MARYLAND

MATERNAL, INFANT AND EARLY CHILDHOOD HOME VISITING PROGRAM

UPDATED STATE PLAN

June 2011

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INTRODUCTION

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's 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), Human 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 serves as the ultimate decision making body for determining at risk communities in which evidence-based models will be implemented.

Other key early childhood systems partners include the Early Childhood Advisory Council (ECAC), Maryland Home Visiting Consortium, the Maryland Home Visiting Alliance, the Ready at Five Partnership, the Judith Hoyer Early Childhood Centers, Head Start and Infants and Toddlers. The promotion of home visiting as a strategy for improving child and family health outcomes is an integral part of the work of each of these partners. For example, the State's Early Childhood Plan identifies home visiting as a key strategy for family support and improving the health of young children. Additionally, since 2001, Maryland has had a Home Visiting Consortium to coordinate efforts to strengthen home visiting services in the state. In 2010, the Maryland Home Visiting Alliance was formed to advocate for young and vulnerable families to have greater access to quality home visiting services. Representatives from each of groups have been integral partners in Maryland's Home Visiting planning and implementation activities.

The Updated State Plan

In this Updated State Plan for use of FY 2010 funds, Maryland has prepared a proposal which identifies two of the state's at-risk communities targeted for initial program implementation in Baltimore City and the City of Cambridge in Dorchester County, and outlines

program goals and objectives for the State Home Visiting Program. In addition, plans are presented for meeting legislatively mandated benchmarks, state home visiting plan administration and continuous quality improvements. Maryland technical assistance needs are also noted. Required letters of concurrence are attached in Appendix 1 along with an updated budget and budget narrative in Appendix 14.

Maryland's Updated State Home Visiting Program is one service strategy aimed at developing a comprehensive, high-quality early childhood system that promotes maternal, infant, and early childhood health, safety, and development, and strong parent-child relationships in the targeted at-risk communities. The aim is to develop a comprehensive plan that addresses community risk factors and builds on strengths identified in the targeted communities, and that responds to the specific characteristics and needs of families residing there.

The Updated State Plan identifies strategies for enhancing staffing and administrative structures at both State and community levels to ensure continuous quality improvement, implementation of data systems, and development of high-quality, ongoing training and supervision of program staff. Maryland's Updated State Plan demonstrates commitment to research and evaluation among all public and private partners involved in carrying out the State Home Visiting Program. The Updated State Plan identifies the ways in which State-level staff will be collaborating among all relevant State agencies, as well as with other public- and private-sector partners, to ensure the success of this multi-faceted program that addresses maternal and child health, child development, and the prevention of child maltreatment. In addition, the Maryland Updated State Plan include measures that will be taken to support the two home visiting models in the 39 targeted communities at risk in Baltimore City.

Section I: Identification of the State's Targeted At-Risk Communities

Background: Home Visiting Needs Assessment and Planning Activities

The Maryland Home Visiting Needs Assessment looked at 15 indicators that put children and families at-risk: prematurity, 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. The state was divided into 368 potential "communities" (including 55 neighborhoods in Baltimore City and census tracts in the rest of the state). Maryland then used a ZIP code/Community Statistical Area (CSA) analysis to identify risk (having at least one elevated indicator) in the 368 communities. Appendix 2 provides more detailed information about the needs assessment and state home visiting tiers. Background information on Maryland's Home Visiting Needs Assessment can also be found on the Maryland Home Visiting website at: http://fha.maryland.gov/mch/hv_needs_assess.cfm.

Based on this analysis, the state's 24 jurisdictions/communities were divided into four Tiers. Tier one communities were deemed most at risk because they were elevated on 10 or more of the 15 indicators described above. These 46 "hot spot" communities were located in six jurisdictions: Baltimore City and Dorchester, Washington, Prince George's, Wicomico and Somerset counties.

The State Home Visiting Team decided to initially begin local planning activities with the six most at risk jurisdictions. As part of the planning process, state home visiting staff held meetings with local health officers and their staff along with the directors of local management boards (LMBs)[1] in each of the jurisdictions. Four of the jurisdictions requested and received funding to assist with local planning (Baltimore City; and Dorchester, Washington and Prince George's counties). The state requested that each jurisdiction complete two self-assessment tools to assist in further determining local need, capacity and readiness for implementation.

The Maryland Home Visiting Team used the following criteria for identifying the state's targeted at risk communities for FY 2010:

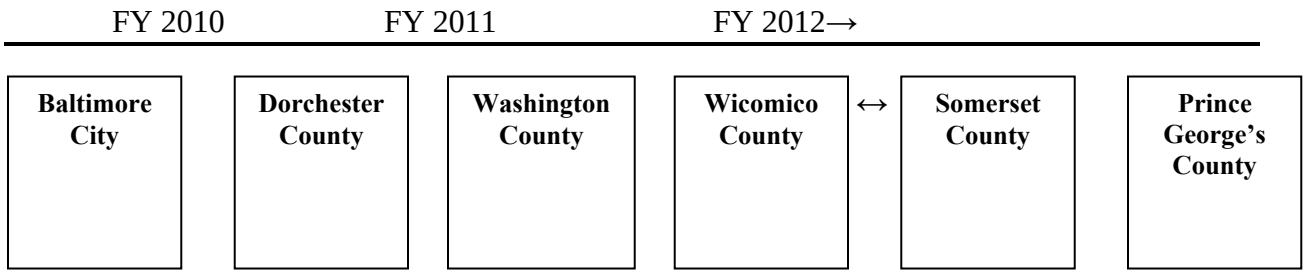
- Ranking on the state's home visiting needs assessment. Priority consideration was given to the six areas ranked as "hot spots" on the needs assessment. These included Baltimore City (1), Dorchester County (2), Washington County (3), Wicomico County (4), Prince George's County (5) and Somerset County (6).
- Current Capacity to reach families/children in need: Priority consideration was given to communities with evidence based home visiting program slots for less than 10% of poor families (as measured by the U.S. Census– number of poor families with children under age 18). Consideration was also given to population size and the ability to support a new or expanded program.
- Community readiness to implement/expand a home visiting program. The state considered such factors as willingness to align/re-align existing home visiting programs; the existence of a well developed local plan; review of community needs to determine the most appropriate home visiting model for implementation and willingness to leverage current home visiting resources to maximize use of new funding.

Baltimore City and Dorchester County

Appendix 2 summarizes the results and identifies jurisdictions by final ranking and shows Baltimore City and Dorchester County on the Eastern Shore (city of Cambridge) ranked as one and two, respectively. Ultimately, Maryland selected these two areas as the state's most at-risk Maryland communities for initial funding with FY 2010 support. Maternal, Infant and Early Childhood Home Visiting (MIECHV) funds will support the implementation of the Nurse Family Partnership and Healthy Families Programs in Baltimore City and an expansion of the Healthy Families Program in Cambridge. Following approval by the Children's Cabinet, and support from the Home Visiting Team, the State is poised to proceed in working more closely with these two jurisdictions to begin local program planning and implementation.

[1] Local Management Boards (LMBs) identify priorities and target resources for a jurisdiction's communities. The major focus is to increase local authority to plan, implement, and monitor children and family services. LMBs serve as the coordinator of collaboration for child and family services. They bring together local child-serving agencies, local child providers, clients of services, families, and other community representatives to empower local stakeholders in addressing the needs of and setting priorities for their communities. There is an LMB in each county and in Baltimore City.

The timeline and plan for implementation of evidence based home visiting (EBHV) programs is demonstrated below. As also described below, the plan is to initially fund Baltimore City's transition to a fully evidence based home visiting system with central intake procedures in place with the federal fiscal year 2010 funds. Additionally, a small amount funds will be used to support curriculum training for the Dorchester Healthy Families Program. As more federal funds become available, then funding for additional jurisdictions will be provided.



BALTIMORE CITY

Baltimore City, located in Central Maryland, is the 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. Baltimore City ranked number one in both need for expanded home visiting services and readiness to begin program implementation as the summarized here.

- **Need**: Identified as the "top" at risk jurisdiction in Maryland with 39 communities scoring 13 or 14 out of 15 indicators of risk on the Home Visiting Needs Assessment.

- **Capacity**: There are currently 484 Evidence Based Home Visiting slots serving families in Baltimore City.

- **Readiness:** Has selected two appropriate evidence-based home visiting programs; has a well-developed plan to implement the model selected; will align/re-align any current HV programs; will leverage current HV resources to maximize new funding in SFY 2012.

CMCH home visiting project staff met with the Baltimore City Health Department (BCHD) and Local Management Board (LMB) directors and staff on February 10, 2011. The LHD and LMB are co-leading the planning and implementation processes with support from the B'more for Healthy Babies Advisory Group. As part of the B'more for Healthy Babies (BHB) Initiative, the Family League of Baltimore City, the City's LMB, has been is working closely with the BCHD to transition to a more efficient, equitable, evidence-based, and equitable home visiting service delivery system. This transition has the full support the Baltimore Health Commissioner and other Baltimore City leaders. The B'more for Healthy Babies Initiative is described further in subsequent sections.

Baltimore City has completed the required jurisdictional self- assessments. An approved request for $41,850 to conduct focus groups with local community input will be completed in early June 2011 and local plan development is nearing completion. A Healthy Families America expansion has been identified as one model. The plan is to transition current LMB home visiting programs to receive training in the Healthy Families America model and identified curriculum. The programs in Maternal and Infant (M&I) will roll out a Nurse Family Partnership (NFP) program, training all the existing home visiting nurses on the NFP model. Both programs will be implemented with fidelity. These programs will then service families Citywide, including the 39 areas most at risk. Baltimore City has submitted a plan to both model developers and met with each several times. A final plan will be completed in early June and training will this summer.

Risk Factors and Community Strengths. Risk factors for home visiting are numerous in the City. 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 2005-2009 estimates that 20.1% of individuals lived below the poverty level including 16.2% of all families, 28.1% of related children under age 18, and 27.5% of families with a female headed householder. According to the 2005-2009 American Community Survey, there are approximately 67,118 families in the City with children under the age of 18. Approximately16,444 (24.5%) of these families with children live have incomes below the federal poverty level.

Infant mortality reduction is one of the Governor's top 15 priority goals. In 2009, the City's infant mortality rate of 13.5 per 1,000 live births was almost twice the state rate of 7.2 per 1,000 live births. Approximately 23.7% of all infant deaths statewide and 34.4% of deaths to African American infants occurred in Baltimore City in 2009. Because of the City's high infant mortality rate, it is one of four jurisdictions in the state targeted for special funding and technical assistance from the state to lower the overall rate as well as racial/ethnic disparities under the Governor's Delivery Unit (GDU) Initiative. The GDU goal is to lower the state's infant death rate by 10% by 2012.

In the recently published County Health Rankings Report[2] 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 needs assessment found that the majority of at-risk communities or "hot spots" (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 3 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.

[2] A collection of 50 reports-one per state - ranks all counties within each state on their overall health.

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. A detailed table of Baltimore City's 39 communities at risk can be found in Appendix 3.

Baltimore City also has many strengths. Baltimore City has in place B'more for Healthy Babies (BHB), which is a full strategy to improve birth outcomes for the City that address children zero to three years of age. This strategy is comprehensive and multi-sectored and based on a 2008 City plan to reduce infant mortality, the Strategy to Improve Birth Outcomes (SIBO). As a result of the strategic planning process for the B'More for Healthy Babies infant mortality initiative, which has been underway for approximately one year, Baltimore City has already been able to provid evidence of commitment and readiness. This initiative involves strategies at the policy, services, community and individual levels. BHB has leveraged funding from various sources including the Office of Women's Health, the Barbara Bush Foundation, the Quality Health Foundation, and the Abell Foundation. BHB is also overseeing the implementation of the City's new home visiting strategy with the Baltimore City Health Department (BCHD) and the Family League of Baltimore City (FLBC) jointly work to coordinate home visiting services in the City.

Other strengths include key partnerships among health care providers in the community. In addition, seven of the eight birthing hospitals in the city have participated very aggressively in the safe sleep campaign and are eager to better connect to home visiting services. The pediatricians in the City are very interested in engaging more closely with the home visiting programs. The City also has access to many students and interns from neighboring Universities to support data analysis and to be trained to become home visitors. More importantly, the City has an extensive centralized home visiting intake system and plans to develop a more intensive system in the future as described below.

Characteristics and Needs of Participants. Baltimore City tracks birth outcomes data by census track and use a comparison rate (generally Maryland) to identify the most vulnerable communities and clients. The neighborhoods identified are also he most vulnerable in terms of other City indicators including socio-economic status, shootings, high school graduation rates, etc. Currently Baltimore City does not differentiate which communities are most in need of

home visiting since there are needs for home visiting across the City. Instead, the City is finalizing a vulnerability index that will allow for the identification of pregnant women and infants by medical/social need rather than by where they live.

Existing Home Visiting Services. The Baltimore City Health Department completed a capacity assessment looking at: providers, 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. There are currently three evidence based programs in the City: Healthy Families, Early Head Start and HIPPY. These three programs have the capacity to serve 484 families.

Table 1. Evidence Based Programs in Baltimore City

Evidence Based Program	Capacity
Early Head Start Centers	234 children per year
Dru-Mondawmin Healthy Families	170 families per year
Home Instruction for Parents of Preschool Youngsters	80 families per year
Parents as Teachers	No programs offered- Used as curriculum only

In addition, there are several non-evidenced programs with the capacity to serve approximately 1600 additional families (see Table 2). These programs include services offered through the federally funded Baltimore City Healthy Start, Inc. Project, BCHD maternal and infant nursing program, federally qualified health centers (e.g., People's Community Health Center, Baltimore Medical Systems), hospitals (Sinai, Bon Secours) and community based groups (e.g., Family Tree, Maryland Family Network). Other family support programs for families with young children include two Judy Centers (Early Child Care and Education Enhancement Centers) and five Family Support Centers as well as Community Based Child Abuse and Prevention Centers serving over 4,900 families and children 0-3, annually.

Table 2. Baltimore City Non-Evidence Based Home Visiting Programs

Program	Current Capacity	Current Home Visitors
Baltimore City Healthy Start, Inc.	880	22
Historic East Baltimore	250	9
Greenmount	100	4
Middle East		
Satellite Sites	280	
Sandtown- Winchester & Greater Rosemont	250	9
Bon Secours Foundation of MD	20	2
The Family Tree	42	2

People's Community Health Centers	70	2
Maternal and Infant- BCHD	400	
Sinai Hospital	100-150 per year 15-20 families at a time	4
Baltimore Medical System (BMS)	60	4
Total Capacity	Up to 1622 families per year	

Baltimore City is submitting a plan to implement NFP and Healthy Families. DHMH has met with BCHD, the LMB, and both model developers as well as acquired the required letters from the model developers. Baltimore City has requested and received funding for focus groups and key informant interviews that have been completed and have informed their process.

Existing Mechanisms for Screening, Identifying and Referring Families. Baltimore Health Care Access (BHCA) serves as the City's centralized intake and assessment mechanism. There are several ways that pregnant women and infants enter the system. (1) via prenatal risk assessments that are faxed to Baltimore Health Care Access from a prenatal care clinic; (2) through a referral from a City clinic (family planning, STI) faxed to BHCA; (3) from home visiting programs alerting BHCA that they have identified a pregnant or postpartum mom in need of services through door-to-door recruitment[3]; (4) through infant referrals from delivery hospitals (largely NICUs); (5) through self referral. All programs except for Baltimore City Healthy Start, Inc. use agreed upon risk criteria to ensure that women who need home visiting services receive these services. Baltimore City Healthy Start, Inc. has no current enrollment criteria and will enroll any mom that agrees to services, whether or not they are considered high risk.

The plan is to change the distribution of home visiting services so that all four quadrants of the City have access to evidence-based and promising programs. Baltimore will use a vulnerability index to ensure that women most in need of service are prioritized. The City is putting in place a resource development strategy to identify potential new funding in the future for home visiting in Baltimore City, however, it is believed that home visiting is just one of multiple strategies that need to be in place to ensure the wellbeing of pregnant women, fathers, and infants in the City.

Pregnant and postpartum women should be triaged into home visiting services through a vulnerability index. The Family League of Baltimore City, Inc. and the Baltimore City Health Department are currently finalizing a home visiting vulnerability index that will be used to triage pregnant women and infants into home visiting programs. The vulnerability index is based on the history of fetal or infant loss, physical illness, domestic violence, history of two or more preterm births, multiple gestation, maternal age, current CPS case, mental health, STDs,

[3] This is one area the City is seeking to improve to ensure all moms are known by BHCA who are recruited by home visiting programs

substance abuse, birth spacing, and documentation of smoking. The triage criteria are based on the Strategy to Improve Birth Outcomes (SIBO) data and the Domestic Violence Emergency (DOVE) Project guidelines.

The City is moving toward a Centralized Intake System for home visiting. Baltimore Heath Care Access (BHCA) will be utilized as a single point of entry into home visiting. Home visiting programs will continue to do door –to-door recruitment, but not door-to-door enrollment. BHCA will screen all new clients and refer them to appropriate services. This is to avoid any redundancy in service and to ensure equitable allocation of service. BHCA will need two additional staff to support the proposed effort. The plan for home visiting coverage is to maintain 1800 slots until all trainings have been completed and programs are evidence-based. The federal money will be used to transition from what is currently in place to the quadrant system using The NFP and HFA evidence-based models. With an increase in capacity, built into the FY 2010 budget, the Central Intake System will have the capacity to triage all incoming referrals to avoid service duplication and ensure the appropriate program referral.

Referral Resources. Baltimore City has other in-home visiting programs including five additional programs located in hospitals, and community health centers as well as one federal Healthy Start. In total, these additional non-evidence based programs serve an additional 1800 families and children per year. Other parent resources and family support programs for families with young children include: two Judy Centers (Early Child Care and Education Enhancement Centers) and five Family Support Centers as well as Community Based Child Abuse and Prevention Centers serving over 4,900 families and children 0-3, annually.

DORCHESTER COUNTY

Dorchester County located on the Eastern Shore is the State's fourth smallest 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 2005-2009 estimates that 13.3% of individuals lived below the poverty level including 10.4% of all families, 20.9% of related children under age 18, and 34.3% of families with a female headed householder. In 2009, the County's infant mortality rate of 21.9 per 1,000 live births was three times 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 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 has one community, Cambridge, with a substantially elevated infant mortality rate at 31.0 per 1,000 live births, nearly 4 times higher than the state average. Based on a Statewide Home Visiting Needs Assessment completed in the Fall of 2010, Dorchester County has been designated as a high-risk community as indicated by 13 out of 14 elevated risk factors for poor infant and child outcomes. Of particular concern is a rise in infant mortality since 2006, peaking at a rate of 21.9 in 2009 compared to the State's rate of 7.2. Eight of the nine infant deaths in 2009 were African American, representing a significant racial disparity. Dorchester County is

also one of the four jurisdictions to be identified for more intensive attention to reduce infant mortality and are participating in the GDU to assist in this effort.

- **Need**: 2nd highest ranking on Maryland Home Visiting Needs Assessment

- **Capacity**: There are currently 80 EBHV slots serving families in Dorchester County.

- **Readiness**: Has selected an EBHV program; is developing a plan to implement the model selected.

CMCH home visiting project staff met with LHD and LMB directors and staff on March 10, 2011. Dorchester County has completed the required jurisdictional self- assessment. Local plan development has started with an approved request for $10,000 to conduct at least two stakeholder meetings, conduct focus groups and hold a community forum. The LMB is taking the lead role with input from the local health department. A Healthy Families America expansion has tentatively been identified as the probable model of best fit. A home visiting consultant has been tasked working with the planning committee to ensure that a final plan is completed by June 30, 2011. The Dorchester County LMB in collaboration with the health department will complete a plan within the next two months. They are using planning funds to facilitate meetings, and hold community meetings and focus groups.

Risk Factors and Community Strengths. Cambridge, in Dorchester County was ranked as the second highest at risk community outside of Baltimore City neighborhoods. In 2004-2008, this community's infant mortality rate of 31.0 infant deaths per 1,000 live births was nearly four times the state average of 7.9. Teen pregnancy prevention is also a priority area of concern. Almost one in ten mothers receives late or no prenatal care. This area's rates of premature births, low birth weight births, substance abuse treatment, and crime are higher than the statewide averages. In preliminary community assessments, infant mortality, teen pregnancy, child abuse & neglect, lack of parenting support, and unemployment were cites as major factors contributing to poor outcomes. Table 4, below, identifies the 13 risk factors in Cambridge identified in the 2010 needs assessment.

Table 3. Dorchester County Risk Factors

Risk Factor	Cambridge	Maryland Average
Percent Preterm Births	17.6	11.2
Percent Low Birth Weight	13.8	9.3
Percent Families in Poverty	30.4	9.5
Infant Mortality	21.9	7.9
Crime Rate	7124.7	4316.5
Percent Ready to Enter School	66%	81%
Substance Abuse Treatment Rate	28.9	7.1
Percent Unemployed	10.7%	7.0%
Abuse & Neglect Investigation Rate	6.5	1.6
Percent Late or No Prenatal Care	9.2%	4.3%
Teen Birth Rate	123.9	33
WIC Participation Rate	45	16.8

Medicaid Enrollment Rate	315.6	112

Dorchester County has identified strengths including: existing partnerships between agencies and community groups, community leaders who are dedicated to improving the lives of families and children, desire to expand existing community supports for families in need. Two evidence-based programs, HFA and Early Head Start already exist in the county. However, the current capacity of those programs is not sufficient to meet the needs of the at risk families in Cambridge. A central intake system can be established with the Local Health Department as the lead agency, and the Healthy Families program has existing infrastructure that would support additional staff to meet the need of clients currently unable to be served because of limited staff.

Convening a consortium of key stakeholders and community leaders will provide an opportunity for the county to address elevated risk factors and how best to address them in the context of the population's culture and values. Residents of "hot spot" areas will also be invited to participate in focus groups in an effort to determine the public's opinion about needs and possible interventions. In terms of the increase in Infant Mortality, action must be taken to address the racial disparity in this jurisdiction. An in-depth review of the infant deaths will be conducted to determine root causes and the need for targeted interventions. Access to comprehensive preconception and prenatal health care are certainly of importance, as are support and information for families expecting newborns that are most at-risk for poor outcomes.

Characteristics and Needs of Participants. The clients served in HFA are primarily pregnant teens, first time mothers and infants. Women served by the Healthy Families Dorchester program are primarily 19 years old or younger (28%) and between the ages of 20 and 30 (60%), with the average age being 23.7 years. Program participants are generally African American (56%) or White (37%), with 7% identifying themselves as Hispanic. Most of them (90%) are single mothers and 38% of them did not complete high school. Fathers with children in the program are primarily between the ages of 20 to 30 (56%) and 19 or under (16%); 55% are African American and 31% are White, with 9% identifying themselves as Hispanic. Twenty-nine percent (29%) did not complete high school, and 35% are employed full-time, 9% part-time.

In terms of household characteristics, 65% of the families receiving services report total income of less than $15,000. Fifty-nine percent (59%) of families have at least one other child in the home, in addition to the target child served by HFA.

Existing Home Visiting Services. Dorchester County currently has two evidence based home visiting programs – Healthy Families and Early Head Start. The Healthy Families Program targets the entire jurisdiction and has approximately 60 total slots. Parents as Teachers is the curriculum used by HFA in Dorchester County. There is an Early Head Start program (family support center) in the county that serves an additional 30 families and children ages 0-3.

Table 4. Evidence Based Programs in Dorchester County

Evidence Based Program	Capacity
Dorchester County Early Head Start Center	30 children per year
Healthy Families Dorchester	50-60 families per year

Home Instruction for Parents of Preschool Youngsters	No programs offered
Parents as Teachers	No programs offered- Used as curriculum only

Existing Mechanisms for Screening, Identifying and Referring Families. The Health Department receives Maryland Prenatal Risk Assessment forms for pregnant women enrolled in the Maryland Children's Health Program (MCHP) program after their first visit to a prenatal provider, as well as Infant Identification forms after the birth of the baby. HFA outreach staff, contact these families to determine interest in and eligibility for the various programs.

Referral Resources. The HFA and EHS programs both have representatives on the Judy Center Steering Committee, and communicate at least bi-monthly through these meetings. HFA often refers families to the EHS program if they do not meet eligibility requirements for HFA. The Health Department would be interested in developing a more formal MOU with EHS for referral. There are two additional agencies to meet the needs of at risk families. These programs offer a variety of resources to families, but do not offer direct home visiting services. However, they are worth mentioning for the referrals and resources offered to meet community need.

Plan for Coordination of Resources and Programs. Through Baltimore's B'more for Healthy Babies (BHB) initiative the City has identified home visiting as one of eleven high impact areas that will have an effect on poor birth outcomes. It is recognized that home visiting is only one intervention, among many to improve birth outcomes and support early childhood development. The Bureau of Maternal and Child Health is looking at each program (WIC, Infants and Toddlers, and Maternal and Infant Care) to ensure that at a minimum there is a vision of linked care within the health department that can help facilitate a more holistic City vision. The partnership with FLBC is critical for connecting the home visiting system to other early childhood services. The City is in the process of strengthening partnerships with Maryland Family Network and Baltimore City Head Start and Early Head Start to ensure a seamless service delivery system.

The Dorchester County Local Health Department and Local Management Board are taking the lead on a county-wide needs assessment and will be conducting focus groups and community forums to determine which EBHV models, beyond HFA, will be implemented or expanded within the communities at risk. Because of the extremely high infant mortality in the identified area at risk, current considerations are for an NFP and expansion of the HFA model using the Partners for a Healthy Baby curriculum model that focuses on infant mortality. Local plan development has started with an approved request for $10,000 to conduct at least two stakeholder meetings, conduct focus groups and hold a community forum. The LMB is taking the lead role with input from the local health department. A Healthy Families America expansion has tentatively been identified as the probable model of best fit. A home visiting consultant has been tasked working with the planning committee to ensure that a final plan is completed by June 30, 2011.

Local Capacity to Integrate Services in Baltimore City and Dorchester County. In Baltimore City, the home visiting system formally partners and collaborates with other early

childhood services to create a comprehensive system of care for young children and their families. During BabyStat, Baltimore City identifies specific needs largely related to learning more about available resources in the city. As the City moves into introducing evidence-based practices, Baltimore will be able to more effectively address technical assistance needs because the EBHV programs will have standardized and consistent goals. Baltimore City leadership brings together key stakeholders from an array of early childhood and related services to inform home visiting system development efforts during BabyStat. The comprehensive structure of B'more for Healthy Babies was developed for the purpose of linking together prenatal and postpartum resources, including home visiting services, to build a foundation for early childhood health and education services. Home visiting services cannot be considered in isolation of all of the other programs and services needed for improved birth outcomes and BHB is the platform to put the pieces of the puzzle together.

The Mayor's Office is looking at maternal and infant outcomes, such as infant safe sleep practices, birth spacing intervals, and smoking rates among pregnant women, through YouthStat, a City monitoring system for the health and wellbeing of pregnant women, infants, children, and teens.

Dorchester County Health Department representatives have met with a Mid-Shore Group to talk about the possibility of additional home visiting services in the region, and have reviewed countywide data as a starting point. A community stakeholders group will be convened to further plan toward expansion. The Judy Hoyer Center Steering Committee membership includes representatives from Healthy Families, Early Head Start, Infants and Toddlers, Head Start, childcare providers, as well as public and private partners who work with young children. While the Judy Center only serves one particular school district, programs are encouraged to share updates and information whether it applies to that district or the entire county.

State Capacity to Integrate. Maryland is fully capable of integrating the proposed home visiting services into an early childhood system because of the strong system of support and collaborative efforts already in place. Many existing efforts to develop a coordinated early childhood system in Maryland began with the Leadership in Action Program. The 40-member LAP Team worked for 10 months to develop the Action Agenda for school readiness. Team members included representatives from major State agencies as well as advocacy groups. This group continues its effort of school readiness since it inception and is currently the overarching early childhood education state plan through the Early Childhood Advisory council. Members of the home visiting administrative staff serve in leadership roles on the ECAC program team, and members of ECAC serve on the home visiting executive steering committee to ensure consistency of planning efforts throughout the state. Home visiting is already embedding into the ECAC and ECCS state plans. There is support from the Governor and Children's Cabinet and interagency collaboration to effect the change needed to implement EBHV programs throughout Maryland.

Section II: Steps in State Home Visiting Program Goals and Objectives

Goals and Objectives. Maryland's Updated State Plan includes clearly articulated goals and objectives for the State Home Visiting Program.

Overarching Goal: Maryland's Home Visiting Program will contribute to developing a comprehensive, high-quality early childhood system that promotes maternal, infant, and early childhood health, safety, and development and strong parent-child relationships.

The home visiting goals are to:

1. Improve maternal, infant, and early childhood health
2. Identify and provide comprehensive services to improve outcomes for families who reside in at risk communities
3. Strengthen parent-child relationships
4. Strengthen and improve programs and activities for families receiving home visiting services
5. Ensure an early childhood system of care that is coordinated and that meets the needs of Maryland's families and children

The Maryland Updated Home Visiting Plan outlines the state and local activities and short term outcomes. Maryland's Updated Home Visiting Plan integrates the maternal and child health, developmental milestones, and early care services for all children from birth through five years of age that support children's early learning, health, and development. The plan addresses family support and quality parent education as well as the integration of health into all early care and settings. Detailed objectives and activities can be found in Appendix 4.

Goal 1. Improve maternal, infant, and early childhood health: The objectives within this goal address high risk pregnancy, increasing healthy babies, and increasing nurturing and attachment. The activities at the state level are designed to support direct and enabling service, public awareness and public and private efforts. At the local level it is projected that community mobilization, increasing access and utilizing EBHV screening tools to ensure referral to needed services will encompass some of the activities to address this goal and assure positive outcomes.

Objectives:

1.1- Intervene with high-risk mothers as early in the pregnancy as possible.
1.2- Increase the number of babies born healthy, full term and normal birth weight.
1.3- Increase early identification and treatment of mothers for whom nurturing and early attachment to the new-born is impaired.

Goal 2. Identify and provide comprehensive services to improve outcomes for families who reside in at risk communities: The objectives within this goal address community linkages and availability of services. The activities at the state level are designed to increase awareness and provide funding and technical support. At the local level it is anticipated that home visitors will have the tools needed to assure positive outcomes for the families they are serving.

Objectives:

2.1- Increase in linkages to community services for families with young children.
2.2- Increase availability of evidenced-based home visiting services in communities at highest risk.

Goal 3. Strengthen parent-child relationships: The objectives within this goal address parenting skills, prevention of abuse and preventable injuries. The activities at the state level are designed to identify and promote appropriate parent curricula as well as assure resources are

directed to needed services addressing the objectives listed. At the local level it is planned that skills and resources assure parents receive services in a timely manner.

Objectives:

3.1- Improve parenting skills.
3.2- Prevent child maltreatment.
3.3- Parental awareness of various preventable injuries.

Goal 4. Strengthen and improve programs and activities for families receiving home visiting services: The objectives within this goal provide that assurances are in place to determine CQI and outcome evaluation data. The activities at the state level require home visitors to collect data and assure state fund will be made available to support CQI activities. At the local level it is planned that the home visitors will be adequately trained to assure family progress is measured and effective.

Objectives:

4.1- Ensure Continuous Quality Improvement (CQI).
4.2- Conduct process and outcome evaluation of the EBP provide in at risk communities.

Goal 5. Ensure an early childhood system of care that is coordinated and that meets the needs of Maryland's families and children: The objective of this goal is to ensure continued capacity to integrate home visiting programs into Maryland's early childhood system of statewide activities and programs. At the state level, the Children's Cabinet will assure that state and public agencies understand goals and activities that can be integrated into their own missions and visions. Locally, this objective strives to ensure a coordinating body comprised of all child serving agencies that communicate on a continuum of care for children and families with the result that home visiting will be integrated into state and local planning efforts.

Objective:

5.1- Ensure continued capacity to integrate early childhood systems into statewide activities and programs.

Coordination and Partnerships. At the State level, there is a governance structure that is Maryland's coordinated system of planning- Maryland Children's 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 serves as an advisory body for selecting high risk communities in which evidence-based models will be funded.

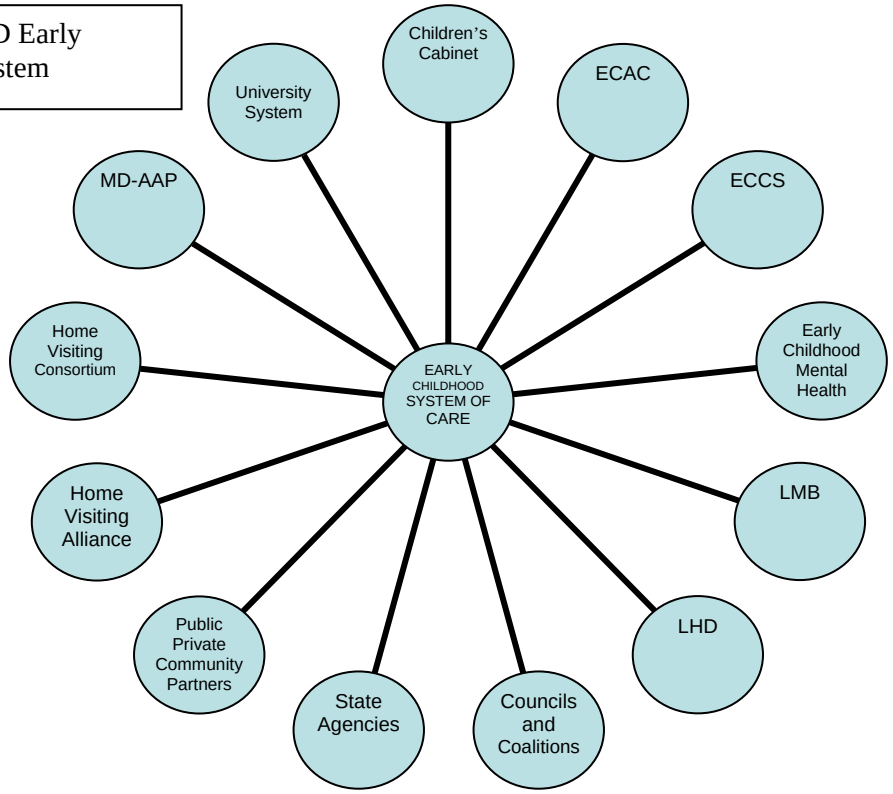
Other collaborative efforts include a State Early Childhood Advisory Council (ECAC) that oversees implementation of a State Plan to improve school readiness. The State's ECCS

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.

The Center for Maternal and Child Health (CMCH, the Title V Agency) has established contacts with all State Departments and Administrations that provided data for the initial needs assessment. These agencies have agreed to continued data sharing for the ongoing evaluation of the home visiting project. CMCH already works in partnership 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. Head Start has already provided CMCH with the most recent needs assessment. The Infants and Toddlers program as well as Judy Centers and the Social Emotional Foundations of Early Learning (SEFEL) are also partners in the statewide early childhood efforts. CMCH also 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 MSDE.

The Alcohol and Drug Abuse Administration (ADAA), the State's substance abuse agency, is a partner in the Governor's initiative to reduce infant mortality which is being led by CMCH. The Early Childhood Advisory Council, Local Management Boards, Local Health Departments, Home visiting Alliance, Home visiting Consortium, the State Council on Child Abuse and Neglect, environmental health advocates, University partners including Johns Hopkins and University of Maryland, the Maryland Academy of Pediatrics, as well as other private partners including Ready at Five and the Krieger Foundation are all partners in the on-going early childhood system efforts within Maryland. In addition, Maryland has a well-established coordination infrastructure led by the Governor's Office for Children. Diagram 1 below shows the many parts of the system of care for young children in Maryland.

Diagram1. MD Early Childhood System

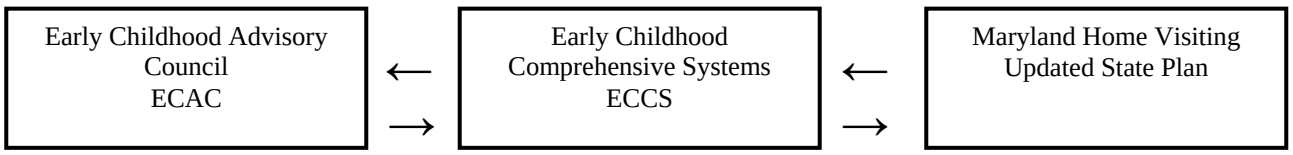


Maryland has a comprehensive system of care that includes the agencies, organizations and partners addressed in the narrative above. The important link to these partners and collaborations is their presence at the table across agencies and topics of interest, with the common denominator being families and young children.

With all these partners in place, Maryland is strongly positioned to continue the forward momentum begun with the inception of ECCS and the Maryland Leadership in Action Program. The schematic above demonstrates the agencies involved in developing this early childhood system of care. Maryland's early childhood system is a continuous flow of information through and across agencies and partners aimed at ensuring communication and support. This continuum of care assures population based needs are met with intensive family support services.

In addition, new initiatives and opportunities to collaborate include the Military Child Education Coalition (MCEC) focused on ensuring quality educational opportunities for all military children affected by mobility, family separation, and transition. Maryland has established a workgroup to ensure the health of military children and their families and DHMH, specifically CMCH and MHA are partners in this effort.

Comprehensive, High-quality Early Childhood System and Program Integration.
The special relationship between ECAC, ECCS and Home Visiting below demonstrates the blending of goals and objectives between these federal initiatives.



Ensuring that children are born healthy and maintain good physical and mental health is a critical first step in a comprehensive early childhood system. The area of maternal and children's health, in particular, is one that is often overlooked and under-funded. Many of the strategies included in Goal 3 of ECAC are designed to draw public attention to this need and garner public support for programs and services that support the health of young children and their families. The Maryland Department of Health and Mental Hygiene (DHMH), Center for Maternal and Child Health (CMCH), uses Goal 3 of the Action Agenda to improve health systems for young children in Maryland by promoting early childhood systems building through strategic planning and collaboration. To maximize partnerships and strengthen existing collaboration, many of the strategies and activities that have been developed through the ECCS planning process have been added to Goal 3 of ECAC. Under this initiative, CMCH is building upon their previous programs as well as the activities begun by ECAC to mobilize new and existing partners to implement strategic planning and collaborative processes to promote child health and school readiness statewide.

The ECCS project adopted Goal 3 of ECAC for school readiness. This goal is the foundation for the ECCS Maryland state plan and includes "Children, birth through age 5, and their families, will receive necessary income support benefits and health and mental health care

to ensure they arrive at school with healthy minds and bodies". The goals and strategies created through ECCS partners encompass five components of early childhood systems including: medical home, early care and education, social-emotional development, parent education and family support. The ECCS project is based on the premise that with adequate access to support systems and benefits the whole family will be able to: nurture early learning, build healthy minds and bodies; create supportive family systems; and ensure their children enter school healthy and ready to learn.

The Maryland Home Visiting Updated State Plan engaged a Home Visiting State Team and Home Visiting State Stakeholder Group to advise and makes recommendations to the Planning Team on policy, implementation strategies and general direction for statewide home visiting. These members included the representatives from the agencies and organizations listed previously. These collaborated efforts, current activities, and MCH policy implementation strategies have helped direct the home visiting state plan. A child's quality of health is directly related to its mother's health therefore, comprehensive services need to include women of child bearing age from preconception through the child's school entry. The rationale for this shared focus is that for a child to have quality physical and emotional health, mom must be healthy before, during and after pregnancy.

The Home Visiting Planning Team successfully collaborated on maternal and child health and welfare with partners including the GOC, DHR, the Maryland Family Network, MHA, MSDE, and the Office of Child Care (OCC) as well as a host of local agencies and home visitors. The result is that local level planning is happening in the six most at-risk areas identified.

During the 2010-2011 time period, the Maryland Home Visiting Project will ensure integration of the home visiting plan into other state maternal, infant and early childhood plans. These initiatives include a revision of the ECAC plan to include additional home visiting objectives as well as ensure home visiting integration into the strategic plan of the early childhood mental health state goals. Ensuring integration of home visiting into appropriate plans and activities statewide will strongly contribute to developing a comprehensive, high-quality early childhood system that promotes maternal, infant, and early childhood health, safety, and development and strong parent-child relationships.

Logic Model. A logic model is located in Appendix 5. This logic model is coordinated with the ECCS logic model and aligned with Maryland's home visiting goals and timeline. This tool presents the conceptual framework for Maryland's plan. While there are many logic model versions, Maryland has chosen this specific design as it summarizes the logical connections among resources and activities as well as the expected outcomes the initiative is designed to achieve.

Maryland's logic model represents the State's role in achieving the goals noted in the previous section; links State and local planning efforts to create a coordinated approach to service delivery; assures that only evidenced based-practices are utilized and are monitored for fidelity and effectiveness; assures that high-risk communities and priority populations, as defined in the needs assessment and Federal guidance will be targeted by these efforts; specifies short-term outcomes that can be tracked and measured by the implementing agencies and local

jurisdictions, and aggregated by the State; and specifies long-term outcomes that can be measured through a number of State data systems and compared with baseline data from the Maryland Needs Assessment and disaggregated and analyzed for use at the program participant and community level.

The targeted population to be served are parents of very young children, including pregnant women who have been assessed to be at high-risk for poor birth outcomes, and whose children are at elevated risk of child maltreatment and developmental difficulties, due to the presence of a number of factors such as substance abuse, lack of prenatal care, homelessness, malnutrition, chronic poverty, mental or physical impairment, history of maltreatment, trauma, intimate partner violence, family dysfunction or other condition that limits the parents' ability to provide adequate care for their children.

Services will be delivered to families with the highest risk factors. These families may have the least ability to access and utilize needed health, mental health and social services that would address threatening conditions and reduce risk of harm to young children. The intent is to serve these most at-risk parents of young children and mothers-to-be, through intensive home-visiting, voluntary engagement and linkage with other health and community services. Nationally recognized, fully accredited evidence-based home visiting services, e.g., Nurse Family Partnership and Healthy Families America, will be replicated by community service providers who have culturally informed practices and community acceptance, to assure that programs with demonstrated effectiveness will reach the most hard-to-reach populations.

Maryland will increase its capacity to provide evidenced-based home visiting services through direct service grants and increased coordination at both the State and local level to maximize public and private resources that are currently available to support home-visiting efforts. State and local planning activities have involved a careful assessment of what home visiting programs currently exist and where resources can be better aligned to have a greater impact in communities of highest need as identified by the Maryland needs assessment. The State and local jurisdictions will use support from this grant for ongoing assessment, program planning and implementation, accreditation and training of new and expanded or re-tooled home visiting programs.

Child development, parent-child interaction, parental knowledge and understanding of infant behavior and overall family functioning will be regularly monitored through standardized tools. Data on each child and family will be collected, progress documented and shared with the family as well as used for supervision and evaluation of program effectiveness. Benchmark indicators will be captured, most of which are process variables.

Prenatal intervention and early screening of high risk pregnancies combined with availability of voluntary intensive services will prevent child maltreatment and injuries from being the precipitating events in bringing at-risk families to the point of receiving family services. Positive outreach and in-home intervention designed to build trust and reduce fear encourages substance abusing families to participate in a treatment program. Self-directed and collaborative approaches to setting goals and solving family issues is less threatening to young parents and makes them more open to learning, practicing effective parenting techniques and addressing family risks. Linkage, good communication and follow-up with referral agencies will

assure that families get connected to appropriate social, health, educational, employment and other support services and continue their participation, as well as increase early identification of developmental delay in order to accelerate enrollment in early childhood learning programs.

Long-term outcomes anticipated if home visiting is part of a system of care include: reduction in rates of child maltreatment, decreasing the number of low-birth-weight and premature births, decreasing injuries to children and decreasing infant mortality. Child development in the areas of social, emotional, cognitive and behavioral and physical health will improve. Rates of domestic violence, substance abuse, transmission of HIV, and untreated mental and physical illness among parents and other family members will decline. Increased birth spacing and rates of unintended pregnancy will be reduced. Family self-sufficiency, economic well-being, workforce participation and educational attainment will increase.

Section III: Selection of Proposed Home Visiting Models and How the Models Meet the Needs of Targeted Communities

Meeting Community Needs. Maryland is proposing a program using two evidence-based home visiting models aimed at addressing the particular risks in the targeted communities and the needs of families residing in Baltimore City. Birth outcomes in Baltimore City have not improved for over a decade despite of significant resources that have been allocated to home visiting services. As a result and as part of B'more for Healthy Babies, FLBC and BCHD worked with BabyStat and individual home visiting programs to study what the strengths and weaknesses of the home visiting system are and what could be improved to streamline home visiting services and make them more equitably distributed. The team worked through a SWOT analysis and a needs assessment of home visiting services and concluded that women and infants were receiving different services for different time periods and with different goals depending mostly on where they lived. This made it challenging, if not impossible, to evaluate what home visiting services were accomplishing citywide. The M&I nurse home visiting staff also responded to a survey that identified strengths and weaknesses of nurse home visiting in Baltimore. One key finding was that even within a single program, staff felt they were not providing standardized services.

The goal, therefore, of introducing a streamlined home visiting service system to Baltimore City was to standardize home visiting services so that it would be possible to measure progress over time and to maximize the use of resources. The goal was also to broaden staff perspective on home visiting and underscore that it is just one of a number of comprehensive strategies that need to be in place to improve birth outcomes in the City. Nurse Family Partnership and Healthy Families America were specifically selected for Baltimore City because: (1) they are evidence-based home visiting models as identified by the Home Visiting Evidence of Effectiveness (HomeVEE) evaluation that directly reflect the staffing mix in the City (nurse home visitors and paraprofessional home visitors); (2) HFA has been operating in the City since 1999 and has been credentialed by the Prevent Child Abuse America's Healthy Families America Credentialing Board (credentialing certifies that the program has met the standards for home visitations as established in the critical elements of the Healthy Families Initiative). The fact that the Program is credentialed demonstrates that it adheres to research based best practices in providing support to families. Though following specific guidelines, the Program still has

adequate flexibility to be responsive to the needs of the community; (3) HFA is very well respected in the community as shown in the Success by Six survey results and the management is entirely collaborative; (4) HFA has offered new services according to clients' wishes. Examples include introducing a parent support group to support networks of families in the programs, starting a creative literacy and learning playgroup to provide parents an opportunity to learn to maximize caring moments for their children, and establishing collaborative partnerships with City schools; (5) NFP is the only evidence-based nurse home visiting program and the management of M&I are eager to reintroduce the program to the city.

It is proposed that the following models be available to four City quadrants (Appendix 6) that are divided by number of pregnant women at risk of poor outcomes. During a recent needs assessment, the State identified 39 of 46 communities as eligible for new federal home visiting funding. Baltimore City's quadrant approach will work well to address the State's need to cover these communities. Baltimore is transitioning to two evidence based home visiting program models. This transition is led by the Baltimore City Health Department and the Family League of Baltimore City.

Selected Models. – Baltimore City will start with four Nurse Family Partnership (NFP) nurses and scale up as mechanisms are put into place for a well-managed system of care. Baltimore Medical System will employ one NFP nurse and BCHD will employ the other three in the first year of implementation.

The number of babies dying in Baltimore City at an alarming rate and the number of repeat teen pregnancies are the motivating factors for reintroducing Nurse Family Partnership. There were 128 deaths to infants under the age of one in 2009 and 27 of these deaths were caused by unsafe sleep practices. Many of the infant deaths occur to younger moms with multiple children who started having babies in their teen years. Also, in 2009, there were 1,494 births to women under 20. Of those, 305 (20.4%) had already had a previous birth. One third of Baltimore's births are to first time mothers and the City is confident that introducing NFP is a critical step to helping these mothers make better choices for their future.

The current home visiting programs offered through the Family League will be transitioned to a Healthy Families model for moms who do not need a nurse or social worker. The training is slated to begin on July 1st and staff will receive HFA training while continuing to implement their current home visiting programs for continuity of care. With the expansion of HFA, Parent as Teacher Curriculum will continue, however, Partners for a Healthy Baby will be the suggested curriculum for Baltimore City because of the infant mortality focus. This curriculum is for other moms in need of nurse/social work home visiting. In 2009, BCHD adapted Partners for a Healthy Baby (PHB) curriculum, to the unique needs, culture, and resources of Baltimore City families. To accomplish this, staff from BCHD's Bureau of Maternal and Infant Care (M&I) forged a fruitful relationship with the original curriculum authors from Florida State University (FSU) and researchers from Johns Hopkins University and University of Maryland. The academic institutions provided new evidence on pertinent topics such as safe sleep, domestic violence, and substance abuse to enhance the prenatal and infant modules of the FSU curriculum. To ensure the curriculum had practical application, M&I program staff and

clients contributed vital feedback. Nurses and social workers from M&I and from Baltimore Medical System were trained and are now implementing the curriculum.

Model Developers. Maryland submitted the required letters for NFP and HFA requesting use of their programs. Maryland has received verification from both model developers of their approval to implement the model as proposed. These letters can be found in Appendix 7 and includes verification that the model developers have reviewed and agreed to the plan as submitted.

Current and Prior Experience with the Models. During the initial introduction of NFP in 1999, the City met many barriers such as lack of sufficient funding for training, supplies and equipment. Nurses were under union rules were not allowed to work out normal business hours which made it difficult to visit clients after hours and weekends. Climate around home visiting had changed due high infant mortality rate in Baltimore City. This resulted in support from the Governor, Mayor and Health Commissioner. Baltimore City has received federal funding for planning of NFP and anticipates implementation funding for home visiting in Baltimore City. In addition, union contracts have been revised to allow flexibility of scheduling home visits for weekends and after normal work hours. Relationships have been developed with Federal Qualified Health Centers (FQHCs), communities, and public and private agencies that will support the re-introduction and sustainability of NFP.

The Baltimore City Health Department is qualified to reintroduce NFP in to first time low-income moms because of the reasons stated above. Baltimore has developed a citywide strategy called B'more for Healthy Babies to decrease preterm births, infant sleep related deaths, and low birth weight births in the City. The B'more for Healthy Babies initiative, which began in 2008, involves strategies at the policy, services, community, and individual level. It provides the infrastructure needed to introduce NFP and includes the political will needed for successful implementation. Baltimore has in place important system support for NFP. First, a central referral system for all home visiting programs through a quasi-government agency is in place, Baltimore Health Care Access. This agency triages all prenatal and infant referrals and refers them to programs based on need and geographic location. Second, every home visiting program meets together monthly in a meeting called BabyStat where data is reviewed, concerns are addressed and new policy and materials that support the work are developed. This provides a collaborative and supportive environment for all programs while ensuring that the work being completed is consistent and up-to-date. Finally, the City has begun to standardize education, counseling, and monitoring across home visiting programs starting with infant safe sleep. Every home visiting program uses the same check list to ensure families have a safe sleeping environment for infants and the same materials for education. These materials and tools are also shared with all service providers who come in contact with families with infants so that messages are reinforced.

Programs are also collaborating to introduce Moms' clubs and group-based sessions using Baby Basics and other relevant materials. Baltimore City is poised to make an impact on the health of infants and families because the City has mobilized the right partners in a comprehensive, multi-level approach that incorporates critical evidence-based programs like NFP and use these programs for their intended audience. It is understood that no one program

will be able to achieve population-based change, but collectively the work can accomplish sustained improved health outcomes. The Baltimore City Health Department and the Family League have had continued discussion with Baltimore City Healthy Start, Inc. to ensure that with the implementation of the centralized referral system, there will not be duplication of services. The M&I staff are prepared for the re-introduction of NFP and staff has been involved in planning stages and understand their role and the intensive training required for NFP nurses. The staff do not anticipate difficulties with various case assignments.

In February 2000, DRU Healthy Families (DRU HF) Program received initial funding to support families using the research based Healthy Family America approach. The initial communities supported by the Program were Druid Heights, Reservoir Hill and Upton. At that time, the Union Baptist-Harvey Johnson Head Start Program was the program's host agency and the Families and Children Services of Central Maryland, Inc. was the lead agency. In its first few years of operation, DRU HF established a parent support group, a Creative Literacy and Learning Playgroup, and a Judy Center. In 2003, the program was credentialed by the Prevent Child Abuse America's Healthy Families America Credentialing Board. In 2004, the DRU Healthy Families Program accepted the challenge of expanding its area of responsibility for support to families and became the DRUM (Druid Heights/Reservoir Hill/Upton/Mondawmin). In December 2005, the program received (501 (c) (3) non-profit status.

The Baltimore City Health Department (BCHD) and the Family League of Baltimore City (FLBC) jointly work to coordinate home visiting services in Baltimore City. FLBC currently uses a combination of City and State dollars to fund five of the eight home visiting programs in Baltimore City, and normally distributes those funds through an annual RFP process which is open and competitive. This year, while transitioning the current home visiting programs to the HFA model, home visiting programs will NOT undergo an open and competitive procurement as they have in previous years. Instead, funding will be limited to those programs currently under contract with FLBC for home visiting services, who agree to participate in all training and accreditation activities necessary to become HFA affiliate programs. In FY2012, contracts with these programs will be extended and will address the expectations and requirements of the training and certification process. In the following fiscal year (FY2013), a competitive RFP process will be facilitated for HFA programs serving Baltimore City.

Under B'more for Healthy Babies, The Family League and Baltimore City Health Department are realigning home visiting resources to achieve a more equitable distribution with respect to geography, need, and evidence. The Family League has moved to an online grants management system this year -- to finalize the FY2012 contract, home visiting programs need to answer several programmatic questions, agree to a scope of work and schedule for transition to HFA, and provide program budget detail. Necessary forms are online and the information upload deadline will be June 27, 2011. The Family League will facilitate an open, competitive process for the provision of federally-named evidence-based home visiting services.

Plan for Fidelity. Fidelity of implementation will be monitored annually. Through a pre-enrollment and on-site analysis, the State will work with the at risk jurisdictions to assess program performance, explore the determinants of that performance, and identify ways to further improve program performance. An annual review process will be conducted. Through this

review process, communities will prepare an action plan that establishes key actions to improve program performance and address program requirements. Communities will also have the opportunity to offer feedback to the State about how policies and guidelines influence program implementation and performance at the state and community levels.

The State will require that polices must be in place in communities for program fidelity and submitted annually for review. In addition, service utilization statistics will be collected as part of the benchmarks captured. Maryland will collect individual-level demographic and service-utilization data on the participants in the identified programs as well as individual-level demographic and service-utilization data including family's participation rate in the home visiting program.

FLBC will contract out work to support an evaluator for the home visiting system. This evaluator will be responsible for (1) developing a full home visiting evaluation strategy including cataloging all indicators, determining data sources, developing a city-wide logic model that incorporates the different models for home visiting to design an evaluation and monitoring plan; (2) ensuring that there is a quality assurance plan for collecting data on program fidelity and regularly reporting it to BCHD and FLBC; and (3) identifying a reporting structure for all stakeholders and developing the framework, protocols, and templates for this reporting process.

Meeting an evidence-based model's initial implementation criteria is only the first step in ensuring program fidelity. Maryland is also developing a mechanism to track how services are delivered over time. Although EBHV models differ in terms of content and structure, they share certain core principles. Among the two models being implemented in Maryland, common indicators of high-quality implementation include:

- Belief that outcomes will be influenced by such factors as relatively low caseloads for home visitors;
- Strong supervision;
- Ability to actually enroll a high proportion of the families referred for service;
- Ability to consistently deliver home visits to enrolled families; and
- Relative stability among home visitors and supervisors.

In addition, many home visiting models set expectations regarding the importance of providing a sufficient service dosage to accomplish the programs' stated objectives. Several models, including HFA, NFP, and PAT, retain participants for multiple years in order to achieve the type of attitudinal and behavioral changes identified in their respective theories of change. Although there is variation across models about the appropriate content for each visit, all share common beliefs with respect to careful assessment and responsive and respectful practice.

Mathematica had developed a potential framework for building an integrated cross model fidelity data collection system. The indicators were developed collaboratively and cover three primary areas of focus: (1) program-level characteristics (including caseload dynamics and service structure), (2) direct service staff-level characteristics, and (3) participant-level characteristics and experiences. It is Maryland's intent to gather information from the local needs assessments and focus groups to finalize the system to ensure fidelity across both models.

Promising Approaches. Maryland is not proposing to use models that are promising approaches at this time.

Section IV: Implementation Plan for Proposed State Home Visiting Program

Engaging At-risk Communities. The State Team has held community meetings with local health department health officers (MCH staff) and the LMB director in the six most at risk communities (Baltimore City and Dorchester, Washington, Wicomico, Somerset, Prince George's counties). The six local health departments completed a self-assessment tool to assist them in further planning. This tool describes the current state of home visiting in their jurisdictions. They were also provided with information about the seven approved home visiting model programs, and guidelines for local plan development. Each has been asked to prepare local plans. Four of the six jurisdictions (all but Wicomico and Somerset) have requested planning funds to complete the local plan. The local plan is to include data on community assets, needs and risk factors, a description of the planning process and how home visiting links to larger early childhood systems initiatives, and a determination of the home visiting model of best fit. The six communities were asked to convene an advisory group on home visiting and to include all relevant stakeholders to assist with plan development.

The six communities are in various states of readiness:

- Baltimore City has submitted a plan to implement NFP and Healthy Families. The State has met with BCHD, the LMB, and the model developers to determine next steps. Baltimore City has completed focus groups and key informant interviews to inform their process going forward.

- The Dorchester County LMB in collaboration with the health department will complete a plan by the end of June 2011. They are using planning funds to facilitate meetings, and hold community meetings and focus groups.

- Prince George's County will use its planning funds to develop a local plan over the next year.

- Wicomico and Somerset Counties have submitted a tri-county plan (along with Worcester) to implement NFP and are also looking at an HFA expansion.

- Washington County will use planning funds to develop a local plan in the next fiscal year. The health department is interested in NFP, while the LMB would like to expand its Healthy Families Program.

- A consultant has been hired to work with the State to facilitate plan development and to provide technical assistance to local planning groups. The consultant will assist in the development of a planning process that includes the rest of the State to position Maryland to be as competitive as possible for FY 2011 funds.

At-risk communities have been engaged in decision-making about home visiting programs in Baltimore City in the following ways: (1) through consumer, provider, and home

visitor focus groups and in-depth interviews; (2) through input on the B'more for Healthy Babies Steering Committee; and (3) through neighborhood action teams.

1. Consumer and provider focus groups and in-depth interviews: In May and June 2011, the Baltimore City Health Department hired a focus group facilitator to conduct eight focus groups: two with women ages 18-24 and two with women ages 25-39, one with men ages 18-39, two with home visiting front line staff, and one with obstetric and pediatric providers. The facilitator also conducted ten in-depth- interviews with representatives from each of these target groups. Topics in the focus groups and interviews included: (1) how best to recruit and retain clients, (2) what information women and men look for from home visiting services, (3) frequency and timing of visits, (4) how best to link in with the formal health system provider network, (5) what can be done about refusal rates in home visiting services, and (6) the perception of in-home family planning. The findings will be used to help BCHD and FLBC fund client-driven home visiting services that better meet high risk needs and are better linked into a continuum of care for families.
2. Input on BHB Steering Committee. The BHB Steering Committee (described in more detail below) recruits community members to participate on the committee. A client from Maternal and Infant Nursing program sits on the committee. In June, the BHB program will put in place a Youth Advisory Committee that will be working on supporting teen pregnancy prevention work, including start up of the Nurse Family Partnership home visiting program. One representative from this committee will also participate on the BHB Steering Committee.
3. Neighborhood Action Teams. Just as the Steering Committee takes recommendations from social and medical provider groups and the Fetal and Infant Mortality review (FIMR) and Child Fatality Review (CFR) teams have put in place actions to reduce infant mortality, each of the BHB neighborhoods has in place a neighborhood action team that helps ensure that activities, including home visiting are oriented to the cultural concerns and health priorities of the communities in which the services are delivered.

Policy Development. Since the two national models chosen have built on those service delivery features and have been found to have a measurable impact on participant outcomes, Maryland will document and disseminate new evaluative findings being generated by the home visiting sites. HFA and NFP have the potential to provide policy and program planners with solid empirical data on a variety of issues. The State has a long standing commitment to policy issues and service delivery issues with birthing hospitals, FQHCs, and government/quasi government entities, community mobilization activities, and individual behavior change. The policy and standards set will be based on the national models chosen to be implemented (HFA and NFP) which will set the standard for quality and policy in Maryland. Programs will be required to implement with fidelity to these models.

Maryland also has the support of the Children's Cabinet. The cabinet is comprised of the Secretaries from the principal child serving agencies in Maryland. A listing of each Cabinet agency and the specific responsibilities each has for the Maryland Maternal, Infant and Early Childhood Home Visiting Program is enclosed in the Memorandum of Concurrence. The Governor's Office for Children (GOC) is the executive and administrative arm of the Children's Cabinet, responsible for assuring that State agencies are aligned with the Governor's priorities

for assuring that Maryland families have access to the supports and programs that will improve child and family well-being. The Memorandum of Concurrence found in Appendix 2 further supports needed policy for home visiting in Maryland. The members of the Cabinet include:

- Dr. Joshua M. Sharfstein, Secretary, Department of Health and Mental Hygiene Responsible for Title V-MCH Block Grant and related MCH programs including State Early Childhood Comprehensive Systems Program, the CDC Public Health Injury Surveillance and Prevention program, and the WIC program, all administered by the DHMH Family Health Administration; SAMHSA programs administered by the Mental Health Administration and the Alcohol and Drug Abuse Administration (State Single Agency for Substance Abuse Services; Medicaid/Children's Health Insurance program including the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program.
- Theodore Dallas, Secretary, Department of Human Resources, is responsible for Temporary Assistance for Needy Families, the Supplemental Nutrition Assistance Program and CAPTA Title I.
- Dr. Nancy S. Grasmick, State Superintendent of Schools, Maryland State Department of Education, Oversees staff who administer: The Child Care and Development Fund, the Maryland Head Start State Collaboration Office; and the Advisory Council on Early Childhood Education and Care (ECAC) as well as, Maryland's Individuals with Disabilities Education Act (IDEA) Part C and Part B Section 619, and the Elementary and Secondary Education Act Title I and State pre-kindergarten program.
- In addition, Margaret Williams- Executive Director of the Capta II Agency has signed a Memorandum of Concurrence providing support from 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 9. 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.

State Plan for Working with the National Model Developers. The State has been working with the evidence-based national model developers to develop benchmark indicators that will best capture the benchmark areas and constructs across the models that are anticipated to be used within the State.

Nurse Family Partnership (NFP): The City has been in contact with the model developers at NFP for information on the specific measures and scales currently being used. The BCHD will have lead responsibility to work with the NFP model program developers. NFP has indicated that they are working on additional measures that will track some of the ACA Home Visiting Program benchmark constructs are currently not being captured (e.g. information on childhood injury prevention), so these developments will be monitored closely.

Over the past several months, BCHD has been working with Lisa Gale Reyes to examine the feasibility and desirability of re-introducing NFP to Baltimore City. Several face-to-face meetings and multiple phone calls and emails related to developing an NFP implementation plan were held. Recently a Regional Nurse Consultant from NFP, Jobena Robinson, began providing technical assistance related to the details of service delivery. On May 24, 2011 a team from the Office of Maternal and Infant Care and the Assistant Commissioner for Maternal and Child Health went on a site visit to NFP programs in Trenton, New Jersey and Harlem, in New York City. Staff from these programs presented information on NFP project development and, in New York's case, how the program was brought to a significant scale in the City. The team used this information to work through additional revisions to the NFP plan for Baltimore City.

The NFP model developers plan to support the City's program with technical assistance. The home visiting team, particularly the M&I nurse supervisor, will work very closely with Ms. Robinson over the next year to get all four identified nurses trained in NFP in Denver and then supported through follow up supervision and online refresher material. Ms. Robinson will provide ongoing consultation through at least monthly consultation to the nurse supervisor as well as annual site visits. She will review data, and will work with the sites around quality improvement. Lisa Reyes will continue to provide administrative guidance and guidance to the program on sustainable resources for the long-term viability of the program. Other resources that will be made available to the Baltimore team through the National Service Office (NSO) will include:

1. Nursing education and consultation processes to build competencies of nurse home visiting staff;
2. Data collection, analytical, and reporting resources to support continuous quality improvement;
3. Marketing, communications and community relations support; and
4. Policy, financing, and government relations support.

Key steps that need to take place over the next year include:

1. Finalization of NFP plan;
2. Development of a sustainability and long term funding plan;
3. Development of a data management plan;
4. Development of contract with an evaluation advisor;
5. Hiring of one nurse;
6. Development of contract with Baltimore Medical Systems (one Spanish speaking nurse);
7. Purchase of materials;
8. Training in NFP for nurses and nurse supervisor;
9. Launch of evidence-based programs;
10. Implementation of NFP and development of QI plan; and
11. Ongoing monitoring and supervision and technical assistance as needed.

Healthy Families America (HFA): Maryland has been in contact with the model developers at HFA for information on the specific measures and scales that are currently used. The FLBC will have lead responsibility for working with the HFA model developers. Over the past several months, FLBC has worked closely by phone and through email with HFA Regional support representatives, Kate Whittaker and Lynn Kosonavich. On June 10, 2011- Ms. Kosonavich will attend an all-day planning session with FLBC and BCHD staff, and TA providers from NFP, to sort out logistical details, data support, and ongoing TA needs of the City's transition to EBPs.

Over the next year, FLBC will work with HFA to transition all HV program currently funded by FLBC to the HFA model. That transition will include trainings for home visitors (core HV training and integrated strategies training) and for supervisors, an advanced training for supervisors to assure quality of service, training in the Partners for a Healthy Baby curriculum, and mid-year coaching sessions for all home visitors that will address questions that arise during the shift to implementation of the evidence based home visiting programs (EBHVP).

Timing for these activities will entirely depend upon the funding availability. Maryland will be requesting technical assistance and support to be provided through the national models as needs arise.

Timeline for Materials. Upon release of the remaining federal funds, training materials and curriculum packages, Baltimore City and the Family League will purchase copies of curriculum and other needed materials for distribution during scheduled trainings. This will be done in as timely a manner as possible. The City would like to begin the initial training in July.

Initial and Ongoing Training. The Nursing Practice team at the Nurse-Family Partnership National Service Office provides both face-to-face and distance learning environments for the core education required of all Nurse-Family Partnership nurse home visitors and nurse supervisors prior to client enrollment. This specialized nurse training helps establish therapeutic relationships between the client and nurse home visitor, which in turn preserves the clinical integrity of the Nurse-Family Partnership model. New nurses also learn the visit-to-visit guidelines, which provide a consistent structure for each of the 64 planned home visits.

With assistance from supervisors and consultation from the National Service Office, nurses develop strong communication, personal relationship building, and problem-solving skills. Teams of nurses at local Nurse-Family Partnership implementing agencies meet regularly for case conferences, where they receive guidance from supervisors and colleagues to help them deliver the best possible care to their clients. Team meetings also help individual nurses cope with the stress inherent in working with clients who may have numerous personal and health-related crises, and who may be at high-risk for violence in their homes and neighborhoods.

In addition to Nurse-Family Partnership core education and the visit-to-visit guidelines, nurse home visitors meet regularly with their supervisors to develop a reflective practice and continuously assess their clinical nursing skills.

The HFA national office staff provide training and technical assistance to help communities implement the HFA model. The following training and technical assistance services are available and are planned for Baltimore City's transition, and will likely begin in fall 2011, depending on flow of federal dollars:

1. Core Training: A required training for all direct service staff and their supervisors/program managers within six months of hire, core training instructs staff in their specific roles. This training must be delivered by certified HFA trainers.
2. Assessment Core Training: Intensive training is provided to all program staff that will administer the assessment tool and provide supervisory support. The training focuses on building skills to engage parents in the assessment process, learning how to gather comprehensive information from parents in regard to their strengths and needs using a conversational style, and obtaining guided practice from a certified user to ensure the tool is administered in a standardized and reliable manner.
3. Home Visitor Core Training: Home Visitors Core Training is an in-depth, formalized training intended for home visitors of a Healthy Families America program. Four full days for the home visitor, plus an additional fifth day for supervisors and program managers, the training outlines the specific duties of the home visitor in their role within Healthy Families America. Topics include, but are not limited to: communication skills, assessing, addressing, and promoting positive parent-child relationships, creating a trusting alliance with families, goal setting, and strategies to enhance family functioning, address difficult situations, and ensure healthy childhood development.
4. Advanced Supervisor Training: Building on the core training for supervisors and program managers of HFA direct service staff positions (as described above), this training consists of three intensive days of in-person training, covering topics that include but are not limited to: the three types of supervision, quality management and improvement techniques, crisis management, case management and reflective practice.
5. Wraparound Training: Wraparound training complements core training and covers the additional training topics necessary to support home visitation staff in their duties. Twelve online self-paced modules are available to all program staff and provide 35 hours of training on important topics such as:

    - Keeping babies healthy and safe;
    - Fostering infant and child development;
    - Addressing domestic violence;
    - Preventing child abuse;
    - Recognizing substance abuse;
    - Responding to relationship issues; and,
    - Promoting mental health.

The Healthy Families America Learning Center website also helps staff and supervisors track successful course completion. Additionally, Supervisors receive notice when staff are nearing due dates to ensure timely receipt as required by HFA best practice standards.

6. Customized Advanced Trainings: Given the comprehensive nature of the model, many HFA sites find that staff benefit from additional training on a variety of topics to further advance their knowledge and skills. HFA national staff are available to deliver customized one, two or three day advanced training that are focused on specialized content areas and based upon need.
7. Partners for a Healthy Baby: A home visitor curriculum training that supplies service providers with strategies for supporting families during the prenatal and first year of an infant's life. This curriculum has been revised and adapted to be geared to Baltimore City and the issues women and families face in an urban environment. It uses the latest research out of Johns Hopkins University regarding postpartum depression, domestic violence, and safe sleep education. Working with the developer at the University of Florida, this adaptation is fully supported.
8. On-site Technical Assistance: HFA program sites can benefit by enlisting the expertise of a national staff person who will provide individually tailored support during a variety of phases (i.e. program planning, implementation, and evaluation). HFA national staff are available to provide individual on-site technical assistance to programs at any time upon request. This is the TA the City will receive from Lynn Kosonavich on June 10.
9. Advanced Supervisor Training: Building on the core training for supervisors and program managers of HFA direct service staff positions (as described above), this training consists of three intensive days of in-person training, covering topics that include but are not limited to: the three types of supervision, quality management and improvement techniques, crisis management, case management and reflective practice.

Other Training. In addition to these models, all home visiting program staff will be trained in a postpartum depression, trauma informed care screening, intervention, and referral process and in an intervention to reduce domestic violence. Home visiting clients will also be supported with Baby Basics.

Staffing: State. Through the initial funding allocation, Maryland hired several key staff to support the infrastructure of home visiting in the State. The project leader is 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, Maryland has hired an epidemiologist, a part time consultant and part time student.

Epidemiologist: This position has 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.

Program Consultant: The consultant provides technical expertise in home visiting and early childhood education and is assisting in the development and implementation of the State plan by helping local jurisdiction in plan development.

Graduate Student: This part-time position will provide support as needed to Project staff for on going needs assessment activities, project coordination, outreach and strategic planning. Specific duties include: providing staff support to the Project Director and staff for needs assessment, strategic planning and policy development; assisting the epidemiologist in conducting analyses and preparing reports; conducting surveys and focus groups as needed and analyzing results; and preparing and conducting presentations about the Project.

Staffing: Local. Baltimore City plans to use as many existing staff as possible to fulfill the program agenda. Three of the four NFP nurses are recent M&I hires and paid through other program budgets. All of the HFA home visiting staff will also transition from existing programs, so that there will be no need for additional salaries for these home visitors. In addition, high level management and supervision of the overall effort is fully supported through private and public sector grants.

To successfully implement the streamlined home visiting services, however, BCHD and FLBC will need to have some supportive infrastructure through the new federal funds, including several staff persons described below. Every effort will be made to find other permanent funding streams for these positions when the program is fully up and running. In addition, BCHD will need the following staff:

Community Health Nurse Supervisor I: Under the NFP model, there needs to be one supervisor for every four nurses and M&I currently only has one nurse supervisor. The existing nurse supervisor is responsible for all nurse and social work home visiting services in the City and cannot become a full time NFP supervisor.

Data Entry Operator: The NFP model requires extensive data collection and monitoring. The M&I program will need to hire one additional data entry operator to ensure high quality data management.

Sub-vendors. **S**ubcontracts will be developed with Baltimore HealthCare Access, Baltimore Medical Systems, and the Family League of Baltimore City. These subcontractors will be responsible for hiring and recruiting a minimal number of staff to support program implementation. BCHD has a great deal of experience contracting with each of these partners and can expedite processes as necessary.

Family League of Baltimore City

As the co-lead on all aspects of B'more for Healthy Babies, FLBC will need additional support for transitioning the current home visiting sub-contractors to Healthy Families America. There are several in-kind positions; however, they will need funding for a Program Coordinator and Evaluator. The Program Coordinator position will likely be shared by two existing staff, the

community program officer for BHB and HV (currently .5FTE), and the project coordinator for B'more Fit (currently 0.5 FTE), who has background in contract compliance and oversight.

Evaluator – FLBC will contract out work to support an evaluator for the full home visiting system. This evaluator will be responsible for (1) developing a full home visiting evaluation strategy including cataloging all indicators, determining data sources, developing a city-wide logic model that incorporates the different models for home visiting, designing an evaluation and monitoring plan; (2) ensuring that there is a quality assurance plan for collecting data on program fidelity and regularly reporting it to BCHD and FLBC; (3) identifying a reporting structure for all stakeholders and developing the framework, protocols, and templates for this reporting process.

Baltimore Health Care Access

Office Assistants: BHCA will hire two office assistants to facilitate data entry to take on the added demands of managing the citywide central data management and referral system. The office assistant staff will be supervised by the MCH Data Manager and the contract will report to BCHD.

Baltimore Medical Systems

This federally qualified health center is a significant BHB partner and currently offers nurse home visiting services. To be sure that the private and public sector are offering equivalent services, one NFP nurse will be assigned to BMS. BMS serves a large Latina community and is adept at crossing the cultural barriers that might exist.

The Estimated Number of Families Served. There are 484 evidence based home visiting slots currently available in Baltimore City. When the transition to NFP and HFA has been completed, there will be an additional 370 additional evidence based slots available to meet the needs of families in the most at risk communities. There are currently 473 families served by FLBC funded home visiting programs. M&I serves and additional 400, inclusive of future NFP clients. In year one it is expected that Baltimore City NFP will serve additional 60-80 women.

A plan for identifying and recruiting participants. The plan is to change the distribution of home visiting services so that all four quadrants of the city will have access to evidence-based and promising programs. A vulnerability index will be used to ensure that women most in need of service are prioritized. A resource development strategy to identify potential new funding in the future for home visiting in Baltimore City is one of multiple strategies that need to be in place to ensure the wellbeing of pregnant women, fathers, and infants in the City.

Pregnant and postpartum women will be triaged into home visiting services through a vulnerability index. This index will be used to triage pregnant women and infants into home visiting programs. The vulnerability index is based on the history of fetal or infant loss, physical illness, domestic violence, history of two or more preterm births, multiple gestation, maternal age, current CPS case, mental health, STDs, substance abuse, birth spacing, and

documentation of smoking. The triage criteria are base on based on the Strategy to Improve Birth Outcomes (SIBO) data and the Domestic Violence Emergency (DOVE) Project guidelines.

Baltimore Health Care Access serves as the City's centralized intake and assessment mechanism. There are several ways that pregnant women and infants enter the system.

(1) Prenatal risk assessments are faxed to Baltimore Health Care Access from a prenatal care clinic;

(2) A referral is made from a City clinic (family planning) and faxed to BHCA;

(3) A current home visiting program alerts BHCA that they have identified a pregnant or postpartum mom in need of services through door-to-door recruitment[4];

(4) An infant referrals is made from local delivery hospitals (largely NICUs); and

(5) Self-referrals are also made.

All programs except for Baltimore City Healthy Start, Inc. use agreed upon risk criteria to ensure that moms who need nurse home visiting services receive these services. Baltimore City Healthy Start, Inc. enrolls any mom they find in their assigned census tracts, as long as she agrees to services.

High Quality Clinical Supervision and Reflective Practice. Both NFP and HFA have built in high quality clinical supervision and reflective practice and both national programs are fully engaged in providing Baltimore the technical assistance necessary to put in place a successful home visiting system. In addition, the contracted evaluator will provide a unique perspective as an outside and fully objective vantage point. The evaluator will work with FLBC and with BCHD to ensure that a continuous quality improvement system is in place and that program managers are following the models with fidelity. Finally, the program request has built in the necessary staffing to ensure that management is not overstretched and unable to fully support home visiting staff.

Attrition Rates for Participants. The focus groups conducted in the past two months have provided critical information for minimizing attrition rates of participants enrolled in the program. There are a number of questions that seek to ascertain what clients want from home visiting and how to keep them interested in the services. In addition, Baltimore will work closely with medical and social service providers to reinforce the messaging that clients should remain in services through the duration of the program. Finally, programs currently monitor attrition rates and this will continue as the standard.

Of note, since the BHB strategy is in place, clients will be offered new services that should be of interest and will reinforce the importance of home visiting including improving literacy, attending group-based weight loss sessions, peer-to-peer support programs for postpartum depression, and Baby Basics moms clubs. BHB will also continue to have in place a mass media campaign reinforcing important messages learned through home visiting (smoking cessation, early entry into prenatal care, safe sleep, etc.)

[4] this is one area to improve in order to ensure all moms are known by BHCA who are recruited by home visiting programs

Estimated Timeline to Reach Caseload. Since the City is not introducing new home visiting slots, but using the current slots in an evidence-based manner, a long timeline for reaching maximum caseload is not anticipated. There will, however, be significant training in year one. It is estimated that 75-80% clients in year one will be transitioned to EBHV programs and by year two, 90-100% capacity will be reached.

Operational Plan for Coordination. Baltimore City has in place a plan for coordinating among existing programs and streamlining use of resources across the community for the purpose of improving birth outcomes. The organizational structure of home visiting in Baltimore is built in such a way that three targeted communities and citywide providers, including home visitors have the technical/content/community experts to ensure all approaches and actions are evidence-based and aligned with community needs. An organizational chart of City home visiting can be found in Appendix 8. Home visiting programs will rely on the BabyStat committee and the supportive resources from the BHB Steering Committee and Core Implementation Team as well as strong State support.

- **The B'more for Healthy Babies Steering Committee** (a list of members can be found in Appendix 10) acts as the key decision-making authority for the strategic direction of BHB and supports the actions of the Core Implementation Team and ad hoc working groups. This committee, made up of leaders from Mayor's cabinet, is responsible for mobilizing and coordinating resources and in prioritizing recommendations from all citywide groups working to improve birth outcomes. The Committee includes a cross-section of city agencies, including federally qualified health centers, delivery hospitals, home visiting programs, business leaders, and community members. It is co-chaired by the Deputy Mayor and the Health Commissioner.

- **The Core Implementation Team** manages the day-to-day operations of BHB. This includes ensuring the detailed implementation plan and budget is effectively completed, implemented, and monitored. Baltimore City Health Department (BCHD) and the Family League of Baltimore City (FLBC) co-lead the Core Implementation Team. Members include Johns Hopkins Center for Communication Programs, home visiting and community-based program representatives, and invited experts, depending on the agenda.

- **BabyStat:** BabyStat brings together managers of Baltimore City and Maryland State agencies and community organizations involved in perinatal health in Baltimore City. BabyStat is an inter-agency group convened by the Baltimore City Health Department and is currently chaired by the Assistant Commissioner for Maternal and Child Health at BCHD and Director of Community Health Initiatives at FLBC. Meetings are held once a month and are primarily designed to help track and monitor home visiting programs in Baltimore City. A sub-committee called the Home Visiting Working Group has been in place since the fall working through some of the details of the Baltimore City Home Visiting Plan.

- **Ad-hoc Work Groups** are used periodically to support the needs of the Steering Committee and the Core Implementation Team. The working groups are composed of persons who represent the high impact areas of the birth outcomes plan and who play a

key role in the plan's implementation. To date, there are three groups that meet regularly: the Safe Sleep Coalition, the Teen Pregnancy Prevention Task Force, and the B'more Fit for Healthy Babies Coalition, dedicated to management of obesity among postpartum women.

- **Neighborhood Action Teams (NAT)** are in place in each of the selected communities. The NATs oversee that the three BHB community-based programs are on track and are linked directly to the FIMR process.

Data Systems. The State intends to procure a commercial off-the-shelf (COTS) data system to enable the tracking, analysis, and reporting of home visiting program data. Products from several vendors are currently being reviewed. Home visiting staff are also meeting with jurisdictions with existing home visiting programs to understand their data system needs. Maryland will then develop system requirements and will proceed through the State procurement process in anticipation of utilizing FY2011 funding to purchase and customize the system for Maryland's use. Initially expected is to utilize the system to capture and track benchmark data for the home visiting programs funded through the ACA Home Visiting Grant. The state hopes to allow jurisdictions not funded through the grant to track information on their home visiting programs through the data system. This will facilitate their ability to improve their programs' effectiveness, and will allow increased visibility into the progress being made by home visiting programs around the State.

Local Data Systems. Under previous home visiting efforts, the City attempted to collect data across a single set of indicators for home visiting programs. This proved to be a challenge for the following reasons: there were multiple programs with multiple goals, there were multiple database systems, and, perhaps most significantly, there was not a person with evaluation expertise assigned to oversee monitoring and evaluation of home visiting citywide. BCHD and FLBC propose contracting with an evaluation expert to work from the beginning with the partners to devise a monitoring system that is meaningful as well practical and flexible to meet the needs of the programs, funders, and city officials.

Home Visiting Program (HVP) data is currently being collected by programs using a variety of manual, hand-written methods. Each program follows its own standard and method for data collection while interviewing mothers. Each program provides its own set of forms and instructions to its field staff for collecting data. While some effort has been made to confer and collaborate on data collection methods and tools, efforts have generally been fragmented, with each program establishing its own criteria for gathering and compiling data. Data is gathered from the field and returned to the office where it is compiled manually in preparation for data entry into one or more database programs –some of which directly serve the needs of the HVP (Insight, ETO) while others serve separate needs specific to the programs themselves. There is some evidence that, in addition to data entry duplication, data collection efforts may be duplicated.

BCHD and FLBC are proposing the automation of the Data Collection Process by introducing a combined hardware and software solution that will consolidate and standardize data collection methodologies and will provide a single, common technology platform for

gathering, compiling and processing (entering) data. BCHD and FLBC propose procuring and distributing Tablet Computers as the hardware interface to a Web Application that provides a Web Form for data entry. Access to the internet will be provided by Wireless Anywhere Service using the Tablet's native browser or any of the standard commercially available browsers to connect to the Web App Web Form. HVPs will use Tablet Computers with a Web Form to enter data directly into the database of choice. Cost analysis of hardware and software solutions has been developed and some local foundations have expressed interest in cost-sharing on this initiative.

Approach to Implementation with Fidelity. Baltimore has in place important system support for NFP. In place is a central referral system for all home visiting programs through a quasi-government agency, Baltimore Health Care Access (BHCA). This agency triages all prenatal and infant referrals and refers them to programs based on need and geographic location. Second, every home visiting program meets together monthly in a meeting called BabyStat where data is reviewed, discuss successes/concerns, and develop new policy and materials that support this work. This provides a collaborative and supportive environment for all programs while ensuring that the work being done is consistent and up-to-date. Finally, the City has begun to standardize our education, counseling, and monitoring across home visiting programs starting with infant safe sleep. Every home visiting program uses the same check list to ensure families have a safe sleeping environment for infants and the same materials for education. These materials and tools are also shared with all service providers who come in contact with families with infants so that messages are reinforced. Programs are also collaborating to introduce Moms' clubs and group-based sessions using Baby Basics and other relevant materials. Baltimore City is poised to make an impact on the health of infants and families because the right partners have been mobilized in a comprehensive, multi-level approach that incorporates critical evidence-based programs like NFP and use these programs for their intended audience. We know that no one program will be able to achieve population-based change, but collectively this work can accomplish sustained improved health outcomes.

Home Visiting Program (HVP) data is currently being collected by programs using a variety of manual, hand-written methods. Each program follows its own standard and method for data collection while interviewing mothers. Each program provides its own set of forms and instructions to its field staff for collecting data. While some effort has been made to confer and collaborate on data collection methods and tools, efforts have generally been fragmented, with each program establishing its own criteria for gathering and compiling data. Data is gathered from the field and returned to the office where it is compiled manually in preparation for data entry into one or more database programs –some of which directly serve the needs of the HVP (Insight, ETO) while others serve separate needs specific to the programs themselves. There is some evidence that, in addition to data entry duplication, data collection efforts may be duplicated.

Anticipated Challenges to Maintaining Fidelity. Some potential challenges the City may have to maintaining quality and fidelity is that home visiting services still will be managed through two entities, the Family League of Baltimore City and the Baltimore City Health Department. The two organizations, however, bring particular skills and connections to the

home visiting system and both are critical to its success. The very strong working relationship between staff in both programs will mitigate potential conflicts in operations.

It is believed that through reducing the number of models, program policies and protocols, data management systems, and curricula that maintaining quality and fidelity will be less complex than in the past. Hiring an evaluator will be critical to ensuring from the start that the correct goals, objectives, and indicators are in place within a practical data monitoring system. Baltimore will be able to monitor programs in a variety of ways, and will maintain monthly BabyStat meetings for data monitoring, trouble-shooting, and sharing success stories. Both NFP and HFA also will be providing a great deal of technical assistance including Advanced Supervisory Training, contract compliance oversight, and access to nationally tested resources.

Collaborative Partners. Maryland is well positioned and has demonstrated collaboration and partnerships at the State level. Early childhood stakeholders in Maryland have a history of commitment to the process of creating a comprehensive early childhood system that delivers integrated, family focused early childhood services throughout the state. ECAC is the statewide body commissioned to specifically address comprehensive early childhood systems development. However, as briefly discussed below, Maryland continues the process of collaboratively addressing early childhood issues through several partnerships and planning efforts. These partnerships include ECAC and the Three Year Action Agenda for School Readiness, as well as strategic planning to address early childhood mental health issues. The Ready at Five Partnership and Maryland family Network are addressing early child care and parent education issues through trainings and partnerships as well as public engagement campaigns.

In 2000, the Early Childhood Mental Health Steering Committee developed a strategic plan for infusing mental health into early childhood settings. The plan, which addresses mental health and socio-emotional issues in children, ages 0 through 5, the plan includes a state funded behavioral support system of mental health consultants. The Steering Committee is co-chaired by representatives from the State Departments of Health and Mental Hygiene (DHMH) and the Maryland State Department of Education. Committee members include: parents, families, advocates, early childhood providers, state and local child and family serving agencies, including the Title V Agency, mental health providers and the faith community.

The Office of Child Care convenes the Child Care Development Fund to put forth a plan for caring for the needs of at risk children in Maryland, including programs and services that effect children with special needs integrated into family support services and the preschool classroom. OCC works closely with the MCH Title V Agency to provide and integrate early education and health into child care settings.

The Maryland State Department of Education is the funding agency for HIPPY, PAT and HFA programs in Maryland. Although no strong coordinating body is in place, the Home Visiting Consortium and the new Home Visiting Alliance pull together the public and private partners to ensure the work of home visiting is clear and with direction. An annual home visiting conference and on-going advocacy are objectives of these groups.

Past and ongoing collaborative efforts have focused on the goal of assuring access to quality health care service and health education for women and children. Examples of selected goals for home visiting related to past partnerships and activities include supporting parents in being active and willing partners inn their child's physical health and well-being by: improving maternal, infant, and early childhood health; identifying and provide comprehensive services to improve outcomes for families who reside in at risk communities; strengthening parent-child relationships; strengthening and improve programs and activities for families receiving home visiting services, and; ensuring an early childhood system of care that is coordinated and that meets the needs of Maryland's families and children in order for Maryland's Home Visiting Program to contribute to developing a comprehensive, high-quality early childhood system that promotes maternal, infant, and early childhood health, safety, and development and strong parent-child relationships. A detailed list of state partners and collaborative efforts can be found in section 6.

Below is a list of collaborative public and private partners in Baltimore City. These partners have some together to strengthen the foundation of early childhood systems and assure healthy moms and babies. A full spreadsheet of Steering Committee members for B-more for Healthy Babies can be found in Appendix 10.

- Citizens and leaders
- Mayor's/Political Office
- Health Department
- Local Management Boards
- Health Insurance Agencies
- Substance Abuse Systems, Inc.
- Managed Care Organizations
- Housing
- Dept of Social Services
- Mental Health Systems
- Pediatricians/Adolescent physicians/Obstetricians
- Home visiting and community outreach programs
- Schools
- Faith-based organizations
- Businesses
- Public Safety Departments

Assurances.

- Maryland assures that the State home visiting program is designed to result in participant outcomes noted in the legislation;
- Maryland assures that individualized assessments will be conducted of participant families and that services will be provided in accordance with those individual assessments;

- Maryland assures that services will be provided on a voluntary basis;
- Maryland assures that the State will comply with the Maintenance of Effort Requirement; and that priority will be given to serve eligible participants who:
    - Have low incomes;
    - Are pregnant women who have not attained age 21;
    - Have a history of child abuse or neglect or have had interactions with child welfare services;
    - Have a history of substance abuse or need substance abuse treatment;
    - Are users of tobacco products in the home;
    - Have, or have children with, low student achievement;
    - Have children with developmental delays or disabilities; and- when applicable;
    - Are in families that include individuals who are serving or have formerly served in the armed forces, including such families that have members of the armed forces who have had multiple deployments outside of the United States.

Research and Evaluation. The legislation does not require States to conduct any evaluation other than to conduct research on promising approaches. The State has provided assurances in the initial FOA of participation in any national evaluation activities. It is the Secretary's intent to fund and carry out the national evaluation described in the legislation. However, HRSA and ACF will not prohibit a State from conducting research and evaluation outside of the national evaluation. If the State intends to conduct research or evaluation activities using funding under the MIECHV Program, the State should describe those activities in the Implementation Plan as stated in the guidance regarding information necessary to provide any proposed research and evaluation activities.

Section V: Plan for Meeting Legislatively-Mandated Benchmarks

Maryland's plan for measuring and collecting data for each construct in the six benchmark areas is centered primarily on process measures which can be used to demonstrate quantifiable improvement in the delivery of services by each home visiting program. The data will be collected on each enrolled family, not sampled, and will be loaded into a State home visiting data system. This system will be used to perform data analysis and create reports for State and local planning and evaluation purposes. The State currently does not have baseline data for these benchmark constructs. Data collected during the first year will be used to establish baseline values for each construct. These baseline data will then be used to develop targets for home visiting program improvement.

The specific descriptions for each benchmark construct are described next, followed by the plans for ensuring data collection quality, data analysis, and reporting. The final section describes plans for ensuring data safety.

Benchmark Area I. Improved Maternal and Newborn Health

(i) Prenatal Care:

A. *Proposed Measure:*
The proposed measure for this construct is the percent of pregnant women referred for prenatal care.

B. *Calculation:*
The percent of pregnant women referred for prenatal care will be calculated as follows:

(# of pregnant women referred for prenatal care/# of pregnant women without prenatal care at enrollment) * 100

C. *Measurement Instrument:*
Not Applicable

D. *Definition of Improvement:*
Improvement will be defined as an increase in the percent of pregnant women referred for prenatal care between the first year of implementation and the three-year mark.

E. *Rationale:*
Prenatal care is addressed in the Healthy People 2020[5] plan. Objective MICH-10 is to "Increase the proportion of pregnant women who receive early and adequate prenatal care". In the year 2009, 80% of live births in Maryland were to women who began prenatal care in the first trimester, and 4.7% were to women who received late (third trimester) or no prenatal care.[6]

F. *Means of Data Collection:*
Data will be collected by the home visitor within one month of enrollment or upon notification of pregnancy.

(ii) Parental use of alcohol, tobacco, or illicit drugs:

A. *Proposed Measure:*
The proposed measure for this construct is the percent of mothers referred for substance abuse services.

B. *Calculation:*
The percent of mothers referred for substance abuse services will be calculated as follows:

(# of mothers referred for substance abuse services/# of enrolled mothers in need of referral) * 100

[5] Healthy People 2020, Available at: http://www.healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicId=26
[6] Maryland Vital Statistics Annual Report, Available at: http://vsa.maryland.gov/doc/09annual.pdf .

C. *Measurement Instrument:*
The Life Skills Progression: Substance Use/Abuse and Tobacco Use Scales (24 & 25) will be used.[7]

This instrument is specifically designed so that individual scales can be used. The validity and reliability of this instrument has been documented.

D. *Definition of Improvement:*
Improvement will be defined as an increase in the percent of mothers referred for substance abuse services.

E. *Rationale:*
Maternal use of alcohol, tobacco and illicit drugs is addressed in the Healthy People 2020 as Objective MICH-11: "Increase abstinence from alcohol, cigarettes, and illicit drugs among pregnant women".[8] Among Maryland women who gave birth in 2009, 10% reported alcohol consumption during pregnancy, and 9% reported cigarette smoking during pregnancy.[9]

F. *Means of Data Collection:*
The data will be collected by the home visitor within one month of enrollment and quarterly.

(iii) Preconception Care:

A. *Proposed Measure:*
The proposed measure for this construct is the percent of mothers referred for preconception care.

B. *Calculation:*
The percent of mothers referred for preconception care will be calculated as follows:

(# of mothers referred for preconception care/# of enrolled nonpregnant mothers who have not already initiated preconception care) * 100

Pregnant women will be excluded from the calculation.

C. *Measurement Instrument:*
Not applicable

D. *Definition of Improvement:*

[7] Wollesen, L., and K. Peifer. 2006. *Life Skills Progression™ (LSP): An outcome and intervention planning instrument for use with families at risk.* Baltimore, MD: Paul H. Brookes Publishing Co., Inc.
[8] Healthy People 2020, Available at: http://www.healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicId=26
[9] Maryland PRAMS, Available at: http://fha.maryland.gov/pdf/mch/2009_PRAMS_Report_births.pdf

Improvement will be defined as an increase in the percent of mothers referred for preconception care.

E. *Rationale:*
This measure is included in the Healthy People 2020 as Objective MICH-16: "Increase the proportion of women delivering a live birth who received preconception care services and practiced key recommended preconception health behaviors".8

F. *Means of Data Collection:*
The data will be collected by the home visitor within one month of enrollment and quarterly.

(iv) Inter-birth intervals:

A. *Proposed Measure:*
The proposed measure for this construct is the percent of mothers receiving family planning information.

B. *Calculation:*
The percent of mothers receiving family planning information will be calculated as follows:

(# of mothers receiving family planning information/# of mothers enrolled) * 100

C. *Measurement Instrument:*
Not applicable

D. *Definition of Improvement:*
Improvement will be defined as an increase in the percent of mothers receiving family planning information.

E. *Rationale:*
Increased inter-birth intervals is addressed in the Healthy People 2020 as Objective FP-5: "Reduce the proportion of pregnancies conceived within 18 months of a previous birth".[10] Family planning services enable individuals to achieve desired birth spacing and family size and contribute to improved health outcomes for infants, children, and women[11].

F. *Means of Data Collection:*
The data will be collected by the home visitor within one month of enrollment and quarterly.

[10] Healthy People 2020, Available at: http://www.healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicId=26
[11] Centers for Disease Control and Prevention. Achievement in public health, 1900–1999: Family planning. MMWR Weekly. 1999 Dec 3;48(47):1073-80.

(v) Screening of maternal depressive symptoms:

A. *Proposed Measure:*
The proposed measured is the percent of mothers screened for maternal depressive symptoms.

B. *Calculation:*
The percent of enrollees screened for maternal depression will be calculated as follows:

(# of mothers screened for depression/# of mothers enrolled) * 100

C. *Measurement Instrument:*
The Edinburgh Postnatal Depression Scale (EPDS) will be administered to mothers in the prenatal and postpartum stages.

The validity of the EPDS has been documented[12,13].

Mothers not in the prenatal or postpartum stage will be assessed using a two-question screening tool recommended by the U.S. Preventive Services Task Force that is considered as effective as other screening tools[14,15]. The following questions will be asked:

(i) Over the past 2 weeks, have you felt down, depressed, or hopeless?
(ii) Over the past 2 weeks, have you felt little interest or pleasure in doing things?

D. *Definition of Improvement:*
Improvement will be defined as an increase in the percent of mothers screened for depression.

E. *Rationale:*
Depressive symptoms among caregivers result in adverse outcomes for children. Seven percent of Maryland mothers who gave birth in 2009 were diagnosed for postpartum depression.[16]

F. *Means of Data Collection:*
The data will be collected by the home visitor within one month of enrollment and quarterly.

[12] Logdson MC, Wayne MU, Nering M. Validation of Edinburgh Postnatal Depression Scale for Adolescent Mothers. *Arch Women Ment Health* 2009; 12: 433-440
[13]Jardri R, Pelta J, Maron M, et al. Predictive validation study of the Edinburgh Postnatal Depression Scale in the first week after delivery and risk analysis for postnatal depression, J Affect Disord 2006; 93:169-76.
[14] U.S. Preventive Services Task Force. Screening for depression in adults: U.S. Preventive Services Task Force Recommendation Statement. *Ann Intern Med* 2009;151:784-792.
[15] Whooley MA, Avins AL, Miranda J, Browner WS. Case-finding instruments for depression. Two questions are as good as many. *J Gen Intern Med* 1997; 12:439-45.
[16] Maryland PRAMS, Available at: http://fha.maryland.gov/pdf/mch/2009_PRAMS_Report_births.pdf

(vi) Breastfeeding:

A. *Proposed Measure:*
The proposed measure is the percent of mothers receiving breastfeeding education.

B. *Calculation:*
The percent of mothers receiving breastfeeding education will be calculated as follows:

(# of mothers receiving breastfeeding education/# of mothers enrolled) * 100

Women who are not in the prenatal or postpartum stage will be excluded from the calculation.

C. *Measurement Instrument:*
Not applicable

D. *Definition of Improvement:*
Improvement will be defined as an increase in the percent of mothers receiving breastfeeding education between the first year of implementation and the three-year mark.

E. *Rationale:*
Increasing the rate of breastfeeding is addressed in the Healthy People 2020 as Objective MICH-21: "Increase the proportion of infants who are breastfed". [17]The benefits of breastfeeding have been well documented. Lower rates of morbidity including ear infections, respiratory infections, gastroenteritis and necrotizing enterocolitis are some of those benefits. More recent studies link breastfeeding to favorable pediatric weight gain status. In 2009, eighty-one percent of Maryland mothers reported that a doctor, nurse, or other healthcare worker talked with them about breastfeeding during prenatal visits. Sixteen percent of mothers never breastfed.[18]

F. *Means of Data Collection:*
The data will be collected by the home visitor within one month of enrollment and quarterly.

(vii) Well-child visits:

A. *Proposed Measure:*
The proposed measure for this construct is the percent of children referred for well-child visits.

B. *Calculation:*
The percent of children referred for well-child visits is calculated as follows:

[17] Healthy People 2020, Available at: http://www.healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicId=26
[18] Maryland PRAMS, Available at: http://fha.maryland.gov/pdf/mch/2009_PRAMS_Report_births.pdf

(# of children referred for well-child visits/# of children enrolled)

C. *Measurement Instrument:*
Not applicable

D. *Definition of Improvement:*
Improvement will be defined as an increase in the percent of children referred for well-child visits between the first year of implementation and the third year mark.

E. *Rationale:*
Increasing the number of children who have healthcare is addressed in the Healthy People 2020 as Objective AHS-5.2: "Increase the proportion of children and youth aged 17 years and under who have a specific source of ongoing care".[19] Well-child visits provide opportunities for a child's developmental delay or disability to be detected, which can lead to treatment, lessening the future impact on both the child and family[20].

F. *Means of Data Collection:*
The data will be collected by the home visitor within one month of enrollment and quarterly.

(viii) Maternal and child health insurance status:

A. *Proposed Measure:*
The proposed measure for this construct is the percent of mothers and children assisted in obtaining health insurance.

B. *Calculation:*
The percent of mothers and children assisted in obtaining health insurance is calculated as follows:

(# of mothers and children without health insurance who were assisted/# of enrolled mothers and children without insurance) *100

C. *Measurement Instrument:*
Not applicable

D. *Definition of Improvement:*
Improvement will be defined as an increase in the percent of mothers and children assisted in obtaining health insurance between the first year of implementation and the third year mark.

E. *Rationale:*

[19] Healthy People 2020, Available at: http://www.healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicId=1
[20] American Academy of Pediatrics, "Developmental Surveillance and Screening of Infants and Young Children *Pediatrics* 2001; 108: 192-195.

Increasing the number of persons with health insurance is addressed in the Healthy People 2020 as Objective AHS-1: "Increase the proportion of persons with health insurance". Lack of health insurance affects access to health care.[19] Between the years 2008 and 2009, 6% of Maryland children less than 6 years of age were uninsured.[21]

F. *Means of Data Collection:*
The data will be collected by the home visitor within one month of enrollment and quarterly.

Benchmark Area II. Child Injuries, Child Abuse, Neglect, or Maltreatment and Reduction of Emergency Department Visits

(i) Visits of children to the emergency department from all causes:

A. *Proposed Measure:*
The proposed measure is the percent of children with visits to the emergency department.

B. *Calculation:*
The percent of children with visits to the emergency department is calculated as follows:

(# of children with visits to the emergency department/ # of children enrolled) * 100

C. *Measurement Instrument:*
Not applicable

D. *Definition of Improvement:*
Improvement will be defined as a decrease in the percent of children with visits to the emergency department between the year of implementation and the third year.

E. *Rationale:*
Reducing nonfatal injuries is addressed in the Healthy People 2020 plan. Objective IVP-1.3 is to "Reduce emergency department visits for nonfatal injuries".[22]

F. *Means of Data Collection:*
Data will be collected by the home visitor within one month of enrollment and quarterly.

(ii) Visits of mothers to the emergency department from all causes:

A. *Proposed Measure:*
The proposed measure is the percent of mothers with visits to the emergency department.

[21] Maryland Health Care Commission, Available at: http://mhcc.maryland.gov/health_insurance/insurance_coverage/insurance_report_2009_20110120.pdf

[22] Healthy People 2020, Available at: http://www.healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicId=24

B. *Calculation:*
The percent of mothers with visits to the emergency department is calculated as follows:

(# of mothers with visits to the emergency department/ # of mothers enrolled) * 100

C. *Measurement Instrument:*
Not applicable

D. *Definition of Improvement:*
Improvement will be defined as a decrease in the percent of mothers with visits to the emergency department between the year of implementation and the third year.

E. *Rationale:*
Reducing nonfatal injuries is addressed in the Healthy People 2020 plan. Objective IVP-1.3 is to "Reduce emergency department visits for nonfatal injuries".[23]

F. *Means of Data Collection:*
Data will be collected by the home visitor within one month of enrollment and quarterly.

(iii) Information provided or training participants on prevention of child injuries

A. *Proposed Measure:*
The proposed measure is the percent of enrollees receiving training or information on child injury prevention.

B. *Calculation:*
The percent of mothers receiving training or information on child injury prevention will be calculated as follows:

(# of mothers receiving training on child injury/# of mothers enrolled)*100

C. *Measurement Instrument:*
Not applicable

D. *Definition of Improvement:*
Improvement will be defined as an increase in the percent of mothers receiving training or information on child injury prevention.

E. *Rationale:*
Reducing fatal and nonfatal injuries is addressed in the Healthy People 2020 plan. Objective IVP-1 is to "Reduce fatal and nonfatal injuries".[23] Home visitors will be trained to provide information to parents about safety practices in the home.

F. *Means of Data Collection:*

[23] Healthy People 2020, Available at: http://www.healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicId=24

Data will be collected by the home visitor within one month of enrollment and quarterly.

(iv) Incidence of child injuries requiring medical treatment

A. *Proposed Measure:*
The proposed measure is the percent of children receiving medical treatment for injuries.

B. *Calculation:*
The percent of children receiving medical treatment for injuries will be calculated as follows:

(# of children receiving medical treatment/# of children enrolled) *100

C. *Measurement Instrument:*
Not applicable

D. *Definition of Improvement:*
Improvement will be defined as a decrease in the percent of children receiving medical treatment for injuries.

E. *Rationale:*
Reducing nonfatal injuries is addressed in the Healthy People 2020 plan. Objective IVP-1 is to "Reduce fatal and nonfatal injuries".[24] In 2008, the rate of emergency department visits due to unintentional injuries among Maryland children less than 4 years of age was 10,240 per 100,000 population.[25]

F. *Means of Data Collection:*
Data will be collected by the home visitor within one month of enrollment and quarterly.

(v) Reported suspected[26] maltreatment for children in the program

A. *Proposed Measure:*
The proposed measure is the percent of children with suspected maltreatment.

B. *Calculation:*
The percent of children with suspected maltreatment will be calculated as follows:

(# of children with suspected maltreatment/ # of children enrolled)* 100

C. *Measurement Instrument:*
Not applicable

D. *Definition of Improvement:*

[24] Healthy People 2020, Available at: http://www.healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicId=24
[25] Maryland Department of Health and Mental Hygiene
[26] Allegations of child abuse, neglect, or maltreatment that were investigated but not necessarily substantiated

Improvement will be defined as a decrease in the percent of children with suspected maltreatment.

E. *Rationale:*
Objective IVP-38 in Healthy People 2020 is to "Reduce nonfatal child maltreatment".[24]

F. *Means of Data Collection:*
Linkage to the Maryland Department of Human Resources (DHR) Child Abuse and Neglect Database will enable the program to identify those children enrolled in the home visiting program for whom there are documented suspected cases of maltreatment. The data will be obtained from DHR at the one-year mark. DHR has provided a Letter of Intent to enter into a Memorandum of Understanding (MOU) with DHMH to perform this data linkage. The MOU will be completed by July 1, 2011. A copy of the Letter of Intent is provided in Appendix 15.

(vi) Reported substantiated[27] maltreatment for children in the program

A. *Proposed Measure:*
The proposed measure is the percent of children with substantiated maltreatment.

B. *Calculation:*
The percent of children with substantiated maltreatment will be calculated as follows:

(# of children with substantiated maltreatment/ # of children enrolled)* 100

C. *Measurement Instrument:*
Not applicable

D. *Definition of Improvement:*
Improvement will be defined as a decrease in the percent of children with substantiated maltreatment.

E. *Rationale:*
Objective IVP-38 in Healthy People 2020 is to "Reduce nonfatal child maltreatment".[28]
In Maryland, the rate of investigations of child abuse or neglect ruled as indicated in the year 2009 was 4.7 per 1,000 children under age 18.[29]

G. *Means of Data Collection:*
Linkage to the Maryland Department of Human Resources (DHR) Child Abuse and Neglect Database will enable the program to identify those children enrolled in the home visiting program for whom there are documented substantiated cases of maltreatment.

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[27] Allegations of child abuse, neglect, or maltreatment that were investigated and substantiated.
[28] Healthy People 2020, Available at: http://www.healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicId=24
[29] The Governor's Office for Children, Available at: http://goc.maryland.gov/PDF/Results_Book_2009_FINAL_7_18_10.pdf

The data will be obtained from DHR at the one-year mark. DHR has provided a Letter of Intent to enter into a Memorandum of Understanding (MOU) with DHMH to perform this data linkage. The MOU will be completed by July 1, 2011. A copy of the Letter of Intent is provided in Appendix 15.

(vii) First-time victims of maltreatment for children in the program

A. *Proposed Measure:*
The proposed measure is the percent of children who are first-time maltreatment victims.

B. *Calculation:*
The percent of children who are first-time maltreatment victims will be calculated as (# of children who are first-time maltreatment victims/# of children enrolled) * 100

C. *Measurement Instrument:*
Not applicable

D. *Definition of Improvement:*
Improvement will be defined as a decrease in the percent of children who are first-time maltreatment victims.

E. *Rationale:*
Objective IVP-38 in Healthy People 2020 is to "Reduce nonfatal child maltreatment".[30]

F. *Means of Data Collection:*
Linkage to the Maryland Department of Human Resources (DHR) Child Abuse and Neglect Database will enable the program to identify those children enrolled in the home visiting program for which there is only one documented suspected or substantiated case of maltreatment. The data will be obtained from DHR at the one-year mark. DHR has provided a Letter of Intent to enter into a Memorandum of Understanding (MOU) with DHMH to perform this data linkage. The MOU will be completed by July 1, 2011. A copy of the Letter of Intent is provided in Appendix 15.

Benchmark Area III. Improvements in School Readiness and Achievement

(i) Parents' support for children's learning and child development (e.g., having toys available, talking and reading with their child):

A. *Proposed Measure:*
The proposed measure is the percent of mothers screened for parental support for children's learning and development.

B. *Calculation:*

[30] Healthy People 2020, Available at: http://www.healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicId=24

The percent of mothers screened for adequate parental support for children's learning and development is calculated as follows:

(# of mothers screened for parental support for children's learning and development/# of mothers enrolled) * 100

Pregnant women who do not have older children enrolled in the program will be excluded from the calculation.

C. *Measurement Instrument:*
The Life Skills Progression (LSP): Relationships with Children Scale 7 will be used.

The reliability and validity of the LSP has been documented[31].

D. *Definition of Improvement:*
Improvement will be defined as an increase in the percent of mothers screened for adequate parental support for children's learning and development between the first year of implementation and the three-year mark.

E. *Rationale:*
Enhancing parenting skills is a focus of many home visiting programs.

F. *Means of Data Collection:*
Home visitors will collect this information within one month of enrollment and quarterly.

(ii) Parent knowledge of child's development and of their child's developmental progress

A. *Proposed Measure:*
The proposed measure is the percent of mothers screened for information on their child's development.

B. *Calculation:*
The proposed measure is the percent of mothers screened for information on their child's development will be calculated as follows:

(# of mothers screened for information on their child's development/# of mothers enrolled) * 100

Pregnant women who do not have older children enrolled in the program will be excluded from the calculation.

C. *Measurement Instrument:*
The Ages and Stages Questionnaire (ASQ) will be used.

[31] Wollesen L, Peifer K, Life Skills Progression, An Outcome and Intervention Planning Instrument for Use with Families at Risk, Brooks Publishing Company, 2005

The reliability and validity of the ASQ has been documented.[32]

D. *Definition of Improvement:*
Improvement will be defined as an increase in the percent of mothers screened for information on their child's development between the first year of implementation and the three-year mark.

E. *Rationale:*
Home visitors work with parents/caregivers to build the parent/caregiver's capacity to support the child's development.

F. *Means of Data Collection:*
Home visitors will collect this information within one month of enrollment or at child's first month of age, and quarterly.

(iii) Parenting behaviors and parent-child relationship (e.g. discipline strategies, play interactions)

A. *Proposed Measure:*
The proposed measure is the percent of mothers screened for parenting behaviors.

B. *Calculation:*
The percent of mothers screened for parenting behaviors will be calculated as follows:

(# of mothers screened for parenting behaviors/# of mothers enrolled) * 100

Pregnant women who do not have older children enrolled in the program will be excluded from the calculation.

C. *Measurement Instrument:*
The Life Skills Progression: Relationships with Children Scales 5 and 6 will be used.

The reliability and validity of the LSP has been documented[33].

D. *Definition of Improvement:*
Improvement will be defined as an increase in the percent of mothers screened for parenting behaviors between the first year of implementation and the three-year mark.

E. *Rationale:*
The parent-child relationship is addressed in Healthy People 2020. Objective EMC-2.1 is to "Increase the proportion of parents who report a close relationship with their child". [34]

[32] Squires J, Twombly E, Bricker D, Potter L, ASQ-3 User's Guide (excerpt), Brooks Publishing, 2009, available at: http://www.brookespublishing.com/store/books/squires-asq/asq3-technical.pdf
[33] Wollesen L, Peifer K, Life Skills Progression, An Outcome and Intervention Planning Instrument for Use with Families at Risk, Brooks Publishing Company, 2005

F. *Means of Data Collection:*
Home visitors will collect this information within one month of enrollment and quarterly.

(iv) Parent emotional well-being or parenting stress

A. *Proposed Measure:*
The proposed measure is the percent of mothers screened for emotional well-being or parenting stress.

B. *Calculation:*
The percent of mothers screened for emotional well-being or parenting stress will be calculated as follows:

(# of mothers screened for emotional well-being or parenting stress/# of mothers enrolled) * 100

Pregnant women who do not have older children enrolled in the program will be excluded from the calculation.

C. *Measurement Instrument:*
The Life Skills Progression: Relationships with Children Scale 4 will be used.

The reliability and validity of the LSP has been documented.[35]

D. *Definition of Improvement:*
Improvement will be defined as an increase in the percent of mothers screened for emotional well-being or parenting stress between the first year of implementation and the three-year mark.

E. *Rationale:*
Parenting stress can lead to negative parenting practices and childhood outcomes.

F. *Means of Data Collection:*
Home visitors will collect this information within one month of enrollment and quarterly.

(v) Child's communication, language and emergent literacy

A. *Proposed Measure:*
The proposed measure is the percent of children screened for communication skills.

B. *Calculation:*

[34] Healthy People 2020, Available at: http://www.healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicId=10
[35] Wollesen L, Peifer K, Life Skills Progression, An Outcome and Intervention Planning Instrument for Use with Families at Risk, Brooks Publishing Company, 2005

The percent of children screened for communication skills will be calculated as follows:

(# of children screened for communication skills/ # of children enrolled) * 100

C. *Measurement Instrument:*
The Ages and Stages Questionnaire (ASQ) will be used.

The reliability and validity of the ASQ has been documented.[36]

D. *Definition of Improvement:*
Improvement will be defined as an increase in the percent of children screened for communication skills between the first year of implementation and the third-year mark.

E. *Rationale:*
Routine screening can be instrumental in noting early signs of deficits in language skills.

F. *Means of Data Collection:*
Home visitors will collect this information within one month of enrollment or at child's first month of age, and quarterly.

(vi) Child's general cognitive skills

A. *Proposed Measure:*
The proposed measure is the percent of children screened for cognitive skills.

B. *Calculation:*
The percent of children screened for cognitive skills will be calculated as follows:

(# of children screened for cognitive skills/# of children enrolled) * 100

C. *Measurement Instrument:*
The Ages and Stages Questionnaire (ASQ) will be used.

The reliability and validity of the ASQ has been documented.[32]

D. *Definition of Improvement:*
Improvement will be defined as an increase in the percent of children screened for cognitive skills between the first year of implementation and the third-year mark.

E. *Rationale:*
Cognitive delays and disorders that go undiagnosed and untreated put children at unnecessary risk for poor academic and social progress during their school years.

[36] Squires J, Twombly E, Bricker D, Potter L, ASQ-3 User's Guide (excerpt), Brooks Publishing, 2009, available at: http://www.brookespublishing.com/store/books/squires-asq/asq3-technical.pdf

F. *Means of Data Collection:*
Home visitors will collect this information within one month of enrollment or at child's first month of age, and quarterly.

(vii) Child's positive approaches to learning, including attention

A. *Proposed Measure:*
The proposed measure is the percent of children screened for positive approaches to learning.

B. *Calculation:*
The percent of children screened for positive approaches to learning will be calculated as follows:

(# of children screened for positive approaches to learning/# of children enrolled) * 100

C. *Measurement Instrument:*
The Ages and Stages Questionnaire (ASQ) will be used.

The reliability and validity of the ASQ has been documented.[37]

D. *Definition of Improvement:*
Improvement will be defined as an increase in the percent of children screened for positive approaches to learning between the first year of implementation and the third-year mark.

E. *Rationale:*
Improving a child's approach to learning is addressed in Healthy People 2020. Objective EMC-1 is to "Increase the proportion of children who are ready for school in all five domains of healthy development: physical development, social development, approaches to learning, language, and cognitive development".

F. *Means of Data Collection:*
Home visitors will collect this information within one month of enrollment or at child's first month of age, and quarterly.

(viii) Child's social behavior, emotion regulation, and emotional well-being

A. *Proposed Measure:*
The proposed measure is the percent of children screened for social behavior.

B. *Calculation:*
The percent of children screened for social behavior will be calculated as follows:

[37] Squires J, Twombly E, Bricker D, Potter L, ASQ-3 User's Guide (excerpt), Brooks Publishing, 2009, available at: http://www.brookespublishing.com/store/books/squires-asq/asq3-technical.pdf

(# of children screened for social behavior/# of children enrolled) * 100

C. *Measurement Instrument:*
The Ages and Stages Questionnaire-Social Emotional (ASQ-SE) will be used.

The reliability and validity of the ASQ-SE have been documented.[38]

D. *Definition of Improvement:*
Improvement will be defined as an increase in the percent of children screened for positive approaches to learning between the first year of implementation and the three-year mark.

E. *Rationale:*
Early screening for behavioral and emotional problems can facilitate proper diagnosis and intervention.

F. *Means of Data Collection:*
Home visitors will collect this information within one month of enrollment or at child's third month of age, and quarterly.

(ix) Child's physical health and development

A. *Proposed Measure:*
The proposed measure is the percent of children receiving annual assessment of height and weight.

B. *Calculation:*
The percent of children receiving annual assessment of height and weight will be calculated as follows:

(# of children receiving annual assessment of height and weight/# of children enrolled) * 100

C. *Measurement Instrument:*
Not applicable

D. *Definition of Improvement:*
Improvement will be defined as an increase in the percent of children receiving annual assessment of height and weight between the first year of implementation and the three-year mark.

E. *Rationale:*
Height and weight are used as indices of growth and development for children. In addition, childhood obesity has become epidemic. As a result, the regular assessment of child BMI status is addressed in Healthy People 2020. Objective NWS-5.2 is to "Increase

[38] Squires J, Bricker D, Heo K, Twombly E. Identification of social-emotional problems in young children using a parent-completed screening measure. *Early Child. Res. Q.* 2001; (16): 405-419

the proportion of primary care physicians who regularly assess body mass index for age and sex in their child and adolescent patients". [39]

F. *Means of Data Collection:*
Home visitors will collect this information at the one-year mark.

Benchmark Area IV. Domestic Violence

(i) Screening for domestic violence:

A. *Proposed Measure*:
The proposed measure used for this construct is the percent of mothers screened for domestic violence.

B. *Calculation:*
The percent of mothers screened for domestic violence will be calculated as follows:

(# of mothers screened for domestic violence/# of mothers enrolled)*100

C. *Measurement Instrument:*
The Abuse Assessment Screen (AAS) will be administered.

The validity and reliability of the AAS has been documented.[40]

D. *Definition of Improvement:*
Improvement will be defined as an increase in the percent of mothers screened between the first year of implementation and the third year mark.

E. *Rationale:*
This measure is relevant as domestic violence is addressed by the Healthy People 2020[41] topic area of Injury and Violence Prevention. Objective IVP-39 is "Reduce violence by current or former intimate partners". A study of Maryland residents showed that more than half of all pregnancy-associated homicides were committed by a current or former husband or intimate partner.[42]

F. *Means of Collection:*
Home visitors will collect this information within one month of enrollment and quarterly.

[39] Healthy People 2020, Available at: http://www.healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicId=29
[40] McFarlane, J., Parker, B., Soeken, K. & Bullock, L. (1992). Assessing for Abuse During Pregnancy Severity and Frequency of Injuries and Associated Entry Into Prenatal Care. *JAMA*; 267:3176-3178.
[41] Health People 2020. Available at http://www.healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicId=24
[42] Cheng D., Horon I. Intimate-Partner Homicide Among Pregnant and Postpartum Women. *Obstet Gynecol* 2010; 115:1181-6

(ii) Number of referrals made to relevant domestic violence services (e.g., shelters, food pantries)

A. *Proposed Measure:*
The proposed measure is the percent of domestic violence assistance referrals.

B. *Calculation:*
The percent of domestic violence assistance referrals is calculated as follows:

(# of domestic violence assistance referrals/ # of mothers that screened positive for domestic violence)

C. *Measurement Instrument:*
The Abuse Assessment Screen (AAS) will be administered.

The validity and reliability of the AAS has been documented.[43]

D. *Definition of Improvement:*
Improvement will be defined as an increase in the percent of domestic violence referrals between the first year of implementation and the third year mark.

E. *Rationale:*
This measure is relevant as domestic violence is addressed by the Healthy People 2020 topic area of Injury and Violence Prevention. Objective IVP-39 is "Reduce violence by current or former intimate partners".[44]

F. *Means of Collection:*
Home visitors will collect this information within one month of enrollment and quarterly.

(iii) Number of families for which a safety plan has been completed

A. *Proposed Measure:*
The proposed measure is the percent of mothers with a completed safety plan.

B. *Calculation:*
The percent of mothers with a completed safety plan is calculated as follows:

(# of mothers with completed safety plans/ # of mothers identified for the presence of domestic violence)*100

C. *Measurement Instrument:*

[43] McFarlane, J., Parker, B., Soeken, K. & Bullock, L. (1992). Assessing for Abuse During Pregnancy Severity and Frequency of Injuries and Associated Entry Into Prenatal Care. *JAMA*; 267:3176-3178.
[44] Health People 2020. Available at http://www.healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicId=24

The Abuse Assessment Screen (AAS) will be administered.

The validity and reliability of the AAS has been documented.[45]

D. *Definition of Improvement:*
Improvement will be defined as an increase in the percent of mothers for which a safety plan has been completed between the first year of implementation and the third year mark.

E. *Rationale:*
This measure is relevant as domestic violence is addressed by the Healthy People 2020 topic area of Injury and Violence Prevention. Objective IVP-39 is "Reduce violence by current or former intimate partners".[46]

F. *Means of Collection:*
Home visitors will collect this information within one month of enrollment and quarterly.

Benchmark Area V. Family Economic Self-Sufficiency

(i) Household income and benefits:

A. *Proposed Measure:*
The proposed measure for this construct is the household's total income and benefits.

B. *Calculation:*
Combination of all income and benefits from members of the household that contribute to the support of the child.

C. *Measurement Instrument:*
Not applicable

D. *Definition of Improvement:*
Improvement will be defined as an increase in the total income and benefits between the first year of implementation and the three-year mark.

E. *Rationale:*
Many home visiting models have a goal of improving the self-sufficiency of participating families. . In 2009, 6.1% of families and 9.1% of individuals in Maryland lived below the poverty level.[47]

F. *Means of Data Collection:*

[45] McFarlane, J., Parker, B., Soeken, K. & Bullock, L. (1992). Assessing for Abuse During Pregnancy Severity and Frequency of Injuries and Associated Entry Into Prenatal Care. *JAMA*; 267:3176-3178.
[46] Health People 2020. Available at http://www.healthypeople.gov/2020/topicsobjectives2020/objectiveslist.aspx?topicId=24
[47] Maryland Department of Planning, Available at: http://planning.maryland.gov/msdc/American_Community_Survey/2009/Counties/Maryland.xls

Home visitors will collect this information within one month of enrollment and quarterly.

(ii) Employment or Education of adult members of the household:

A. *Proposed Measure:*
The proposed measure for this construct is the percent of adult household members referred to job training, employment or educational services.

B. *Calculation:*
The percent of adult household members referred to job training, employment or educational services will be calculated as follows:

(# of adult household members referred to job training, employment or educational services/# of adult household members) * 100

C. *Measurement Instrument:*
Not applicable

D. *Definition of Improvement:*
Improvement will be defined as an increase in the percent of household members referred to job training, employment or educational services between the first year of implementation and the three-year mark.

E. *Rationale:*
Some home visiting models facilitate participants' engagement in educational and training programs, and encourage their pursuit of employment.

F. *Means of Data Collection:*
Home visitors will collect this information within one month of enrollment and quarterly.

(iii) Health Insurance Status:

A. *Proposed Measure:*
The proposed measure is the percent of enrollees assisted in obtaining health insurance.

B. *Calculation:*
The percent of enrollees assisted in obtaining health insurance will be calculated as follows:
(# of enrollees assisted in obtaining health insurance/# of enrollees without health insurance) * 100

C. *Measurement Instrument:*
Not applicable

D. *Definition of Improvement:*

Improvement will be defined as an increase in the percent of enrollees assisted in obtaining health insurance between the first year of implementation and the three-year mark. In 2009, 11.1% of Maryland's population had no health insurance.[48]

E. *Rationale:*
Lack of health insurance affects access to health care.

F. *Means of Data Collection:*
Home visitors will collect this information within one month of enrollment and quarterly.

Benchmark Area VI. Coordination and Referrals for Other Community Resources and Supports

(i) Number of families identified for necessary services:

A. *Proposed Measure:*
The proposed measure is the percent of families screened for necessary services.

B. *Calculation:*
The percent of families screened for necessary services will be calculated as follows:

(# of families screened for any service/# of families enrolled) *100

C. *Measurement Instrument:*
Not applicable

D. *Definition of Improvement:*
Improvement will be defined as an increase in the percent of families screened for necessary services between the first year of implementation and the third year.

E. *Rationale:*
Referral for other community resources is a possible outcome of some home visiting models.

F. *Means of Data Collection:*
The home visitor will collect this information from the enrolled families quarterly.

(ii) Number of families that required services and received a referral to available community resources

A. *Proposed Measure:*
The proposed measure is the percent of families that received referrals for needed services.

[48] Maryland Department of Planning, Available at: http://planning.maryland.gov/msdc/American_Community_Survey/2009/Counties/Maryland.xls

B. *Calculation:*
The percent of families that received referrals will be calculated as follows:

(# of families that received a referral/# of families that needed a referral) * 100

C. *Measurement Instrument:*
Not applicable

D. *Definition of Improvement:*
Improvement will defined as an increase in the percent of families that received referrals between the first year of implementation and the third year.

E. *Rationale:*
Referral for community resources is a possible outcome of some home visiting models.

F. *Means of Data Collection:*
The home visitor will collect this information from the enrolled families quarterly.

(iii) Number of Memoranda of Understanding (MOUs) or other formal agreements with other social service agencies in the community

A. *Proposed Measure:*
The proposed measure for this construct is the number of MOUs.

B. *Calculation:*
Not applicable

C. *Measurement Instrument:*
Not applicable

D. *Definition of Improvement:*
Improvement will be defined as an increase the number of MOUs and/or formal agreements between the first year of implementation and the three-year mark.

E. *Rationale:*
Coordination with other community resources and supports enables more potential opportunities for home visiting enrollees.

F. *Means of Data Collection:*
Administrative data will be obtained from the home visiting agency at the one year mark.

(iv) Number of agencies with which the home visiting provider has a clear point of contact in the collaborating agency that includes regular sharing of information between agencies

A. *Proposed Measure:*

The proposed measure is the number of agencies collaborating with the home visiting provider.

B. *Calculation:*
Not applicable.

C. *Measurement Instrument:*
Not applicable.

D. *Definition of Improvement:*
Improvement will be defined as an increase in the number of collaborating agencies between the first year of implementation and the three-year mark.

E. *Rationale:*
Clear points of contact within collaborating agencies facilitate efficient services delivery to home visiting enrollees.

F. *Means of Data Collection:*
Administrative data will be obtained from the home visiting agency at the one year mark.

(v) Number of completed referrals

A. *Proposed Measure:*
The proposed measure is the percent of completed referrals.

B. *Calculation:*
The percent of completed referrals will be calculated as follows:

(# of completed referrals/# of referrals) * 100

C. *Measurement Instrument:*
Not applicable

D. *Definition of Improvement:*
Improvement will be defined as an increase in the percent of completed referrals between the first year of implementation and the three-year mark.

E. *Rationale:*
Many home visiting programs provide follow-up for referrals issued to ensure the enrollees are accessing needed services.

F. *Means of Data Collection:*
Home visitors will collect this information quarterly.

Additional Demographic and Service Utilization Data. The home visiting programs will also be collecting demographic and service utilization data on each family enrolled in their programs. These data will be transmitted to the State's data system on a quarterly basis.

The following demographic data will be captured for each enrolled family:

- Total number in household
- Census tract of household residence
- Home visiting program type (e.g. Nurse Family Partnership, Healthy Families America)
- For each enrolled child: date of birth, sex, race/ethnicity[49], exposure to languages other than English (Y/N)
- Mother: date of birth, race/ethnicity, pregnancy status, employment status[50], primary spoken language, education level[51]
- Father: age at enrollment, race/ethnicity, employment status, primary spoken language, member of household (Y/N)
- Other caregivers in household: age at enrollment, race/ethnicity, employment status, primary spoken language

The following service utilization information will be captured for each enrolled family:

- Date of enrollment
- Date of each session, type of session (home visit, phone)

- To enable data linkage with the Department of Human Resources for cases of child abuse, neglect or maltreatment, the following information will be captured:
  - Mother: Full name and social security number
  - Enrolled child: Full name and social security number

Ensuring Data Collection Quality. Acquiring large amounts of data is futile if the data collected are not measured in an accurate, repeatable, and timely manner. Therefore it is the State's goal to ensure that all measurements are made by trained home visitors who then immediately and precisely record the results. In some programs the data will be recorded directly to electronic devices, in others the measurements will be recorded on program provided paper forms and then entered into electronic data systems by trained data entry personnel. Computer generated reports of all data entered into the data system will be reviewed and signed by each home visitor to document that the data was transcribed accurately.

The State is requiring that each home visiting program document their home visitor staff training plans, including details regarding benchmark measurement and recording. The programs will also be required to document their process for home visitor data collection and recording. Each home visiting program will be required to submit these plans to the State for review annually.

[49] All Race/Ethnicity data will be categorized as: White non-Hispanic, Black non-Hispanic, Asian non-Hispanic, Other non-Hispanic, Hispanic)
[50] Employment status will be categorized as: unemployed, part-time, full-time
[51] Education level will be categorized as: <12 years, 12 years, <16 years, 16+ years

The qualifications for personnel involved with data collection vary according to the national model being used by each program. It is estimated that home visitors will spend 30% of their time performing data collection and review. The minimum educational qualification for a home visitor performing data collection is a bachelor's degree. The minimum educational qualification for personnel at the State and program level doing data management is an associate arts degree. It is estimated that personnel performing data management, including data entry, or data system management and administration may be up to 100% of their time.

Data Analysis Plan. The data gathered by the home visiting programs and transmitted to the State will be analyzed by the State's Home Visiting Epidemiologist. The goal of the data analysis will be for the State to understand the progress being made by the MIECHV programs in providing services and meeting the needs of home visiting program enrollees.

The initial analysis will involve identification of any data outliers, so that any problems with data collection and transmittal can be identified and corrected quickly. The next phase will involve the aggregation of the data across programs to establish statewide baseline values for each construct. The data will then be disaggregated by home visiting program to analyze differences between the programs.

The data analysis will progress to disaggregation of the service utilization and benchmark data by many of the demographic variables captured, including income level, race/ethnicity, household composition, children's age, language spoken, and pregnancy status. The most detailed analysis will involve comparing the benchmark and service utilization data by various demographics across home visiting programs.

As the data are transmitted to the State quarterly, it will be possible to perform trend analysis to detect changes over the course of each year, and then over the three years for which the MIECHV program is asked to measure improvement. This quarterly data analysis should allow for Continuous Quality Improvement (CQI), because the results will be available at the State and local level (see next section). After review of each quarter's results, it will be possible for programs to identify areas where changes might be needed in order to improve service utilization or the delivery of interventions. One of the important responsibilities of the Home Visiting Epidemiologist will be the development of a large set of reports that will be useful to State home visiting planners and the local programs for program evaluation purposes. These reports will be designed after seeking input on the report requirements from State and local home visiting program representatives.

The minimum educational qualifications for staff performing data analysis will be a master's degree in epidemiology or biostatistics. It is estimated that the Home Visiting Epidemiologist will spend 100% of their time on data analysis and needs assessment activities.

Data Reporting Plan. Following the quarterly update of home visiting data, the epidemiologist will perform an analysis of the data and create a standard set of reports for distribution to stakeholders. Reports pertaining to individual home visiting programs will be sent to them directly. Aggregated reports will be sent to all stakeholders and programs. The

epidemiologist will respond to requests from stakeholders for custom reports and provide these as needed.

Eventually it is expected that the State's Home Visiting Data System will permit the home visiting programs to generate established reports on-demand, and perhaps to create their own custom reports. This should facilitate their CQI efforts. See section 7 for a more detailed discussion of how the data reporting will enhance State and local CQI efforts.

Ensuring Data Safety. All home visiting data stored by the Maryland Department of Health and Mental Hygiene (DHMH) will be kept secure behind a firewall and subject to the full security policies of the Department. No data on individuals or families will be released or reported, except for the purpose of performing the data linkage with the Maryland Department of Human Resources (DHR) to identify cases of child abuse, neglect, or maltreatment. DHMH and DHR will submit and operate under an IRB protocol for the linkage of confidential child abuse and neglect data.

Data transferred between DHMH and DHR for this purpose will be strongly encrypted. All State staff members involved with data management and analysis will be required to take human subject protection training provided through DHMH.

The State is requiring that each home visiting program document their data collection, data entry, and data management confidentiality and security policies and provide them annually to the State for review. This documentation must include details on staff training on data confidentiality and human subjects protection. The State will require that programs whose policies are deemed deficient immediately implement recommended safeguards to ensure enrollee protections.

Section VI: Plan for Administration of State Home Visiting Program

Lead Agency. Staff in the Center for Maternal and Child Health will manage and oversee project activities. The project personnel are well qualified by training and/or experience for the support sought, and CMCH has adequate facilities and manpower. Staff in the Center for Maternal and Child Health manage and oversee diverse project activities. The Center for Maternal and Child Health is located within the Department of Health and Mental Hygiene's Family Health Administration. The mission of the Maryland's MCH Program is to protect, promote and improve the health and well-being of women, children and adolescents, including those with special health care needs. Major goals include improving pregnancy and birth outcomes, improving the health of children and adolescents, including those with special health care needs, assuring access to quality health care services, eliminating barriers and health disparities, and strengthening the MCH infrastructure. Responsibility for the administration of the Title V MCH Block Grant and the Title X Family Planning Grant and ECCS grant are housed within the Center. Programs and activities include PRAMS, perinatal health, school health, women's health, abstinence, disparities, early childhood and environmental health including lead and asthma.

Statewide Administrative Structure. The Center's Director, Ms. Bonnie Birkel, CRNP, MPH, oversees the Home Visiting Project. Ms. Yvette McEachern, MA, Director of Federal-State MCH Partnerships oversees Title V related programs and grant activities. Ms. Mary LaCasse, MS, Ed brings 15 years of early childhood and adult education that include behavioral and developmental health. She is responsible for the day-to-day management of program activities. Ms. LaCasse is involved extensively in inter-agency collaborative efforts and represents the Title V Agency on numerous coalitions, councils, committees, and work groups; ensuring early childhood health is infused throughout the state. Ms. Lee Hurt, MPH is MCH Surveillance Analyst for the Center. She has worked for the last four years as an epidemiologist at the in the Center for Maternal and Child Health as the lead epidemiologist on all projects requiring data. Lee is responsible for maternal and child health surveillance, including analysis of the Maryland PRAMS data. Ms. Hetty Amofa, hold a Masters in Public Health with concentration in Epidemiology from the University at Albany. Her experiences include preparing epidemiological reports, managing and analyzing large data sets using Statistical Analysis Software (SAS), and the use of ArcGIS to present data to stakeholders. Linda Heisner, LLC is a private consultant hired for 200 hours to assist in local community plan development.

Curriculum vitae for each of the key staff are attached (Appendix 11). An organizational chart of the home visiting project can be found in Appendix 12.

In addition to the key personnel, several MCH staff provide input into the Home Visiting work plan including the program administrator for the Babies Born Healthy Initiative, The Medical Director of the PRAMS survey, the program administrator who oversees lead prevention well as the Fetal Alcohol Spectrum Disorder Coalition, and the Child Fatality Review and Fetal & Infant Mortality Review Coordinator who oversees activities for those projects. The Center is responsible for addressing several federal (e.g., Title V, Title X) and state mandates for improving the health of women and children. State mandated activities and programs concerned with the health of young children include the program for hearing impaired infants, the lead targeting plan, sentinel birth defects, the Maryland Asthma Control Program, Babies Born Healthy Initiative, and Child Fatality Review. CMCH works collaboratively with the Office of Genetics and Children with Special Health Care Needs and the Office of Injury Prevention to ensure that state and federal funds are administered efficiently and according to best practice standards in public health.

Collaborative Partners in the Private and Public Sector. Maryland's key partners represent the stakeholders central to the Home Visiting project. The Governor's Office for Children, the Maryland State Department of Education (Office of Child Care), the Department's Mental Hygiene Administration, Medicaid, the Alcohol and Drug Abuse Administration, the Maryland Academy of Pediatrics, the Home Visiting Consortium, the Maryland Department of the Environment, and various representatives from family support and parent education networks, including Friends of the Family, Ready at Five, and Maryland Family Network are some of the active participants. This Executive Team, includes all the ECCS Core Team representatives as well as other major stakeholders in early childhood that coordinate Maryland activities. The role of each of these partners is to continue to form strong collaborations that will assist the state in its goal of successful home visiting in Maryland as part of a system of care in early childhood.

Maryland is addressing child and family issues including early childhood through unified partnerships and planning efforts. Major partners in these efforts include:

- Maryland Department of Health and Mental Hygiene
    - Maryland Medical Assistance Program
    - Mental Hygiene
    - WIC Program
    - Genetics and Children with Special Health Care Needs
    - Alcohol and Drug Abuse Administration
- Parents and families of children 0-5 in a variety of settings
- Parent Place of Maryland- for families of CSHCN
- Child Resource Center- Community College early learning center
- Maryland Family Network- the CAPTA II Agency for Maryland
- American Academy of Pediatrics, Maryland Chapter-a professional group of pediatricians
- University of Maryland- a university system with many campuses
    - School of Medicine
    - School of Dentistry
    - College Park- training in results based accountability
    - Baltimore County- MIPAR
- Department of Business and Economic Development-provide businesses in Maryland with workforce training and financial assistance.
- Maryland Department of Juvenile Services- provides input on preventing bad outcomes for youth
- Maryland State Department of Education (MSDE)- houses all education systems for children preschool through 12th grade
    - Infants and Toddlers Program- Part C of Medicaid
    - Head Start- federally funded preschool fro low income and disadvantaged children- and the ECAC
    - Judy Centers- early child and learning centers that promote school readiness
    - Maryland Head Start Collaboration Council
    - Office of Child Care- regulatory office for formal and informal preschool care
- Maryland Department of Human Resources, Social Services Administration
    - Foster Care
    - Child Protective Services
- Healthy Child Care Maryland has been a part of ECCS since 2005 and is joint effort between the American Academy of Pediatrics and the US Department of Health and Human Services' Child Care Bureau and Maternal and Child Health Bureau. HCCA seeks to ensure that all children experience quality child care within a nurturing environment and have a medical home.
- Maryland Department of the Environment – Lead Poisoning Prevention
- Baltimore City Health Department- B'More for Healthy Babies and Baby Stat
- The Ready at 5 Partnership-public/private partnership whose goal is to increase the number of children entering school ready to succeed
- Family League of Baltimore- Baltimore City's local management board that facilitates broad based partnerships

- Georgetown University, Center for Child and Human Development- relationship with individuals who conducted research on the early childhood mental health pilot and the Maryland SEFEL project
- Coalition to End Childhood Lead Poisoning- community organization with the goal of ending lead poisoning in Maryland
- Maryland Association of Public Libraries- supports early learning and early literacy
- Governors Office for Children- emphasizes prevention, early intervention, and community-based services for all children and families
    - Local Management Boards

The Mental Hygiene Administration of DHMH receives early childhood mental health funding and collaborates extensively with CMCH. MSDE supports MHA through legislative funding to improve mental health systems for preschool children. CMCH has committed resources and funding that positively impact the Babies Born Healthy Initiative. The Babies Born Healthy Initiative focuses on prevention services and quality improvement, believing that improving infant health requires a comprehensive multifaceted approach that addresses family, community and systems factors associated with poor pregnancy outcomes. There is a strong environmental health agenda involving childhood lead testing and the asthma control program targeting children and adults. CMCH is funding local health departments throughout the state to provide fetal infant mortality review and in a few jurisdictions, prenatal care plans as well as lead poisoning prevention outreach. This case management coordination is for families most at risk for poor birth and child outcomes. CMCH collaborates with numerous and diverse partners.

Great effort has been made to ensure continued family, faith-based and community involvement in the planning process. Families and representatives from local communities continue to be invited to serve as members of the state meetings and have been an integral part of moving the work forward at the local level. The collaborative effort of parents, advocates, coalition members, businesses, state agencies, and MSDE and DHMH has further strengthened this process and helped us succeed in completing focus groups, getting buy-in and preparing the community to implement the home visiting strategies. An interagency agreement between Title V, Medicaid and WIC states, "this Cooperative Agreement is entered into with the Medicaid Program, the Title V Agency and the WIC Program in order to establish roles and responsibilities between the parties for the purpose of providing coordination of services to promote prompt access to high quality prenatal, intrapartum, postpartum, postnatal and child health services for women and children eligible for benefits..."

Overall Management and Coordination at State and Local Levels. Overall administrative management of the home visiting program at the State lies within the Center for Maternal and Child Health. The Center's Director, Ms. Bonnie Birkel, CRNP, MPH will be actively involved in advising and consulting on the Project's collaborative and strategic planning processes. Ms. Mary LaCasse, MS, Ed the Project Director is responsible for the day-to-day management of program activities. She is involved extensively in inter-agency collaborative efforts and represents the Title V Agency on numerous committees and work groups concerned with early childhood health issues. The Center's Director has been an integral part of membership expansion in all state-level committees/workgroups that are multi-agency in nature and focusing on early childhood system development. Some examples of partners that are

increasing health representation include members from Medicaid, MHA, Parents Place and the program administrator for the ECCS grant.

Research and related support for this initiative will be provided by Ms. Lee Hurt and Ms. Hetty Amofa. Ms. Hurt is a doctoral candidate in epidemiology. Amofa has received her masters degree in epidemiology. They are responsible for: analyzing Maryland early childhood data and compiling a profile of health status and needs, assisting in the development and implementation of an early childhood benchmarking, on going needs assessment and evaluation plan.

Administrative oversight for this initiative will be provided by the Center's Director of Federal-State MCH Partnerships, Ms. Yvette McEachern, MS. Ms. McEachern will oversee fiscal and budgetary issues related to the grant, the RFP process and selection of vendors to carry out grant activities as well as other related MCH activities including the Title V funding.

Ms. Linda Heisner, a private consultant will assist DHMH support staff with specific grant requirements including state planning, on-going capacity assessments and advisory group facilitation. Heisner, LLC has a rich history of working with the Maryland State Department of Education as a consultant for home visiting programs throughout Maryland. Heisner, LLC knows the local work of the programs and is the most knowledgeable person to provide support to the Home Visiting Grant Project because of her extensive background in this subject and her continued statewide reach to the partners involved. Through previous work, Ms. Heisner has been the: Deputy Director at Advocates for Children and Youth, Executive Director of the Child Care Administration and the Director of the Office of Family and Children's Services at Maryland Social Services Administration.

Maryland's Updated State Plan will meet the legislative requirements because the home visiting project has incorporated well-trained, competent staff (see resumes: Appendix 11 and detail staff description in Section 6: Statewide Administrative Structure) who can provide high quality supervision and have a strong organizational capacity to implement the activities involved. Job descriptions for the key staff of the home visiting project can be found in Appendix 13.

The primary public agencies that are collaborating to implement the home visiting project are: the Maryland Department of Health and Mental Hygiene (DHMH) which is responsible for: maternal and child health programs, mental health, developmental disabilities, substance abuse, public health and Medicaid; The Governor's Office for Children; the Maryland State Department of Education (MSDE) which is the lead agency for Part C of IDEA, child care licensing and subsidies, special education, Head Start and Judy Centers, school readiness initiatives ECAC; the Maryland Department of Human Resources (DHR) which is responsible for child welfare and protection, foster care, food stamps, and other public welfare programs; the Maryland Department of Business and Economic Development (DBED) which is responsible for homeless families, and economic development and housing, the Department f Juvenile Services that is responsible for developing youth competency and character to assist them in becoming responsible and productive members of society and the Maryland Family Network, the CAPTA II agency.

Local Management and Coordination. Maryland is supporting two home visiting models within Baltimore: NFP and HFA. The plan for coordination of referrals, assessment, and intake processes across the different models includes a centralized intake system that has been developed and is being rolled out with Baltimore Health Care Access as the Central source to triage all pregnancy risk assessments and infant referrals. The comprehensive structure of B'more for Healthy Babies was developed for the purpose of linking together prenatal and postpartum resources, including home visiting services, so that a foundation was built upon which early childhood health and education services could depend. Home visiting services cannot be considered in isolation of all of the other programs and services needed for improved birth outcomes and BHB was the platform to put the pieces of the puzzle together.

For home visiting, BCHD will implement a Nurse Family Partnership home visiting program at BCHD and Baltimore Medical Systems. Through state, city, and foundation resources, BCHD will also fund nurse home visiting for multiparous moms and will evaluate the effectiveness of these services. The Family League will manage the Healthy Families America home visiting programs and will be responsible for transitioning the current home visiting partners to the HFA model. Finally, Baltimore City is a major recipient of federal Baltimore Healthy Start, Inc. dollars and will continue to collaborate closely with the 500 families served through this program. All of these programs are active members of BHB and of BabyStat. Baltimore Health Care Access serves as the city's centralized intake and assessment mechanism as described above.

Baltimore City has a strong referral and service network in place to support the home visiting program and the families it serves in at-risk communities in Baltimore City and will be used as the model as Maryland rolls out the plan statewide. Monitoring of fidelity of program implementation both at the state and local levels provides a system of checks and balances to ensure services are delivered pursuant to the specific models identified: HFA and NFP.

Related Evaluation Efforts. 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.

Nurse-Family Partnership, Healthy Families America, Early Head Start, Home Instruction for Parents of Preschool Youngsters and Parents as Teachers each collect data to report to their funders, but there is no centralized data system or coordination at the state or local level. With the addition of a statewide data entry system, it is the long term goal to be able to capture data across programs for CQI and ensuring models of best fit.

Coordination with Other Maryland Plans. Maryland's Updated state Plan is coordinated, to the extent possible, with other State early childhood plans including the Early Childhood Advisory Council Plan and the State Early Childhood Comprehensive Systems Plan.

The Plan addresses how Maryland and the identified communities will comply with HFAs and NFPs prerequisites for implementation (see Section 4). At this time no modifications needed to the State administrative structure. Long before the home visiting initiative, back in 200b, Maryland was building the foundation for a comprehensive early childhood system with the state. The Inception of the Leadership in Action Program began the structure for the system by pulling together a committed team of stakeholders for young children and families. The 40-member LAP Team worked for 10 months to develop the Action Agenda for school readiness. Team members included representatives from major State agencies as well as advocacy groups. This group continues its effort of school readiness by merging LAP membership, by Governor appointment into the current ECAC. Members of the home visiting administrative staff serve in leadership roles on the ECAC team, and members of ECAC serve on the home visiting stakeholders team to ensure consistency of planning efforts throughout the state.

The Governor's Office for Children and the Center for Maternal and Child Health have continued to strengthen that foundation for home visiting to be a successful component of a comprehensive, integrated early childhood system by ensuring a crosswalk of all 21 existing state plans to ensure integration of goals and objectives into the early childhood system of care. By using ECAC as the overarching statewide early childhood plan, Maryland has a strong voice backed by Children's Cabinet and Governor support for early childhood initiatives and funding opportunities.

Section VII: Plan for Continuous Quality Improvement

State

Maryland's will utilize continuous quality improvement (CQI) methods to drive changes in the home visiting programs that should result in improved services and outcomes for Maryland's at-risk families. As described in Section 5, the State will collect demographic, service utilization and benchmark data from all funded programs. These data will be used to monitor the delivery of home visiting services and to pinpoint problems in these programs. The State will provide regular reporting and analysis of the benchmark data to local programs and jurisdictions. As the State's home visiting program data system becomes operational, it will be possible for local programs to review their data directly, facilitating a quick cycle of program changes and improvements.

Interpretation of the benchmark and service utilization data may permit identification of best practices, which can then be replicated across programs. Documentation regarding the effectiveness of referral networks in some geographic areas of the State may encourage other areas to strengthen their networks. Review of the data may also help programs identify curriculum areas that might benefit from additional training or other available resources from the national model developers.

Baltimore City

The Baltimore City Health Department (BCHD) and the Family League of Baltimore City (FLBC) propose contracting with an evaluation expert to work from the beginning with the

partners to devise a monitoring system that is meaningful as well as practical and flexible to meet the needs of the programs, funders, and City officials.

Home Visiting Program (HVP) data are currently being collected by programs using a variety of manual, hand-written methods. Each program follows its own standard and method for data collection while interviewing mothers. Each program provides its own set of forms and instructions to its field staff for collecting data. While some effort has been made to confer and collaborate on data collection methods and tools, efforts have generally been fragmented, with each program establishing its own criteria for gathering and compiling data. Data is gathered from the field and returned to the office where it is compiled manually in preparation for data entry into one or more database programs, some of which directly serve the needs of the HVP (Insight, ETO) while others serve separate needs specific to the programs themselves. There is some evidence that, in addition to data entry duplication, data collection efforts may be duplicated.

BCHD and FLBC are proposing the automation of the Data Collection Process by introducing a combined hardware and software solution that will consolidate and standardize data collection methodologies and will provide a single, common technology platform for gathering, compiling and entering data. BCHD and FLBC propose procuring and distributing tablet computers as the hardware interface to a Web Application that provides a Web Form for data entry. Access to the internet will be provided by Wireless Anywhere Service using the tablet's web browser to connect to the Web App Form. Home Visitors will use tablet computers with a Web Form to enter data directly into the database of choice. Cost analysis of hardware and software solutions has been developed and some local foundations have expressed interest in cost-sharing on this initiative.

Hiring the evaluator will be critical to ensuring from the start that the City's Home Visiting programs have the correct goals, objectives, and indicators, and that there is a practical data monitoring system in place. This will enable programs to be monitored in a variety of ways, including the monthly BabyStat for data monitoring, trouble-shooting, and sharing success stories. Both NFP and HFA also will be providing a great deal of technical assistance including Advanced Supervisory Training, contract compliance oversight, and access to nationally tested resources.

Section VIII: Technical Assistance Needs

HSRA technical assistance opportunities have enabled the Maryland to more effectively reconstruct the plan and articulate the inter-relatedness of the benchmarks. Information gained through the webcasts and teleconferences was transferred to the Updated State plan so that the plan would be more robust as evidenced in the bullets below. Local technical assistance requests were addressed in Section 4 in the description of NFP and HFA.

Past Requests

- During the development of the State Needs Assessment, Maryland requested technical assistance for the analysis of Census Bureau data. This assistance was not provided.

- Maryland requested technical assistance in the form of a cross-walk between the questions and scales that each evidence-based model was currently using and the SIR Benchmark constructs. HRSA has promised to provide this, but its delivery on this item has been so long delayed that it has lost much of its value.
- Maryland requested clarification of whether it was possible to use either a process indicator or an outcome indicator for each benchmark. This clarification was provided in a timely fashion.
- Maryland requested a technical assistance session with a benchmark expert. This session was provided quickly and was very useful.

Future Requests

- Would like assistance with conducting on-going needs assessments
- Would like assistance with conducting continuous quality improvement

Section IX: Reporting Requirements

Maryland agrees to comply with the legislative requirement for submission of an annual report to the Secretary regarding the program and activities carried out under the home visiting program. Maryland agrees to report on:

- Home Visiting Program Goals and Objectives
- Home Visiting Promising Program Update
- Implementation of Home Visiting Program in Targeted At-risk Communities
- Progress Toward Meeting Legislatively Mandated Benchmarks
- Home Visiting Program's CQI Efforts
- Administration of State Home Visiting Program
- Technical Assistance Needs

APPENDIXES:

The required attachments have been submitted:

Memorandum of Concurrence (Appendix 1)

Budget and Budget Narrative (Appendix 14)

MARYLAND

Governor's Office for Children

Promoting the well-being of Maryland's children

State of Maryland Executive Department

Martin O'Malley	Anthony Brown	Rosemary King Johnston
Governor	Lieutenant Governor	Executive Director

May 26, 2011

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:

As Executive Director of the Governor's Office for Children and Chair of the Maryland Children's Cabinet, I am writing this letter of concurrence with the Updated State Plan for the Maternal, Infant and Early Childhood Home Visiting Program Updated State Plan proposed by the Maryland Department of Health and Mental Hygiene (DHMH) to the Children's Cabinet on May 26, 2011. As designated by Governor Martin O'Malley, DHMH, as the State Title V Agency, is administering the program on behalf of the Children's Cabinet.

The Children's Cabinet is comprised of the Secretaries from the principal child serving agencies in Maryland. Attached please find a listing of each participating Cabinet agency specifying the responsibilities each has for the Maryland Maternal, Infant and Early Childhood Home Visiting Program. The Governor's Office for Children (GOC) is the executive and administrative arm of the Children's Cabinet and in that capacity has responsibility for ensuring that State agencies are aligned with the Governor's priority that Maryland families have access to the supports and programs that will improve child and family well-being.

The new Title V-Section 512 Maternal, Infant and Early Childhood Home Visiting Program has been an exciting opportunity for collaboration among State agencies. DHMH has provided periodic updates to the Children's Cabinet over the past year. Ongoing progress has also been tracked by the staff of the Governor's StateStat Office. We look forward to approval of Maryland's Updated State Plan so that full implementation may begin by July 1, 2011.

Sincerely,

Rosemary King Johnston

Rosemary King Johnston
Executive Director, Governor's Office for Children
Chair, Children's Cabinet

301 West Preston Street, 15th Floor · Baltimore, Maryland 21201
410-767-4160 · Fax 410-333-5248 · www.goc.state.md.us

Enclosure

CC: Sam Abed, Secretary, Department of Juvenile Services
Theodore Dallas, Secretary, Department of Human Resources
T. Eloise Foster, Secretary, Department of Budget and Management
Nancy Grasmick, State Superintendent of Schools, MD State Dept. of Education
Catherine Raggio, Secretary, Department of Disabilities
Joshua Sharfstein, Secretary, Department of Health and Mental Hygiene

Maryland Children's Cabinet Agencies
MIECHV Responsibilities

State Agency	Secretary	Agency Responsibilities Related to MIECHV Program Concurrence Requirements
Department of Budget and Management	T. Eloise Foster, Secretary	No direct responsibility noted within the SIR
Department of Disabilities	Catherine Raggio, Secretary	No direct responsibility noted within the SIR
Department of Health and Mental Hygiene	Dr. Joshua M. Sharfstein, Secretary	Responsible for Title V-MCH Block Grant and related MCH programs including State Early Childhood Comprehensive Systems Program, the CDC Public Health Injury Surveillance and Prevention program, and the WIC program, all administered by the DHMH Family Health Administration; SAMHSA programs administered by the Mental Health Administration and the Alcohol and Drug Abuse Administration (State Single Agency for Substance Abuse Services; Medicaid/Children's Health Insurance program including the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program.
Department of Human Resources	Theodore Dallas, Secretary	Responsible for Temporary Assistance for Needy Families, the Supplemental Nutrition Assistance Program and CAPTA Title I
Department of Juvenile Services	Sam J. Abed, Secretary	No direct responsibility noted within the SIR
Maryland State Department of Education	Dr. Nancy S. Grasmick, State Superintendent of Schools	Oversees staff who administer: The Child Care and Development Fund, the Maryland Head Start State Collaboration Office; and the Advisory Council on Early Childhood Education and Care (ECAC) as well as, Maryland's Individuals with Disabilities Education Act (IDEA) Part C and Part B Section 619, and the Elementary and Secondary Education Act Title I and State pre-kindergarten program

MARYLAND
FAMILY
NETWORK

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May 18, 2011

Bonnie S. Birkel, CRNP, MPH, Director
Center for Maternal and Child Health
Family Health Administration
Maryland Department of Health and Mental Hygiene
201 West Preston Street, Room 308
Baltimore, Maryland 21201

Dear Ms. Birkel:

I write to advise you that Maryland Family Network strongly concurs with the updated State plan for home visiting, as discussed at our recent meeting at the Governor's Office. We are fully committed to collaborating with the State and other partners with the plan to utilize the FY 2010 funds, first in Baltimore City because of its capacity, readiness, and great need. We are also committed to supporting efforts to assist the other five communities in greatest need (Tier 1) with achieving the capacity and readiness to implement new or expand current evidence-based home-visiting programs with additional federal funding as it becomes available. We also hope that funding will become available for additional Maryland communities with significant risk and unmet need.

We have long advocated home visiting as an important part of a continuum of early childhood services in Maryland. As you know, Maryland Family Network and its predecessor, Friends of the Family, have been Maryland's lead agency for the 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 the FY 2010 plan.

We look forward to working in partnership with you and others at the Department of Health and Mental Hygiene to strengthen early childhood home visiting throughout Maryland. Please do not hesitate to let me know how Maryland Family Network can support the Department's work.

Sincerely yours,

Margaret E. Williams
Executive Director

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

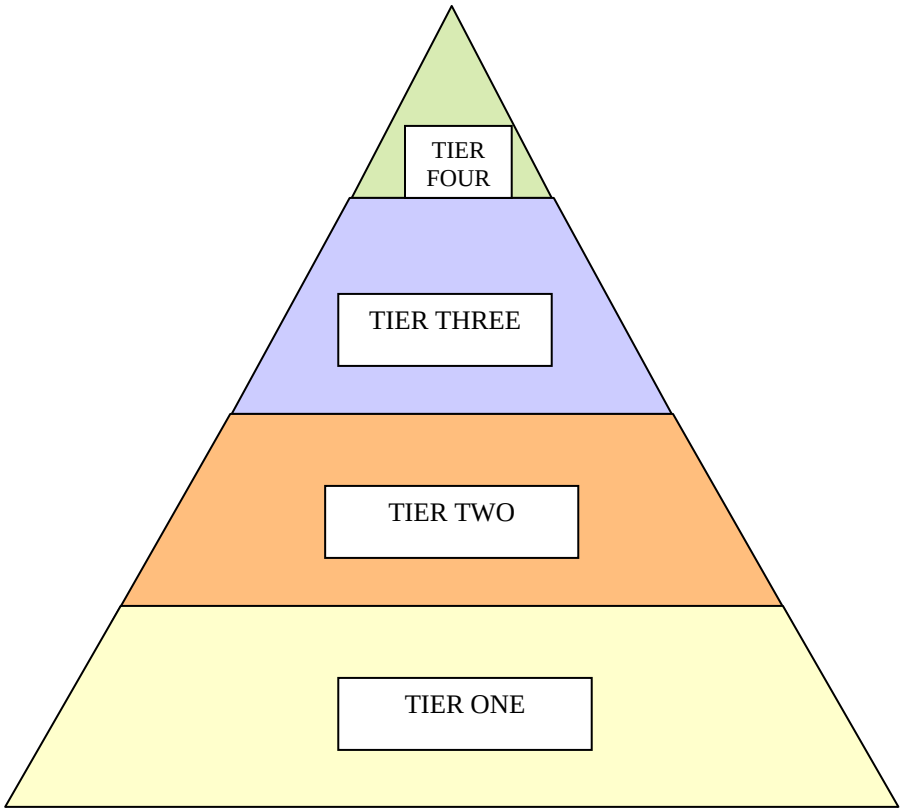
* Indicates rate < 1 standard deviation above mean

Communities At-Risk

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

Maryland's Statewide Home Visiting Needs Assessment
Identified At Risk Communities by Tier



Maryland grouped the State in four Tiers. Tier 1 being the communities most at-risk with 10 or more indicators. Tier 2 with 7-9 indicators, Tier 3 with 4-6 indicators, and Tier 4with 0-3 indicators of risk will be focused on in future grant years. Each Tier is described in detail below.

Tier 1: Hot Spots – Score: 10-14

There were six jurisdictions of the 24 in Maryland with at least one hot spot. As addressed above and discussed in some detail they are:

- Baltimore City- by Community Statistical Area: Irvington, Cherry Hill, Mondawmin, Rosemont, Greenmount, Madison, Pimlico, Sandtown, Southwest, Clifton, Walbrook, Oldtown, Midtown, Midway, Patterson Park, Hollins Market, Southeastern, Park Heights, Upton, Edison, Brooklyn, Claremont, Dorchcester, Charles Village, Penn North, Perkins, Washington Village, Westport, Cedonia, Edmondson Village, Highlandtown, Lauraville, Hampden, Highlandtown, Waverly, Beechfield, Downtown, Fells Point, Govans

- Dorchester County- by census tract overlayed with zip codes: Cambridge
- Washington County -by census tract overlayed with zip codes: Hagerstown
- Wicomico County- by census tract overlayed with zip codes: Salisbury
- Prince George's County- by census tract overlayed with zip codes:Hyattsville, Lanham, and Capitol Heights
- Somerset County- by census tract overlayed with zip codes: Crisfield

Tier 2 – Warm Spots – Score: 7-9

Nine jurisdictions had at least one warm spot:

- Baltimore County- by census tract overlayed with zip codes: Essex, Dundalk
- Allegany County- by census tract overlayed with zip codes: Cumberland
- Caroline County- by census tract overlayed with zip codes: Federalsburg
- Harford County- by census tract overlayed with zip codes: Aberdeen
- Baltimore City: Canton, Dickeyville, Echodale, Howard Park, Violetville, Belvedere, Cheswolde, Falstaff, Hamilton, Federal Hill, Northwood, South, Loch Raven
- Prince George's County: Riverdale, Hyattsville, Bladensburg, Mount Rainier, Suitland, District Heights, Upper Marlboro
- Washington County: Hagerstown
- Dorchester County: Federalsburg, Hurlock
- Wicomico County: Salisbury

Tier 3: Cool Spots – Score: 4-6

Sixteen jurisdictions had at least one cool spot:

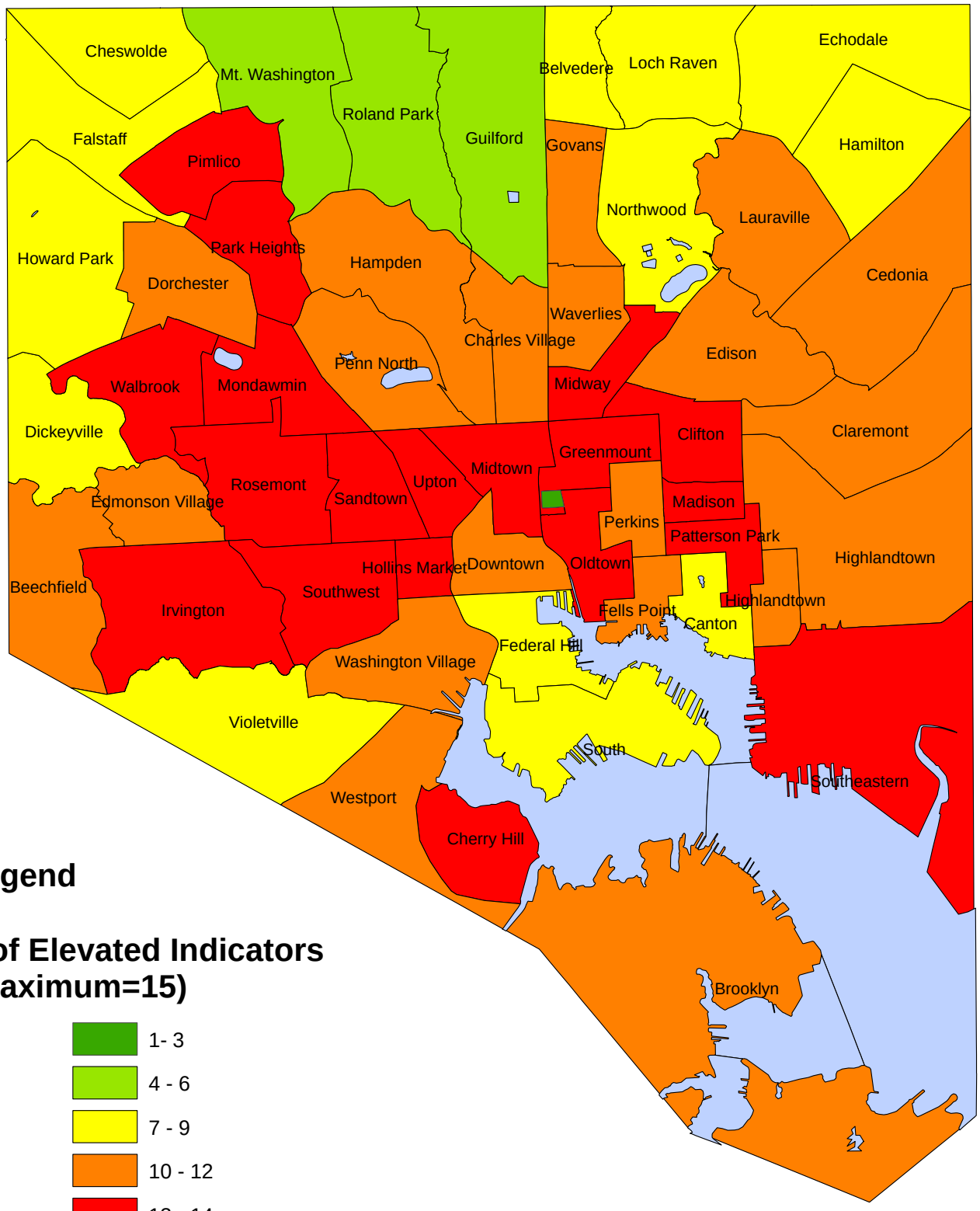
- Anne Arundel County- by census tract overlayed with zip codes: Brooklyn, Severn
- Charles Count- by census tract overlayed with zip codes: Indian Head, La Plata
- Worcester County- by census tract overlayed with zip codes: Pocomoke City, Berlin, Snow Hill
- Frederick County- by census tract overlayed with zip codes: Frederick
- Montgomery County- by census tract overlayed with zip codes: Takoma Park, Gaithersburg, Silver Spring
- Cecil County- by census tract overlayed with zip codes: Elkton
- St. Mary's County- by census tract overlayed with zip codes: Park Hall
- Dorchester County: Linkwood, Vienna, Rhodesdale, Church Creek
- Harford County: Edgewood
- Baltimore County: 21206, Gwynn Oak, Halethorpe, Randallstown, 21224, 21229, 21235, Rosedale, Windsor Mill
- Baltimore City: Mt. Washington, Roland Park
- Caroline County: Greensboro, Marydel, Denton, Henderson
- Prince George's County: Brentwood, Fort Washington, Oxon Hill, temple Hills, Greenbelt, Upper Marlboro, Beltsville, Clinton, College Park, Brandywine, Cheltenham, laurel, Bowie

- Somerset: Eden, Princess Anne
- Washington: Smithsburg, Cascade, Sabillasville, Williamsport
- Wicomico: Eden, Delmar, Fruitland

Tier 4: Rest of State – Score: 0-3

The rest of the State had seven counties identified as having three or less indicators of risk. They are: Garrett County, Talbot County, Kent County, Queen Anne's County, Calvert County,
Howard County, and Carroll County.

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



Legend

of Elevated Indicators (Maximum=15)

- 1- 3
- 4 - 6
- 7 - 9
- 10 - 12
- 13 - 14

Prepared by MD DHMH, Center for Maternal and Child Health

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
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
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
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

* Indicates rate < 1 standard deviation above mean

MARYLAND'S HOME VISITING GOALS AND OBJECTIVES

Overarching Goal: Maryland's Home Visiting Program will contribute to developing a comprehensive, high-quality early childhood system that promotes maternal, infant, and early childhood health, safety, and development and strong parent-child relationships

Goal 1: Improved maternal, infant, and early childhood health			
Objective	State Level Activities	Local Level Activities	Expected Short-term Outcome
1.1- Intervene with high-risk mothers as early in the pregnancy as possible.	Support enhancement of direct and enabling services through a continuum of interventions for improved birth outcomes, including community engagement and outreach.	Implement a broad community mobilization campaign targeting maternal health and addressing factors affecting poor birth outcomes. Establish coordinated intake and referral for MA/MCHIP screened families in accordance with their level of risk.	Increase the number of women accessing prenatal care in the first trimester; Increase number of high-risk mothers identified and receiving intensive pre-natal home visiting and case management.
1.2- Increase the number of babies born healthy, full term and normal birth weight.	Support professional and public awareness of conditions that effect birth outcomes through statewide and local planning efforts and development of needed services.	Implement local interagency plan based on assessment of gaps in service linkages, access to needed health, mental health, and other parental supports, prenatally. Home visitors engender trust by high-risk mothers-to-be, and promote their use of needed services	Increase formal agreements between local agencies providing services such as mental health, substance abuse, domestic violence intervention, to assure that pregnant women have access. Increase utilization rates by pregnant women.
1.3- Increase early identification and treatment of mothers for whom nurturing and early attachment to the new-born is impaired.	Support public and private efforts to expand evidenced–based interventions that focus on early attachment and parent-infant intervention.	Home visitors will be trained to use a maternal depression screen tool and to assess parental capacity to respond appropriately to the nurturing needs of a newborn.	Mothers will be identified earlier, referred and treated for depression or other mental health issues. Increase number of high-risk mothers receiving parent training in nurturing a new born.

Goal 2: Identify and provide comprehensive services to improve outcomes for families with young children who reside in at risk communities.			
Objective	State Level Activities	Local Level Activities	Short-Term Outcomes
2.1- Increase in linkages to community services for families with young children.	Increase understanding of the importance of addressing threatening conditions such as domestic violence, family and community safety, substance abuse, homelessness, chronic poverty, and family self-sufficiency in preventing child maltreatment, promoting child development and increasing parenting capacity to meet the needs of young children.	Home visitors will have knowledge to assist families with accessing needed supports and services. Home visitors will empower families to advocate for themselves and to address family risks through community services.	Increase formal agreements between local agencies providing a variety of family support services to assure that at risk families have access. Increase utilization rates by high-risk families with young children.
2.2- Increase availability of evidenced-based home visiting services in communities at highest risk.	Provide funding and technical assistance for replication of EBP in identified at risk communities.	Home visiting programs and home visitors will be trained, supervised and supported in meeting the training and performance standards required by the national accrediting organization for their Home Visiting model.	Increase number of home visitors providing quality evidenced-based home visiting services in communities of highest risk.

Goal 3: Strengthen parent-child relationships			
Objective	State Level Activities	Local Level Activities	Short-Term Outcomes
3.1- Improve parenting skills.	Identify and promote development and replication of parenting curricula that is most effective in teaching parenting at all stages of child development and to families of diverse cultural, ethnic and educational levels.	Home visitors will have core training in recognizing parenting practices and behaviors that may be detrimental to a child's well being and be equipped to teach, model and encourage parenting behaviors that promote parent-infant attachment, emotional, social and cognitive development.	Increase parent knowledge of the importance of parental behavior in fostering healthy child development and promoting child safety.
3.2- Prevent child maltreatment.	Assure that home visiting programs prioritize caregivers of children at high risk for child abuse and neglect for intensive services. Assure that Child Protective Services agencies are aware of role and availability of intensive home visiting services.	Assure that parents at highest-risk of child abuse or neglect are referred quickly for intensive home visiting services. Home visitors will be trained to identify child abuse and neglect and will intervene immediately to protect children from harm and to seek Child Protective Service involvement.	Reduce incidence of child maltreatment among families receiving home visiting services.
3.3- Parental awareness of various preventable injuries	Assure that State resources, training, education on preventable injuries, properly installing infant/child car seats, lead poisoning prevention and safe sleep are widely available.	Home visitors will be trained to increase parental ability to protect young children from injury through knowledge of safe sleep, recognition of environmental hazards and age-appropriate supervision.	Decrease in incidence of preventable injury to young children in families receiving home visiting services.

Goal 4: Strengthen and improve programs and activities for families receiving home visiting services			
Objective	State Level Activities	Local Level Activities	Short-Term Outcomes
4.1- Ensure Continuous Quality Improvement (CQI)	Require that State funds be used to support CQI activities at each home visiting program site. Provide data collected and aggregated at the State level regarding local programs to inform CQI processes.	Home visiting program staff and administrators will be trained in CQI practices. Data on each child and family served will be collected and utilized to evaluate program effectiveness, and to improve service delivery.	The home visiting programs will conduct ongoing CQI activities.
4.2- Conduct process and outcome evaluation of the EBP provide in at risk communities	The State will require home visiting programs to collect and report a number of benchmark measures on program participants and program inputs. The State will support data collection efforts, and aggregate and analyze data from program participants as well as non-participants living in high risk communities.	Home visiting program staff will be trained to monitor and document family functioning with standardized tools at regularly scheduled intervals. Aggregate data will be used to measure family progress, to address unmet family needs and to increase staff training and supervision, as well as for State reporting.	Quality of care and services will be measured for effectiveness. Strengths and weaknesses of home visiting programs and policies will be assessed.

Goal 5: Ensure an early childhood system of care that is coordinated and that meets the needs of Maryland's families and children			
Objective	State Level Activities	Local Level Activities	Short-Term Outcomes
5.1- Ensure continued capacity to integrate early childhood systems into statewide activities and programs	At level of the Children's Cabinet, assure that state and public agencies understand goals and activities that can be integrated into their own mission and vision	Ensure a coordinating body comprised of all child serving agencies that communicate on a continuum of care for children and families	Home visiting will be integrated into state and local planning efforts

Logic Model
Maryland MIECHV Program

Inputs → **Outputs** (Activities, Participation) → **Outcomes- Impact** (Short Term, Long Term) ↻

What We Invest

Resources
↑ Capacity to provide EBHV at State and local level, and prevention and early childhood interventions, new funding

Activities
Planning and needs assessment, alignment and coordination of existing programs, transition to EBHV, ongoing assessment, planning and implementation, service expansion

Services
Engagement and linkage with other community services, nationally recognized, EBHV services implemented with fidelity, community providers use culturally informed practices

What We Do

- Intervention
- Early Identification
- Increase linkages
- Improve parenting
- Increase awareness
- Ensure CQI
- Continue Capacity Integration
- Training

Who We Reach

- Children
- Families
- High Risk Mothers
- Communities

What are the Short Term Results?

- -Pre-natal support
- -Early screening-high risk pregnancies
- -Availability of voluntary intensive services
- -Positive outreach
- -Build trust and reduce fear
- -Encourages high-risk families
- -Linkage to needed services
- -Communication and follow-up with referral agencies
- -Connection to appropriate supports
- ↑ Access to EBHV programs

What are the Long Term Results?

Reduction in: child maltreatment, low-birth-weight, injuries to children, infant mortality

Improved child development in: social, emotional, cognitive, behavioral and physical health

Decline in: domestic violence, substance abuse, transmission of HIV, and untreated mental and physical illness

Increase in: Family self-sufficiency, economic well-being, workforce participation and educational attainment

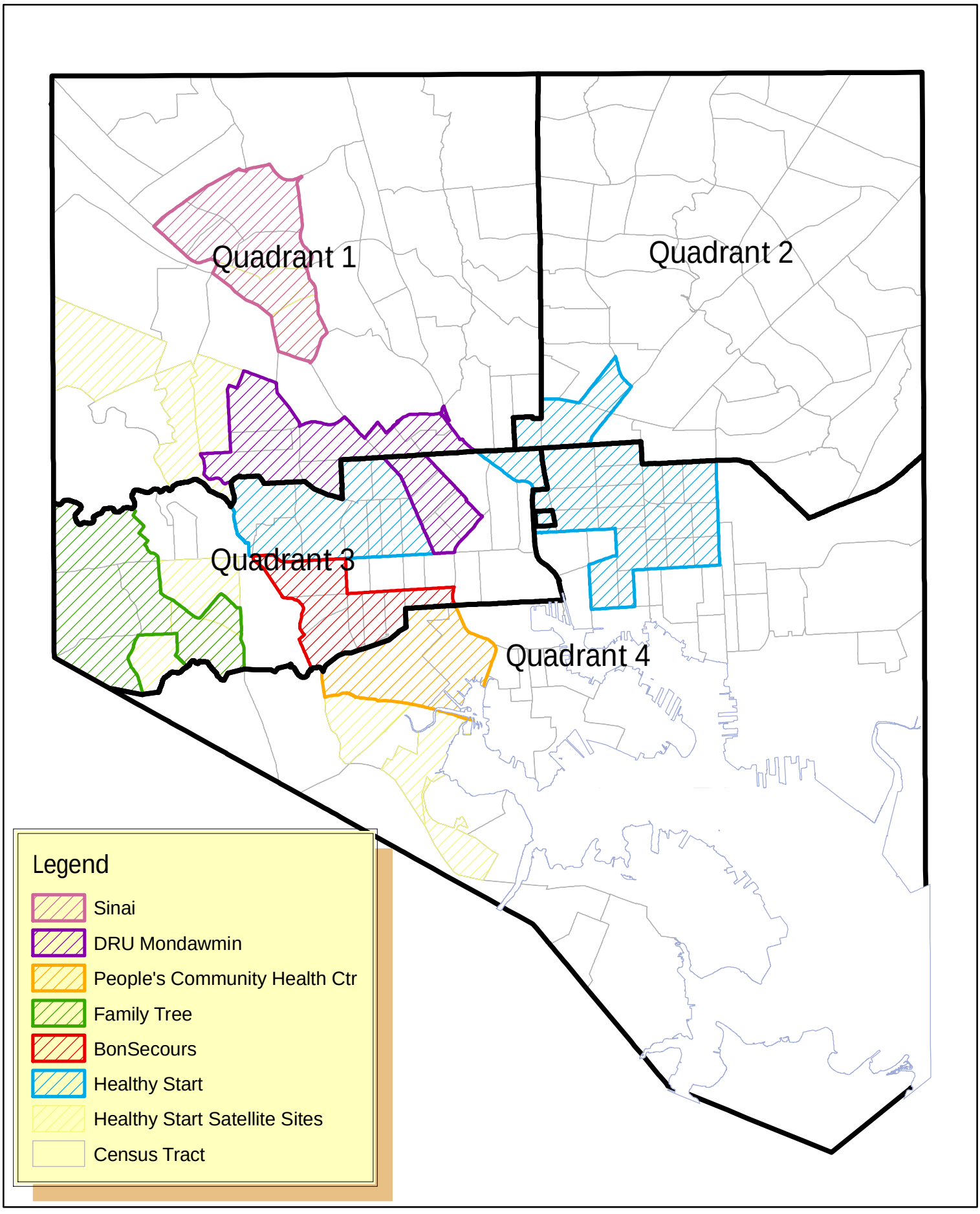
Assumptions

Maryland's Home Visiting Program will contribute to developing a comprehensive, high-quality early childhood system that promotes maternal, infant, and early childhood health, safety, and development and strong parent-child relationships

External Factors

Programs used, community buy-in, staff training, political will and administrative support

Home Visiting Quadrants (proposed)



Nurse-Family Partnership
Helping First-Time Parents Succeed

April 20, 2011

Ms. Bonnie S. Birkel, BSN, CRNP
Director, Center for Maternal and Child Health
Family Health Administration
Department of Health and Mental Hygiene
201 W. Preston Street, Room 308
Baltimore, MD 21201

Dear Ms. Birkel:

Based on the information provided in your state plan, I am pleased to grant approval from the Nurse-Family Partnership National Service Office (NFP NSO), so you may include the Nurse-Family Partnership® Program (NFP) in your revised state plan submission to the Health Resources and Services Administration as part of the Affordable Care Act-Maternal, Infant, and Early Childhood Home Visiting Program (MIECHVP). Specifically:

- NFP NSO verifies that we have reviewed Maryland's plan as submitted and that it includes the specific elements required in the SIR; and
- NFP NSO is supportive of Maryland's participation in the national evaluation and any other related HHS effort to coordinate evaluation and programmatic technical assistance.

Because the Updated State Plan, as required by the SIR, must include additional information on how you will implement the model(s) chosen, it will be important to provide a copy of this to the NFP NSO. We would like to review the following additional details in order to better support the implementation of NFP in your state:

- Identification of the evidence-based home visiting model(s) to be implemented in the State and describe how each model meets the needs of the community(ies) proposed;
- A description of the State's current and prior experience with implementing the model(s) selected, if any, as well as their current capacity to support the model;
- A plan for ensuring implementation, with fidelity to the model, and include a description of the following: the State's overall approach to home visiting quality assurance; the State's approach to program assessment and support of model fidelity; anticipated challenges and risks to maintaining quality and fidelity, and the proposed response to the issues identified;
- Any anticipated challenges and risks of selected program model(s), and the proposed response to the issues identified, and any anticipated technical assistance needs.

As part of our ongoing partnership to support implementation with fidelity to the model, and as part of our required processes, as referenced in the SIR, NFP NSO expects that Maryland will enter into a service agreement with NFP NSO and implement NFP in accordance with that agreement. This agreement will outline expectations for the State as well as what supports will be provided by the NFP NSO to include:

- Working directly with the NFP NSO and designated program development staff to implement NFP as designed, including:

- Understanding the 18 required model elements;
- Using NFP-specific implementation planning tools;
- Accessing NFP support as appropriate with RFP processes and a list of program requirements for inclusion in such processes; and
- Adhering to NFP agency selection requirements contained in the Implementation Plan and Guidance documents.

- Ensure that every team of nurses employed to deliver NFP will:
  - Receive NFP-specific education as well as expert NFP nursing practice consultation to develop basic competencies in delivering the program model successfully;
  - Receive adequate support and reflective supervision within their agencies;
  - Receive ongoing professional development on topics determined by nursing supervisors to be critical for continued growth. Professional development may be offered within a host agency or through more centralized or shared venues;
  - Engage in individual and collective activities designed to reflect on the team's own practice, review program performance data, and enhance the program's quality and outcomes over time; and
  - Utilize ongoing nurse consultation for ongoing implementation success.
- Participate in all NFP quality initiatives including, but not limited to, research, evaluation, and continuous quality improvement;
- Assure that all organizations implementing NFP use data and reports from our web-based Efforts to Outcomes ™ data system to foster adherence to the model elements in order to achieve outcomes comparable to those achieved in the randomized, controlled trials. This may include creating necessary interfaces between local or state-based data and information systems with our national web-based data system.

This letter also affirms our commitment to work with you as your state implements NFP using designated funds from the MIECHVP. In order to further assist you, we have a set of online resources that can serve as your guide for our continued work together. We are particularly eager to partner with you to consider the kind of support that would enable you to successfully establish NFP in the communities identified in the statewide needs assessment.

Successful replication of Nurse-Family Partnership as an evidence-based home visitation program is dependent on both unwavering commitment to program quality as well as creative and sensitive adaptability to local and state contexts and available resources. We are excited to partner with you to plan how best to support the successful development of Nurse-Family Partnership.

Sincerely,

Kammie Monarch.
Chief Operating Officer
Nurse-Family Partnership National Service Office

1900 Grant Street, Suite 400 | Denver, CO 80203-4304
303.327.4240 | Fax 303.327.4260 | Toll Free 866.864.5226
www.nursefamilypartnership.org

healthy families america®
a program of Prevent Child Abuse America

228 S. Wabash, 10th Floor
Chicago, IL 60604
312.663.3520
healthyfamiliesamerica.org

April 22, 2011

Ms. Bonnie S. Birkel, BSN, CRNP
Director, Center for Maternal and Child Health
Family Health Administration
Department of Health and Mental Hygiene
201 W. Preston Street, Room 308
Baltimore, MD 21201

Re: Documentation of Approval to Utilize the HFA Model

Dear Ms. Birkel:

This letter is in response to the requirement of the Supplemental Information Request (SIR) from the Affordable Care Act Maternal, Infant and Early Childhood Home Visiting Program (MIECHV Program) to obtain documentation of approval by the model developer to implement the model as proposed. We have had an opportunity to review the information you provided regarding implementation of the Healthy Families America (HFA) model in Maryland. **This letter outlines the approval from the HFA national office at Prevent Child Abuse America to use the HFA model in Maryland (herein referred to as "the State").** Approval to make adaptation to the model has not been granted as adaptations were not proposed.

Currently, HFA is present in 35 states and D.C., including existing HFA programs in a variety of communities in Maryland. We understand that given the current funding available in the initial year through the MIECHV program the State has targeted Baltimore City as the area of highest risk. The Family League of Baltimore City will work to align 4 local home visiting programs with the Healthy Families America model and those 4 will join the Dru Mondawmin Healthy Families program that is already in existence.

The State agrees to complete the application process to affiliate this site(s) and, should any additional HFA sites be established in Maryland at a later time through the MIECHV program, those sites will also affiliate with the HFA National Office. The State has agreed to pay the required annual fees ($1,350 per site in 2011) and will use Maryland in-state trainers to provide core training. The State has indicated its intent to work in partnership with the HFA National Office to obtain model specific technical assistance and support related to site planning, development, implementation, and accreditation. Technical assistance will be made available to you from the HFA National Office's Central Region Director at no cost via phone and email, and at a cost of $1,250 per day plus travel for on-site technical assistance. Finally, the State has indicated its intent to use the Partners for a Healthy Baby parenting curriculum series developed by Florida State University and will secure the necessary curriculum training from the curriculum developers to use within the HFA program site.

In order to maintain HFA affiliation and the right to use the Healthy Families America name and to insure model fidelity, the State agrees that within the first 3 years of site affiliation, the program will complete the accreditation process. The State also agrees to complete an annual site survey (distributed by PCA America on an annual basis), and to utilize a data management system to better provide information to the National Office. It is PCA

America's intention to affiliate individual program sites and multi-site systems and to authorize use of the name "Healthy Families" and use of variations of the name (*i.e*., Healthy Families Place, County, or City), provided they are committed to the best practice standards identified by PCA America through research. Should there be any instance that would impede the program's ability to implement the critical elements (such as a loss of funding, etc.), it is understood that it is the program's responsibility to notify PCA America immediately. It is also understood that PCA America is the sole grantee of the right to use the HFA name and/or affiliation with the HFA model. PCA America reserves the right to revoke use of the name, and/or affiliation with the Healthy Families model, at any time before, during, or after the community/program enters the HFA Accreditation process. Finally, once entering the HFA Accreditation process, it is understood that the program will be subject to the policies and procedures of that process.

We are pleased to grant approval to the State of Maryland to implement the HFA model. **A formal Memorandum of Agreement detailing the aforementioned will be sent to the State within the next 30 days and must be fully executed prior to the State's SIR submission for this approval to remain in effect.** If you would like to discuss this further, I can be reached at lkosanovich@preventchildabuse.orgmailto: or 703-888-3135. I applaud your commitment to Maryland's children and families and look forward to working together in partnership with you.

Sincerely,

Lynn H. Kosanovich

Lynn H. Kosanovich, MA
Director, HFA Northeast Region
Prevent Child Abuse America

Cc: Cydney M. Wessel, MSW
Senior Director of HFA
Prevent Child Abuse America

BHBOrganizational System

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.

	• to recruit parents to participate actively in center-based services; and • to engage parents in community services.	
Description of Number of Families Served	Outreach to Special Populations	Parent Leadership
• 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.	• 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.	• 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

		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

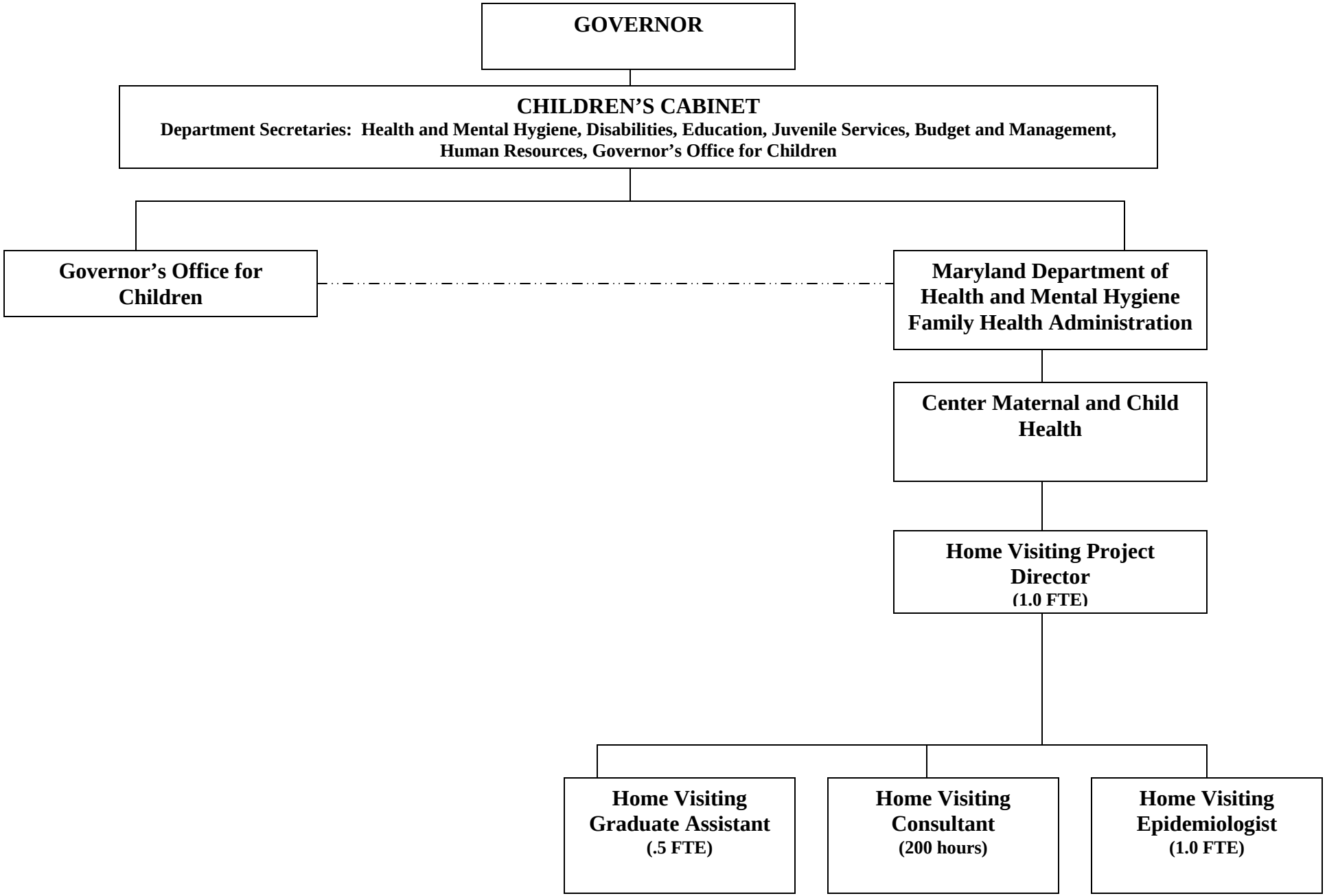
WICOMICO COUNTY
Wicomico Family Support Center
SHORE UP! Inc.
500 Snow Hill Road
PO Box 430
Salisbury, MD 21804
tel 410.860.9194 fax 410.860.9373
Director Sheree Sample-Hughes
Sponsor SHORE UP!, Inc.

Revised 8.9.10

B-More For Healthy Babies Steering Committee Roster

Role	Organization	Name	Title	Phone	Email	Address	Exec Assist	Comments
Foundation	Annie E. Casey Foundation	Nelson, Doug	President and Chief Executive Officer	(410) 547-6600	DNelson@aecf.org	701 St. Paul Street Baltimore, MD 21202		
Cabinet Membership and Affiliates	Mayor's Office	Marriott, Salima	Deputy Mayor		Salima.Siler.Marriott@baltimorecit			
Cabinet Membership and Affiliates	Baltimore City Health Department	Farrow, Olivia	Interim Commissioner of Health	(410) 396-4421	Olivia.Farrow@baltimorecity.gov	1001 E Fayette St Baltimore, MD 21202		
Cabinet Membership and Affiliates	Baltimore City Health Department	Duval-Harvey, Jacquelyn	Deputy Commissioner for Youth and Families	(410) 396-2714	Jacquelyn.Duval-Harvey@baltimorecity.gov	1001 E Fayette St Baltimore, MD 21202		
BCHD/BHB Planning Committee	Baltimore City Health Department	Dineen, Rebecca	Bureau Chief, Maternal and Infant Care	(410) 396 - 9404	rebecca.dineen@baltimorecity.gov	620 N. Caroline St.		
BCHD/BHB Planning Committee	Baltimore City Health Department	Rutledge, Regina	Epidemiologist	(410) 396 - 1849	Regina.rutledge@baltimorecity.gov	1001 E Fayette St Baltimore, MD 21202		
Cabinet Membership and Affiliates	Baltimore HealthCare Access, Inc.	Westcoat, Kathy	President	(410) 649-0521	KWestcoat@bhca.org	201 E. Baltimore St Baltimore, MD 21202		
Cabinet Membership and Affiliates	Baltimore Mental Health Systems	Plapinger, Jane	President and Chief Executive Officer	(410) 837-2647	jplapinger@bmhsi.org	201 E. Baltimore St . # 1340, MD 21202		
Cabinet Membership and Affiliates	Baltimore Substance Abuse Systems	Warren, Greg	Executive Director	(410) 637-1900 ext. 211	gcwarren@dpscs.state.md.us	One North Charles Street, Suite 1600 Baltimore, MD 21201		
Cabinet Membership and Affiliates	Baltimore City Public School System	Alonso, Andres	CEO	(410) 396-8803	aalonso@bcps.k12.md.us;	200 E. North Avenue, Room 405 Baltimore, MD 21202	KWhitacre@bcps.k12.md.us	
Cabinet Membership and Affiliates	Baltimore City Department of Social Services	McGrath, Molly	Director	(443) 378-4600	mmcgrath@dhr.state.md.us	Talmadge Branch Building 1910 N. Broadway Baltimore, MD 21213		
Cabinet Membership and Affiliates	Department of Housing & Community Development/Housing Authority	Graziano, Paul T.	Commissioner/Executive Director	(410) 396-3232	paul.graziano@baltimorecity.gov	417 E. Fayette Street, Suite 1346 Baltimore, MD 21202		
Cabinet Membership and Affiliates	Office of Neighborhoods	Fraser, Angela	Director	(443) 984-1081	angela.fraser@baltimorecity.gov	City Hall, Baltimore 21202		
Cabinet Membership and Affiliates	Department of Recreation and Parks	Thomas, Dwayne	Director	(410) 396 6128	Dwayne.Thomas@baltimorecity.gov	3001 East Drive Baltimore, MD 21217		
Cabinet Membership and Affiliates	The Family League of Baltimore City, Inc.	Lopez, Rafael	Executive Director	(410) 662-5500	rlopez@flbcinc.org	2700 N. Charles Street, Suite 200 Baltimore, MD 21218		
Cabinet Membership and Affiliates	The Family League of Baltimore City, Inc.	O'Keefe, Gena	Director of Healthy Community Initiatives	(410) 662-5500	gokeefe@flbcinc.org	2700 N. Charles Street, Suite 200 Baltimore, MD 21218		
Cabinet Membership and Affiliates	Department of Transportation			(410) 396-6802		417 E. Fayette Street – 5th Floor Baltimore, MD		

Funder	CareFirst BlueCross BlueShield	Burrell, Chester	President and Chief Executive Officer			1501 South Clinton Street Baltimore, MD 21224		
Funder	CareFirst BlueCross BlueShield	Doyle, Ann	Director, Clinical Innovations	(410) 528-7992	Ann.Doyle@carefirst.com	1501 South Clinton Street Baltimore, MD 21224		
Community	Community Representative	Tillman, Denise		(410) 383-9222 (410) 502-2128	mct2400@yahoo.com	2013 N. Bentalou Street Baltimore, MD 21216		
Policy Expert	Johns Hopkins School of Public Health	Guyer, Bernard	Professor	(443) 287-0088	bguyer@jhsph.edu	615 N. Wolfe St, E4146 Baltimore, MD 21205		
FQHC	Baltimore Medical System	Wovlovsky, Jay	President and Chief Executive Officer	(410) 732 8800		3501 Sinclair Lane Baltimore, MD 21213		
FQHC	Total Health Care	Cherot, Dennis G.	President	(410) 728-4090	dcherot@totalhealthcare.org	1501 Division Street Baltimore, MD 21217		
Hospital	Johns Hopkins Hospital and Health System	Peterson, Ronald	President	(410) 955-9540	rpeters@jhmi.edu	733 North Broadway St. Baltimore, MD 21205		
Hospital	Mercy Health Systems	Mullen, Thomas R.	President and Chief Executive Officer	(410) 332-9000	tmullen@mdmercy.com	701 St Paul Place Baltimore, MD 21202		
Hospital	University of Maryland School of Medicine	Rivest, Jeffrey A.	President and Chief Executive Officer	(410) 328 - 0313	jrivest@umm.edu	22 S Greene St # G1J27 Baltimore, MD 21201		
Teen	Healthy Teen Network	Paluzzi, Patrica, MD	President/CEO	(410) 685-0410	pat@healthyteennetwork.org	1501 St. Paul Street, Suite 124 Baltimore, MD 21202		
Domestic Violence Commission	Baltimore City Criminal Justice Coordinating Council	Barranco, Kimberly S	Executive Director	(410) 396-5024	kbarranco@baltimorecitycjcc.org	111 N. Calvert Street Courthouse East, Room 51 Baltimore, MD 21202		
MD Opportunity Comp	Safe and Sound	Ferebee, Hathaway	Executive Director	(410) 244-5299	hferebee@safeandsound.org	2 E Read St # 601 Baltimore, MD 21202		
Medicaid	Offices of Health Services, MD Department of Health and Mental Hygiene	Tucker, Susan	Executive Director		tuckers@dhmh.state.md.us	201 West Preston St, 2nd Fl Baltimore, MD 21201		


GOVERNOR
CHILDREN'S CABINET
Department Secretaries: Health and Mental Hygiene, Disabilities, Education, Juvenile Services, Budget and Management, Human Resources, Governor's Office for Children
Governor's Office for Children
Maryland Department of Health and Mental Hygiene Family Health Administration
Center Maternal and Child Health
Home Visiting Project Director
(1.0 FTE)
Home Visiting Graduate Assistant
(.5 FTE)
Home Visiting Consultant
(200 hours)
Home Visiting Epidemiologist
(1.0 FTE)