester, Garrett, Harford, Montgomery, Washington
Does the program have a name?	Early Head Start
What home visiting model or approach is used?	Home-based only. Weekly 90 minute home visiting or a monthly 90 minute home visit and attending the center 2x's per week
Name the specific service(s) you provide.	Comprehensive child development, health (including oral health), nutrition, social services, mental health, prenatal education
List the intended recipients of the service (e.g., pregnant women, infants).	Pregnant women, children ages 0-3
What are the targeted goals/outcomes of the intervention (e.g., child maltreatment reduction, maternal and child health, early literacy, reduction of domestic violence)?	Literacy, social competence, health, nutrition, mental health, and identification of children in high risk populations
What are the demographic characteristics of individuals or families served?	Must meet Head Start eligibility for age and income
How is the demographic data collected (e.g., intake sheet, questionnaire done by staff, self report…)	Done by staff
What is the number of individuals or families served per month?	Based on funded enrollment. For FY 2010, 296 statewide
What is the geographic area served (e.g., entire county, certain neighborhoods, or zip codes)?	Entire counties in Allegany, Anne Arundel, Caroline, Cecil, Talbot, Dorchester, Garrett, Harford, Montgomery, Washington; South East Baltimore City, Eastern Baltimore County
Are you state or federally funded?	Federally funded and state funded
What is your current funding for this fiscal year?	About $6.5 million for all of Head Start- which includes Early Head Start

CAPACITY ASSESSMENT: Nurse Family Partnership

What county (ies) does your program serve?	Garrett County
Does the program have a name?	Garrett County Nurse-Family Partnership (GC NFP)
What home visiting model or approach is used?	Nurse-Family Partnership (NFP National Service Office contracts with the GC Partnership/LMB to provide GC NFP)
Name the specific service(s) you provide.	RN Nurse home visiting - prenatally and postnatally until the target child is age 2
List the intended recipients of the service (e.g., pregnant women, infants).	Low income (MCHP eligible), first-time mothers (no previous live births) up to 28 weeks gestation are eligible for enrollment. Target children are served up to age 2. All services are voluntary.
What are the targeted goals/outcomes of the intervention (e.g., child maltreatment reduction, maternal and child health, early literacy, reduction of domestic violence)?	NURSE-FAMILY PARTNERSHIP GOALS 1. Improve pregnancy outcomes by helping women engage in good preventive health practices, including thorough prenatal care from their healthcare providers, improving their diets, and reducing their use of cigarettes, alcohol and illegal substances 2. Improve child health and development by helping parents provide responsible and competent care 3. Improve the economic self-sufficiency of the family by helping parents develop a vision for their own future, plan future pregnancies, continue their education and find work Consistent program effects found in 2 or more randomized controlled trials: • Improved prenatal health • Fewer childhood injuries • Fewer subsequent pregnancies • Increased intervals between births • Increased maternal employment • Improved school readiness
What are the demographic characteristics of individuals or families served?	For NFP clients enrolled in FY 2010: • 100% were first-time mothers • 100% White (the county is 98% White) • 75% enrolled at or prior to 12 weeks gestation; 100% by 28 wks. gestation • Median household income = $17,500 • 42% of mothers were unemployed • 20% of mothers had less than a high school education • 63% were age 19 or younger • 57% smoke cigarettes • 27% had a mental health concern
How is the demographic data collected (e.g., intake sheet, questionnaire done by staff, self report…)	Demographic data is collected at intake and periodically by staff on tablet computers utilizing computerized data collection forms adapted from the NFP National Service Office forms. The NFP client forms are downloaded from a flash drive and then manually entered into an online web-based client information system (the NFP CIS).
What is the number of individuals or families served per month?	• 97 families served in CY '09 • 93 families served in CY '10 (1st 6 mos.) • 119 families and 92 children served between 8/23/2007 and 6/30/2010 • 68 families with 57 target children currently being served (this is a 6/30/10 snapshot)
What is the geographic area served	Entire county
Are you state or federally funded?	State
What is your current funding for this fiscal year?	$282,000 – Garrett LMB CPA funding from the MD Governor's Office for Children $120,000 - MD Health Resources Commission grant to the GC Health Department to expand the GC NFP

CAPACITY ASSESSMENT: Parents as Teachers

There are only two PAT programs in our state. All other programs use the PAT curriculum as part of the home visiting program

What county (ies) does your program serve?	Garrett County, Somerset County and the 21852 zip code in Pocomoke	
Does the program have a name?	Parents as Teachers (PAT)	
What home visiting model or approach is used?	Parents as Teachers (national affiliation)	
Name the specific service(s) you provide.	The Parents as Teachers Born to Learn™ curriculum is provided during home visits to: a) Older siblings ages 3-5 of currently enrolled Healthy Families families b) At-risk families discharged from Perinatal (short-term) or other Early Care services that request continued support c) Almost all families receiving HFGC home visiting voluntarily participate in PAT. PAT activities are provided during the HFGC home visits.	
List the intended recipients of the service (e.g., pregnant women, infants).	Families with young children birth to age five enrolled in HFGC and previously served families now enrolled in PAT only.	
What are the targeted goals/outcomes of the intervention (e.g., child maltreatment reduction, maternal and child health, early literacy, reduction of domestic violence)?	PAT Goals: • **Goal #1:** Increase parent knowledge of early childhood development and improve parenting practices • **Goal #2:** Provide early detection of developmental delays and health issues • **Goal #3:** Prevent child abuse and neglect • **Goal #4:** Increase children's school readiness and school success Independent randomized controlled trials (RCT) have consistently confirmed the effectiveness of Parents as Teachers. PAT has been shown to be effective by: • improving children's development across multiple domains • increasing school readiness • improving parent knowledge of early childhood development and parenting practices • identifying delays and health issues • preventing child abuse and neglect	
What are the demographic characteristics of individuals or families served?	Garrett Co. For the 100 PAT families served in FY '10: • 42% were teen moms (age 19 or younger) at intake • 74% had an annual household income under $20,000 • 70% were single parents • 69% were first-time mothers • 41% had less than a HS education • 43% were unemployed at intake	Somerset: For the 100 PAT families served in FY '10: 13-38 year old mothers 66% African American 4% Hispanic 30% Caucasian
How is the demographic data collected (e.g., intake sheet, questionnaire done by staff, self report…)	Demographic data is collected during the referral process and at intake utilizing locally-developed data collection forms. This information is entered into a locally-developed MS Access database.	
What is the number of individuals or families served per month?	FY 2010: Garrett and Somerset 200 families participated in PAT	
What is the geographic area served	Entire counties of: Garrett County, Somerset County and the 21852 zip code in Pocomoke	
Are you state or federally funded?	State	
What is your current funding for this fiscal year?	Garrett: A Maryland ADAA grant of approximately $60,000 to the local HD funds the PAT component for older siblings of Healthy Families Garrett County Families. PAT is infused into HFGC also – with no additional funding.	Somerset: $42,6893.00

CAPACITY ASSESSMENT: Healthy Families Maryland

What county (ies) does your program serve?	Baltimore City and the following Counties: Baltimore, Calvert, Charles Dorchester, Frederick, Garrett, Howard, Lower Shore, Prince Georges, Montgomery, Queen Anne's/Talbot, Washington, Wicomico
Does the program have a name?	Healthy Families
What home visiting model or approach is used?	Healthy Families America
Name the specific service(s) you provide.	Nurse/Para-professional home visiting prenatally and/or until the target child transfers out to another early childhood program or reaches age 5. RN nurses provide staff supervision, administer assessments, and provide mental health services, as indicated.
List the intended recipients of the service (e.g., pregnant women, infants).	At-risk pregnant or parenting families (with an infant up to age 3 months), (except first-time, low-income mothers who enroll prior to 28 weeks gestation) are eligible for enrollment. All services are voluntary. Families scoring 25+ on "The Family Survey" are offered services, and home visits must begin before baby is three months old and are weekly for at least six months.
What are the targeted goals/outcomes of the intervention (e.g., child maltreatment reduction, maternal and child health, early literacy, reduction of domestic violence)?	**Healthy Families America Program Goals:** • To systematically reach out to parents to offer resources and support • To cultivate the growth of nurturing, responsive, parent-child relationships • To promote healthy childhood growth and development • To build the foundations for strong family functioning Outcomes from randomized control trials and quasi-experimental research are: • Reduced child maltreatment; • Increased utilization of prenatal care & decreased pre-term, low weight babies; • Improved parent-child interaction and school readiness; • Decreased dependency on welfare, or TANF (Temporary Assistance to Needy Families) and other social services; • Increased access to primary care medical services; and • Increased immunization rates.
What are the demographic characteristics of individuals or families served?	Most parents are low income and between the ages of 17-35; in some areas up to 25% are non-english speaking
How is the demographic data collected (e.g., intake sheet, questionnaire done by staff, self report…)	Demographic data is collected during the referral process and at intake utilizing locally-developed data collection forms. This information is entered into a locally-developed MS Access database.
What is the number of individuals or families served per month?	FY 2010: • 81 mothers, 79 fathers and 94 target children were served
What is the geographic area served (e.g., entire county, certain neighborhoods, or zip codes)?	Entire counties of: Baltimore, Calvert, Charles Dorchester, Frederick, Garrett, Howard, Lower Shore, Prince Georges, Montgomery, Queen Anne's/Talbot, Washington, Wicomico and In Baltimore City: West Baltimore, Druid Heights, Upton, Mondawmin, Reservoir Hill and parts of Rosemont
Are you state or federally funded?	State and/or [Federal] TANF funds
What is your current funding for this fiscal year?	Varies by county from $300,000 to $800,000

Appendix F. LHD Capacity Chart

Name of local health department	**Allegany**	**Allegany**	**Calvert County**	**Calvert County**	**Carroll County**	**Carroll County**	**Carroll County**	**Cecil County**	**Charles County**	**Dorchester County**
Name of home visiting programs that serve your county.	Allegany County Infants and Toddlers Program	Perinatal Substance Use Intervention Program	Maternal Child Program	Children With Special Health Care Needs Program	Maternal Child Health	Children with Special Health Care Needs	Chronic Disease Management Program	Healthy Start- County Funded	Maternal/Child Health/Healthy Start	Healthy Families—Beth Nossick Infant & Toddler—BOE—Donna Greenleaf Infant & Toddler—DCHD—Yvonne Church, Ruth Baker Early Head Start—Shore-Up—Director vacant Healthy Start/Baby Matters—Yvonne Church Children with Special Health Needs (nursing Component)—Carolyn Hallowell
Does your home visiting program serve any other counties?	No	No	No	No	No	No	No	No	No	No
What home visiting models or approaches are used?	Governed by state and federal polices and procedures	Infant and Toddlers portion- state and federal policies and procedures. Substance using prenatal and postpartum women- based on Dr. Chasnoff's evidenced-based findings and recommendations- 4Ps.	Targeted nurse home visiting case management Follow the Healthy Start Nurse home visiting model with local modifications to meet the needs of the county	Single point of entry program that provides care coordination and home visiting nurse case management to children with special needs and their families to facilitate access to health care and services	Case management, health assessments, health education & instruction, linkages to services	Education, advocacy & linkages to medical & health services, educational programs and respite care	Short term case management, patient assessment, health education and instruction, linkages to medical & health care support services	Modeled after original HS program- try to see pregnant women a minimum of 1X/trimester, more as needed. Infants up to 2 years of age Postpartum moms are usually seen once to confirm 6 weeks check and birth control. Pregnant drug abusing women are given priority followed by teens All of this is dependent on staffing and continued funding	The Healthy Start model	Healthy Families—Healthy Families America Early Head Start—Parents as Teachers
Name the specific service(s) you provide through the LHD.	Monthly nurse service coordination, non-clinical.	Monthly nurse service coordination, non-clinical.	Maternal Case Management (pregnant women) Child Case Management (Newborns up to age Two)	Care coordination Case management Nurse home visits Community and provider outreach	MCHP, ACCU, WIC, FP, CD, Infants & Toddler, Child Immunization Clinic, CSHCN, Health Education, Addiction Services, partnership with	MCHP, ACCU, WIC, Infant & Toddler, Health Education, Child Dental Services – all referred to by the CSHCN program	SCSM Program refers to Adult Education ad Review Services and Medial Assistance Personal Care Services	See above	Medical case management where residents of Charles County receive education and guidance regarding medical	Healthy Families (information already completed and sent by Beth Nossick—a copy of her responses is included) Screening, referral, assessment, intensive home visiting, quarterly newsletter. Visits focus on attachment,

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Name of local health department	**Allegany**	**Allegany**	**Calvert County**	**Calvert County**	**Carroll County**	**Carroll County**	**Carroll County**	**Cecil County**	**Charles County**	**Dorchester County**
			Provide intensive case management to high risk pregnant women and children who are at greater risk for poor health outcomes without nurse intervention		local Hospital for OB care for undocumented pregnant women, child dental services – These are all services that MCH may refer/ link patients				insurance and resources, health education for a healthy pregnancy outcome, and infant/child health and safety, education regarding community resources, and advocacy with the goal of ensuring that the client is linked to all necessary resources and services. These services are provided face to face, by mail and telephone.	nurturing, positive parent-child interaction, healthy childhood growth and development.
List the intended recipients of the service (e.g., pregnant women, infants).	Special needs infants, toddlers and pre-schoolers, birth to age five.	Infants and Toddlers- via I&T program. Prenatal and postpartum women with positive substance use during current pregnancy or infant test positive for substance exposure.	All high risk county residents that include: Pregnant Women, Post Partum Women, Newborns and Children up to age two	All children with special health care needs and their families ages 0-21	High-risk pregnant women & infants/ babies up to one year of age and children up to 2 years of age.	Pre-school and school age children with newly diagnosed medical conditions, acute episodes of chronic health problems, functional cognitive and learning disabilities	Adults, age 19 years and older, with chronic health problems	Pregnant and postpartum women and children up to 2 years of age	Women who are pregnant or post delivery and families with children under the age of 2 years.	Pregnant women/women with newborns. Home visits must begin before baby is three months old and are weekly for at least six months
What are the targeted goals/outcomes of the intervention (e.g., child maltreatment reduction, maternal and child health, early literacy, reduction of	Eliminate or reduce developmental delay outcomes related to diagnosis.	Infants and Toddlers- Eliminate or reduce effects of substance exposure or addiction in infants. Prenatal women-	Healthy Pregnancies Injury Prevention Decreased fetal and infant mortality Prevention of poor pregnancy outcomes Reduction of	All children with special health care needs will attain their highest level of physical and mental health	Maternal & Child Health/ Wellness practices. Immunization compliance Parent education and skills Growth and development milestones	Nursing case management & resource coordination for pre-school and school age with special health care needs necessitating nursing, medical, and psychosocial management,	Improvements/ stabilization of chronic health problems, promotion and implementation of wellness practices	Reduce infant and fetal mortality. Promote maternal and child health. Prevention of child maltreatment.	Healthy pregnancies with a healthy birth outcome (reducing infant mortality), infant/child safety in the home, overall health education	Child maltreatment prevention/reduction; child health & safety; school readiness is a long-term goal

Appendix F. LHD Capacity Chart

Name of local health department	Allegany	Allegany	Calvert County	Calvert County	Carroll County	Carroll County	Carroll County	Cecil County	Charles County	Dorchester County
domestic violence)?		referral and treatment for substance use during pregnancy and maintenance after delivery; and other support services as needed. Postpartum women- Referral to addictions and family planning services; and other support services as needed.	maternal drug use		Smoking Cessation/ drug abuse abstinence Family support and advocacy Health education School Health services Community outreach Provider Visits	interventions and linkages to needed services, contacts/ resource coordination with medical providers, identify and support respite care			for healthier families and improved health for women for future pregnancies.	
What are the demographic characteristics of individuals or families served?	All children who qualify based on program eligibility set by the state. Insurance is not a factor.	Pregnant women, infant and postpartum women with substance use/exposure.	FY 2010 – total new referrals – 403 369 – Pregnant women on medical assistance 330 – number of individuals served White- 273 (82%) Black -93 (23%) Hispanic – 14 (4%) Asian – 4 (1%) Biracial – 1 Unknown – 15 (4%)	Total – 58 White -39 26 – female Black - 17 32 – male multi -1 Indian -1 < 1yr - 16 1-2 - 6 3-9 -21 10-15 -12 16-18 -2 19 -1	High risk pregnant women and their babies and young children	Pre-school and school are children, families needing assistance with accessing medical, health, and respite care including financial support	Patients referred to CDCM Program need monitoring of blood pressure, diabetic testing, medication instruction & management, health & nutrition education, and community resource planning	Characteristics and demographics cover our entire county and any pregnant woman and their children. Most of the participants have Medical Assistance, but we do have some mothers with private insurance	The eligible population are all Charles County residents, regardless of legal status, so the characteristics span all income levels, races and religions.	FY10: MOMS - 16% under 18; 18% 18-19; 56% 20-30 yrs old; Average age 23.1; Age range 14 – 38; 65% Black; 31% White; 4% Hispanic;78% single; 44% less than HS diploma; 31% Diploma or GED; 11% in school; 7% full-time employed; 11% part-time employed; 51% unemployed, not looking; 20% unemployed, but looking; 51% household income < $10,000; 20% income btwn $10,000-20,000; 93% English speaking; 4% Spanish speaking.
How is the demographic data collected (e.g., intake sheet, questionnaire done by staff, self	This is done by the main office/agency within Allegany County-the Board of Education.	Infant Toddlers data is collected by main agency- BOE Prenatal and postpartum	Maryland Prenatal Risk Assessment Nurse Risk assessment with client self reporting	Intake sheet by nurse	CCHD Nursing Bureau Referral Form MCH Referral Routing Resource Education Form	Referral form (CCHD Nursing Bureau), provider consultation, family contact, Special Needs Care Coordination Form	AERS evaluation forms, referral form Patient/ family contact, provider consultation	MPRA and new pregnant MA recipients info followed by nurse interview and chart forms that include	Professional partners complete the Maryland Prenatal Risk Assessment or the Local	Assessment Workers collect some demographic data at time of their initial visit; additional data collected by Support Workers if family enrolls for HV services.

Appendix F. LHD Capacity Chart

Name of local health department	Allegany	Allegany	Calvert County	Calvert County	Carroll County	Carroll County	Carroll County	Cecil County	Charles County	Dorchester County
report…)		women data is collected is collected by, intake sheet and self report via MD Prenatal Risk Assessment						demographic information	Services Request depending on the client, residents may also refer themselves and in that situation the agency staff would collect the information, additionally referrals are accepted from internal partners in the agency.	
What is the number of individuals or families served per month?	Entire Program caseload is 115. Local health department provides service coordination for approx. 65% of caseload- 2.1 nursing FTE. (6) of these are in the extended 3-5 option.	(1) Nurse position in this grant: Infants and Toddlers- 25 substance exposed/affected infants and toddlers/month Prenatal- approx. 8-10pregnant women with substance use/month Postpartum- approx. 12 postpartum/month (woman testing positive at labor and delivery or infant tested positive)	120 – average active case load per month	Average active caseload 30 to 40 per month 65 – total number of children case managed	Average : 20 individuals/ month (one nurse in the program)	Average: 9 children/ month (one nurse in the program)	16 patients (3 nurses – each 1day/week in program)	The average number of individuals serviced in the last half of FY10 was 75 per month. This number does not include those that were contacted and refused the service.	123	35-45 depending upon service level
What is the geographic area served (e.g., entire county, certain	Entire county	Entire county	Entire county	Entire county	Entire county	Entire county	Entire county	Entire county	The entire county.	Entire county

Appendix F. LHD Capacity Chart

Name of local health department	**Allegany**	**Allegany**	**Calvert County**	**Calvert County**	**Carroll County**	**Carroll County**	**Carroll County**	**Cecil County**	**Charles County**	**Dorchester County**
neighborhoods, or zip codes)?										
Are you state or federally funded?	Infant and Toddlers grant to the BOE funds only 8 hours/week for providing a nurse to service coordinate the extended option-age 3-5. Traditional service coordination providers funded and employed by the LHD are possible through DHMH grants, MCHRC partial grant and health department CH core funding.	Joint funding by DHMH-MCH and MCHRC	no	State	State and Federal	State and Federal	State	County	The program is funded by county, state and federal resources.	State
What is your current home visiting funding for this fiscal year?	In order to continue its commitment to the interagency program with the BOE and DSS, the health department contributes approx. $225,000/year for service coordinators and support staff.	$93,677 joint ($40,000 DHMH-MCH supplemental, $40,000 MCHRC and Medicaid collections for Infant and Toddler service coordination- $13,677.	Local Funding	State	$281,657 – MCH Budget	CSHCN Budget - $41, 209	$31,622	$132,279	$113,000.00	F371N--$363,132

Name of local health department	**Dorchester County**	**Dorchester County**	**Dorchester County**
Name of home visiting programs that serve your county.			
Does your home visiting program serve any other counties?	No	No	No
What home visiting models or approaches are used?			
Name the specific service(s) you provide through the LHD.	Infant & Toddler (nursing component) Screen, assess and identify children birth to age 3 to determine developmental delays and to coordinate and secure a program of therapy and treatment in areas of identified need	Healthy Start/Baby Matters/Core Child Health Complete a health and environment assessment and/or to offer further education and counseling on nutrition, smoking, drug use, family planning and parenting skills	Children with Special Health Needs (nursing component) Assessment and evaluation of children with special health needs requiring a nursing plan of care. Home visits are made if child is not yet in school.
List the intended recipients of the service (e.g., pregnant women, infants).	Individuals with 25% developmental delay or a diagnosed physical or mental condition that puts them at risk for delay	*Pregnant women with MA and risk factors *Infants/children with MA under 2 yo with risk factors	Any child identified by the Board of Education that requires a nursing plan of care be developed.
What are the targeted goals/outcomes of the intervention (e.g., child maltreatment reduction, maternal	Child health school readiness	Child maltreatment reduction; maternal & child health	Child health; school readiness

Name of local health department	Dorchester County	Dorchester County	Dorchester County
and child health, early literacy, reduction of domestic violence)?			
What are the demographic characteristics of individuals or families served?	FY ’10-8 children/8 families	FY ’10—36 children; 71 families	22 children
How is the demographic data collected (e.g., intake sheet, questionnaire done by staff, self report…)	Interview, assessment sheet	Interview, prenatal risk sheet	Nursing assessment
What is the number of individuals or families served per month?	8 children receive a home visit every 1 – 3 months, depending on need	Each woman and/or child gets at least two visits a year	Funded for 20, current case load is 22

Name of local health department	**Dorchester County**	**Dorchester County**	**Dorchester County**
What is the geographic area served (e.g., entire county, certain neighborhoods, or zip codes)?	Entire county	Entire county	Entire county
Are you state or federally funded?	No funding—in kind service with BOE	Federal/Special/County	Federal
What is your current home visiting funding for this fiscal year?	$0	F564N--$10,000 F416N—36,801 E816N--$25,922 (county)	F675N--$12,000

Name of local health department	Frederick County	Harford County	Howard County	Montgomery County	Prince George's County	Queen Anne's County	Somerset	Washington County	Wicomico County	Worcester County
Name of home visiting programs that serve your county.	Healthy Start Case Management Program: a telephonic CM program with opportunities for face to face contact with the client.	none	Family OPTIONS Program	DHHS PHS/CHS Nurse Case Management Program. Family Services, Inc. Healthy Families Family Services, Inc, Early Head Start. Family Services, Inc., Help Me Learn Program. Montgomery County Infants and Toddlers Program, SMILE, the African American Health Infant Mortality Reduction Program Mental Health Association's Families Foremost Center Early Head Start Program at the Reginald S. Lourie Center for Infants and Young Children	Healthy Start/Infant at Risk Programs	1.Healthy Families Queen Anne'/Talbot 2. Parents As Teachers 3. Family Support of Queen Anne's County 4. Even Start	Babies Born Healthy Home Visiting (BBH) BabyNet Home Visiting (BN)	Healthy Families of Washington County Maternal and Child Home Visiting Early Head Start Washington County Family Center Parent-Child Center Judy Center	Healthy Families Wicomico	1. Early Care: (WCHD) 2. Healthy Families Lower Shore: 3. HIPPY (Home Instruction Program for Youngsters: (MSDE) Judy Center 4. Family Preservation Program, Families Now, Family Stabilization Services 5. Infant and Toddler Program:(WCHD) 6. Early Intervention Services (WCHD): Mental Health Program 7. Early Head Start/ Head Start (Shore UP)
Does your home visiting program serve any other counties?	No	No	No	No	No	Healthy Families QA/T serves Queen Anne's and Talbot counties.	No	No	No	No
What home visiting models or approaches are	The program is modeled after the State Healthy Start Program	None	Nurturing program for teen parents and their children	Healthy Families is the only national model	Approach is Nursing assessment by telephone or	Healthy Families America, Parents as Teachers	Home visits based on an educational model that includes	RNs provide case management services.	Uses Healthy Families model (this site is accredited through	Early Care is based on the State of Maryland's previous Healthy

Name of local health department	Frederick County	Harford County	Howard County	Montgomery County	Prince George's County	Queen Anne's County	Somerset	Washington County	Wicomico County	Worcester County
used?					hospital bedside for risks for healthy pregnancy and/or infant outcomes and early Nursing home visiting intervention and follow-up for teaching and resource connection.		anticipatory guidance provided by community health nurses; provides linkage to resources and other community services as indicated	Depending on the needs of the clients, nurses may visit monthly or every 3 months.	September 2014 by the national service office, Healthy Families America)	Start program.
Name the specific service(s) you provide through the LHD.	Comprehensive care coordination services Assist access to MCHP/MA Assist access to OB and PCP services Telephonic Case Management with opportunities for face to face contact at intake clinic, FMH Prenatal Center or coordinated with a visit to the LHD. Facilitate linkages to community agencies and resources. Prenatal education to Hispanic pregnant women – (Healthy Journey Class) who are not eligible for CM services.	administrative desk top case management	Case management; In home prenatal and parenting education; Weekly curriculum based psychoeducationa l group sessions	Community Health Services provides HV /case management uninsured prenatal women and children Care Coordination, immunizations/flu administration, Lead Prevention Program, pregnancy tests, emergency preparedness training and activities, dental services. Contract out Reproductive Health, Clinical Maternity Service to low income, uninsured	Nursing home visits to high-risk pregnant women to assure adequate pregnancy follow-up for prenatal care, WIC etc, and teaching and support about pregnancy; Assessment and early intervention at the birth hospital bedside; follow-up inter-conceptual and infant Nursing home visits to provide parenting support and education, to assess infant health and safety in the home and to assure connection to needed services;	Healthy Families QA/T	Home visiting standard is: BBH: Pregnant women: 2 prenatal home visits, one PP home visit Infants: monthly for first 6 months of life; again at 9 mos. and 12 mos. BN: Pregnant women only (undocumented and uninsured): one prenatal and one post-partum home visit Additional visits may occur based on individual need Program addresses medical, nutritional and psychosocial factors and assists participants to access healthcare and related services, practice healthy behaviors, and good parenting skills	Maternal and Child Home Visiting	Intensive weekly home visitation of pregnant and parenting mother to prevent child abuse and neglect through age 5 of child. Utilizes paraprofessionals as Home Visitor and nurse as consultant/perfor ms assessment	Early Care, Infant and Toddler, and Early Intervention are the home visiting programs provided through the health department to the target population (pregnant women and children).

Name of local health department	Frederick County	Harford County	Howard County	Montgomery County	Prince George's County	Queen Anne's County	Somerset	Washington County	Wicomico County	Worcester County
List the intended recipients of the service (e.g., pregnant women, infants).	Pregnant, postpartum women, infants & children up to the age of 2 yrs that are MA eligible or potentially MA eligible	Eligible or potentially eligible Medicaid recipients (includes pregnant women and children)	Pregnant (18 yo and under) and parenting teens; Infants to age 2; Fathers of the baby	Pregnant and postpartum women, infants and children, dental services to children, maternity adults and seniors	At-risk pregnant women, postpartum/interconception women and at-risk infants to age 2 who live in the County.	Pregnant women through the child's 5th birthday.	BBH: Medicaid pregnant women and infants at risk for poor health outcomes BN; Undocumented (therefore uninsured) pregnant women	High-risk pregnant women and children up to 2 years of age. First time mothers Adolescents 18 years of age or less Alcohol/Drug use Disability (mental/physical/developmental) History of abuse or violence History of fetal/infant death Homelessness Late registration or no prenatal care (> than 20 wks. Gestation) Lack of social/emotional support Less than 1 year since last delivery Mental Health (Current or Hx)	Pregnant and parenting women under age 25 Infants and children to age 5	Early Care is the only home visiting program offered through the health department targeting pregnant women. All three, as listed above, target infants and/or children.
What are the targeted goals/outcomes of the intervention (e.g., child maltreatment reduction, maternal and child health, early literacy, reduction of domestic violence)?	Maternal and child health Improving access to early and continuous prenatal care Reduce the incidence of premature and low birth weight births Reduce infant mortality and morbidity	Maternal and child health	Reduction of child abuse and neglect; Reduction of out of home placements; Promotion of child and family health; Optimal child development; Reduction in the incidence of repeat teen	DHHS programs- Reduce infant mortality, preparing children to live and learn, Healthy Mothers and Babies	Reduction of infant mortality (reducing SIDS and other infant deaths), reducing low birth weight and premature births; improving maternal and child health and psycho-social outcomes in a high risk population; assuring	Reduce the occurrence of child abuse and neglect, build the capacity of first time parents to raise a young child who will have the social, emotional, language and learning skills to be ready for school, and to improve parenting	Improve maternal health, birth outcomes, reduce infant mortality, establish a medical home for infants	Decrease in pre-term deliveries Decrease in Fetal and Infant mortality Increase in access to preventive healthcare services Decrease in subsequent teen births Decrease in incidence of child	To prevent child abuse and neglect, to assure children enter school ready to learn, parent to complete GED and have employment and/or further education, promote positive parenting skills, children have a medical home and	The goal of the Early Care program is the reduction of infant mortality, low birth weight babies and elimination of the racial disparities that exist in these perinatal outcomes.

Name of local health department	Frederick County	Harford County	Howard County	Montgomery County	Prince George's County	Queen Anne's County	Somerset	Washington County	Wicomico County	Worcester County
			pregnancy/birth; Early literacy		connection to a medical provider and needed services.	outcomes.		abuse and neglect	are current with well baby visits and immunizations.	
What are the demographic characteristics of individuals or families served?	County resident MA or potentially MA eligible Psychosocial risk or first time mom Hx of preterm or low birth weight birth	Medicaid or potentially Medicaid eligible	Teens 18 yo and under: 13% 13-15 yo; 70.3% 16-18 yo; 10.8% over 19 yo; Multiracial: 8.1%; Hispanic: 13.5%; Caucasian: 27%; African American: 51%	Low income, uninsured Immigrant, non-English Speaking	75% African American, 18% Latino, 11% white,1%other Mainly low income, Medicaid eligible, uninsured and underinsured clients	22%- under 18 yrs old 23%- 18-19 yrs old 50%- 20-30 yrs old 5%- over 30 yrs old 23%- African American 38% Caucasian 37%- Hispanic 2%- Multi-racial 56% Single 38%- Living together 3%- Married 3%- Other 7%- less than 7th grade education 42%-8-12th grade 21%- HS diploma 2%- GED 25%- some college 18%-FT employment 21%-PT employment 7%- Student 12%- Looking for employment 33%- Not looking 8%- Disabled	BBH: Somerset County Medicaid recipients with a targeted risk factor that increases the risk of a poor outcome BN: All pregnant women eligible for home visiting	The majority of the recipients are white, single parent females with low incomes/poverty level. Maternal ages range from 15 to 40.	Target low income (Medicaid or Medicaid eligible) women under age 25 who receive a positive score upon full assessment that indicates that they are at risk for child abuse/neglect.	Early Care serves pregnant women and infants less than one year of age who are recipients of Medical Assistance and who at the highest risk for poor birth outcome.
How is the demographic data collected (e.g., intake sheet, questionnaire done by staff, self	Intake sheet and entered onto excel database	Intake sheet	Initial referral intake using Maryland Prenatal Risk Assessment (MPRA) form generated by	Through Service Eligibility and/or nurse assessment	Intake/assessment sheet	Data collected through questionnaire completed by staff member	Health Department risk evaluation form completed on women accessing HD pregnancy related services and provider	Demographic information is collected through staff interview.	Intake form completed by staff	There is an intake assessment completed for all clients.

Name of local health department	Frederick County	Harford County	Howard County	Montgomery County	Prince George's County	Queen Anne's County	Somerset	Washington County	Wicomico County	Worcester County
report…)			medical providers; Referrals from Social services, Juvenile services, school system and self; Comprehensive information obtained from the Nurturing program social history questionnaire				referral via the Maryland Prenatal Risk Assessment Infants are identified at the PP home visit or via community referral			
What is the number of individuals or families served per month?	Average per month = 107	Very limited home visits with ACCU / Hs funds	20-25	For all services provided in the two area DHHS health centers, 1617/mo For HV/CM of prenatal women and children in FY 10, maternity 2027, children 2259 Unable to estimate the number of individuals services in all PH programs	An average of 200 families per month	Families served per month is approximately 80-100 depending on the levels of service provided.	Pregnant women: average of 40 per month Infants: average of 31 per month	25-30	40	This varies. The average case load in FY2010 was 43 clients/month open to care and an average of 29 clients/month pending (follow-up efforts).
What is the geographic area served (e.g., entire county, certain neighborhoods, or zip codes)?	Entire county	Entire county	Entire county	The entire county	Entire County	Healthy Families QA/T serve the entire counties.	All Somerset residents served	Entire county.	Wicomico County	Early Care serves the entire county.
Are you state or federally funded?	State CORE	ACCU and HS funds	Federal grant administered through the local Department of Social Services	County Funded	State and County funded	Healthy Families QA/T receives TANF funds through MSDE and administered through both counties Local Management Boards. Both counties Local Management Boards provide additional state	State and county funds support the programs	State funded.	Funded through MSDE	Early Care is supported by county funds.

Name of local health department	Frederick County	Harford County	Howard County	Montgomery County	Prince George's County	Queen Anne's County	Somerset	Washington County	Wicomico County	Worcester County
						funds to support the program. Beginning FY 11 the Queen Anne's portion of the program receives state funding through Department of Human Resources to serve families residing in Queen Anne's county only.				
What is your current home visiting funding for this fiscal year?	County and State CORE	Limited for home delivery verifications	$85k	unknown Funding is not broken out for the home visiting intervention.	State: High Risk Infant:$117,645. Local/CORE Healthy Start: $1,395,700.	Healthy Families QA/T budget for both counties is $500,594	$176,000.00	$122,669	$283,448.00	We only have funding for one nurse for the entire county. This significantly limits the case load and level of care. Home visits more often than once every three months are limited to those clients at greatest risk of those at highest risk that qualify for the program. Months that visits do not occur, phone contact is attempted and/or a mailing occurs. Office visits are also coordinated with WIC appts.

Name of local health department	Baltimore City
Name of home visiting programs that serve your county.	See below
Does your home visiting program serve any other counties?	No
What home visiting models or approaches are used?	The Maternal & Infant Nursing Program uses a standardized curricula series called Partners for a Healthy Baby. All services are provided by registered nurses and licensed social workers who work as a team. Cases are assigned by discipline. For example, cases with medical problems are assigned to a nurse as the primary case manager while mental health and domestic violence cases are assigned to a social worker. Each client, however, will be assessed by both the nurse and the social worker. The variety of home visiting programs and the models used can be seen in the attached chart.
Name the specific service(s) you provide through the LHD.	All M&I clients are referred to the following Baltimore City Health Dept. agencies as needed: Infants and Toddlers, Family Planning , STD Clinics , WIC and other agencies.
List the intended recipients of the service (e.g., pregnant women, infants).	Pregnant women (and families) and infants 0-2 with early discharge at 1 year also possible
What are the targeted goals/outcomes of the intervention (e.g., child maltreatment reduction, maternal and child health, early literacy, reduction of domestic violence)?	Improved birth outcomes (reduce pre-term birth, low birth weight birth, and deaths due to unsafe sleep practices). Also have infant development indicators.
What are the demographic characteristics of individuals or families served?	Low income, Medicaid eligible, high-risk (see attached triage criteria)
How is the demographic data collected (e.g., intake sheet, questionnaire done by staff, self report…)	All data is collected using a standardized assessment tool during the home visit. Data is entered into a database.
What is the number of individuals or families served per month?	M&I serves approximately 300 families each month
What is the geographic area served (e.g., entire county, certain neighborhoods, or zip codes)?	M&I is citywide with the exception of the Federal Healthy Start areas listed in the chart below
Are you state or federally funded?	M&I is state funded
What is your current home visiting funding for this fiscal year?	

Home Visiting Program	Contact Information	Target Area Served
Baltimore City Healthy Start, Inc.	Alma Roberts Phone-410-396-7318	Sandtown-Winchester/Harlem Park; Greater Rosemont; Middle East; Highlandtown; Greater Greenmount Census Tracts: 202, 301, 601-604; 701-704; 803.01; 803.02; 804; 806-808, 907-909, 1001-1004, 1204-1205, 1501-1502; 1601-1604; 1605-1607;
DRU Mondawmin Healthy Families	Dr. Barbara Hughes 410-225-3555	Druid Heights/Reservoir Hill/Upton; Mondawmin Census tracts: 1301; 1302; 1303; 1402; 1403; 1503; 1504; 1506; 1507; 1702; 1703
The Family Tree	Carolyn Finney 410-889-2300 ext 1202	Allendale/Irvington/S. Hilton; Beechfield; Morrell Park; Violetville Census Tracts: 2007.02; 2008; 2501.01; 2804.01, 2804.03, 2804.04
Bon Secours Foundation of Maryland	Lori Fagan 410-362-3629	West Baltimore Census Tracts: 1803; 1902; 1903; 2003; 2005; 2004; 2002
Peoples Community Health Ctrs.	Wanda Irving 410-467-6040 ext 2021	Pigtown Neighborhood, Carroll Park, Washington Village Census tracts: 2101 and 2102
Maternal and Infant Nursing Program	Rebecca Dineen 410-396-9404	City-wide
Sinai Hospital	Pam Young 410-601-5314	Park Heights Census tracts: 1512, 1513, 2716, 2717, 2718.01, 2718.02
Baltimore Medical Systems	Pam Brown 410-558-4946	BMS clients

Maryland Home Visiting Stakeholder Meeting

Rice Auditorium, Spring Grove Hospital campus
August 9, 2010

Rena Mohamed, Meeting Facilitator

Agenda

8:30 AM	**Registration and Continental Breakfast**
9:00 AM	**Welcome and Purpose** *Bonnie S. Birkel, Director* *DHMH Center for Maternal and Child Health* *Rosemary King Johnston, Director* *Governor's Office for Children* *Rena Mohamed, Meeting Facilitator*
9:15 AM	**The Patient Protection and Affordable Care Act of 2010, "Maternal, Infant and Early Childhood Home Visiting Programs: An Overview"** *Yvette McEachern, Director, Federal-State MCH Partnerships* *Center for Maternal and Child Health*
9:30 AM	**Evidence Based Home Visiting Programs: An Overiew** *Jill Antonishak, Project Manager, Research, Pew Home Visiting Campaign* *Pew Center on the States*
10:30 AM	**Break**
10:45 AM	**Preliminary Results, Communities At Risk, Home Visiting Needs Assessment** *Lee Hurt, Senior MCH Epidemiologist* *Center for Maternal and Child Health*
11:30 AM	**Participant Feedback by Region and Report Out**
12:15 PM	**LUNCH (provided)**
1:00 PM	**Preliminary Results, Home Visiting Capacity Assessment** *Mary LaCasse, Chief, State Early Childhood Comprehensive Systems* *Center for Maternal and Child Health*
1:15 PM	**Participant Feedback by Region and Report Out**
2:00 PM	**Pulling It All Together** *Rena Mohamed, Meeting Facilitator*
2:30 PM	**Next Steps and Closing Remarks** *Bonnie Birkel and Rosemary King Johnston*

Home Visiting Stakeholder Meeting Summary

August 9, 2010

Goals of Stakeholder Meeting

1. Provide stakeholders with an overview of The Patient Protection and Affordable Care Act of 2010, "Maternal, Infant and Early Childhood Home Visiting Programs"

2. Review preliminary home visiting needs assessment data and capacity survey results

3. Engage stakeholders in the development of Maryland's State Plan

Tasks to accomplish as required by The Patient Protection and Affordable Care Act of 2010, "Maternal, Infant and Early Childhood Home Visiting Programs":

- Complete a state needs assessment that includes:
  - What are Maryland's at risk communities?
  - What is Maryland's current capacity to provide home visiting services?
    - Who is currently providing services?
    - How many children and families are currently served by a home visiting program?
    - What are the current gaps in services
    - What is Maryland's current ability to meet the needs of eligible families?
    - What substance abuse services are provided to enrolled families

- Develop State Plan for implementing home visiting services

STAKEHOLDER FEEDBACK

Defining Communities at Risk

Participant Feedback Guiding Questions

1. Tell me one thing that was important to you about this presentation. Did you have an "ah-ha" moment that you would like to share?
2. Are there any additional metrics/indicators (please include rationale as well) that the state should consider in determining communities at risk? (Suggested metrics should be available for every jurisdiction in the state).
3. What are your suggested methodologies for prioritizing communities at risk?
4. Please provide feedback/suggestions if there are indicators that should be weighted more heavily than others (i.e., do you consider any of the indicators more of a priority than another). Please specify which one and why?
5. Please provide any additional comments or information that you would like the state to consider in defining communities at risk and developing the State's Home Visiting Plan.

Table 1& 2: State Agencies

I. "Ah-ha" Moments
- Race and ethnic disparities were not addressed
- Data looks good but unclear about what the data tells us
- Look at MSDE data
- How do we meet needs of large groups

II. Additional Metrics/Indicators
- WIC usage
- Free and reduced meals
- Juvenile Justice Data – crime by age, jurisdiction, gender
- Mental Health data – maternal depression from MHA by jurisdiction

III. Prioritizing Communities
- Subgroup analysis (i.e. infant mortality – age of mother, race, ethnicity, geo code address)
- Vital Statistics
- CFR information
- ADAA – Drug addicted infants

IV. Prioritizing Indicators
- Infant mortality because it spotlights social problems within a community
- Reduce weight of family economic self sufficiency
- High School Drop Out rate – is this a good measure of teen pregnancy?
- Adjust teen pregnancy age to include teens younger than 15
- Include percentage of children enrolled in Medicaid rather than percentage utilizing MA services

V. Additional Comments
- Look at available resources available in various communities
- Concentration of resources - access vs. usage (i.e. transportation, dentists, obstetricians, etc.)
- Cultural competency (i.e. racial disparities)
- Title I Schools
- How do communities define themselves? Communities should be defined by the individuals who live and work there.

Table 3: Central Maryland – Anne Arundel, Carroll, Harford, Howard

I. Additional Metrics/Indicators
- Add School Readiness data – MMSR
- Add indicators to capture undocumented population
- Adjust adolescent age to 13 – 17
- Homeless population not included
- Data on substance abusers not in treatment
- FARM data

- Mental health needs of primary caregiver

II. Prioritizing Communities
   - Decisions should be guided by the best return on investment

III. Additional Comments
   - Involve consumers in the planning process
   - Disaggregate data
   - Need disaggregated data and trends
   - How is data going to be used for application, to make funding decisions, etc.
   - Need to weigh the benefits of expanding existing services vs. starting something new
   - Concern that this region will not get funding because do not look needy based on indicators currently under consideration

Table 4: Lower Shore – Somerset, Wicomico, Worcester

I. "Ah-ha" Moments
   - Question about the red substance abuse area in Wicomico County

II. Additional Metrics/Indicators
   - Population density and how it impacts transportation and access to vital services
   - Title I designated schools or number of children on free and reduced meals
   - Health Professionals Shortage Area and MUA designated areas
   - Single parent households
   - Racial disparity in communities vs. the jurisdictional level
   - SIT rate – identifies risky behavior (metric doe perinatal outcomes)

III. Prioritizing Communities
   - Maryland PNRA data
   - Medical Assistance vs. Non-Medical Assistance as a mechanism for describing the MA population
   - Maryland perinatal, risk assessment data (some offices)

IV. Prioritizing Indicators
   - Poverty
   - Racial disparities
   - Heavily weight the four indicators Maryland selects

V. Additional Comments
   - Include school readiness data
   - Look at indicated abuse and neglect rate
   - Early Care programs – access to programs, parenting skills, school readiness

Table 5: Mid-Shore – Caroline, Dorchester, Kent, Queen Anne, Talbot

I. Additional Metrics/Indicators
   - MCHIP, Free and reduced lunch, WIC to look at poverty
   - Maryland Adolescent Survey administered by MSDE – self report of substance abuse for teens

- Teens under 15 giving birth
- Health Professionals Shortage Area designation (HRSA)
- Census data does not capture undocumented population
- Prenatal Risk Assessment (Infants)
- Youth Risk Behavior Survey to assess indicators of risk behavior
- Literacy rates

II. Prioritizing Communities
   - Define community – this could be different for rural, suburban, and urban jurisdictions
   - Collaborative system of care applications

Table 6: Baltimore City and Baltimore County

I. Additional Metrics/Indicators
   - WIC participation
   - Free and reduced lunches
   - Vacant or subsidized housing – lack of affordable housing
   - Homeless management system
   - Juvenile crime (serious crime) by gender
   - Children entering school ready to learn – Work Sampling System, Infant and Toddler referrals
   - Out of home placements
   - Maternal smoking (birth records)
   - Inter-pregnancy intervals

II. Prioritizing Communities
   Look at trends over the 10 year period – are there jurisdictions that are trending down?

Table 7: Prince George's & Southern Maryland – Calvert, Charles

I. "Ah-ha" Moments
   - Comforted regarding openness to different home visiting programs
   - Concerned about use of old census data (2000) in light of changes, growth in communities in the last decade
   - What about pockets of poverty in rural communities using current methods (i.e. large census tracts)
   - Accessibility and lack of services (gaps) issues do not seem to be reflected in map
   - What about using injuries for child abuse data reporting rather than deaths?

II. Additional Metrics/Indicators
   - WIC data
   - Income maintenance data
   - Drug affected new born data (substance abuse measure)

III. Prioritizing Communities
   - Take into account multiple risk factors

- Can population be targeted as opposed to geographical area? Could communities be defined this way?

IV. Prioritizing Indicators
Based on data and experiences of practitioners:
- Infant mortality
- Domestic violence
- Access to prenatal care

V. Additional Comments
- Spread the wealth
- In order to retain staff plan for yearly increases to support staffing
- Look at expanding/supporting existing programs – taking special care to improve programs to reach outcomes

Table 8: Montgomery & Frederick Counties

I. "Ah-ha" Moments
- Using old data – huge shifts in data
- Multicultural issues not reflected
- Using Medical Assistance data excludes people – run into access issues
- Breath of data and then index – FARMS data

II. Additional Metrics/Indicators
- MCHIP
- Juvenile crime rate
- Percent of families per jurisdiction
- Percent of poverty level per jurisdiction
- Immigrant population
- DJS/State police – Gang Net data
-

III. Prioritizing Communities
- Percent of population that are
    - families
    - under 8 years old
- Multicultural families
- Foreign born families
- Multilingual families
- Seat belts in cars

IV. Prioritizing Indicators
- Poverty
- Maternal education
- School Readiness – single identifier, infant and toddlers
- Race/ethnicity
- Immigrant rate

- Missing teen rate (under 15 years of age)
- Multicultural demographics

V. Additional Comments
   - What about the stories – need qualitative and anecdotal data
   - Do we just to focus on the negative data? Positive data reflects where things are working well.

Table 9: Western Maryland – Allegany, Garrett, Washington

I. "Ah-ha" Moments
   - $1,000,000 does not go far across the state

II. Additional Metrics/Indicators
   - Assess where we are doing well – resources, what's at risk, stability/sustainability in the future
   - Where are EBPs based across the State/region? How does their data look?
   - Access to services – medically underserved areas
   - Include child poverty
   - Educational attainment

Capacity Assessment

Participant Feedback Guiding Questions

1. Tell me one thing that was important to you about this presentation. Did you have an "ah-ha" moment that you would like to share?
2. Are there other home visiting programs within your region/community that we should contact for inclusion in the capacity assessment?
3. In addition to the survey, please identify other suggested methods for assessing home visiting capacity in Maryland.
4. Please provide any additional comments or information that you would like the state to consider in defining capacity and developing the State's Home Visiting Plan.

Table 1& 2: State Agencies

I. "Ah-ha" Moments

   How is a unit of service defined? Ask jurisdictions how they define a unit of service.
   - Healthy Families and Home Visiting Consortium have each defined service.
   - Develop overall definitions for home visiting – definitions need to move the work forward
   - Programs have variable methods of referrals – how are families identified and referred?
   - Do all programs have an outreach component?   How is outreach defined?
   - Establish common data elements - face to face contact in the home for a specified amount of time
   - Do programs do prevention work?

II. Other Home Visiting Programs

- Given the timeframe we should focus on who is currently involved. Others can be included along the way
- Conduct key informant interviews
- Share survey with providers and families served
- Review evaluations that have been done for each program. Can they be used in further assessments

III. Other Methods for assessing capacity

- Contact local or state agencies to cross reference information
- Should identify target population and include representative in planning process
- Identify if programs have a wait list, if so how long and do they receive some services while on the wait list
- Identify length of service for programs
- Identify who is receiving the service (mom only, baby only, legal guardian, mom and baby, mom, baby and dad). Define family.
- Identify local community leaders/organizations to facilitate focus groups and identify key informants (faith community, coalitions, Judy Centers etc.)

IV. Additional Comments

- Clear list of existing programs – funding amount, sources of funding, who they serve, funded capacity, contact information, education level of staff, staffing pattern

Table 3: Central Maryland – Anne Arundel, Carroll, Harford, Howard

I. "Ah-ha" Moments

- Survey was very program specific and not generalized to capture the need of the community
- Population served was not discussed (i.e. parents with cognitive impairments). How do programs adapt service delivery to meet the needs of different populations
- Are intergenerational needs addressed through service delivery?
- Review length of survey and some folks had difficulty completing

II. Other Methods for assessing capacity

- Develop a shorter more generalized survey to send out to a broader audience
- Include input from consumer and other agencies (i.e. DSS, DJS, DDA)

III. Additional Comments

- Desire to have had this meeting earlier in the planning process. Will the information gathered be utilized as the process moves forward?
- Need to develop and consider criteria for readiness to expand services
- Hold focus groups with atypical populations
- With the limited funding available may not be able to only consider high need and low capacity because capacity building takes time and the funding may not be available to support
- If considering existing program capacity need to also consider results and impact

- Identify community readiness to expand existing services

Table 4: Lower Shore – Somerset, Wicomico, Worcester

I. "Ah-ha" Moments
   - Concerns about some survey responses – high volume reported may be due to multiple agencies reporting duplicated count
   - Some respondents may have been unclear when responding to questions
   - Concern about focusing on areas with high need/low capacity to determine priorities

II. Other Home Visiting Programs
   - Missing some possible home visitors
   - See continuum - gaps in ages, focus

III. Other Methods for assessing capacity
   - Collaborative case coordination as an asset (i.e. Multi-D)
   - Additional funding may be needed for new/existing information sharing
   - Need to establish strategy for assessing organizational capacity particularly for new organizations

Table 5: Mid-Shore – Caroline, Dorchester, Kent, Queen Anne, Talbot

I. "Ah-ha" Moments
   - Lack of funding decreases capacity
   - Need to identify what programs are in each region, who they are serving, and their capacity
   - Could not complete the survey if you were not operating a home visiting program

II. Other Home Visiting Programs
   - Determine if there are home visiting programs in schools that serve children 6 – 8 years old
   - Link to local Infants and Toddlers programs
   - Reach out to DSS Family Preservation programs, Child and Behavioral Health programs, Project Right Steps

III. Other Methods for assessing capacity
   - Capacity assessment should include required staffing pattern and identified population as identified by the model being implemented
   - Look at capacity to implement, evaluate, and sustain program
   - Assess cost effectiveness of program to include the fact that implementing prevention strategies decreases the need for intervention later.
   - Capacity should also cost out service hours provided (i.e. travel, services, administrative/paperwork, number of attempts to reach family)

IV. Additional Comments
   - Time needs to allotted for implementation
   - Is there language in the funding language that prohibits serving undocumented families?

Table 6: Baltimore City and Baltimore County

I. Other Home Visiting Programs
- Contact funding agencies or national associations
- Utilize local health departments or local management boards
- Distribution of Family Support Network and Health Start Network around state

II. Other Methods for assessing capacity
- Identify current capacity (i.e. low, high); what percentage of need is met
- What models are available to meet need/capacity?
- Triage need – develop an array of services to meet various levels of need

III. Additional Comments
- Gain understanding of duplication/overlap of services

Table 7: Prince George's & Southern Maryland – Calvert, Charles

I. "Ah-ha" Moments
- Thought there was more federal funding available
- Some questions regarding survey design – who was supposed to complete, duplication of responses

II. Other Home Visiting Programs
- Judy Centers
- Early Head Start
- Parents as Teachers
- MCH
- HIPPY

III. Other Methods for assessing capacity
- How do we capture undocumented families?
- How do we capture families who deliver out of county (i.e. high risk pregnancy delivering in DC or Baltimore)?
- Include consumers in surveying
- Need interpreters/bilingual staff to assist with service delivery and to assist with ensuring non English speaking families have the opportunity to contribute

IV. Additional Comments
- State plan needs to allow for flexibility to implement innovative and promising practices
- Funding allocations need to have lower administrative costs so more dollars can be allocated for direct services
- Sustain program infrastructure over the duration of funding (i.e. technical assistance, training, evaluation)
- Build in funding increases from year to year to support staff retention
- Expand existing programs that have demonstrated successful outcomes

Table 8: Montgomery & Frederick Counties

I. "Ah-ha" Moments
- Define models vs. curriculums (i.e. Healthy Families vs. Parents as Teachers)
- Survey should have questions to identify gaps in services
- Definitions needed for the survey to ensure consistent responses; some questions might have been subject to different interpretations
- Include definition of annual evaluation
- What agencies/programs were targeted for completing the survey?

II. Other Home Visiting Programs
- How is home visiting defined?
- How is partnership defined? Service provided by Agency A may not be feasible without Agency B
- Has Infants and Toddlers been considered?

III. Other Methods for assessing capacity
- Complete a time study to compare programs and capacity
- Define home visiting
- Ensure that there is not duplication in responses

IV. Additional Comments
- Ensure that training costs are included in budget
- Account for model intensity – step down models, match model with family need
- Is the program's service capacity able to meet the need of the eligible population

Table 9: Western Maryland – Allegany, Garrett, Washington

I. "Ah-ha" Moments
- There was some confusion on some of the survey questions (i.e. how many families were served in your whole program or just on your home visiting program?)

II. Other Home Visiting Programs
- DSS Family Preservation programs
- Identify programs being implemented but may not have sustainable funding

III. Other Methods for assessing capacity
- Concerned about obtaining outcomes if focus on areas with high need and low capacity

IV. Additional Comments
- Staff retention rates and training is a concern

Emerging Themes:

1. Discuss the possibility of accessing more recent data for needs assessment
    a. Race/ethnicity
    b. School readiness
    c. Undocumented population
    d. WIC utilization
    e. Medicaid eligible families
2. Develop a mechanism for gathering consumer input
3. Develop standard definitions for capacity survey
4. Develop a state plan that is inclusive of
    a. home visiting programs that are effective with families with various levels of need (i.e. a home visiting system on care)
    b. support, funding, and time needed to develop and implement a sustainable program

Maryland Home Visiting Stakeholder Meeting
Rice Auditorium, Spring Grove Hospital Campus
August 9, 2010
EVALUATION RESULTS

Rena Mohamed, Meeting Facilitator

1. The content of the meeting was useful to help Maryland move forward with the needs assessment.

Responses:

Strongly Agree – 2
1) – 11
2) – 23
3) – 16
4) – 5
5) – 1
Strongly Disagree – 1

Comments:

- Thank you for including everyone
- The requirement of the meeting was well met
- Request for data from School Readiness and Title V/ FARMS
- Decisions seemed to already be made prior to meeting

**There seems to have been some confusion with the survey numbering/ responses.*

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2. The meeting met my expectations.

Responses:

Strongly Agree – 1
1) – 9
2) – 22
3) – 18
4) – 7
5) – 2
Strongly Disagree – 1

Comments:

- There was a lack of regard for local input – 2
- Thank you for taking the time to listen
- The meeting was held after the fact
- Not clear on home visit program

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3. The meeting facilitated collaboration and networking on home visiting issues.

Responses:

Strongly Agree – 2
1) – 10
2) – 25
3) – 13
4) – 7
5) – 2
Strongly Disagree – 1

Comments:

- The focus was only on the needs assessment. There as no idea or resource sharing
- GREAT networking opportunity

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4. The round table discussion on DATA as relevant and helpful.

Responses:

Strongly Agree – 2
1) – 12
2) – 20
3) – 18
4) – 5
5) – 1
Strongly Disagree - 0

Comments:

- It was too late to change the focus of data collection, decisions already made
- We need to collect updated/ new data
- The round table needed more participants

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5. The round table discussion on CAPACITY was relevant and helpful.

Responses:

Strongly Agree – 2
1) – 11
2) –17
3) – 21
4) – 8
5) – 1
Strongly Disagree – 0

Comments:

- The round table needed more participants

Please rate the meeting location:

Responses:

Excellent – 9
Good – 25
Adequate – 19
3.5) – 1
Marginal – 2
Poor – 1

Comments:

- The directional signs were helpful
- The chairs were very uncomfortable
- The meeting needed better directions
- Free parking is always good
- The food was excellent – 4
- Since the focus was by region, it would be nice to see future meetings on Lower Eastern Shore, for Worcester, Wicomico, and Somerset Counties
- It was a long drive for those from the shore – maybe a later start time?
- The acoustics were terrible – 2
- Space was good

Additional Comments:

- There were too many housekeeping issues
- Very informative meeting. It as very productive to get so many individuals into one room.
- The notice for the meeting seemed to have come out at the last minute. There was no time to share the notice with other partners that should have been there
- Please continue to send information regarding this topic, this "meeting does not stop here."
- The meeting was promptly executed
- There was an opportunity to have input
- "State staff need to make sure their comments (and sometimes laughter) at what was offered are not observed. It could make the effort seem in-genuine."
- Need to look at rural areas separately from the urban areas
- There was a lot of useful information on the status of the Needs Assessment to take back to the local counties.
- Unfortunately the theme at our table was the decision for money has already been determined.
- "The event is a Catch 22: Not enough definition and guidance from the federal level in order to be truly purposeful, but without a stakeholder meeting or focus groups, programs would have felt slighted and left out of planning and decision making."

Home Visiting Stakeholders Responses

County	Name	E-mail	HFM	LMB	PAT	LHD	EHS	HIPPY	Other/ name
ALL	Melissa Crowe	mcrowe@allconet.org		X					
	Carole Kenny	ckenny@dhmh.state.md.us				X			
	Rebecca Krampf	Bkrampf21502@yahoo.com				X			
AA	Pamela M. Brown	Srbrown00@aacounty.org		X					
BCO	Toya Singletary	tsinglet@dhr.state.md.us							DSS
	Elise Andrews	eandrews@baltimorecountymd.gov		X					
	Tomaka Jupiter	tjupiter@abilitiesnetwork.org							Dir. Program Dev./Abilities Network
	Linda Grossman, MD	lgrossman@baltimorecountymd.gov				X			Bureau Chief, Clinical Services
	Margie Koretzky	mkoretz@baltimorecountymd.gov				X			Youth, Family Services
	Deanna Cavagna	dcavagna@bcps.org							BC Public Schools
CAL	Theresa Booker	bookert@calvertnet.k12.md.us						X	
CARO	Renee Woodworth	rwoodworth@cchsc.org							Human Services Council, Inc.
	Leland Spencer	ldspencer@dhmh.state.md.us				X			HO – Kent/Caroline*
	Jennie Holmes	jennieg@dhmh.state.md.us				X			
	Terri Miller	(none given)					X		Designee for Teresa French
CARR	Mary Scholz	mscholz@ccg.carr.org		X					
	Penny Bramlet	pbramlett@dhmh.state.md.us				X			

County	Name	E-mail	HFM	LMB	PAT	LHD	EHS	HIPPY	Other/ name
CEC									
CHAR	Catherine Meyers	Meyers@center-for-children.org	X						Exec.Dir. – Center for Children, Inc.
	D. Mia Gray	grayd@charlescounty.org		X					Early Childhood Coordinator
DOR	Beth Nossick	bnossick@dhmh.state.md.us				X			
FRED	Shannon Aleshire	saleshire@menha.org							MHA of Frederick, MD.
	Donna Devilbiss	ddevilbiss@frederickcountymd.gov				X			
GAR	Earleen Beckman	beckmane@dhmh.state.md.us				X			
	Crystal Stewart	cstewart@garrettpartnership.org		X					
	Lucia Barger	larger@garrettpartnership.org		X					
HAR	Elizabeth Hendrix	Bhendrix@harfordcountymd.gov							Deputy Director, Dept. of Community Services
	Melinda Kreisel	mkreisel@dhmh.state.md.us				X			Div. of Care Coordination
HOW	Keri Hyde	khyde@howardcountymd.gov							Office of Children's Services
	Brenda Radtka	bradtka@fcsmd.org	X						
	Lisette Osborne	LOsborne@howardcountymd.gov				X			For HO Beilenson

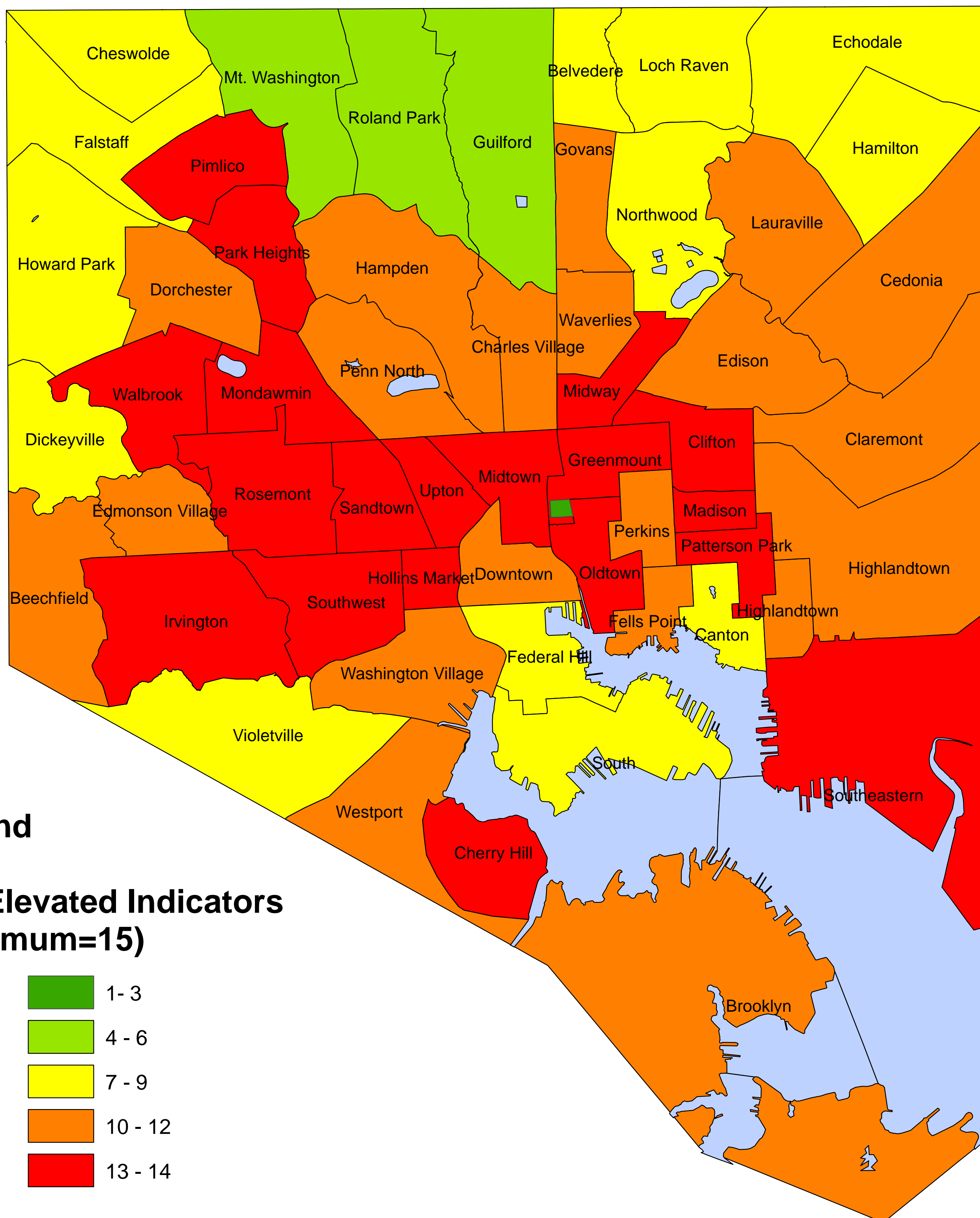
County	Name	E-mail	HFM	LMB	PAT	LHD	EHS	HIPPY	Other/ name
KENT	Rebecca Lepter	rlepter@kentgov.org		X					
	Leland Spencer	ldspencer@dhmh.state.md.us				X			HO – Kent/Caroline*
	Karen Hill	Ihi2@familiesshine.org			X				In-home Interventionist
MONT	Monica Ortiz	ortizm@fs-inc.org							Family Services, Inc.
	Janet Curran	curranj@fs-inc.org	X						
	Carol Walsh	Carol.walsh@collaborationcouncil.org							Collab. Council for CYF, Inc.
	Debbie Shepard	Debbie.shepard@montgomerycountymd.gov							Dept of HHS
	Shari Waddy	swaddy@mhamc.org							MHA/Families Foremost
	Isabel Cassen	Isabel.Cassen@montgomerycountymd.gov							Dept of HHS/PHS/CHS
	Helma Irving	irvinghelma@fs-inc.org							Family Services, Iinc.
PG	Judy M. DuBose	imdubose@co.pg.md.us		X					PG's Child Resource Center
	Marti Worshtil	mworshtil@pgcrc.org							
	Lillian Janssen-Checa	Ljanssen-checa@pgcrc.org	X						
	Rosa Bowers	rbowers@pgcrc.org							Adelphi Langley Park, Famiy Support Center
QA	Mary Ann Gleason	mgleason@qa.org							Community Partnerships for Children & Families
St.M									
SOM	Lori Conklin	lori@dhmh.state.md.us				X			Dir. Of Community Health
	Susanna Henson	shenson@sclmb.org		X					Exec. Director
	Dawn Rea Scher	dawn@hfls.us	X						

County	Name	E-mail	HFM	LMB	PAT	LHD	EHS	HIPPY	Other/ name
TAL	Thomas McCarty	tjmccarty@dhmh.state.md.us				X			Deputy HO
	Gloria Dill	gwdill@dhmh.state.md.us				X			CHN
WASH	Susan Parks	susanparks@dhmh.state.md.us				X			
	Melissa McElroy	Mmcelroy@headstartwashco.org					X		
	Tracy Soffe	tsoffe@dhmh.state.md.us	X			X			Healthy Families/WCHD
WIC	Micaela Tedford	mtedford@wicomicocounty.org							Partnership for Families & Children
	Carrie Connelly	cconnell@dhmh.state.md.us	X						
	Rose Johnson	rose@dhmh.state.md.us		X		X			
WOR	Rebecca Brunet	RCBrunet@mail.worcester.k12.md.us						X	
	Andrea Mathias	amathias@dhmh.state.md.us				X			
BC	Alma Roberts	Alma.roberts@baltimorecity.gov							CEO – Balt.City Healthy Start
	Jean Mitchell	jmitchell@marylandfamilynetwork.org							Director – Maryland Family Network, Inc.
	Nancy Corcoran	ncorcoran@marylandfamilynetwork.org			X				MD Family Network
	Avril Melissa Houston	Avril.houston@baltimorecity.gov				X			Assn't Commissioner, MCH
	Rebecca Dineen	Rebecca.dineen@baltimorecity.gov				X			Bureau Chief, Mat. & Infant
Univ of MD	Kay Conners	kconners@psych.umaryalnd.edu							Program Director
MSDE	Barb Scherr	bscherr@msde.state.md.us							Family Involvement Coordinator
	Linda Zang	lzang@msde.state.md.us							Branch Chief, Collaboration and Program Improvement
	Linda Heisner	Lheisner1@juno.com	X						Healthy Families Programs
DHMH	Rosemary Murphey	murpheyr@dhmh.state.md.us							Nurse Consultant - Medicaid
	Lee Hurt	lhurt@dhmh.state.md.us							MCH Epidemiologist
	Pam Putman	putmanp@dhmh.state.md.us							Chief, MCH Systems Improv.

County	Name	E-mail	HFM	LMB	PAT	LHD	EHS	HIPPY	Other/ name
	Russ Moy	moyr@cmch.state.md.us							Director, FHA
	Mary LaCasse	mlacasse@dhmh.state.md.us							
	Yvette McEachern	mceacherny@dhmh.state.md.us							
	Bonnie Birkel	birkelb@dhmh.state.md.us							
	Diedre McDaniel	dpearson@dhmh.state.md.us							
	Rachel Hess-Mutinda	rhessmutinda@dhmh.state.md.us							
	Christine Evans	clevans@dhmh.state.md.us							
	S. Lee Woods, MD	sleewoods@dhmh.state.md.us							
DHMH/ MHA	Joyce C. Pollard	Jpollard@dhmh.state.md.us							Early Childhood MH
DHMH/ ADAA	Suzette Tucker	stucker@dhmh.state.md.us							Regional Serv. Manager/ Women's Coordinator
DBM	Allan Pack	apack@dbm.state.md.us							Budget Analyst
GOC	Rosemary King Johnston	rjohnston@goc.state.md.us							Executive Director
	Kim Malat	kmalat@goc.state.md.us							Chief, Grant/Contracts Admin.
DJS	Jennifer Maehr	maehrj@djs.state.md.us							Medical Director
MFN	Margaret Williams	mwilliams@marylandfamilynetwork.org							Exec.Dir. MD Family Network

Appendix H.

Number of Elevated Indicators by CSA (Neighborhood), Baltimore City, Maryland



Prepared by MD DHMH, Center for Maternal and Child Health

MARYLAND
FY 2009

Development, Operation & Expansion of Community-based & Prevention-focused Programs	Services Provided to Families by Local Programs	Unmet Needs Identified by the Inventory
• Maryland Family Network, as the lead agency continued to work with funders, partners, and stakeholders to improve the system of child abuse and neglect prevention and the delivery of family support services in Maryland. Partners included the Early Childhood Mental Health Steering Committee, Child Care Advisory Council, the Maryland State Department of Education's Judith P. Hoyer Early Child Care and Education Enhancement Advisory Council, State Superintendent's Family Involvement Council, Baltimore Babies Born Healthy Leadership in Action Program, and Maryland's Home Visiting Consortium. • Maryland's family support network consists of two parts: the statewide lead intermediary agency, Maryland Family Network; and 24 community-based initiatives, each led by a public or private non-profit agency that partners with others in the community to provide prevention-oriented, family resource and support services. The network's core funding comes from state and federal sources, including the Community-Based Child Abuse and Prevention grant, administered under contract by Maryland Family Network.	• Local family support programs in Maryland delivered prevention-oriented, community-based, voluntary services that support parents and their children, primarily infants and toddlers. Twenty-three programs located in 16 out of the State's 24 jurisdictions (Baltimore City and 23 counties) operated during the fiscal year. The State and Maryland Family Network continued to target family support dollars to areas with high concentrations of pregnant and parenting adolescents, children living at or below the poverty level, births of low birth-weight babies, adults who have not completed high school, and unemployed adolescents and adults. • Respite services were available at every local family support program in the network (23 locations) to any primary caregiver with a young child who visits a local family support program. Local family support initiatives funded with CBCAP dollars in Maryland are expected not only to offer developmentally appropriate care to very young children at least 35 hours per week, but also to support children's parents, directly or through linkages to other community-based providers – with skilled counseling, peer support, and other services (whatever the parent needs) – while the children are on site. • Home visiting within the network's family support programs supports high-risk parents of children from birth through age three in their role as parents by improving the quality of parent, child, and family interactions. CBCAP funds are used to augment home visiting services throughout the network. Home visiting program objectives are: • to engage "hard to reach" families by offering them home-based services;	• There continues to be a large, unmet need for programs specifically designed to provide stable fatherhood services that will help to reduce the risk of children being abused, neglected, or removed from their natural homes. Maryland Family Network continued to support local programs to insure that retention and recruitment efforts are successful in involving fathers and significant men in children's lives, and that center-and home-based services meet the needs of fathers in a welcoming, supportive, responsive environment. MFN supported local programs by funding small local grants to support fatherhood/family activities.

<table>
<tr><td></td><td>• to recruit parents to participate actively in center-based services; and
• to engage parents in community services.</td><td></td></tr>
<tr><th>Description of Number of Families Served</th><th>Outreach to Special Populations</th><th>Parent Leadership</th></tr>
<tr><td>• During this reporting period, programs receiving CBCAP funding through the lead agency provided direct services to:
  • 6,913 individuals;
  • 2,643 families;
  • 2,271 children birth through three years; and
  • 112 children with developmental disabilities.

• In addition, the lead agency provided training services to 400 staff and parents.</td><td>• Maryland Family Network has ensured that all programs target their services to young parents of very young children, as they are most vulnerable to the negative consequences of early childbearing, especially long-term poverty.

• Several local programs provided services at homeless shelters and transitional housing sites including on-site parenting classes, parent/child activities, and other support services.

• Many programs in areas with migrant workers and citizens not born in this country have hired staff that can speak compatible languages and provided services at locations outside their normal bases of operation in order to meet the needs.

• A substantial number of participants in local programs were identified as having learning disabilities. Adults with other mild and moderate disabilities are a target population of the network, and the lead agency worked with various public and private non-profit groups in the State for reaching out to and serving this group.

• Local CBCAP funded programs served as “natural environments” for treatment programs designed as part of the Intensive Family Service Plans for Part C/IDEA.</td><td>• Parent support and involvement activities are designed to develop a wide range of participant skills, strengths, and interests. Activities include providing advisory and volunteer opportunities at the programs, and recreational and social activities. Empowering young families requires holistic programming—not only educational and parenting sessions. but also opportunities to develop the wide range of skills, strengths, and interests of participants. Recreational programs are therapeutic in the sense that they are vehicles for creative expression, group linkages, challenges, and achievements. Often other family members and community are included.

• Building on previous success with Parent Leadership training, Maryland Family Network secured funding through Mid Atlantic Equity and continued its partnership with the development of the Parent Involvement and Resource Center project (PIRC). Parent leadership training was provided to mothers, fathers, and primary caregivers of children birth through five years who participated in Judy Hoyer Partnerships, Early Head Start, and Family Support Centers.

• Promoted by the Parent Leadership Institutes, parent involvement at the State level occurs with the Early Head Start Policy Council and a parent member who serves on the Board of Directors of Maryland Family Network. Parent involvement at the local level is encouraged in all areas of program activity. Community-based partners in Maryland’s family support network are required to have regular participant</td></tr>
</table>

		meetings co-facilitated by parents.
Training and Technical Assistance	**Child Abuse Prevention Month Activities**	**Innovative Funding Mechanisms**

• Members of the network share a common approach to practice, participate in joint training, receive technical assistance from or through Maryland Family Network, and report on operations using a common Management Information System (MIS).
• CBCAP funding was provided to the Maryland Respite Care Coalition to sponsor and underwrite costs for the 11th Annual Maryland Respite Awareness Day Conference held in October 2008. MFN awarded CBCAP funds to Caring Communities, a private, nonprofit organization that provides pediatric respite care services for families, and co-sponsored the World of Possibilities Disabilities Expo 2009 in Maryland.
• Parent Leadership training was conducted by two MFN Program Consultants with expertise in operating complex community-based programs through direct service providers. Two days of skill-building training and practice in essential communication skills, decision-making, and advocacy was offered to 60 parents at three locations.
• After completing the two-day Parent Leadership training, PIRC participants were invited to attend a special parent leadership track at the Annual Spring Training and Staff Development Conference held in May 2009. Parents from Family Support Network programs were also invited to attend the two days of leadership training, which included discussions on leadership, advocacy, influence and power; and skill building
	• State and private organizations, such as The Family Tree and People Against Child Abuse (the Maryland Chapter of Prevent Child Abuse), and the Maryland CASA Association (Court Appointed Special Advocates) provided public awareness activities to increase the visibility of prevention during April 2009. Maryland Family Network and the network of local family support initiatives worked with these agencies and many other organizations at both state and local levels to support these activities whenever needed and throughout the year. Community Resource Packets were distributed in family support communities throughout the State. MFN partnered with organizations in Harford County, Maryland to offer a symposium during Child Abuse Prevention Month to enhance skills and increase knowledge of professionals and others in the field. The main focus of the symposium was to address investigative, judicial and treatment issues regarding child victims of abuse and their families.	• During this funding period, the lead agency and network programs leveraged $2.93 for every $1 invested by the State of Maryland. According to audited financial statements, approximately 4% of the total amount has gone to administrative and fund raising expenses; the rest has gone directly to community-based services.
		• Maryland Family Network secured the following funding during the fiscal year:
		  ◦ A three- year grant award for continued grants management, technical assistance, training, and quality assurance monitoring services for the network from the Maryland State Department of Education.
		  ◦ Secured private foundation and corporate funding to support family literacy and early learning activities in the family support network. MFN provided thousands of new books for children ages 0-3 years through Reading Is Fundamental.
		  ◦ Maryland State Department of Education awarded funding to coordinate the State's Home Visiting Consortium (HVC); MFN convenes and co-facilitates meetings and training opportunities for the HVC membership for the purpose of quality assurance, professional development, and networking.
		  ◦ Funding was awarded by the Mid-Atlantic Equity Center to support training and implementation of a parent education curriculum "The Nurturing Program" for participating families at family support programs.

related to listening and communication and public speaking skills. • Maryland Family Network provided a variety of staff development opportunities to the Maryland Family Support Network. Training was provided to nearly 400 network staff, and approximately 100 staff development sessions were offered with the goal of heightening awareness, building skills, and empowering staff. • Two major conferences, two week-long orientation programs, two three- day child development staff training programs and additional staff training sessions were held for Family Support Network staff over the course of the funding year. These network-wide staff development activities provided over 60 structured learning opportunities over the course of the year.		• State supplemental funds were awarded to provide child development program enhancements at Early Head Start programs within the network. • MFN received funding from Bank of America to improve the MFN website. • Secured ARRA funding to improve the Health and Safety environments of Early Head Start programs operating within MD Family Network.
Linkages with Other Systems (Child Welfare, PSSF, Early Childhood, etc.)	**A. PART Data Efficiency Measure that Supports EBP and EIP Practices**	**B. Demonstration of High Level of Satisfaction Among Families**
• The Birth through Three Business Plan for Maryland developed by Maryland Family Network in partnership with the Maryland State Department of Education, and with stakeholders representing state agencies, local government agencies, private service providers, corporate leaders, research institutions, and parents was completed during the past year. Work progress this reporting period included printing the plan and networking with public and private agencies around the State to promote it. • Maryland Family Network staff serves on the Child and Family Services Planning Committee (CFSPAC), the statewide advisory	• Nineteen CBCAP funded programs use promising programs and practices.	• The fulfillment of the parent involvement requirement is monitored as part of the network's On-Site Monitoring Process. Maryland Family Network's Program Monitor interviews program participants during the on-site visits to get a sense of their involvement with satisfaction with Center programming and services. • The family support network in Maryland is designed to be customer-driven. The theory is that parents vote with their feet: if programs are good, they will be well used. If participation is spotty and retention poor, the programs are changed or closed. Participation rates and other process data are used as important indicators of

group responsible for reviewing the State's IV-B Child and Family Services Plan which outlines Maryland's mission and vision and plans to meet goals and objectives to promote and ensure safety, permanence, and well-being for children and families. Maryland has incorporated priorities of the Program Improvement Plan (PIP) into its CFSP. The Committee assists this initiative in the following ways: 1) identify challenges facing Maryland's child welfare system; 2) provide information and experience from various perspectives; and 3) identify potential collaborative strategies to meet the challenges. • Maryland Family Network worked collaboratively and actively with the State Department of Health and Mental Hygiene Center for Maternal and Child Health in support of its application as the State Title V Agency for continuation of the State Early Childhood Comprehensive Systems (ECCS) program.		parent satisfaction and are regularly collected, analyzed, and disseminated to and for all local programs. Maryland Family Network generates Monthly Participation Summaries from the MIS for all local programs. • In partnership with the Mid Atlantic Equity and US Department of Education, the lead agency secured funding to address the changing needs of participating parents through the provision of parent education and implementation of the Nurturing Program. Maryland Family Network conducted a parent/caregiver evaluation in order to ensure the quality and usefulness of program services and activities. Parents completed the survey ranking their level of satisfaction with program services and reporting their knowledge, skills, practices, and responsibility in essential communication, decision-making, advocacy, and parenting. Parents self-report family demographics and provide opinions, experiences, and suggestions for program improvements.
C. Results of Peer Review	**D. Evaluation Data on Funded Programs, the Lead Agency & the Network**	**Other Elements:**
• In honoring the commitment to accountability and quality assurance, Maryland Family Network involves peers wherever possible and includes other parties impacted by the practice or policy being reviewed. • The fifth formal Peer Sharing Process involved team members (from the same Center, and teams were comprised of the Director), the Child Development Specialist and the Services Coordinator/Family Services Advocate. Peer Review teams were not allowed to visit a program in the same or adjacent district. Directors used a master	• Maryland Family Network continues to maintain a database that tracks the status of completion of required training for all network staff employed at Family Support and Early Head Start programs. The database includes a variety of professional information about each staff person including: date of hire, highest level of education, field in which education was obtained, any additional certification (PAT, 90 Hours, CDA), and years of experience in the field. The database tracks staff completion of required training for their specific position: all staff who work 30+ hours per week are required to complete the Family Support Network Orientation within six months of hire, all child development staff working 30+ hours per week are required to complete Early	• Maryland Family Network continued to focus on working with State and local partners to implement recommendations of the Maryland's comprehensive plan to ensure that infants and toddlers, ages 0-3, receive a strong foundation for learning. • Maryland Family Network continued to serve on the State's Child and Family Services Planning Committee (CFSPAC) established to develop, review, and provide input to the State's Child and Family Services Plan (CFSP). The Advisory Committee meets quarterly and focuses efforts to determine how best to support Child Welfare

calendar to schedule their own teams for visits as well as for scheduling the Review Team to visit their own program. Program Directors (designated team leaders) complete a report of the visit based upon the Peer Sharing Tool, and present a copy to the Center visited. A signed copy is forwarded to their Program Consultant at MFN. Directors reported that the time spent with their own management team traveling together and visiting another program and then discussing the visit, planning, strategizing and gathering new ideas, was very productive.	Childhood Best Practices within six months of hire, and other training requirements are to be completed within the first year of hire. Most required training is completed by participation in MFN-sponsored training. • Maryland Family Network evaluated the performance of the network's family support programs by using the qualitative information gathered during scheduled and impromptu visits to the Centers and by quantitative information provided by the participant database or Management Information System (MIS). The MFN MIS system provides information about Center participants and their utilization of Centers, and these data are used to monitor services provided by the programs and compare results with contract requirements and program performance goals—standards based on numbers and types of participants, types of service provided, and intensity of service utilization. Data are recorded on a daily basis to document services, progress toward outcomes and changes in a participant's status, collected quarterly, and used to provide case management services and to document outcome measures for the network and for individual Center use.	Outcomes and to develop and implement strategies for collaboration to achieve Child Welfare Outcomes.

Maryland's Family Support Centers

BALTIMORE CITY
Bon Secours Family Support Center
26 N. Fulton Avenue
Baltimore, MD 21223
tel 410.362.3629 fax 410.362.3649
Director Lori Fagan
Sponsor Bon Secours Baltimore Health System, Inc.
Our House
2707 Sethlow Road
Baltimore, MD 21225
tel 410.396.8469 fax 410.545.0195
Director Cassandra DeLeon
Sponsor HABC/Division of Family Support Services
Park Heights Family Support Center
4330-D Pimlico Road
Baltimore, MD 21215
tel 410.578.0244 fax 410.367.1927
Director Linda Harvey
Sponsor Family & Children's Services of Central MD
Southeast Baltimore Early Head Start Center
2811 Dillon Street
Baltimore, MD 21224
tel 443.923.4300 fax 410.563.2725
Director Gayne Barlow-Kemper
Sponsor Kennedy Krieger Family Center
Waverly Family Support Center
829 Montpelier Street
Baltimore, MD 21218
tel 410.235.0555 fax 410.366.7720
Director Sharon Thomas
Sponsor Goodwill Industries of the Chesapeake, Inc.

ALLEGANY COUNTY
Cumberland Family Support Center
205 Baltimore Avenue
Cumberland, MD 21502
tel 301.724.5445 fax 301.724.0642
Director Janice Cannon
Sponsor Cumberland YMCA

ANNE ARUNDEL COUNTY
Annapolis Family Support Center
80 West Street
Annapolis, MD 21401
tel 410.269.4478 fax 410.974.2139
Director Stacey King
Sponsor Anne Arundel Co. Dept. of Social Services
Anne Arundel Early Head Start
6243 Shady Side Road
P.O. Box 158
Shady Side, MD 20764
tel 410.867.8945 fax 410.867.8947
Director Carmelia Hicks
Sponsor AA Co. Economic Opportunity Committee

BALTIMORE COUNTY
Young Parent Support Center
201 Back River Neck Road
Baltimore, MD 21221
tel 410.853.3860 fax 410.686.5479
Director Kevin McShane
Sponsor Baltimore Co. Dept. of Social Services

CAROLINE COUNTY
Caroline County Family Support Center
100 N. 6th Street
Denton, MD 21629
tel 410.479.3298 fax 410.479.3789
Director Tearesa French
Sponsor Caroline County Board of Education
Federalsburg Judy Hoyer/EHS Center
323 S. University Avenue
Federalsburg, MD 21632
tel 410.754.2467 fax 410.754.7091
Director Tearesa French
Sponsor Caroline County Board of Education

CARROLL COUNTY
Carroll County Family Support Center
10 Distillery Drive
P.O. Box 489
Westminster, MD 21158
tel 410.876.7805 fax 410.386.6675
Director Joyce Tierney
Sponsor Human Services Program of Carroll County

CECIL COUNTY
Family Education Center
200 Road B Hollingsworth Manor
Elkton, MD 21921-6623
tel 410.287.1100 fax 410.392.9548
Director Barbara Istvan
Sponsor Cecil College

DORCHESTER COUNTY
Dorchester County Early Head Start Center
824 Fairmount Ave.
PO Box 215
Cambridge, MD 21613
tel 410.901.2015 fax 410.901.2057
Director
Sponsor SHORE UP!, Inc.

FREDERICK COUNTY
Family Partnership
8420 Gas House Pike Suite EE
Frederick, MD 21701
tel 301.600.2206 fax 301.600.2209
Director Shelly Toms
Sponsor Frederick Co. Office for Children & Families

Up-County Family Support Center
303 W. Lincoln Avenue
P.O. Box 158
Emmitsburg, MD 21727
tel 301.600.7450 fax 301.447.6325
Director Michelle Gallipoli
Sponsor Frederick Co. Office for Children & Families

KENT COUNTY
Kent Family Center
601 High Street
Chestertown, MD 21620
tel 410.778.7911 fax 410.778.6328
Director Marianne Peltier-Allison
Sponsor Shared Opportunity Service, Inc.

MONTGOMERY COUNTY
Families Foremost Support Center
1109 Spring Street, Suite 300
Silver Spring, MD 20910
tel 301.585.3424 fax 301.585.8382
Director Shari Waddy
Sponsor Mental Health Association

PRINCE GEORGE'S COUNTY
Adelphi/Langley Park Family Support Center
8908 Riggs Road
Adelphi, MD 20783
tel 301.431.6210 fax 301.431.6212
Director Danitza Simpson
Sponsor Prince George's Child Care Resource Center

QUEEN ANNE'S COUNTY
Family Support of Queen Anne's County
103 N. Linden Street
PO Box 201
Sudlersville, MD 21668
tel 410.438.3182 fax 410.438.3806
Director Dorothy Carpenter
Sponsor Queen Anne's Co. Board of Education

TALBOT COUNTY
Talbot County Family Support Center
215 Bay Street, Suite 1
Easton, MD 21601
tel 410.820.6940 fax 410.820.6958
Director Stella Lee Coulbourne
Sponsor Talbot County Health Department

WASHINGTON COUNTY
Washington County Family Support Center
920 W. Washington Street, Suite 100
Hagerstown, MD 21740
tel 301.790.4002 fax 301.790.4007
Director Dori Yorks
Sponsor Washington Co. Dept. of Social Services

WICOMICO COUNTY
Wicomico Family Support Center
SHORE UP! Inc.
500 Snow Hill Road
PO Box 430
Salisbury, MD 21804
tel 410.860.9194 fax 410.860.9373
Director Sheree Sample-Hughes
Sponsor SHORE UP!, Inc.

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