Montgomery County Early Childhood Initiative

Project HOME

Year III Evaluation Report

July 1, 2002 – June 30, 2003

Prepared by
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August 2003
Rev. October 2003

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Funding for this evaluation was provided by the Montgomery County Collaboration Council

TABLE OF CONTENTS

List of Appendices

List of Tables and Figures

INTRODUCTION

In recent years, there has been increasing national interest in the long-term benefits of early childhood prevention efforts and on identifying and developing ways to improve the cost, efficiency and effectiveness of comprehensive social service programs. The realities tied to this national interest are largely economical, given current budget crises in states around the country. At the same time, they are also practical, in that demonstrated program accountability and effectiveness in meeting the needs of families at risk separates viable programs from failing ones and provides local and state officials with a better understanding of the models and approaches that best effect community change through the utilization of scientifically-based best/effective practices. These interests have been particularly salient for coordinators of early childhood services, where local initiatives have identified ways to streamline costs while improving service delivery to children at risk for poor social and cognitive development. In June 2000, the Montgomery County Early Childhood Initiative developed a model for an integrated system of early childhood services. The model, and the accompanying *Early Childhood Initiative Comprehensive Plan*, was grounded in a series of fact-finding efforts that examined the needs of the County's families with young children. Such efforts helped determine service capacity, resource stability, cost and intensity of services, population(s) served, services provided, and data capacity for home visiting organizations in the County. Moreover, a gap analysis conducted on service utilization in the county yielded significant information regarding risk factors impacting families with young children by highlighting important national and local statistics on child outcomes and the County's capacity to meet the needs of growing numbers of at-risk families.

Findings from the Early Childhood Initiative and the accompanying *Comprehensive Plan* resulted in the establishment of two significant but separate entities designed to both improve and streamline home visiting services in the County. The Montgomery County Home Visiting Consortium (the Consortium), established in 2001 with funding from the Montgomery County Collaboration Council, was created specifically to develop and implement an integrated approach for using home visiting, including a universal screening tool and modular assessment instrument. Home visiting programs across the County were invited to join and to serve as active participants in the construction of these tools and the integrated system. Also created in 2001 was a pilot program designed to expand home visiting to at-risk families currently unserved through existing County models. Specifically, the Montgomery County Home Visiting Pilot Project (Project HOME) was designed to target low-income families with toddler-aged children not already receiving early childhood services from other programs. The Pilot was also used to determine if home visiting was an effective strategy with families with older children and for families already involved with Child Welfare Services. Identification of ways to increase use of effective practices, streamline costs, and coordinate home visiting services for at-risk families drove initial efforts of the Consortium. Over time, members have worked to collect outcome data, as recommended in the *Comprehensive Plan* and later spearheaded by the Early Childhood Chief, and have focused their efforts on the five state outcome indicators that target children and families. These indicators include: 1) healthy children; 2) children safe in their family, school and community; 3) families making smart choices; 4) stable and economically secure families; and 5) children will enter school ready to learn. Success on these outcomes remains a top priority for officials at the Montgomery County Collaboration Council, who has provided sustained support and funding for both the Consortium and the Project HOME program.

While Project HOME is no longer considered a pilot program, having just completed Year III of programming, it and organizations that participate in the Consortium aim to be continually responsive to the evolving characteristics and needs of the county's families and to incorporate research-based effective practices and measurable outcomes into services. This year, Project HOME entered into a partnership with Child Welfare Services (CWS) in efforts to increase this responsiveness and expand home visiting services to high-risk families recognized by the system as at risk for child abuse and neglect. This partnership, made possible through a state Youth Strategies Consolidated Grant, was designed to help local communities provide a "continuum of care" that targeted at-risk children and youth through prevention and early intervention.

Project HOME has experienced fundamental shifts in program design and implementation over the past three years, which staff have weathered surprisingly well. This is due in part to strong communication and support among Project HOME staff, and the relationship fostered between program and leadership staff. However, these continual changes to program design and implementation of Project HOME impeded efforts to establish a sound infrastructure and direction until midway through Year III, when the Project began to hit its stride. It was this lack of structure that contributed most to the recent decision to transfer the program to another lead agency within Montgomery County. In July 2003, County officials decided to transfer Project HOME participants to the Families Foremost Center, a community-based program sponsored in part by the Montgomery County Mental Health Association. Families Foremost serves a similar, largely Hispanic population and provides parent training and supports, making it a viable program to accommodate all currently active families and allowing for increased capacity. Families Foremost has also hired one of the Project HOME Home Visitors, providing continuity for families during the transition.

The purpose of this report is to describe program activities over the course of this past year and to summarize design, implementation, and outcomes for Project HOME, particularly as they reflect on expanded services to CWS recipients and the transition to another lead agency. A specific focus of this report is to determine the extent to which Project HOME met its Year III goals and objectives and to describe lessons learned from this pilot project.

Evolution of Project HOME

Analysis and interpretation of outcomes achieved in Year III of Project HOME are better understood when considered within the historical context of the program. Specifically, changes to program design, structure and implementation over the past three years have resulted in a program that is vastly different today than in the past. The evolution of the program becomes increasingly important to highlight, not only because of recent decisions to transfer Project HOME to another agency, but so that the full impact of program accomplishments and lessons learned can also be more fully recognized.

In establishing the Montgomery County Home Visiting Consortium and securing funds for creation of a home visiting pilot program targeting toddler-aged children at risk for poor childhood outcomes, members of the Early Childhood Initiative envisioned a process that would

meet multiple purposes. First, efforts to streamline and integrate early childhood services throughout the county would produce more cost and service efficient services for at-risk families. This was to be accomplished while maintaining the range and diversity of programs, service intensity, and individual program focus so that a full continuum of early childhood services could be offered to families of Montgomery County. At the same time, the needs of a growing low-income, non-English speaking population, then considered underserved by existing service organizations, would be better met. Increasing efficiency while expanding quality service delivery, if achieved, would be a tremendous accomplishment for the County.

Using the available list of approved models from the state RFP, the Home Visiting Consortium determined that the Infants and Toddlers (ITP) program model and Public Health Services through the Community Health Services (CHS) Healthy Start model were the most universal, comprehensive, strength based, and family centered services in the County. As such, they were considered the best quality candidates upon which to base the new home visiting pilot. The Infants and Toddlers Program was selected because it is a strength-based, family-focused model that uses early assessment and comprehensive intervention services for children with confirmed developmental delays. The Community Health Services Unit of the Department of Health and Human Services, Public Health Services Division was selected for its broad reach in the community and its focus on health issues for low-income families. Unique program elements of each (e.g., focus on parent education and development of Family Support Plans; focus on health and utilization of Nurse Case Managers) provided the foundation upon which the pilot program was built. This pilot, aptly named Project HOME, was to be an education and early intervention program targeting parent-child interaction and child physical, social and emotional health and development. Services were to be on a short-term basis, with program staff referring participating families to more established service organizations for longer-term care once immediate early childhood needs were alleviated.

Year I of Project HOME was awarded initial funding for the period beginning October 15, 2000 and continuing through June 30, 2001, and almost immediately, the initial design of Project HOME started to evolve. A Project Director and Community Nurse Practitioner were hired to supervise and implement the pilot. However, program implementation based on the ITP and CHS models proved to be a difficult fit for Project HOME needs. The ITP model is specifically focused on providing intervention services only to children identified as developmentally delayed, thereby addressing only a potential percentage of the broader needs targeted by the Project HOME program. And while the CHS model is available to a more extensive population, it too is more narrowly focused in that its emphasis is on pre-and postnatal health issues. In order to appropriately serve the population targeted for the pilot, the integrated Project HOME model needed to be broader in scope with more emphasis on prevention than intervention.

Recommendations to program design made at the end of Year I proved to be among the most pivotal and greatly impacted the success of the program in Years II and III. Project HOME staff recognized the need for better definition of the project's goals, and a clearer description and determination of the services being offered, both for themselves and for participants. As such, staff worked to develop a more formalized mission that highlighted the program's *family-centered* approach and primary focus on improving health and developmental outcomes for

children through home visiting, as well as its primary mission to help families ensure that their young children (ages 2 to 4) enter school "ready to learn." Although fairly basic, this focus on family and school readiness was fundamental in shaping services. With a new emphasis on school readiness, the Program Director could better ensure the appropriateness of incoming referrals and the identification of program curricula, materials and staff trainings. Moreover, Project HOME staff could become more systematic in their efforts to help families develop goals related to self-sufficiency and the social and emotional health of their children and focus more on helping parents understand what young children need in order to enter school prepared to succeed.

It was also decided that professionals with an understanding of and experience in home visiting approaches would best serve the design of Project HOME. As such, Home Visitors were hired to replace the departing Community Nurse Practitioner and serve as a link between communities and populations served by the program. This link would enable Home Visitors to establish rapport with high-risk families and comprehend the range of issues these families confront on a daily basis. Through home visiting sessions, the Home Visitors would engage families in a series of activities that met their evolving, individual goals, educate them on the most effective ways to ensure school-readiness in their children, and utilize the Best Practices approach for successful home visiting as defined by the Early Childhood Initiative **(*see Appendix A – Best/Effective Practices*).** New home visiting protocols, new leveling criteria, and implementation of new curricula rounded out the considerable changes assumed by program staff in Year II, creating a program that was no longer short-term and transitional, but one built on quality relationships between Home Visitors and families and formalized procedures for service delivery.

Program Description

As a blend of discrete programmatic elements from both the Infants and Toddlers Program (ITP) and Community Health Services (CHS) models enhanced with research based effective practices, Project HOME has consistently focused on 1) increasing and supporting the use of effective practice in early childhood services provided through a home visiting strategy; 2) supporting and educating parents on child health and development; and 3) strengthening families through linkages to community resources; and 4) promoting school readiness through best practice. With the addition of the CWS families to the target population, an additional emphasis was placed on preventing child abuse and neglect. As a child-centered and strength-based program, these objectives aim to minimize gaps in early childhood development and help at-risk children enter school ready to learn. This is accomplished through a comprehensive set of services that includes child development activities and parenting education (Parent as Teachers curriculum), supportive case management and linkages to community resources and health care, identification of and referrals for behavioral health needs for both children and parents, and support for parents in navigating their children's transition to school. Indeed, school readiness has become a primary focus of both Project HOME and the Home Visiting Consortium, making the recruitment of families with toddler-aged children in Project HOME both a necessary and unique element of program design.

During Year III of Project HOME, recruitment and enrollment efforts were expanded to include families affiliated with Child Welfare Services (CWS) in addition to the initial target population. In summer 2001, representatives from CWS approached representatives from the Early Childhood Services (ECS) department of Montgomery County Human Services for assistance in broadening the scope of services available to their children and families. During this initial phase, representatives from both organizations formed the Child Welfare/Early Childhood Workgroup, which identified ways to educate existing service organizations about CWS and its capacity to help families in crisis (and vice versa), as well as to involve at-risk families in services that would promote increased family functioning. Based on recommendations from the Workgroup, an application was submitted to the State of Maryland's Office of Crime Control and Prevention in fall 2001 for monies under the Youth Strategies Consolidated Grant that would help support the establishment of a partnership between CWS and ECS. The Youth Strategies Grant is designed to help counties provide comprehensive, wrap-around care to at-risk families so as to minimize and/or prevent delinquency and risk behavior. In combining efforts, CWS and ECS professionals could achieve many goals, including increased service delivery, enhanced understanding and awareness of available early childhood services, and more importantly, improved family functioning.

Upon approval of the application, the Workgroup reconvened and met on a regular basis in spring and summer 2002 to identify and define a plan by which healthy parent-child interaction among high-risk families could be promoted. The plan drafted by the Workgroup included two phases: 1) providing intensive, family-centered therapy and support to families enrolled in CWS and 2) providing training and education on early childhood development to CWS staff. Given its focus on intense home visitation with toddler-aged children, the Workgroup decided that Project HOME would be an ideal program through which to provide intervention services to CWS families. As capacity and cost dictated a more narrow scope than was perhaps desired, representatives of CWS wanted to target and enroll those families who would most benefit from services. The Workgroup carefully considered the available population from CWS and decided on the following intervention groups:

1. Children between the ages of 0-5 being reunited with their parents
2. Children between the ages of 0-5 receiving continuing services from CWS

The Workgroup felt that families within these groups would be the most eager for support and in a prime position to benefit from intervention services. This is particularly salient since Project HOME is a voluntary program in which parents must consent to participate. Additional referral criteria included location (families had to reside in Montgomery County), enrollment (families must be an 'open case' within CWS at the time of referral), and need (families must not be participating in other early childhood services). Moreover, members of the Workgroup recognized the pre-existing objectives for Project HOME to be particularly relevant for CWS families. These objectives are stratified and include short-term (e.g., increased number of successful reunifications, decreased accounts of documented child abuse), intermediate (e.g., improved parent-child interaction, increased awareness and utilization of community resources) and long-term outcomes (e.g., school readiness).

In order for this collaboration to be truly effective, however, efforts to promote awareness and support of Project HOME among CWS staff were needed. In summer 2002, the Workgroup agreed that extending training opportunities to CWS staff would bolster the collaboration between organizations by providing support to program implementation. ECS representatives agreed to reserve slots for CWS staff at any of the regularly scheduled early childhood training sessions sponsored by the Home Visiting Consortium. CWS supervisors were to encourage their staff to participate in trainings so as to maximize awareness and support of Project HOME within the CWS community. At the same time, CWS representatives provided additional contexts for potential participant recruitment. In fall 2002, the Betty A. Kranke Shelter was offered as a possible place to hold much-needed parenting groups, and Project HOME staff were encouraged to contact the Director. Project HOME staff were also encouraged to contact directors at the CWS regional offices to ensure that CWS staff were well informed of the availability of home visitation services for families. The CWS professional community was 'blanketed' in the hopes of establishing early childhood related services for families across multiple domains.

By early 2003, CWS staff was participating in training sessions on early childhood development and gained a better understanding of the social, cognitive and behavioral issues facing the children under their supervision. Project HOME staff were receiving referrals from CWS staff and were busy clarifying the program design elements and protocols essential to establishing new inter-agency collaboration. Such achievements strongly support the efforts of the county to create a coordinated, integrated service delivery system.

Staffing

Initially, Project HOME was designed to target high-risk, non English-speaking residents in Montgomery County, specifically immigrants from Latin and South America. As such, it was imperative that staff be bilingual, culturally sensitive and representative of the families they served. At the beginning of Year II, Project HOME prioritized the hiring of bilingual program staff in order to ensure that participating families' needs could be identified and addressed in a culturally sensitive and appropriate manner. With the large majority of participants identifying themselves as Hispanic, this prioritization was well timed.

Unfortunately, Year II of Project HOME saw tremendous turnover in program staff, making it more difficult to ensure the delivery of quality services and/or collection of data. In sharp contrast, there was no program staff turnover during Year III, only expansion, as the two Home Visitors hired late in Year II were joined by another Home Visitor hired at the beginning of Year III ***(see Appendix B - Staff Tenure)***. Specifically, two Home Visitors were hired in April 2002, while the third was hired in August 2002. Two of the three home visitors possess college degrees and each brings unique strengths to services (e.g., strong case management, good rapport with teen mothers). Moreover, two of the three home visitors are bilingual and all have been formally trained in the Parents As Teachers (PAT) curriculum. Project HOME is currently listed on the PAT website as an official program in compliance with PAT procedures. That two Home Visitors also have considerable experience in home visiting made Project HOME well-equipped to navigate the changes that came with the expanded service delivery and participant recruitment efforts under the Youth Strategies/CWS partnership.

Supervision and support of the Home Visitors was recognized to be an essential aspect of quality programs and staff retention. This became even more critical as Project HOME included the CWS families in their caseloads. Project HOME leadership and program staff were provided clinical supervision on a contractual basis by an LCSW. The clinical supervisor conducted both individual and group supervision with all three Home Visitors. Each received one hour of individual supervision, along with two hours of group supervision per month. The Project Director received supervision on a bi-monthly basis for one hour. Further, weekly staff meetings were held with the three Home Visitors, who use this time for coaching and support. Once a month the weekly staff meeting included the Project Director and was used as a time to discuss case management and troubleshoot problems that arose in program implementation.

Leadership staff for Project HOME saw slight changes in Year III in that the Project Director of two years left the program in late spring 2003 on maternity leave. An independent contractor with the Montgomery County Infants and Toddlers Program was asked to assume leadership as Interim Project Director. Interestingly, staff communication and program supervision were reported as improved under the Interim Director, thereby strengthening, rather than weakening the developing program infrastructure as might be expected with such change.

Stability in staffing can have tremendous impact on program implementation and success, particularly with a home visiting program, where intense relationships between parents and Home Visitors are likely to develop. While Year II saw little to no interruption in service delivery despite changes in staff, program implementation in Year III was likely enhanced by continuity in staffing. As observed in meetings and interviews conducted with staff, program infrastructure for Project HOME seemed stronger in Year III, as evidenced by better communication between staff members, stronger leadership, and collective understanding and endorsement of the program's mission.

METHODS

Procedure

The Project HOME program evaluation was delayed in its planning and implementation in Year III. This delay was in large part due to the Collaboration Council's efforts to coordinate evaluation efforts with the Youth Strategies grant and the state cross-site evaluation being conducted by the University of Maryland, Department of Criminology and Criminal Justice. A contract was executed in spring 2003, and as the evaluation team had been away from the project for over 6 months, it was decided that an assessment of the current status of Project HOME activities and data collection efforts would be the best 'first step' in the Year III evaluation. The status review consisted of two phases, including: 1) meetings and informal interviews with Project HOME staff to establish a profile of project implementation and progress during the first part of Year III, and 2) a comprehensive file review to track data collection efforts to date. Specifically, the status review examined program infrastructure, program activities, new partnerships, and participant data. Findings were summarized in a brief report and submitted to

program leadership staff **(*see Appendix C- MCHV Project HOME Status Report*)**. Findings from the status review helped define and inform Year III evaluation activities, which focused on staff meetings and observations, data monitoring and entry, structured interviews, and survey administration **(*see Appendix D - Project HOME Year III Evaluation Proposal*).**

In Year II, Project HOME and its evaluation drew on lessons learned from its Year I pilot and worked to incorporate findings from the Maryland State Department of Education (MSDE) on school readiness and County demographic statistics into programming and outreach. The evaluation conducted in Year II focused primarily on examination of program implementation, identification of effective practices, and areas for program improvement. Additionally, the Year II evaluation directed efforts at establishing data collection mechanisms for ongoing monitoring as well as the collection of baseline data on participating families so as to promote stronger program infrastructure.

Year III of Project HOME, while expanding its focus to highlight the involvement of the newly targeted CWS population, retained much of the scope outlined in its initial program design. The evaluation of the project, supported by findings from the status review, was directed toward basic documenting program implementation, particularly in terms of the impact of including CWS families, and overall improvements in program infrastructure. And while Project HOME staff demonstrated significant gains in data tracking in Year II, evaluation efforts in Year III continued to focus on ways to better time all data administration and collection and to build evaluation infrastructure, as these sources continue to provide the program with a measure of success in achieving targeted outcomes.

Population Sample

The target population for Project HOME was initially defined by findings outlined in the *Comprehensive Plan*, which identified unserved, low-income families with children ages 2 to 4 who are in need of child health, child development, or family support services. At that time, target communities included Gaithersburg and, later, Wheaton, largely because these communities demonstrated either general high risk or a strong concentration of young children entering school without sufficient readiness skills. The partnership with Child Welfare Services (CWS) in Year III further concentrated efforts on the Wheaton area, but also extended into Silver Spring, MD, slightly redefining the geographic parameters of Project HOME.

Successful recruitment of Project HOME participants during Year III was largely based on improved referral coordination within the Montgomery County Home Visiting Consortium and partnerships with outside agencies. Specifically, the introduction of the referral hotline, *ChildLink*, into the system of Early Childhood Services helped streamline referrals and improve overall recruitment. Moreover, successful relationships with the Linkages to Learning Program at Highland Elementary School helped provide continual referrals to Project HOME, making it easier for Home Visitors to reach out and connect with families in need. Linkages to Learning is a school-based program offering mental health, social services and improved access to health care services and other community resources. Yet while the program is highly effective in meeting such needs, Linkages staff is not equipped or trained to meet the developmental needs of very young children. A partnership with Project HOME provided a resource for Linkages to

Learning families with concerns about their youngest family members and the two programs maintain ongoing communication on an individual and staff-wide basis.

At the same time, the partnership developed with CWS expanded the range of children and families to be targeted for support, providing additional opportunity for service coordination across the county. The Child Welfare/Early Childhood Workgroup spent considerable time trying to identify ways to maximize resources across agencies and provide more families with quality home visiting services. As with the Linkages program, CWS staff are not as equipped as Project HOME staff to meet the developmental needs of families, needs that directly impact the extent to which families enter and stay in the county "system" of risk. It was expected that in coordinating efforts with CWS staff to provide professional, culturally sensitive and competent home visiting therapy, Project HOME staff would help families increase their odds of reunification (if the child has been taken from the home) or remaining intact throughout their case review.

With such changes and improvements, capacity for Project HOME increased from Year II to Year III. In Year II, Project HOME received 73 referrals and enrolled 42 (58%) families for services. Year III saw fewer referrals at 66, but 58 (88%) were enrolled for intensive services, with an additional eight families carried over from Year II through active, intensive service delivery. Such trends reflect improvements in stability and capacity of Project HOME. Clearly, program staff continue to meet significant needs of participating families. All enrolled families are included in the evaluation analyses for attrition, but only families who received a minimum of four (4) home visits are included in the outcome analyses. No other exclusionary criteria are used.

Goals and Objectives

The goals for Project HOME have remained constant over the last two years, reflecting the mission of the Consortium to increase and integrate home visiting services for unserved at-risk families. At a general level, Consortium goals aim to promote better parenting, child health and development, and family self-sufficiency. The goals of Project HOME speak more specifically to identified gaps in services, enhanced quality of home visiting services, and increased school readiness **(*see Appendix E – Montgomery County Project HOME Assessment Plan*).** The goals of the program include:

1. To utilize Best/Effective Practices in Home Visiting
2. To improve Health and Development Outcomes for Children
3. To support Families through Goal Setting and Community Linkages
4. To link Best Practices to School Readiness Goals of the County.

The goals and objectives outlined for Project HOME have never been extensive because the program is designed to capitalize and expand on existing home visiting services in the county. As such, overall program model and objectives remain broad, with the single largest difference being that services of Project HOME are targeted to families with toddlers, not necessarily families with newborns.

Outcome Measures Descriptions

1. Home Observation for Measurement of the Environment (HOME) 3rd Edition, 2001

The HOME is used to measure the quality of the home environment. It has a strong track record in previous research and has been used with a variety of different racial/ethnic groups. Studies using the HOME have repeatedly found that cognitive stimulation in the homes of young children is associated with language development, intellectual development, and academic achievement.

The Infant/Toddler version of the HOME (IT-HOME), used with Project HOME families, is comprised of 45 items designed to assess the following domains: (1) emotional and verbal responsivity of parent, (2) acceptance of child=s behavior, (3) organization of physical and temporal environment, (4) provision of appropriate play materials, (5) parental involvement with child, and (6) opportunities for variety in daily stimulation. Scores are categorized in three groups: 0-25 - Lowest Quartile; 26-36 - Middle Half; and 37-45 - Upper Quartile.

The HOME is a semi-structured, sixty-minute observation/interview which is conducted in the child=s home. It may be administered by a paraprofessional in the home at a time when the child is awake and can interact with his/her mother or primary caregiver. Approximately 70% of information regarding the child=s environment is attained through interview, while 30% is acquired through observation.

2. Ages & Stages Questionnaire: Social-Emotional (ASQ:SE)

The ASQ: SE was developed by a multidisciplinary team at the University of Oregon's Center on Human Development as a companion tool to the ASQ, a well researched system that uses parent report to screen the development of infants and young children. The ASQ: SE was developed in an effort to assist parents, caregivers, and early childhood personnel in the timely identification of children with responses that may indicate future social or emotional difficulties. It was designed as a screening tool to identify children who are in need of further evaluation.

The ASQ: SE addresses seven behavioral areas: self-regulation, compliance, communication, adaptive functioning, autonomy, affect and interaction with people. ASQ: SE questionnaire intervals correspond with the ASQ system, screening children from 3 months to 5½ years of age. Questionnaire intervals are as follows: 6, 12, 18, 24, 30, 36, 48, and 60 months.

The ASQ is administered through parental interview. It is essential that each questionnaire be administered within the proper window of reliability surrounding its age interval (+ /- 3 months to age 3 ; + /- 6 months to age 5). It takes approximately 15 minutes to complete.

3. Parenting Stress Index - Short Form (PSI/SF)

The PSI/SF measures the three primary components of the parent-child system for the purpose of early identification of stressful circumstances related to parenting. It focuses on the parent, the child, and their interactions.

The PSI/SF contains 36 statements, which are divided into three subscales: Parental Distress, Parent-Child Dysfunctional Interaction, and Difficult Child. The Parental Distress subscale assesses the distress a parent is experiencing as a result of his/her role as a parent. The Parent-Child Dysfunctional Interaction subscale focuses on the parent's perception that his/her child does not meet expectations and interactions with the child are not reinforcing his/her as a parent. The Difficult Child subscale looks at basic behavioral characteristics of children that make them either easy or difficult to manage. The statements are rated on a 5-point Likert scale, ranging from "strongly agree" to "strongly disagree." High scores in any of these subscales may indicate problems with adjustments to parenting, weak or threatened parent-child bonds, or the need for professional assistance in child management strategies. Parents who obtain a Total Stress score in the 85th percentile or above are considered to be at risk for significant levels of stress.

4. Denver Developmental Screening Test II (DENVER II)

The DENVER II is a valuable as a screening tool, which provides an organized impression of a child's overall development and to alert the administrator to potential developmental difficulties. Originally developed in 1967, it was extensively revised and restandardized in 1989. It is designed to be used with children between one month and six years of age, and compares a given child's performance on a series of age-appropriate tasks with other children the same age. Results are interpreted as "Normal", "Suspect", or "Untestable."

The DENVER II consists of 125 items, arranged in four domains: Personal-Social (getting along with people, caring for personal needs), Fine Motor-Adaptive (eye-hand coordination, manipulation of small objects, problem solving), Language (hearing, understanding, and using language), and Gross Motor (sitting, walking, jumping, and overall large muscle movement).

RESULTS

Significant strides were made by the end of Year III of Project HOME. As a more mature program with competent and stable staff, stronger leadership, and expanded linkages within the community, Project HOME became recognized as a quality program for at-risk families and children who could not be served by other County programs. The substantial modifications to program design and staffing that occurred in Year II provide a context in which to assess program outcomes in the current year. As noted in the Year II evaluation report, Project HOME made significant gains in reducing the gap in home visiting services to unserved families with young children and demonstrating the viability of this strategy with toddler-aged children. In Year III, this was accomplished with families already involved with Child Welfare Services (CWS). Successful collaborations were established with existing service organizations and better referral procedures resulted in increased participation. At the same time, progress was made in formalizing program policies and procedures and strengthening staff knowledge through training. Revision of participant forms, development of new forms, and training in cultural competency and early childhood development lent legitimacy to the efforts of Project HOME to establish itself as a viable early childhood prevention/early intervention program within Montgomery County. Overall, the program served increased numbers with more qualified staff and a standardized curricula, connected families to needed resources and services, and accomplished some of the program's goals and objectives. Additionally, the program advanced toward a more sustainable infrastructure with the establishment of ongoing data mechanisms to track program activities and outcomes.

It is worth noting that these achievements were accomplished in the face of considerable programmatic, staffing and population modifications experienced largely during the first two years of the program, lending significance to the viability of the model. Unfortunately, delays in the development of a stable program infrastructure prompted the decision to transfer Project HOME to the Families Foremost Center at the Mental Health Association.

The following section includes results from both the Process and Outcome Evaluations. Process Evaluation findings are presented first and were based on the analysis of quantitative data related to service utilization and population demographics. These were supplemented with qualitative data collected from a review of program documentation on staff development, service delivery, records management, and staff and participant satisfaction. Outcome Evaluation results are based on analysis of standardized measures and progress toward identified goals and objectives. Finally, recommendations for future program activities and lessons learned are presented.

PROCESS EVALUATION

Program Implementation

Program efforts in Year III have successfully built on the momentum generated during Year II. Specific accomplishments in the past year include the further development of high quality staff, refinement of program protocols, improved data administration and tracking, and continued modifications to program design to accommodate CWS families. This progressive evolution of Project HOME has required program staff to continually redefine their work. This is most clearly manifested in the partnership between Project HOME and CWS forged in Year III. This partnership was supported through a Youth Strategies Consolidated Grant from the State of Maryland, which is designed to provide communities with resources to better coordinate prevention and intervention services for high-risk youth and families. This alliance proposed to determine if a home visiting strategy could be used effectively with higher risk families that are at the 'intervention level' of need. Pre-existing relationships with both the Linkages to Learning Program and the Reginald S. Lourie Center for Infants and Young Children also continued to evolve so that services between programs remained comprehensive and complementary.

Although an increasingly more structured and effective program during Year III, Project HOME staff faced some challenging, if not unanticipated needs among their participants. As designed, Project HOME provides a series of comprehensive services to families, a range of trainings to staff and partners, and consistent supervision to staff to accomplish the stated goals. Services provided to families through home visits included parenting education and child development activities using the Parents as Teachers (PAT) curriculum; screening and assessment of children for early identification of possible developmental delay using the Ages and Stages-Social Emotional questionnaire and the Denver II; family needs assessments and Family Parenting Agreements; and linking families to additional resources in the community, such as housing, ESOL, health care, mental health, substance abuse, and legal resources. One mother was even supported in acquiring her driver's license. At the same time, however, home visitors found that parents were often overwhelmed by community institutions, such as the school system, legal system, or housing authorities. Consequently, staff also found themselves providing guidance, support, translation, and transportation to assist families in navigating these systems. For example, several of the families had older children in the school system who had developmental delays. The task of working through an Individual Educational Plan (IEP) with the school educational specialists was very challenging for parents. The support received from the home visitors, and specifically from Linkages to Learning partners for Highland Elementary School participants was crucial. These challenges were exacerbated if the family was non-English speaking. Unfortunately, although ESOL classes were offered in several venues, with child care and food provided to reduce barriers to attendance, very few parents took advantage.

Project HOME staff also faced considerable challenges when addressing the behavioral health needs of their families. Not only were mental health issues very common and complex in nature, but community resources were scarce and difficult to access. This was particularly true for the adults. Although the Lourie Center provided mental health services to the children, the parents needed these services also. Often times, it was the multiple, overlapping issues that

families have that were the most difficult for the home visitors to resolve. Economic, legal, and housing pressures led parents to work long hours, often at several different jobs. Children were unattended, even if the parents were home, as they were too exhausted to provide adequate supervision and attention. Safety issues then became paramount. Maternal depression rates were high, but cultural barriers prevent many families from recognizing mental health issues and accessing services. Since Project HOME serves families with multiple children, home visitors were confronted with the socio-behavioral issues of the older siblings. Typically, the older children had not received any previous early childhood services. Consequently, developmental delays were evident in their lack of knowledge of colors, shapes, how to cut and paste, and other pre-school readiness skills. Finally, home visitors also found it necessary to work on basic life skills with families. These activities included organizational skills for the home, cooking, grocery shopping, finances, and planning budgets. The challenge for the Project HOME staff was to be able to provide appropriate developmental activities for the range of children's ages and skill levels within each family, while also addressing the behavioral health and case management needs.

In addition to providing services to individual families through home visiting and case management, home visitors were also involved in group activities. Project HOME staff conducted parent groups, such as a workshop on child discipline for parents at Fox Chapel Elementary School; participated in a soccer program at Broad Acres Elementary School; and conducted workshops for CWS staff. These supplemental activities were accomplished in addition to a full home visiting schedule. Indeed, the Home Visitor's caseload typically exceeded the program's best practice target of 15-16 families. Only one home visitor had a caseload in this range, while the other two had caseloads ranging from 18-30+ families. The program worked hard in Year III to establish a more clearly defined 'Leveling System' that would account for the intensity and duration of services that each family needed. This system was more firmly established toward the end of Year III.

Interviews and surveys conducted with staff indicate that they faced more complex needs among their families during Year III. While they often felt overwhelmed by the multiple tasks required to support these high-risk families, staff remained supportive of and committed to the program. Still, this level of dedication was not able to compensate for the seeming lack of program infrastructure that was evident at the start of Year III. In mid-2003, senior executive and financial officers with the Montgomery County Collaboration Council were growing increasingly concerned about the financial status of Project HOME. They found it difficult to gain a clear perspective on program costs and could not reconcile why state funds went unused at the end of each program year. At the same time, officials were increasingly frustrated by the seeming lack of data that had been collected over the course of program implementation. Determined to see funds used more efficiently for families and to secure better quality data on outcomes, County leadership met with executive staff at both Project HOME and Early Childhood Services to discuss the possibility of opening a competitive bid for Project HOME programming and funds. In the end, Project HOME and Early Childhood executive staff convinced County officials to examine pre-existing contracts within the county for programming that was already in place. They proposed that linking Project HOME goals and activities with a pre-existing program would likely be the best way to implement a transition with the least interruption of service. Two early childhood models in the county were considered that most fit

the targeted goals and objectives of Project HOME. Closer examination of these programs and discussion with the Program Directors of the initiatives revealed Families Foremost to have a more flexible design, increasingly the likelihood of a smooth, successful transition.

Once the decision had been made to transfer funds and programming services to Families Foremost, county officials and MHA executives met with Child Welfare Services staff to review the basic components of the program design and to conceptualize the transition of programming for the 2003-2004 year. It was agreed that MHA would give priority to families currently enrolled in Project HOME but who do not qualify for Youth Strategies monies and, as such, are supported by funds from the Governor's Office of Children Youth and Families (GOCYF). At the same time, MHA staff would maintain responsibility for providing 'in-home family support' to those CWS families funded through the Youth Strategies grant sponsored by the Governor's Office of Crime Control and Prevention (GOCCP). Eligibility criteria for newly enrolled families under GOCYF funds would still focus on toddlers aged 2-4 who are ineligible for any current program. In contrast, eligibility criteria for newly enrolled families under the GOCCP funds would expand to include families with children aged birth to 10 years.

By July, Project HOME had been informed of the decision to transfer programming to MHA. Staff met with leaders of the Collaboration Council, MHA and Families Foremost to discuss the transition process and to finalize activities they would use to notify their families of the change. Negotiations for transfer of Project HOME staff were also discussed at this time, resulting in the hiring of one Project HOME Home Visitor to work at Families Foremost and serve an instrumental role in the transition process. The Transition Plan that was submitted to the Council by the Center Director of Families Foremost was a calendar schedule of transition events. All families interested in transferring to Families Foremost were to be in place by August 31st.

Ultimately, the decision to transfer services from Project HOME to Families Foremost came down to programmatic and fiscal capacity. Moving the program to MHA meant that family needs for services beyond the capacity of home visiting therapy could be met directly by other MHA programs or through their existing partnerships. By its very design, Project HOME is a home visiting program that can support, but not manage the complex environmental needs of families in ways that MHA staff might be able. This increased coordination of services at MHA could then, in turn, free monies to be funneled into 'flex' funds that would support costs for family services not available in the county. In the end, participants would have access to a 'one-stop' approach to services within an agency that possessed a contained, integrated system of delivery.

The decision to transfer programming from Project HOME to Families Foremost, while justifiable, was viewed by project staff as unfortunate, given the marked improvements observed in service coordination and program implementation by the end of Year III. If given another year, it is quite possible that Project HOME would have developed an infrastructure that was more responsive and responsible to the programmatic and fiscal needs of the county. Given current economical constraints, however, the ability to suspend the transition seemed impossible. Utilizing the programming of a more established, more formalized agency will likely maximize limited resources for families in need of multiple services.

Partnerships

Several key partnerships impacted Project HOME in Year III. They continued their very successful partnership with the Linkages to Learning program at Highland Elementary School. Through this partnership, Project HOME received referrals and coordinated services with participating families whose older children attend Highland. The project also continued to partner with the Lourie Center around children's mental health issues. Referrals were also received from the Lourie Center, while the Center provides therapeutic services to Project HOME participant children. The relationships with both the Linkages to Learning Program and Lourie Center continued to evolve in Year III with each contributing valuable expertise. Linkages staff demonstrate excellent case management skill and tremendous knowledge of community resources, while Project HOME staff provide parenting and child development expertise. Project HOME had the added benefit of doing home visiting, which enables them to contribute valuable insights about the family and its needs. Relationships between Linkages staff and Project HOME staff continued to be based on mutual respect and collaboration. Together, the services are comprehensive and complementary. The partnership with the Lourie Center yielded multiple benefits. For example, some Project HOME families have been enrolled in Lourie Center's Early Head Start program, providing access to services and additional county programs for assistance. Additionally, children were connected with therapeutic services. However, Project HOME staff found that the Lourie Center services were often too difficult for families to access, possibly due to the fact that they are offered exclusively to the child and not the parents or family as a whole.

The significant new partnership with CWS and the expansion of services to higher-risk families under the Youth Strategies Consolidated Grant dramatically altered the landscape for Project HOME. This year program staff have met families with multiple needs across a range of situations, including poverty and abuse, homelessness, and mental health disorders (i.e., schizophrenia and sexual abuse). While these issues are not uncommon in high risk families, program staff found the complex profile of needs among CWS cases to more intensive than in previous years. Many adults enrolled in CWS have long-standing relationships with the organization that date back to their own childhood victimization and many have several children, each with their own risks and vulnerabilities. The demands on Project HOME staff have grown to include intervention with and treatment of several siblings at one time, as well as comprehensive case management and assistance. The wide range of ages and developmental levels of the children has made it more difficult to implement appropriate child development activities, curricula, and assessments. Such demands have made staff increasingly more aware of the need for family-based intervention and behavioral health services for these families and the lack of existing programs to which to refer them.

Although there were initial challenges to building strong partnerships and establishing good lines of communication, efforts coalesced and members collaborated to contact direct service staff/groups to get them on board. Ongoing efforts at collaboration centered on ways to differentiate the role of CWS staff from that of the Project HOME staff so that program implementation and service delivery remained seamless. At a rudimentary level, defining and

establishing an effective chain of command was problematic. Project HOME staff was not involved in the actual design and submission of the Youth Strategies grant application and, as such, was largely unaware of the objectives and tasks that lay before them going into Year III. As a result, staff were unprepared to implement the best method to successfully recruit families from CWS for services. On several occasions, the Project HOME Program Director contacted and made presentations to various CWS supervisors but failed to receive a substantial number of referrals from them. Ultimately, the Program Director appealed directly to front-line staff and encouraged their participation. Building this rapport improved the appropriateness and timing of referrals and helped establish quality relationships and collaboration between Project HOME and CWS workers. Both parties had to learn to communicate effectively with each other regarding their respective strengths and limitations in helping CWS families, but such efforts proved worthwhile and resulted in an unofficial protocol for enrollment. For example, when a referral was received from CWS, Project HOME staff would contact the CWS staff member in charge of that family's case, initiating a discussion of joint case management. The joint work with the families occurred either through phone correspondence or through joint visiting of families to ensure effective service delivery. Both Project HOME and CWS staff found this system to work effectively in providing comprehensive services to families.

Staff also faced challenges with participant enrollment and recruitment from an administrative standpoint. As outlined above, select groups of CWS families were initially targeted for participation in Project HOME. When services were officially opened to CWS families, however, Project HOME staff received referrals for families outside the targeted range. This likely delayed actual enrollment and service delivery to CWS families until the Workgroup amended the original parameters for the target population and opened enrollment to all CWS families, regardless of status. Such amendments, coupled with improved relationships with CWS front line staff, resulted in better flow of referrals to Project HOME and helped establish a stronger foundation upon which to build this new partnership.

Issues surrounding initiation of service are not uncommon when establishing new partnerships and collaborations. Indeed, the extent to which they are acknowledged and resolved becomes a critical, if not obvious index of both current and future success of the program. By the close of Year III, staff from CWS and Project HOME, as well as general members of the Workgroup, spoke favorably of the partnership and positively about progress made toward goals and objectives. CWS staff were enthusiastic about the achievement of their goals and objectives, namely the increased level of awareness and understanding of the role CWS can and does play in protecting young children at risk. CWS staff were also highly supportive of home visitation and the Project HOME model, where staff were viewed as greatly skilled in the ability to take services to families and help empower them to be more proactive in the development of their children. That services also helped inform CWS families of existing resources further supported the mission of family preservation. For their part, Project HOME staff viewed the partnership as a success in extending services to new populations. They welcomed the inclusion of CWS staff in early childhood development trainings, which when combined with the establishment of communication channels, resulted in better, more consistent flow of referrals. Relationships between CWS and ECS will be nurtured, in the hope that future opportunities for partnership will surface. This seems especially critical, given the transfer of Project HOME. Tracking mechanisms to measure the rate of change in family functioning among CWS families who

participated in Project HOME will need to be developed. Additionally, the collaborative functions, including referral systems and joint work with families will need to be fleshed out and formalized between CWS staff and Families Foremost. Information from leadership regarding the direction of the Youth Strategies Consolidated Grant would likely alleviate expressed concerns by staff about how the services provided through the new partnership will now be obtained.

The biggest challenge, however, was arguably in the actual implementation of Project HOME among the new subset of high-risk families. From the beginning, the policies and procedures utilized by Project HOME and CWS respectively were discordant, requiring both parties to consider the best approach to interacting with families for the sake of the collaboration. Since its inception, Project HOME has been a voluntary program, open and available to families who independently have sought out assistance from their community. By its very design, CWS is a legally mandated program, making volunteer participation a non-issue. Not wanting to weaken the quality of services provided to families, CWS representatives agreed in early 2003 to support the Project HOME protocol. For their part, CWS did not require Project HOME program staff to report non-compliance and Project HOME staff agreed to field additional paperwork on CWS families so as to assist caseworkers in their reporting obligations.

Additional differences in the policies and procedures guiding these two organizations became evident as families were contacted for services. For example, Project HOME program staff have always worked on an appointment basis, in which families are contacted in advance and a meeting time is arranged. This is an important component of the home visiting model, in that it indicates to participants that their time is valued by the Home Visitor. At the same time, the procedures of Project HOME have centered on service provision to a targeted child within a family. Specifically, Home Visitors tailored activities and interventions to the needs of that particular child, aged two to four, and worked to build a better relationship between that child and his/her parents. Procedures among CWS program staff differ considerably. In contrast to Project HOME staff, CWS caseworkers often drop in on their families without calling and often rely on third-party contacts (e.g., relatives, bosses) to communicate with families. CWS staff also work more readily with families in which there is more than one child and are more accustomed to case management across multiple issues and domains. In working with CWS families, Home Visitors found themselves often providing services to children, aged birth and five years, and their siblings, placing new demands on them and the extent to which they felt they could provide quality services to each child. These differences may have initially impeded effective communication delayed the implementation of services to these families.

Finally, the recommended partnership with the Betty A. Kranhke Shelter never materialized. Logistical difficulties experienced by shelter staff made it impossible to establish parenting education classes on a regular basis, even after repeated contacts by Project HOME staff. Moreover, attempts to hire additional staff to help absorb the number and rate of referrals were thwarted because leadership could not ensure funding beyond the 2002 fiscal year.

Program Documentation and Data Tracking

A tremendous step Project HOME took this year was the recent hiring of a database specialist. During Year III, data was entered into the HATS system, an Excel database containing all the variables required for the external evaluation and the Local Management Board (LMB) reporting. After much development, the HATS data program, originally designed for use with Montgomery County with the addition of an early childhood module, is no longer considered a viable system for data tracking and was dropped by the County. Project HOME staff still used the HATS system for internal purposes only, but noted complications. Progress notes on families could be entered, but could not be combined for aggregate profiles. Intake forms were geared primarily for medical policyholders and, as such, were not appropriate for the program. Further, the HATS system contained no relevant assessment category under which to enter scores on outcome measures. These problems made it difficult for Project HOME staff to run reviews and reports on their data that could be distributed to funders and local policymakers.

While facing the barriers related to data entry and HATS, efforts in Year III of Project HOME have centered on developing effective strategies for better data collection and tracking. To better identify family need at program enrollment, the Project Director created a simple leveling criteria for assignment of Home Visitors that could be used to inform Family Parenting Agreements and guide program activities. To assist Home Visitors in data collection efforts, the director also created a Data Summary Checklist that highlights all primary forms of program (e.g., consent for participation in evaluation, consent to release information) and participant (e.g., notes and observations of home visits, formalized measures) documentation that is to be collected. Assistance from the Evaluation Team has also ensured that Spanish versions of all forms are available.

Recommendations from the Year II Annual Report spoke to the increased need for participant data and a formalized schedule of assessment. In response to these recommendations, the Project Director conducted an extensive file review of participant records in March 2003 in order to determine quality of documentation and data collection efforts in Year III. Notes were collected on the Data Summary Checklist and Home Visitors were advised to minimize identified gaps in participant records. The Evaluation Team then returned to Project HOME offices in late April and early May 2003 to determine what improvements, if any, had been made to participant files. Files for two of the three Home Visitors were much improved and nearly complete. Recommendations made during the initial file review had largely been addressed, particularly regarding program documentation like consent forms, family service plans, and program notes and observations. Follow-up on data collection on outcome measures was less complete for most participants. Files for the third Home Visitor were in need of improvement and were completed by the conclusion of Year III.

It is worth noting that Project HOME staff is fully aware of outstanding needs for additional data tracking methods and forms. There is no formal policy regarding Home Visitor safety while conducting a home visit. In addition, while forms documenting case closures and policies for referring closed cases to other agencies had recently been developed, criteria for initiating a case closure was still under discussion. Other recommendations from the Year II

Evaluation Report, including policies and procedures for security clearance and background checks, were in development at the end of the year.

Sample

Screening and Referral

As mentioned earlier, a universal screening and assessment plan for the County was to be designed by the Consortium to support efforts in the establishment of an integrated system of early childhood services. The initial plan involved the use of two measures, which were designed to both engage families in available services and target appropriate referrals for increased service delivery. The new Montgomery County Early Childhood Referral Checklist (previously known as the Early Childhood Screening Checklist) (***see Appendix F***) was originally designed to serve as an introductory form, to be completed by parents or interested parties in search of appropriate child and family social services. Upon completion of the Referral Checklist, families were then supposed to be contacted by a trained specialist for additional screening. This screening was to employ Early Childhood Screening Checklist – 2, for a more in-depth identification of family need and to increase family awareness of existing services **(*see Appendix G – Screening Checklist-2*).** Data from this screen was to then be used as a foundation upon which to coordinate services and match families to programs that met their needs. Much effort during early collaboration of the Consortium was directed toward the development of these tools and the design of the screening process **(*see Appendix H - Montgomery County Universal Screening and Assessment Flow Chart of Service*).**

Although well-intentioned, referral processes implemented over the last two years suggested to Consortium members that the use of two separate screening tools was impractical and possibly unwarranted. As such, efforts were made to modify the initial Screening Checklist in ways that more efficiently tracked essential data needed for referral while also more correctly targeted emerging family needs (e.g., mental health). Consortium members also formally changed the function of the form from that of a Screening Checklist to that of a Referral Checklist.

Project HOME is one of the few Consortium member organizations that reported consistent and reliable use of the Referral Checklist. This trend speaks well of improvements made in FY2003 in establishing an integrated delivery system. In FY2002, the Project Coordinator for Project HOME unintentionally became the informal "clearinghouse" contact for any and all agencies or families seeking services for young children, meaning she was the primary contact for phone calls from and triage for families who presented with concerns and limited knowledge of available services. In this role, the Coordinator also took referrals from other professionals (e.g. private physicians), including other early childhood programs, who often contacted her when they "couldn't think of anyone else" to help a family. While such efforts likely diverted attention of the Project Coordinator from Project HOME program monitoring and implementation in Year II, the introduction of the formalized "telephone triage" system, *ChildLink*, which serves as a centralized resource for families with young children throughout the County, helped minimize the burden placed on the Project HOME Coordinator in Year III of serving double-duty as the referral source for the county.

Basic referrals, referral source, and common reasons for referral to Project HOME were tracked during Year III as they were in Year II. Specifically, 58 referrals were made to Project HOME in Year III, all of which were enrolled for services. **Table 1** below highlights referral source across Years II and III of Project HOME. While the majority of referrals (55%) came from the Linkages to Learning Program in Year II, Child Welfare Services (CWS)/Family Preservation was the largest referral source in Year III (41%). This is not surprising, given the programmatic changes and subsequent partnership between Project HOME and CWS during Year III of the project. What is interesting is that there were twice as many self-referrals received in Year III than in Year II, suggesting increased public awareness and utilization of the early childhood intervention system.

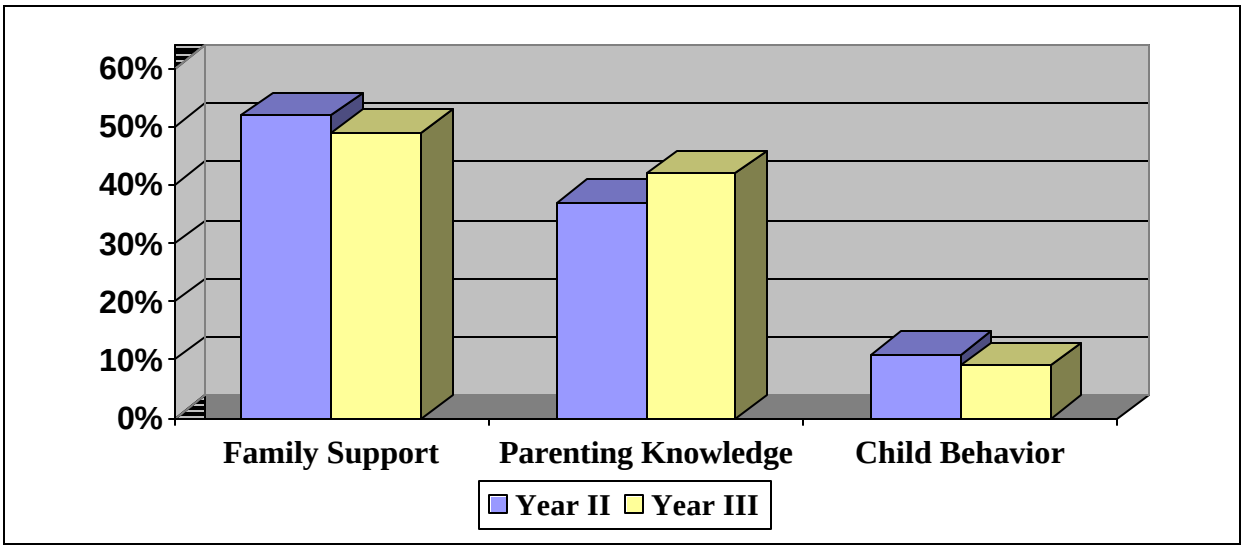
Table 1. Referral Sources for Project HOME – Year III

Referral Source	**Referrals – YR II**	**Referrals – YR III**
Linkages to Learning	23	8
Mont. Co. Infants and Toddlers (MCITP)	12	5
Parents as Teachers	12	1
Self-Referral	6	12
Mont Co. Early Childhood Mental Health Consultants	6	
Care for Kids	3	
MCITP and Public Health	3	3
MCITP/ Child Welfare Services Liaison	2	
Montgomery County Protective Services/ Child Find	2	1
Crossway Community	1	
Montgomery County Protective Services	1	
Child Welfare Services/ Family Preservation	1	22
Healthy Families Montgomery	1	1
ChildLink		1
TOTAL:	**73**	**54***

* Referral source information missing on 4 families

Reasons for referral were identified for 53 of the 58 families who enrolled in Project HOME in Year III. Needs for services were strikingly similar to those identified in Year II and were categorized into one of three general areas, including Knowledge, Family Support, and Child Behavior/Development. Knowledge includes those families who reported need in learning more about child development issues. Family Support includes those families who reported need based on acute family issues or problems, while Child Behavior/Development includes families who reported need based on acute or developing child behaviors. **Figure 1** illustrates Year III referral activity to Project HOME.

Figure 1. Project HOME Enrollees – Reason for Referral(n=53)



As can be seen in the figure, nearly half (49%) of the families enrolled in Project HOME during Year III were referred due to family needs and concerns. This is down slightly from Year II, where 52% of referrals were based on family need. Interestingly, a primary family issue in Year III centered on teen pregnancy (n=9), an issue not reported in Year II. Interest in gaining Parenting Knowledge was more prevalent in Year III at 42%, up from 29% in Year II. Concerns with specific Child Development and Behavioral issues fell from 19% in Year II to 9% in Year III. When examined collectively, this data reveals slight differences in the population using Project HOME services over time likely reflect the differences in referral sources in Year II and III.

Attrition and Enrollment

Normally, the attrition rate for Year III of Project HOME would be determined by identifying the number of families receiving services at the end of Year III. Unfortunately, status information (i.e., active vs. closed) is missing on 23 of the 58 enrolled families (40%), making the attrition rate difficult to calculate. For the remaining 35 families for which data is available, 31 (89%) families were active and four families were closed at the close of the reporting period. Interestingly, eight families from Year II retained an active status over the course of Year III. This serves as valuable evidence of the evolution of Project HOME from a short-term, transition-type home visiting program, as originally intended, to one providing intensive, long-term services to families in need.

Of the 39 active cases across Years II and III on which data is available, the average length of enrollment ranged from 1 – 12 months, with an average 5.2 months of service utilization. Over 60% of families received services on a bi-monthly basis. Any additional inferences about enrollment are difficult to make, given the level of outstanding data on so many families. Participant enrollment and service dosage could benefit from better data tracking mechanisms and processes.

Population Demographics

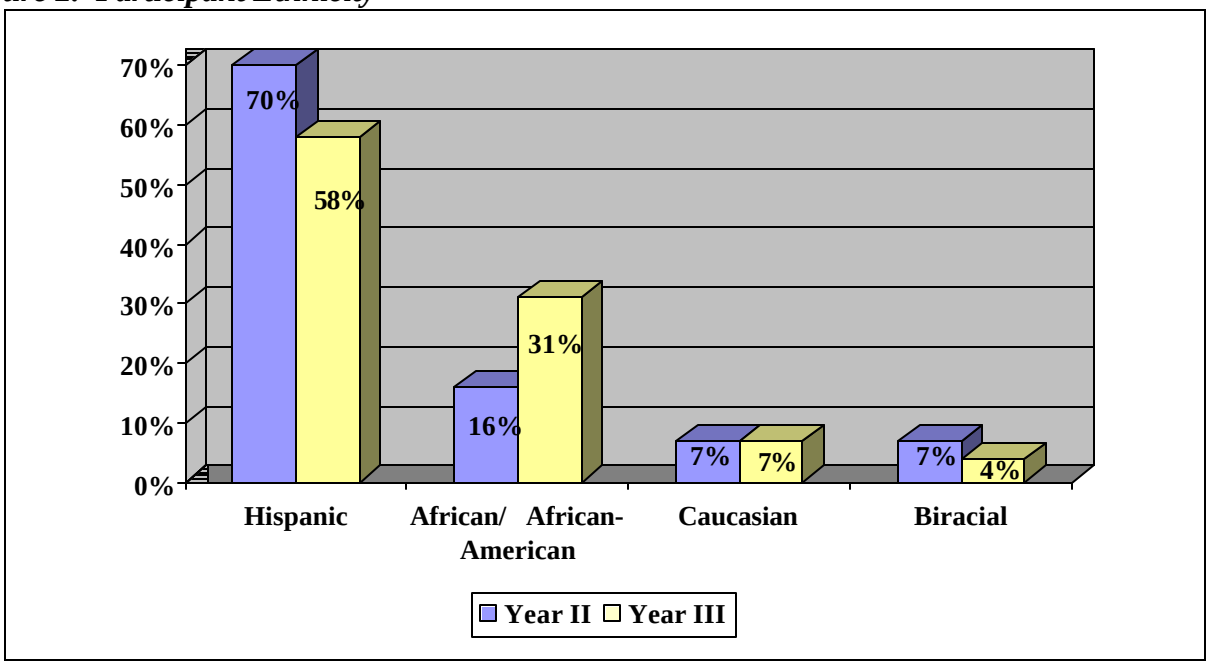
The characteristics that define the program population continue to serve an important function because they act as mediating influences on overall program effect. Population demographics illuminate the risk and resiliency factors families bring with them upon entry to the program and assist in data interpretation. The following discussion includes data on families enrolled in Year III across three key variables, including 1) Ethnicity; 2) Marital Status; and 3) Employment Status. When possible, Year III data will be compared to Year II data in order to track changes in population profiles over time. Data on age, education, and county of origin for parents was not reported and thus could not be included in these analyses.

Ethnicity

Data on ethnicity was reported for all 58 families enrolled in Year III and is compared to Year II profiles in **Figure 2** below. Home visiting staff continues to represent racial and ethnic diversity, making them well-equipped to handle changing participant profiles with ease. This is critical, given that language and cultural differences can serve as primary barriers to participation in social services and, subsequently, improvements in family functioning. As noted in Year II, documenting reported efforts on the part of participants to learn English could serve as invaluable data in any discussion of self-sufficiency and social competence, two important outcomes for early childhood interventions.

Thirty-four families identified themselves as Hispanic in Year III, making it the largest ethnic group represented by Project HOME. This is not surprising, given the sustained interest in recruiting high-risk, non English-speaking populations for participation in Project HOME. What is surprising is the nearly two-fold increase in the number of African-American families participating in Project HOME in Year III. This increase could, in part, be explained by efforts to expand and recruit families from CWS into the program. In addition to assessing data on the research sample overall, data was also assessed across group population (CWS vs Non-CWS). Reports indicate that 14 of the 23 CWS participants (61%) on which data was available were African-American, compared to four of the 32 participants (13%) not from CWS. At the same time, the number of participants from CWS who identified themselves as Hispanic was much lower (five of 23 families, or 22%) than those who were not from CWS (27 of 32 families, or 84%). Such indices support efforts on the part of Project HOME to expand services to more diverse populations and create a more comprehensive network of care. It is also worth noting that changes in the ethnic profile of research participants could also reflect improved referral methods or changing demographic profiles of the County. As in Year II, only a few Caucasian and biracial families participated in Project HOME Year III.

Figure 2. Participant Ethnicity



Marital Status

Data on marital status was available for 51 of the 58 families enrolled in Project HOME. Of these 51 families, 67% (n=34) report being single, while 33% (n=17) reported being married. This ratio is nearly opposite of that reported in Year II, where 62% of families reported being married and 33% reported being single. Interestingly, 5% (n=2) of families reported being divorced in Year II, but no families reported such status in Year III. While the contrast between years is so stark, such numbers are likely supported by data collected on referral source by way of 1) the increased prevalence of teen mothers and 2) the decreased prevalence of need for family support. Such numbers are also likely supported by data assessed across groups. Analyses indicate that 21 of the 23 families (91%) from CWS on which data was available reported being single, compared to 12 of the 26 Non-CWS families (46%) with available data.

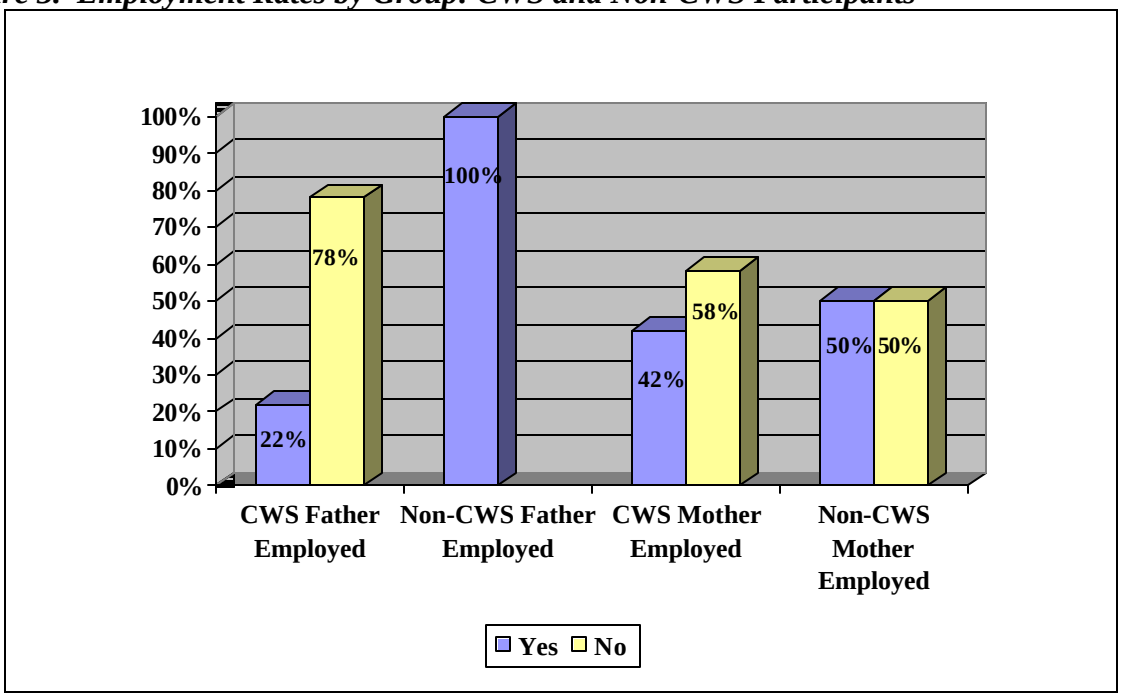
Employment

Participants' employment status is a good index of their economic independence and upward mobility and was available, albeit in limited fashion, for 29 fathers and 46 mothers enrolled for services in Year III. Over 70% of fathers reported gainful employment compared to over 40% of mothers, but this percentage for fathers is considerably lower when compared to reports in Year II. Specifically, 100% of fathers for which data was collected in Year II reported being employed. Only 38% of mothers reported being employed during the same time period, showing little difference across years.

When assessed across groups, however, a better interpretation of the data is available. As seen in **Figure 3** below, only 22% of fathers from CWS reported working, compared to 100% of

fathers not from CWS. Employment rates for mothers were more evenly distributed across groups, with a higher percentage of CWS mothers reporting employment. Unfortunately, it is difficult to draw inferences about self-sufficiency with this data, given the lack of information on participant age, employment level (e.g., full-time vs. part-time employment) or employment history. Such reports would provide a richer understanding of the types of resiliency factors present among participating families.

Figure 3. Employment Rates by Group: CWS and Non-CWS Participants



Qualitative Findings

Understanding the demographic profile that characterizes the Project HOME population is critical to understanding the successes and challenges of the program and the mediating influences that likely contribute to or inhibit abilities to succeed. While the Outcome Evaluation demonstrates the program's achievement in outlined goals and objectives, the perceptions and experiences of program participants and the experiences of the staff members themselves serve as valuable testimony to the overall success of the program. The section summarizes important qualitative data describing staff development and satisfaction, along with participant satisfaction and summary on change in perspectives over the course of the program.

Staff Development

Efforts to develop a credible staff development plan have met with challenges over the course of Project HOME, but finally achieved considerable success this year. In response to evaluation feedback provided at the end of Year I, an outside consultant was hired to provide ongoing, reflective supervision for Home Visitors during Year II. This supervision initially provided an opportunity one to two times/month for Home Visitors to receive guidance in their

work with families and further their professional development. While this effort met with some success, neither of the two full-time Home Visitors hired in Spring 2002 received individual or group supervision; nor did the Project Director receive supervision. This lack of supervision may have led to difficulty experienced by staff in setting priorities and establishing boundaries in terms of what services were feasible to provide. This often results in staff and management that are overburdened and increases risk of attrition. However, the quality and competency of Project HOME staff development was significantly reinforced over the past year by way of formalized training and structured clinical supervision.

At the start of Year III, program staff received formalized training and certification in the Parents as Teachers (PAT) curriculum. PAT is an internationally recognized program designed to help parents learn and adopt strategies and techniques that maximize early childhood development. Those officially trained in the PAT model become Parent Educators who serve as liaisons to parents, teaching them about social, behavioral and neurological development from birth to 5 years and link to school readiness. It is a highly successful and accessible program, responding to the needs of all families regardless of race, ethnicity, or socioeconomic status. Perhaps more importantly, the primary form of service delivery under the PAT model is personal contact or home visits, making it an ideal curriculum for use by Project HOME staff. Two Home Visitors were formally certified in both the 'Zero-Three' and the 'Three-Five' age brackets, while the remaining Home Visitor was formally trained in the 'Three-Five' bracket. As mentioned earlier, the Project HOME program is currently listed on the national PAT website as an official program in compliance with PAT procedures.

During the early part of Year III, Project HOME staff implemented the PAT curriculum within the program and met with considerable success. Use of the curriculum has helped Home Visitors maintain a uniform focus on individual family progress and has been useful in identifying developmental goals/milestones. Moreover, the PAT curriculum has supported the development of Family Service Plans, which provides additional structure to services and ties in with Montgomery County Public Schools (MCPS) school readiness procedures. Securing this training and certification demonstrates continued interest and investment on the part of program and leadership staff members to provide best practice within comprehensive services and referrals to their families.

As further testament to improved service delivery, Project HOME leadership and program staff prioritized time for clinical supervision and staff program development this year. A licensed clinical social worker was hired to conduct both individual and group supervision with all three Home Visitors on a regular basis. Specifically, each Home Visitor received one hour of individual supervision and two hours of group supervision a month. The Project Director for Project HOME also received supervision on a bi-monthly basis for one hour. Staff program development was conducted through weekly staff meetings between the Home Visitors, who used this time for coaching and supporting one another. Once a month the weekly staff meeting included the Project Director and was used as a time to discuss case management and troubleshoot problems that arise in program implementation. Such efforts have likely provided partial support or the noted improvements in program infrastructure and overall communication between staff.

Finally, as with Year II, Home Visitors also participated in trainings regularly offered to staff members of all County early childhood programs. The Consortium sponsors these trainings as part of its professional development initiative. The ultimate goal of this initiative is for home visiting staff to participate in joint trainings that minimize program duplication (and training costs), while simultaneously ensuring that all home visitors are equipped with a basic set of "core competencies." It is worth noting that CWS staff also participated in several trainings sponsored by the Consortium, including those on performance outcome measures (e.g., The Ages and Stages Questionnaire: Social-Emotional; The Denver Developmental Screening Test-II) and Filial Therapy. Such interest and commitment speaks to multiple issues, including 1) improved efforts in coordinated service delivery; 2) improved understanding and implementation of program goals and objectives and 3) improved awareness of early childhood and child welfare services offerings. Trainings offered to all Consortium members continue to cover a wide range of topics **(*see Appendix I – Staff Training Schedule*).**

Staff Satisfaction

For the past two years, Project HOME staff have been asked to complete the Staff Satisfaction Survey in order to track overall effectiveness of program implementation and staff ability to meet targeted goals and objectives. Specifically, the Staff Satisfaction Survey addresses issues relating to program infrastructure, program design and personal fulfillment and encourages recommendations and feedback from staff on aspects of the program that are most and least effective. Items on the survey incorporate a 5-point Likert Scale with range of response patterns ranging from 'Strongly Disagree' to 'Strongly Agree.' Surveys were distributed to all persons involved in Project HOME program, including leadership, program, and technical support staff. All six staff members completed the survey in Summer 2003 **(*see Appendix J - Project HOME Staff Survey*).**

Responses to items targeting program infrastructure, including supervision, support and training, reveal staff to be fairly satisfied with their work climate. Five of 6 staff members (83%) reported having adequate supervision for their position and feeling that leadership is responsive to the needs of staff. Five staff members also reported feeling that that had received an adequate amount of training and job preparation. Only one staff member felt supervision, support and training to be inadequate.

Responses to statements targeting program design were also very favorable and are highlighted in **Table 2**. As can be seen in the Table, staff consider Project HOME to be an effective, worthwhile program for needy children and families. Specifically, efforts to optimize child development and prepare children for school were viewed as particular strengths of the program, as was the availability of and accessibility to culturally sensitive and appropriate materials for participating families. Experiences with Child Welfare during the past year were extensive, embodying collaboration at various levels (from program expansion and design to actual service delivery) with various staff (leadership and program). Such intense involvement might explain the more moderate impression reported with this organization along with Linkages to Learning.

Table 2. Staff Perceived Effectiveness of Program Design

Item	Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
I understand the goals and objectives of Project HOME.				33%	67%
Project HOME is designed to optimize child development through support to families.				17%	83%
The program is responsive to the needs of the children and their families.				33%	67%
Materials are appropriate and culturally sensitive to the families.			17%		83%
Project HOME prepares children to be ready for school.				17%	83%
Project HOME staff coordinates well with CWS and LTL staff to meet families' needs.				83%	17%

Staff were also asked to reflect on the sense of personal fulfillment they receive from their job. **Table 3** highlights responses to such statements, which suggest high levels of job fulfillment on the part of staff, particularly in the areas of perceived enjoyment and worthiness. Moreover, all staff felt that their position in Project HOME enhanced their professional skill and development. Although half of those surveyed felt unsure or unsatisfied with their level of compensation, all reported moderate to high levels of overall job satisfaction. Only two of the six respondents felt their work was sometimes difficult, but no staff member considered their work boring

Table 3. Perceived Job Fulfillment

Item	Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
I enjoy my work				50%	50%
I find my work worthwhile				17%	83%
I feel the work I do is hard	17%	33%	17%	33%	
I find my work boring	33%	67%			
The work I do uses my skills				17%	83%
I am satisfied with my position				50%	50%
I believe I have made a positive impact on the children and families I work with*				25%	75%
I am appropriately compensated for my position		17%	33%	33%	17%

** Data missing on two respondents*

Finally, staff insight on most and least effective aspects of Project HOME were comprehensive and targeted both the structural and functional capacity of the program. Areas of the program that are considered particularly strong were more functional, including utilization of a quality home visiting model, networking and linkages with local partners, training and materials and the collaborative strength of the home visiting team. Areas in need of improvement were more structural in nature, including increased monitoring and involvement of the Montgomery County Collaboration Council, more formalized policy and procedures and better outreach efforts. Also recommended as needing improvement were fiscal and collaborative endeavors. Specifically, staff requested increased clarification and stabilization of

funding, along with improvements to the partnership with CWS. Such factors relate directly to significant changes to program design and implementation in Year III and will be examined more fully later in this report

Overall, Project HOME staff report high satisfaction with their work. Program infrastructure meets the personal and professional needs of staff, while program design is strongly considered to meet the needs of participating families. While the majority of staff members did report that their job is sometimes stressful (83%), this stress does not appear to impede both the desire and the ability to do good work for families at risk. Participants' perceptions of overall program success serve as an index of staff performance and are discussed below.

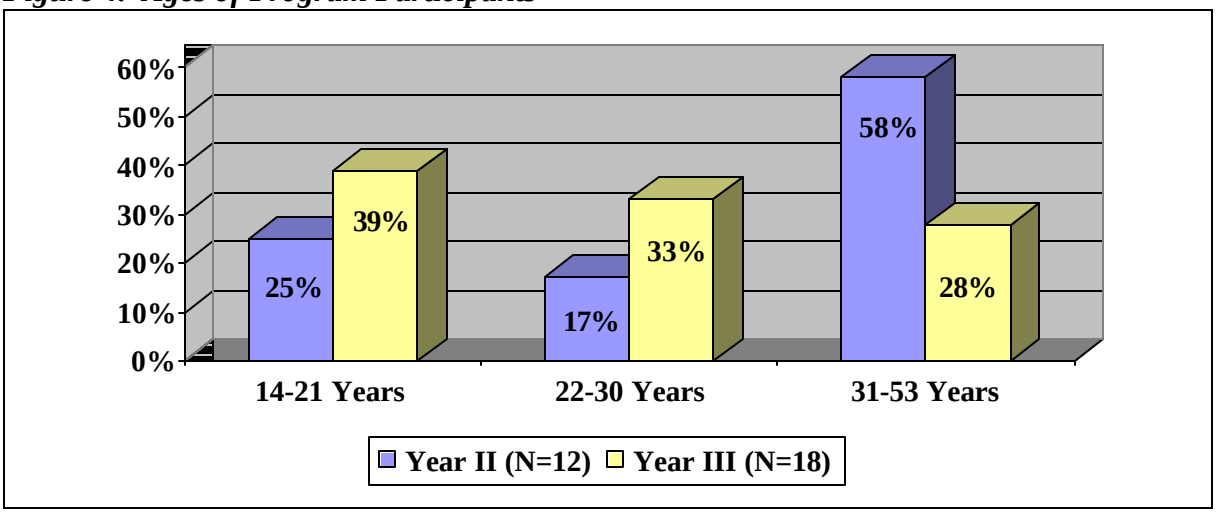
Participant Satisfaction

Participants can also provide invaluable insight on overall implementation and function of a program. As such, a Participant Satisfaction Survey was distributed to track critical data on the success with which program implementation targets primary goals and objectives and helps promote gains in family functioning. As with the Staff Survey, the Participant Satisfaction Survey targets participants' overall perceptions of the success of Project HOME, but with a particular focus on perceived outcomes and benefits.

In an effort to better reflect participants' experiences in and involvement with Project HOME, the Participant Survey was revised from Year II. Changes were both structural and functional. From a structural perspective, many yes-no items were revised to incorporate a 5-point Likert scale model in order to provide participants with greater flexibility and accuracy of response. From a functional perspective, the content of several target statements was tweaked to more accurately reflect language that participants would more readily recognize (e.g., changing 'plan of service' to 'setting goals'). Once revisions were approved by both Project HOME staff and the evaluation team, Home Visitors took a copy of the Participant Satisfaction Survey to their respective families and provided them with a self-addressed sealed envelope in which to return it to the evaluation team **(*see Appendix K - Project HOME Participant Questionnaire*).**

Descriptive information collected on participant language, age and enrollment reveals slight changes in profile of participants across program years. As with Year II, questionnaires were distributed to participants in both English and Spanish. Of the 21 surveys returned, 8 were completed in English (38%) while the remaining 13 were completed in Spanish (62%). This is a marked difference from reports in Year II, where only 25% of surveys were completed in English. Data on age also reflects participant differences across years. For the 18 participants on which data was available, ages ranged from 14 to 53, with an average age of 26.5 years. While most participants are in their late teens and in their twenties (72%; n=13), nearly a third of participants are in their thirties and fifties (28%; n=5). Age of participants across Years II and III of the program are included in **Figure 4** below. As can be seen in the Table, the percentage of young mothers was considerably higher in Year III, with twice as many teen mothers aged 19 and under in Year III (n=4) than in Year II (n=2), while the number of older mothers enrolled in Year II was more than double the number in Year III.

Figure 4. Ages of Program Participants



Lastly, in terms of leveling data, half of participants surveyed reported being visited by their Home Visitor weekly (50%; n=10) and the other half reported being visited bi-weekly (50%; n=10). This schedule closely mirrors that from Year II. Only one participant reported a monthly scheduled visit. Of the 21 respondents, 19 also reported on number of home visits received, which ranged from 1 to 52 home visits. Average number of home visits for participants was 22, while the average length of enrollment was 8.5 months. As 6 of the 21 (29%) respondents reported average length of enrollment to be one year or longer, it is safe to assume that they were enrolled in Year II, thus slightly inflating the numbers for Year III. Finally, all 21 participants (100%) reported being visited by the same Home Visitor every time.

Questions and statements targeting program impact and referral capacity were also included on the Survey. Findings indicate high levels of satisfaction among participants, as reflected in **Table 4**. Specifically, in response to a series of eight statements regarding the effectiveness of the program, 100% of respondents agreed that their home visitors provided positive feedback and support, and that the home visitors respected individual families' cultures and ethnicities. The majority of participants also agreed that their home visitors helped them gain a deeper understanding of their child's development, behavior, and health needs, and that they had opportunity to contribute to and develop goals for themselves. This high level of satisfaction mirrors levels identified in Year II, suggesting that Project HOME staff continue to provide quality services to families in need.

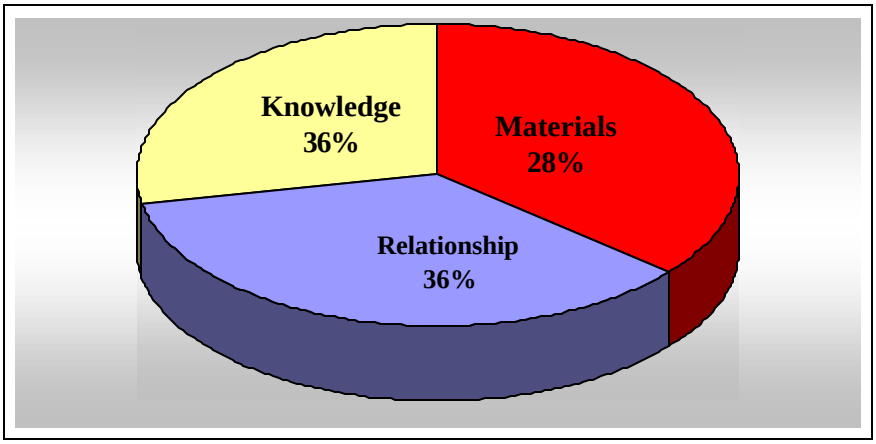
Table 4. Participant Perceived Satisfaction with Project HOME

Survey Questions*	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
Do you feel you were visited often enough?		5%		43%	52%
Did your Home Visitor help you understand your child's development and behavior?			5%	33%	62%
Did your Home Visitor provide positive feedback and support?				33%	67%
Did your Home Visitor help you understand and provide for your child's health needs?			6%	47%	47%
Do you feel your Home Visitor respected your family's way of doing things including your family's culture and ethnicity? *				30%	40%
Did your Home Visitor give you materials that respected your culture and language?			5%	33%	62%
Were you given the opportunity to participate in setting goals?			10%	42%	47%
Was this program helpful to you as a parent?			5%	24%	71%

** Only 20 participants responded to this question.*

Project HOME was also seemingly effective at linking participants to additional resources in the community, as evidenced by the comprehensive list of services to which many respondents reported being referred. These included WIC, mental health services, childcare, camp and preschool enrollment, financial services, and assistance with obtaining housing, food, and clothing. This support and case management likely colored attitudes about perceived benefits to participation, where a total of 28 comments regarding most-liked aspects of the program were received across participants. Of these, 25 comments spoke directly to gains in one of three categories, including 1) knowledge; 2) relationship; and 3) materials. As can be seen in **Figure 5** below, 36% of mothers reported increased understanding of child development, parenting, discipline and goal-setting. At the same time, 28% of mothers reported enjoying the games and activities used with their children and that involvement increased pre-school learning. Finally, 36% of mothers identified the quality relationship developed with their Home Visitor as a significant benefit to participation. It appears that the best-liked aspects of Project HOME were fairly evenly distributed across categories, reflecting well on program design and staff to provide services to these families that address their needs in a comprehensive and professional manner. Three comments merely stated that everything was good, while 11 responses (79%) stated that Project HOME needed 'no improvement'.

Figure 5. Participant Perceived Benefits of Participation



One final question targeted participants' overall perception and rating of the program. Rating choices included 'Excellent', 'Good', 'Fair', and 'Poor' and were recorded for 20 of the 21 respondents. Of those who responded, fourteen (70%) rated Project HOME as an 'Excellent' program, while the remaining six (30%) rated Project HOME as a 'Good'. Clearly, participants value Project HOME and consider it a worthwhile endeavor. This perceived value is further supported by the finding that all (100%) of the 21 participants surveyed reported that they would recommend Project HOME to a friend or neighbor.

A total of 21 participants (36%) completed the Participant Satisfaction Survey. This is an improvement over Year II, where only 29% of participants completed the survey. Yet while participation rates may be different across program years, participants' perceptions of and attitudes toward Project HOME are strikingly constant. Participants reported a high level of satisfaction with Project HOME at end of Year II. Almost all reported being satisfied with the implementation of the program and felt that Project HOME helped them better understand their child and their child's development and helping them become better parents. Such responses were also received in Year III. Moreover, there was a strong sense of satisfaction with the relationship participants formed with their Home Visitor across Years II and III, as evidenced by questions targeting the cultural respect and sensitivity shown by Home Visitors and the comments regarding the caring and commitment demonstrated by Home Visitors during sessions. This relationship remains the key component to continued success of Project HOME and the primary mechanism through which families will likely stay committed to the program.

OUTCOME EVALUATION

During Year I, high quality evaluation tools were selected to track and document changes in child well-being and family functioning. Utilization of these tools remained constant over the course of the program and include the Home Observation for Measurement of the Environment (HOME), which assesses the home environment, particularly as it reflects the quality of parent-child interaction; the Ages and Stages Questionnaire: Social Emotional (ASQ:SE), which identifies children at risk for social and emotional developmental delay; and the Denver Development Screen II, which identifies children at risk for developmental delay. For additional documentation of the stress parents may feel in relation to their parenting role, the Parenting Stress Index (PSI) was added to the list of measures in Year III.

Project HOME staff has grown increasingly more comfortable with and more capable in administering evaluation tools over the course of the program, resulting in marked improvements in data administration. Home Visitors varied significantly in the administration of program tools and documentation of program activities in Year II. This is likely due in part to two factors: 1) there was significant staff turnover during the bridge between Year I and Year II, which could easily have impacted the timely administration of core measures, and 2) many of the cases seen initially were short-term, based on the nature of the child/family's needs, while families seen by the Home Visitor who had to resign partway through the year were seen briefly as well. That the two Home Visitors hired in April 2002 had only been seeing families for a maximum of two months by year's end also likely impacted the completion of assessment measures, particularly those that are administered after several visits. With the 2002-2003 program year, however, Home Visitors revealed more consistent effort to administer baseline measures and track family progress on service plans and through observation notes. Program staff also identified a desire to have a standard protocol for the delivery and administration of all program forms and measures, as well as information and recommendations regarding leveling and dosage criteria. Such requests indicate a growing awareness of the need for high quality data that supports improvements in parent and child outcomes and service delivery.

The following section presents data on the evaluation tools and the extent to which they reflect baseline performance. Participant responses were examined for levels of parental stress, quality of home environment and profiles of child developmental delay. As stated earlier, only those families who received four or more home visits were included in analyses on outcome measures. Under such parameters, the 'research sample' included 30 families in Year III. Moreover, as two distinct populations were recruited for participation in Project HOME this past year (CWS and Non-CWS), data will be also explored for group differences across these domains.

Progress Towards Goals and Objectives

Goal I: To Utilize Best/Effective Practices in Home Visiting

The Best/Effective Practices that were developed as part of the *Montgomery County Early Childhood Initiative Comprehensive Plan* in 2000 identified a range of practices that promote ideal conditions for optimal child development (***see Appendix A- Best Practices***). Several of those practices have continuously been addressed by Project HOME, particularly in the areas of Child Development and Family Support.

The efforts undertaken by Home Visitors during Year III *to establish caring and attentive relationships with families and their children* are documented in the results of the participant satisfaction surveys. Participants seem to truly appreciate the efforts of the Home Visitors on personal and professional levels and welcome the relationship that the Home Visitors established with their young children. The surveys also provide evidence that parents were *assisted in developing nurturing relationships with their children*. The majority of participants reported that the program not only increased their understanding of child development and helped them better provide for their child's needs, but also that they welcomed the manner in which Home Visitors interacted with their children through activities and age appropriate materials. Results of the HOME Inventory and Parental Stress Index (PSI), presented below under ***Goal II,*** verify the presence of positive parent-child relationships in the majority of families.

The very nature of the home visiting strategy supports the creation and preservation of *a safe environment for children, with adequate space to learn and play*. Starting in Year II and continuing in Year III, Home Visitors worked to establish consistent, regularly scheduled weekly or bi-weekly meetings with families. Moreover, Home Visitors prioritized the need to work with families in their own contexts and support the dynamics of that context that contribute to optimal child development. The presence of a safe and stimulating home environment conducive to cognitive development was assessed using the HOME Inventory, results of which are presented below.

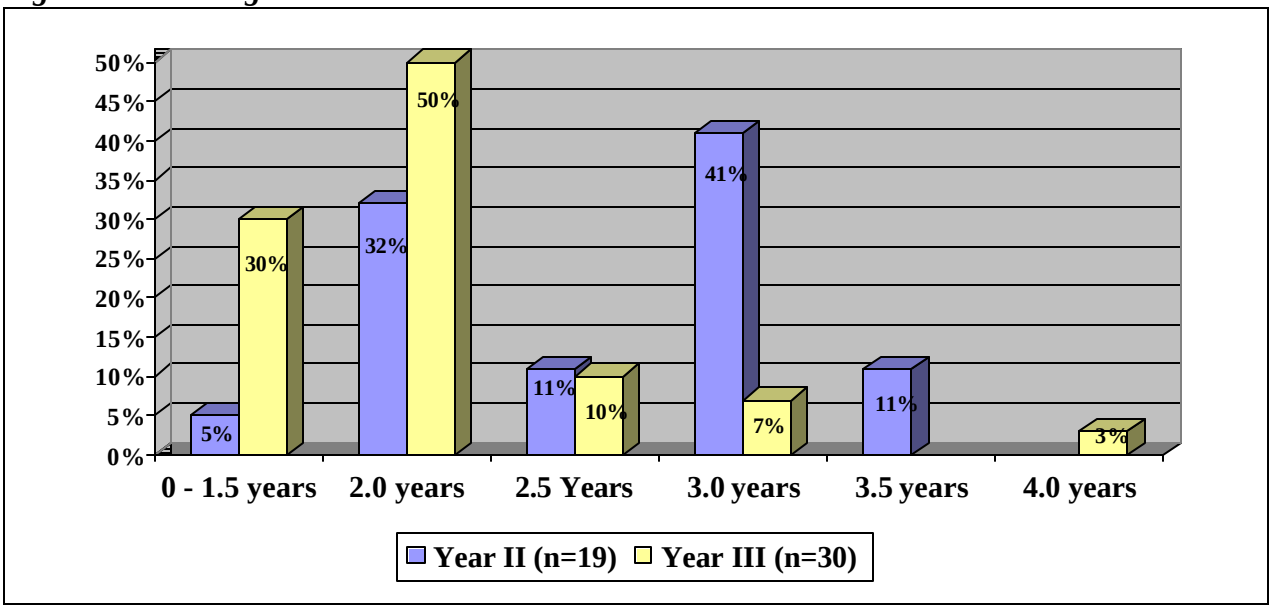
Project HOME has employed best practices in ensuring that *staff is adequately prepared, including formal schooling and high quality ongoing training and supervision*. At the end of Year III, two of the three Home Visitors had college degrees. In addition, all Home Visitors participated in trainings regularly offered to staff members of all County early childhood programs. Formalized training and certification in the 'Parents as Teachers' (PAT) curriculum for all Home Visitors during Year III strengthened the programmatic and professional capacity of Project HOME. Additionally, a licensed clinical social worker was hired to conduct both individual and group supervision with all three Home Visitors on a regular basis. In an effort to ensure that *services and staff were culturally and linguistically competent*, bilingual Home Visitors who were representative of the families they served were hired. Moreover, participant reports suggest that Home Visitors, regardless of their ethnic background, respected the cultural identity of the families. This level of respect likely influences the degree to which participating families commit to and stay with Project HOME.

Goal II. To Improve Health and Development Outcomes for Children

In order to document the presence of environmental factors that contribute to optimal child development, as well as the parent-child relationship, the Home Observation for Measurement of the Environment (HOME) and the Parent Stress Index (PSI) were administered. Further, to identify potential developmental or social-emotional difficulties, the Denver Developmental Screening Test-II (Denver II) and the Ages and Stages Questionnaire: Social-Emotional (ASQ:SE), were administered to program children. Data reported reflects Baseline performance only. No repeated measures were available.

The children of the families enrolled in Project HOME ranged in age from one to four years old. **Figure 6** below contains age at intake for the children participating in the research sample across Years II and III of the program.

Figure 6. Child Age at Intake

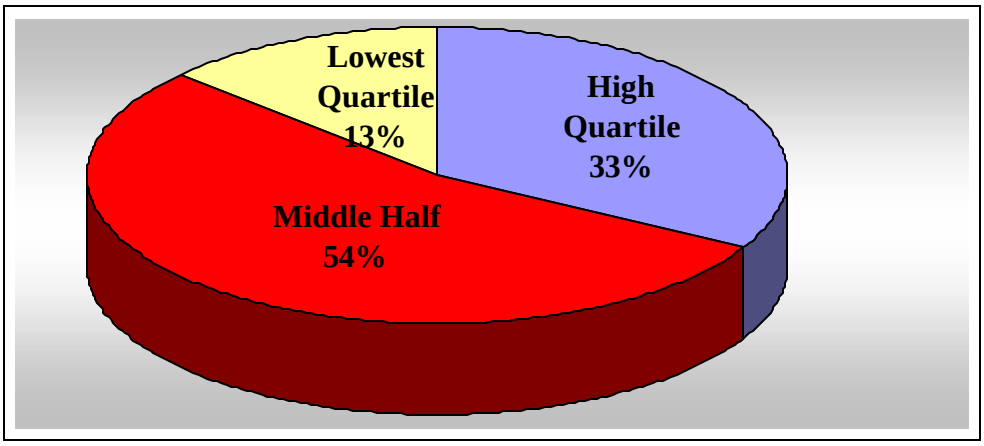


Data contained in the figure reveals interesting trends in the age of children targeted for services. In Year II, the majority of children were between two and three years of age (84%). In contrast, the majority of children enrolled in Project HOME in Year III were two years or younger (80%). Age of child at intake can dictate not only the types of services and activities that Home Visitors utilize through home visiting sessions, but can also provide a context for interpreting outcomes on evaluation tools

Home Observation for Measurement of the Environment (HOME Inventory). The HOME Inventory is designed to assess, through semi-structured observation and interview, the quality of the home environment as it relates to aspects of parent-child interaction. Due to the fact that families who enroll in Project HOME stay for an average of 5 months, only baseline administrations were able to be completed. Data collection efforts during Year III resulted in

baseline HOME assessments for 24 of the 53 families that comprise the research sample. As can be seen in **Figure 7** below, the majority of participants (54%; n=13) scored in the Middle range, indicating that these families are providing adequate support and stimulation to their children within the context of the family environment, while one-third of families (33%, n=8) actually scored in the High Quartile, and 13% (n=3) scored in the Low Quartile. Although it is surprising that most of HOME Baseline scores on these high risk families indicate adequate to good home environments, oftentimes administration of the HOME is positively biased when administered by staff that is working directly with the family. This fact coupled with the lack of evaluation oversight and recalibration training on the HOME in Year III may have resulted in inflated baseline scores.

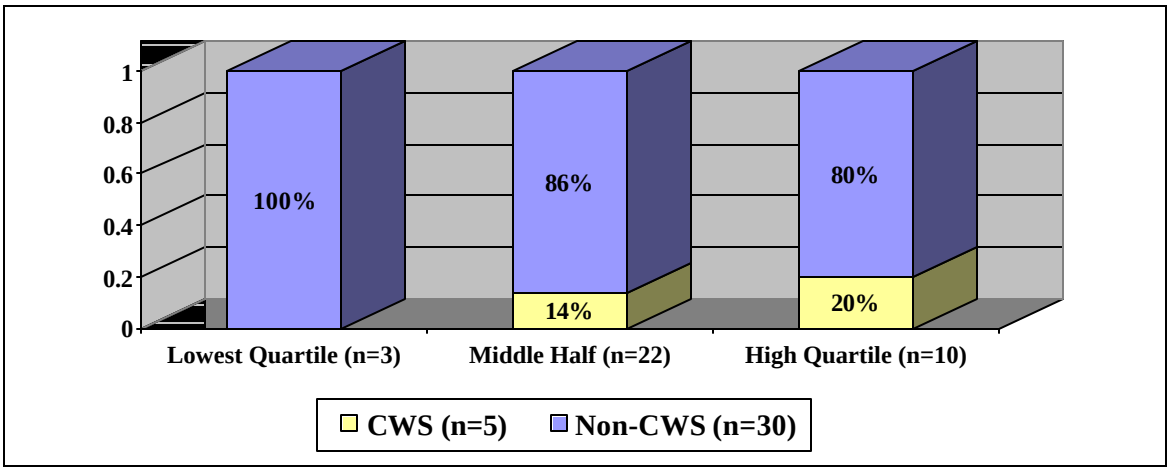
Figure 7. HOME Baseline Scores (n=24)



Group Differences

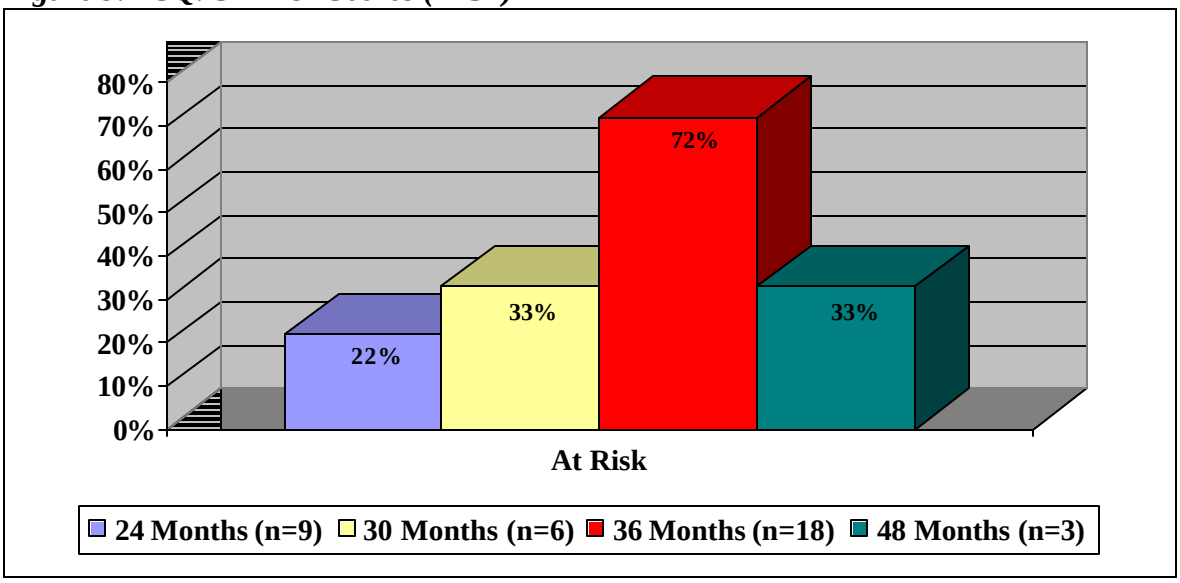
Data on the HOME Inventory was also assessed for group differences. Group membership (CWS vs. Non-CWS) information was available for all 24 families on which HOME data was collected. As seen in **Figure 8**, there were only a small number of CWS families (n=4) on whom HOMES were completed. These families scored in the High or Middle range, indicating adequate support and stimulation in the family environment. Overall, only 3 families, both from the non-CWS population, scored in the Lowest Quartile, suggesting possible risk for not providing adequate stimulation and support.

Figure 8. HOME Baseline Scores by Group (n=35)



Ages & Stages Questionnaire: Social-Emotional (ASQ: SE). The ASQ: SE is a screening tool used to identify children who show potential problems in their social and emotional development. As such, children are referred for further testing and/or early intervention services if scores fall below designated cutoff points. As with the administration of the HOME Inventory, data was only collected on participants at baseline, making it difficult to generate a profile that reflects a true rate of change in children's social and emotional status. Data was collected on 37 of the 53 participants included in the research sample. Approximately half (49%) of the children were found to be at risk for social-emotional delay. This percentage of children at risk is significant and indicates a need for infant and child mental health services, particularly for children around three years of age (**see Figure 9**).

Figure 9. ASQ: SE Risk Scores (n=37)



The cross-sectional profile presented reveals risk levels to be highest for children assessed at 36 months of age. Given the low number of participants on which data was collected, however, reports should be interpreted with caution, as should inferences that might impact such findings.

Group Differences

ASQ: SE score data was available on 36 families for which group membership was also identified. Of these 36 families, 50% had children who earned scores indicating healthy social and emotional development. However, of great concern is that half of the children (50%) scored at risk for social-emotional delay in both groups. There were no significant differences between the two groups, however, the number of assessments conducted for each group (CWS n=5 vs non-CWS n=31) differed greatly making comparisons unreliable.

Parenting Stress Index (PSI). The PSI provides a profile of stress as it relates specifically to parenting, and examines three major domains of stress: Parental Distress, Parent-Child Dysfunctional Interaction, and Difficult Child. Parents are considered at risk if they score at or above the 85th percentile.

Administration of the PSI was inconsistent in Year III, likely because of delays in training for Home Visitors. As such, data is only available for 15 of the 53 families in the research sample. While scores on the PSI ranged from the 39th to the 118th percentile for these 15 families, only three parents earned scores above the 85th percentile, indicating high risk for parental stress at any timepoint. However, the percentage of parents scoring at risk at baseline (29%; n=2/7) was higher than after 6-months (14%; 1/7).

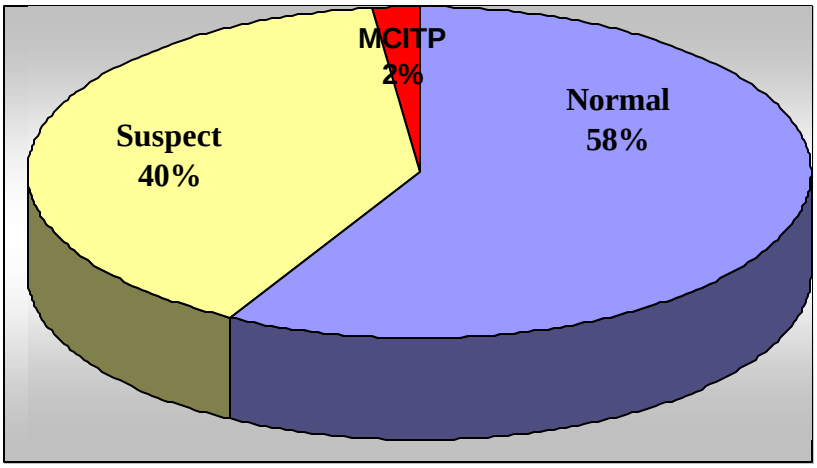
Group Differences

When examined for group differences, analyses revealed that families from CWS (n=2) reported slightly higher stress levels, on average, than families not affiliated with CWS (74th and 66th percentiles, respectively). In fact, 2 out of the 3 families who scored at risk were CWS families. Independent samples t-tests were conducted to see if group differences were significant. Analyses revealed no significant difference in group scores on the PSI (t (1,11) = .70, p>.05).

The Denver Developmental Screening Test-II (Denver II) is designed to detect potential developmental problems in young children and is administered by assessing a child's performance on a series age-appropriate tasks. Raw scores are converted to a scale reflecting no delay ('Normal') or possible delay ('Suspect'). **Figure 10** reflects Denver scores for 40 of the 53 families included in the Project HOME research sample in Year III. As can be seen in the figure, the number of children who scored 'normal' (57.5%; n=23) is just slightly higher than the number of children who scored "Suspect" for delay (40%; n=16), while 2.5%, n=1 were already identified as having a confirmed delay and receiving services from Montgomery County Infants and Toddlers Program (MCITP). This is consistent with findings from Year II, where the number of children who scored "Suspect" nearly equaled the number of children who scored "Normal" (46% vs. 54%, respectively). However, as the national and local rates for confirmed

developmental delay stand at approximately 4%, a rate of 40% risk for delay within the participant population is of great concern.

Figure 10. Denver Scores



Group Differences

When analyzed by group, scores on the Denver indicate a substantial number of children at risk for developmental delay. Of the six families from CWS on which data is available, two (33%) scored as suspect. Likewise, of the 33 families not affiliated with CWS on which data is available, 14 (42%) scored as suspect.

Re-screening all 'Suspect' cases is the only way to rule out factors that might have confounded these findings (i.e., illness, fear, etc.) and to secure appropriate referrals, should the re-screen test positively for delay. At the time of analyses, no re-screens had been conducted for Year III participants. However, re-screens were conducted for four of the 6 active cases from Year II. As might be expected, one child improved standing and passed the second screen. However, the status for two children dropped from "Normal" to "Suspect" at re-screen, while status remained "Suspect" at re-screen for the fourth child. Such findings highlight the need to closely monitor children who demonstrate a potential developmental delay so that appropriate referrals can be made to other specialized agencies within the Consortium that expand the coverage of care.

Goal III. To Support Families through Goal-setting and Community Linkages

Linking needy families to the appropriate services can make an indelible difference in overall family functioning, as can helping them identify goals that will promote better child development and better parent-child relationships. At the same time, referrals by program staff support the mission of the Montgomery County Home Visiting Consortium, which is the creation of an integrated, coordinated home visiting service system. Staff at Project HOME make family needs a top priority and, when necessary, suggest appropriate referrals to programs that provide support for issues outside the scope of Project HOME. **Table 5** reveals linkage information for the research sample across both program years.

Table 5. Referrals for Research Sample Participants

Linkage	Year II*	Year III*
Child Care Subsidy	1	-
Child Find	3	3
Crossway Community and Greentree Shelter	-	1
EEEP/ Early Head Start at Lourie Center	1	3
Head Start	4	4
Linkages to Learning	1	-
Manna Food Bank	-	1
Montgomery County Infants and Toddlers	2	1
Montgomery County LOCATE	1	-
Multicultural Center (family therapy)	-	1
Parent Resource Center (PRC)	2	3
Respite Care Organizations	1	-
Sandy Cove Summer Camp	1	-
Section 8 Housing Authority	1	-

** Not all participants in the research sample received or needed additional referrals*

As can be seen in the table, referrals to additional support and service organizations remains diverse, ranging from other early childhood programming (e.g., Head Start) to housing and food supply (e.g., Manna Food Bank, Housing Authority). New linkages for Year III focused on family functioning, including food and shelter and family therapy. Also of interest was the referral to the Montgomery County Infants and Toddlers program (MCITP), which works exclusively with children diagnosed for developmental delay. Using the Denver to identify potential development delay serves a critical role when children get the quality care they need in a timely manner, thus preventing further impairment.

To further support the mission of the Consortium and the development of an integrated service delivery system, Project HOME staff welcomed families who were receiving other services at the time of enrollment. Specifically, eight families were enrolled in other services at the time of enrollment in Project HOME in Year III. These services included center-based child care and participation in Head Start or Families Foremost. Increasing coordination and partnership between members of the Consortium furthers the cause of the need for an integrated service system and highlights the "service overlay" that many families have because their needs are so extensive.

Goal IV. To Link Best Practices to School Readiness Goals of the County

One of the primary objectives for Project HOME and the Home Visiting Consortium continues to be the establishment of a link between home visitation services and school readiness among children and families at risk. As indicated above, Home Visitors continue to use Best/Effective Practices to guide interventions with families and utilize measures that track cognitive and situational factors that may impact the development of school readiness. Recently, performance rates on the 2002 Maryland Measure of School Readiness (MMSR) were released

to the public. The extent to which children participating in Project HOME can be 'tracked' upon entry into Kindergarten and their performance on school readiness measures attained will serve a crucial link in determining the effectiveness of home visitation and early childhood intervention services in minimizing disparities between those children at risk for poor academic achievement and those that are not.

SUMMARY AND RECOMMENDATIONS

The evolution of the Project HOME pilot home visiting project over the past three years provides several key lessons learned in how to identify and fill gaps in early childhood services. The original model, which was restricted by parameters of the state RFP, did not enable the Early Childhood Consortium to design a program that effectively incorporated the best practices identified in their preliminary studies, adequately address the gaps in the service continuum in early childhood services in the county, and further, forced a mismatch in terms of philosophy and infrastructure that slowed startup and implementation of the program. At the same time, the split duties of the Program Director, which included oversight and management of the Home Visiting Consortium and Project HOME, as well as filling the role of ad hoc referral source (now ChildLink) for the Consortium, made it impossible to quickly and effectively get the program operational and put the necessary infrastructure in place (i.e., policies and procedures, forms, protocols). It was difficult to develop independent data tracking, monitoring, and reporting mechanisms which may have been redundant with the County HATS database, then under construction. Over time, these challenges delayed efforts to construct a stable infrastructure, resulting in the transfer of program funds and resources to another County agency with existing family support infrastructure and a demonstrated ability to meet the data and fiscal needs of the County, as well as the comprehensive service needs of participants.

The decision to transition Project HOME came at a time when the program was beginning to hit its stride, albeit late in the process. The Montgomery County Collaboration Council and Project HOME leadership had commissioned an ongoing external evaluation in Year I and used annual results and recommendations to make significant refinements and alterations to the program's operation. These actions helped shape program infrastructure and promote increased accountability in outcomes. For example, in Year II, bilingual program staff with experience in home visiting and child development were hired. Additionally, throughout the second year of operation, leadership and program staff worked with the evaluators to develop forms for tracking services, policies and procedures for referrals and program implementation, and methodology to guide evaluation tasks, including informed consent and administration of standardized instruments. However, it was not until the middle of Year III that Project HOME advanced significantly. By that time, Project HOME had a team of competent home visitors, improved management and leadership, effective clinical supervision, and strong partnerships with referring and collaborating agencies, including Linkages to Learning, the Lourie Center, and CWS. Improved data tracking and the procurement of a Database Specialist facilitated more consistent tracking of service provision, referrals, evaluation, and outcome measures administration. By the second half of Year III, Project HOME was also implementing effective

practices with a culturally competent staff, delivering a comprehensive range of services to the most underserved and highest risk families in the county, and supporting a stronger program infrastructure, which emphasized regularly scheduled staff training and supervision. With ongoing referral systems both to and from the program running smoothly and file and data tracking systems nearly complete, Project HOME staff could focus most of its energy on helping their participant families confront the difficult situational issues they faced. Had these factors been in place earlier, the decision to transition the program to Families Foremost might have been avoided.

Despite these start-up challenges and the high level of risk associated with the families participating in Project HOME, the program demonstrated significant success in meeting stated goals and objectives and establishing itself as a program by which the County's neediest families could be served. Referral data from Year III suggests that high-risk families were accessing a range of services from the community as a result of their worker's case management efforts. Data reflect that the majority of families were referred to Project HOME for family support (e.g., need for greater understanding of child development; assistance with domestic problems). At the same time, data suggest that participants enrolled with a complex constellation of overlapping risk factors, including severe mental health, substance abuse, economic, educational, and health issues. Despite the high level of risk in participant families, Project HOME staff clearly provided much needed support as evidenced by the overwhelmingly positive findings on the Participant Survey. Families reported their satisfaction with the Home Visitors' positive support, and cultural sensitivity, as well as their own improved understanding and expectations of their children. Nearly two-thirds of participants rated the program as 'Excellent' and all stated they would refer the program to a friend.

Although only baseline data was available on participants, these data inform leadership about the outstanding service needs of these families. The most striking finding is the high percentage of children who score at risk for delay in both general developmental ability (Denver-III) and in social-emotional development (ASQ:SE), where about half of the children scored at risk on both measures. These findings indicate the critical need for developmental screening and referral to services, such as the Infant and Toddlers Program (ITP). However, it also sharpened the contrast between needed and existing mental health services for children and families in the County. Baseline performance on measures of parental stress and quality of the home environment were less revealing, in large part due to the low number of administrations completed and potential bias in administration. There were, however, no significant differences in the performance of the CWS families when compared to the non-CWS families. This might indicate that the families captured by Project HOME are similar in risk level to those already involved with protective services. In that case, the efforts of the Consortium and Project HOME have been successful in filling a critical gap in services.

The lessons learned from the Project HOME pilot indicate that in order to execute an effective home visiting program with at-risk families of toddler-aged children, it may be beneficial to extend existing models and infrastructure. Effective practices that initially guided the development of the pilot can continue to provide direction in the development of program infrastructure and implementation. Additionally, there are several existing home visiting programs in the County that use national models of excellence on whom pilot projects could rely

for guidance. Consistent across these programs is an emphasis on appropriate staff qualifications and cultural competence, a strong program infrastructure that includes policies and procedures, community linkages, and ongoing staff training and supervision. However, without the addition of more comprehensive mental health services for children and their families, gaps will continue to exist in the continuum of early childhood services.

At the conclusion of Year III, the decision to transition Project HOME reflects strongly on the need to build a quality infrastructure and develop effective lines of communication between front line staff, their leadership team and the County officials who fund the program. Moreover, new programs must consistently rely on effective practice research and on the results that stem from a formative evaluation so that administrators know how to best move initiatives forward. Overall, the most successful pilot programs will remain focused on the needs of the at-risk families that they serve and the utilization of identified effective practices that are aligned with the short and long-term goals of the county, state and nation. This strategy is the most likely to result in a cost effective, continuum of comprehensive early childhood services that achieves the goals of healthy children, families that are self-sufficient, and children that enter school ready to learn.

Appendix A

Best/Effective Practices: Broadly Defined

I. Child Development

1. Services should be intensive and long-lasting.
2. Providers should establish caring and attentive relationships with children.
3. Groups should be small, with low child/teacher ratios.
4. Children should have a safe environment with adequate space to learn and play.
5. Curricula for children should include teacher-structured, child-initiated learning experiences that are individualized to each child's special needs.
6. Providers should have a positive work environment that maximizes staff retention and provides adequate salaried, high quality training and support.
7. Providers should be adequately prepared, including formal schooling and high quality, ongoing training and supervision.

II. Child Health

1. Children and families should be assisted in accessing health care (including medical, dental and mental health services)
2. Children should receive timely preventive and primary health care, including immunizations, well-child check ups, etc.
3. Children should be exposed to a broad variety of nutritional foods.
4. Families should be assisted in providing adequate nutrition, including providing education on nutrition and budget management.
5. Parents and providers should be trained to handle medical and dental emergencies, as well as in the areas of injury and illness prevention and environmental safety.
6. Standards for hygiene, sanitation, and food safety should be established and maintained.

III. Family Support

1. Home visiting services should be initiated prenatally whenever possible, or at birth, and should be intensive (in terms of frequency of visits)
2. Parents should be assisted in developing nurturing relationships with their children, which include appropriate discipline and affirm family and cultural values and traditions.
3. Services and staff should be culturally and linguistically competent.
4. Parents should be empowered to be active partners in their children's education, including knowing their rights and responsibilities.
5. Parents should have access to and encouragement to be involved in their children's early educational experiences.

Appendix B

Project HOME Staff Tenure

2002 - 2003

NAME	TITLE	% TIME	START DATE	EXIT DATE
Jennifer Simpson	Project Coordinator	75%	12/00	7/31/03
Carol Cober	Contract Consultant, Interim Project Director	100%		7/31/03
Marlene Clark*	Home Visitor	100%	4/15/02	
Myrta Molina	Bilingual Home Visitor	100%	4/15/02	7/31/03
Lucia Torres	Bilingual Home Visitor	100%	8/01/03	7/31/03

* Will carry on as Home Visitor under Families Foremost

Appendix C

MCHV Project HOME
Status Report

Prepared by

Donna D. Klagholz, Ph.D. & Associates, LLC

May 2003

For the past two years, the Montgomery County Collaboration Council has received funding for implementation of a home visiting pilot which was designed to address identified gaps in services, enhance the quality of home visiting services, and focus on school readiness outcomes. Project HOME evolved from its original framework in response to formative feedback from participants, stakeholders, and the evaluation. Project HOME has also been modified in order to integrate recent findings from the Maryland State Department of Education (MSDE) on school readiness and county demographic statistics.

The goals of the pilot are:

1. To utilize Best/Effective Practices in Home Visiting
2. To improve Health and Development outcomes for Children
3. To support Families through goal setting and community linkages
4. To link Best Practices to School Readiness goals of the County

Before moving into formal evaluation procedures identified for Year III of Project HOME, a review was conducted on program infrastructure and staff development, program activities, new partnerships, and participant data. This review was designed to serve as an index of program status in order to more specifically identify and prioritize evaluation tasks necessary to complete within the remaining fiscal year. This was accomplished through meetings and interviews with Project HOME staff and through reviews of participant files. This report highlights review findings and provides recommendations for next steps that assist data collection efforts to ensure a strong Year III evaluation of Project HOME.

I. Program Infrastructure - Staff Development

Over the past two years, Project HOME staff has received formative feedback from participants, stakeholders, and evaluators that speaks directly to improvements and suggestions for better program implementation. As a result, Project HOME staff has worked hard to revise the program to better meet the needs of participants (i.e., better service delivery, formalized training of staff) and evaluators (i.e., better data collection and tracking). Based on meetings and interviews conducted with staff, program infrastructure for Project HOME seems stronger, as evidenced by better communication between staff members, stronger leadership, and collective understanding and endorsement of the mission of the program, *which is to provide quality services to high-risk families with toddlers.*

The project currently has three Home Visitors on staff. Two Home Visitors were hired in April 2002, while the third was hired in August 2002. Two of the three home visitors possess college

degrees and each brings unique strengths to services (e.g., strong case management, good rapport with teen mothers). Moreover, two of the three home visitors are bilingual and all have been formally trained in the Parents As Teachers (PAT) curriculum. Formalized training in the PAT curriculum has been a big accomplishment this year. In fact, the Project HOME program is listed on the PAT website as an official program in compliance with PAT procedures. Home Visitors are currently using the curriculum, which helps them stay focused and which they have found to be useful in identifying developmental goals/milestones. They report developing a Family Service Plan, which also ties in with Montgomery County Public Schools (MCPS) school readiness procedures. Both program and leadership staff members are working hard to provide comprehensive services and referrals to their families.

As further testament to improved service delivery, Project HOME leadership and program staff have been provided clinical supervision on a regular basis. Robin Berenstain, LCSW conducts both individual and group supervision with all three Home Visitors. Each receives 1 hour of individual supervision, along with 2 hours of group supervision, a month. Jennifer Simpson, Project Director for Project HOME, also receives supervision on a bi-monthly basis for one hour. Further, weekly staff meetings are held between the three Home Visitors, who use this time for coaching and support. Once a month the weekly staff meeting includes Ms. Simpson and is used as a time to discuss case management and troubleshoot problems that arise in program implementation.

II. Program Activities - Partnerships

A new addition to Project HOME program design is the inclusion of the Youth Strategies Grant, which provides funding for the inclusion of the Child Welfare Services (CWS) population in the Project HOME pilot. The purpose of the merger was to determine if a home visiting strategy could be used effectively with higher risk families that are at the 'intervention level' of need.

While CWS has become a successful partner and the merger has resulted in some impact on this population, implementation has been bumpy. Challenges initially revolved around the chain of command and who to talk to at CWS to get connected and get word out about the program. A Workgroup, comprised of both CWS and DHHS Early Childhood staff, was established to hammer out issues and parameters of collaboration with Project HOME, ITP & CWS. Initially the Workgroup had a difficult time establishing a rapport, but once efforts coalesced, members collaborated to contact direct service staff/groups to get them on board. Referrals started flowing and availability of services has spread via word of mouth. Currently there is a good network base with this staff; five or six CWS staffers typically do all the referrals. Ongoing efforts at collaboration have centered on ways to differentiate the role of CWS staff from that of the Project HOME staff so that program implementation and service delivery is seamless.

Primary challenges have centered on the profiles and need of CWS families and the extent to which Project HOME staff can provide quality services. Usually there are a number of children in the family that are eligible for services; often there are multiple children under the age of 5 years, and that can be overwhelming for the Home Visitors. In addition, the age range of children served is very broad. Most are 0 – 5 years old, so activities need to vary greatly. This

too can be challenging for the Home Visitor to find developmental activities that are appropriate for all ages.

Lastly, mental health issues of parents (i.e., schizophrenia and sexual abuse) are severe and not within the skill set of Project HOME staff. Still, Home Visitors have been good at setting boundaries and identifying the differences with CWS and Project HOME. Sometimes staff from both agencies meet with families together to discuss critical issues.

Referral relationships with both the Linkages to Learning Program and Lourie Center continue to evolve. Linkages staff are great with case management and very knowledgeable about community resources. Relationships between Linkages staff and Project HOME staff are based on mutual respect and collaboration. Together, services are comprehensive and complimentary; what Linkages staff lack in training (no specialty in child development), Project HOME staff are qualified to supply. Services at the Lourie Center, however, are often too difficult to access, but some Project HOME families have been enrolled in Head Start so that they can access services and work through other programs for assistance.

III. Participant Data

Enrollment. The enrollment process for CWS families has been a challenge. Oftentimes, CWS paperwork does not have the phone number or contact information for the family. Instead they rely heavily on 3rd party contacts to track family (relatives, addiction counselor, child care center.). This is difficult for Project HOME staff, who have no way of contacting families to set up a home visit, making the elapsed time between the referral and contact by Project HOME lengthy. To complicate matters, families also express frustration and confusion regarding their contact representative and complain that too many individuals from too many sources contact them for appointments and information. Project HOME has strengthened their paper trail to document process and procedure accordingly.

Participant Records. A tremendous step Project HOME took this year was the recent hiring of a database specialist. Currently data is being entered into both the HATS system an Excel database containing all the variables required for the evaluation and the LMB reporting. After much development, the HATS data program, which was originally designed for use with Montgomery County, with the addition of an early childhood module, is no longer considered a viable system for data tracking. Project HOME staff still use the HATS system for internal purposes only, but note complications. Progress notes on families can be entered, but cannot be combined for aggregate profiles. Intake forms are geared primarily for medical policyholders and as such are not appropriate for the program. Further, the HATS system contains no relevant assessment category under which to enter scores on outcome measures. These problems make it difficult for Project HOME staff to run reviews and reports on their data that could be distributed to funders and local policymakers.

While facing the barriers related to data entry and HATS, efforts in Year III of Project HOME have centered on developing effective strategies for better data collection and tracking. To better identify family need at program enrollment, Jennifer Simpson created a short, delineated criteria for assignment of Home Visitors (leveling criteria) that could be used to inform Family Service

Plans and guide program activities. To assist Home Visitors in data collection efforts, Ms. Simpson also created a Data Summary Checklist that highlights all primary forms of program (e.g., consent for participation in evaluation, consent to release information) and participant (e.g., notes and observations of home visits, formalized measures) documentation that is to be collected. Assistance from the Evaluation Team has also ensured that Spanish versions of all forms are available.

Recommendations from the Year II Annual Report spoke to the increased need for participant data and a formalized schedule of assessment. In response to these recommendations, Ms. Simpson conducted an extensive file review of participant records in March 2003 in order to determine quality of documentation and data collection efforts in Year III. Notes were collected on the Data Summary Checklist and Home Visitors were advised to minimize identified gaps in participant records. The Evaluation Team then returned to Project HOME offices in late April and Early May 2003 to determine what improvements, if any, had been made to participant files. Files for two of the three Home Visitors were in adequate shape. Recommendations made by Ms. Simpson during the initial file review had largely been addressed, particularly regarding program documentation like consent forms, family service plans, and program notes and observations. Follow-up on data collection on outcome measures was less complete for most participants. Files for the third Home Visitor are still in need of much improvement.

It is worth noting that Project HOME leadership staff is aware of outstanding needs for additional data tracking methods and forms. To date, there is no formal policy regarding Home Visitor safety while conducting a home visit. In addition, while forms documenting case closures and policies for referring closed cases to other agencies have recently been developed, criteria for initiative a case closure are still under discussion. Other recommendations from our Year II Report including policies and procedures for security clearance and background checks are still in development as well.

Summary

The original goal of the pilot was to fill gaps, provide short-term services to populations not already served by existing programs, and refer for additional services as needed. Efforts initiated during Year III of Project HOME have worked toward this goal by strengthening program infrastructure, expanding program activities and partnerships, and participant data tracking. At the same time, the profile of need expressed by Project HOME families stands in contrast to the original design of the program. Most families enrolled in Project HOME are considered long-term cases, as their level of need dictates intensive home visiting services. Mental health problems, employment and education issues, and legal barriers are pervasive among parents, while children express difficulties learning and forming quality attachments with their parents. Referral processes are also a challenge, as the needs of Project HOME families are greater than what other programs can provide. Limited capacity, turnaround for services, and concerns about future funding make provisions for multiple services difficult to establish.

Nonetheless, recommendations made to Project HOME staff at the end of Year II have been well considered and strategies and techniques to improve program implementation and management have resulted. Program infrastructure has improved, with the formalized training of Home Visitors in the PAT curriculum and the routine clinical supervision that is offered monthly.

Moreover, Project HOME staff has successfully resolved challenges and barriers to expand program activities to Child Welfare families, thus increasing the visibility and credibility of the program. At the same time, while participant data collection and tracking has improved, more work is needed and efforts to provide a formalized schedule of assessment to Home Visitors are critical. To that end, next steps in the evaluation of Project HOME will center on providing staff with service level criteria and developing a formalized schedule of assessment so that Home Visitors can be sure to administer outcome measures in a timely manner. Support will also be given to complete collection of standardized measures and ensure proper administration. This will be accomplished through staff meetings and observations. Better data collection will result in increased understanding of the extent to which Project HOME meets targeted goals and objectives and improves the quality of life for families enrolled in the program. It will be necessary also to monitor the data entry into both the HATS system and the Excel database to facilitate end year reporting.

Additionally, the evaluators will interview representative staff from the partnering programs, including Child Welfare Services and Linkages to Learning in order to better document the referral process, more clearly define the partners' roles, and refine the leveling criteria. Staff and Participant Satisfaction Surveys will be collected at the conclusion of the fiscal year.

Appendix D

Project HOME-Year III
Evaluation Proposal

Introduction

For the past two years, the Montgomery County Collaboration Council has received funding for implementation of a home visiting pilot which was designed to address identified gaps in services, enhance the quality of home visiting services, and focus on school readiness outcomes. Project HOME evolved from its original framework in response to formative feedback from participants, stakeholders, and the evaluation. Project HOME has also been modified in order to integrate recent findings from the Maryland State Department of Education (MSDE) on school readiness and county demographic statistics.

The goals of the pilot are:

5. To utilize Best/Effective Practices in Home Visiting
6. To improve Health and Development outcomes for Children
7. To support Families through goal setting and community linkages
8. To link Best Practices to School Readiness goals of the County

Table 1 provides a delineation of the tasks and projected hours for the Year III evaluation.

Proposed Evaluation Activities for Year III

Preliminary Evaluation Tasks for Year III will focus on:

1. First completing a status report on the data that is currently available on the participants, the program activities, the program infrastructure, and staff training needs.
2. Provide consultation to program staff on outcome measures and data management.
3. Collect missing baseline data on families as identified in the status report.
4. Collect follow-up outcome measures, family updates, and satisfaction surveys at end of fiscal year.
5. The development of a comparative evaluation design and analysis of the current Project HOME population and a new Child Welfare Services cohort. This cohort will introduce an intervention component that is qualitatively different than the prevention/early intervention focus of most early childhood home visiting programs. Study design will examine the impact of serving populations already involved in the child welfare system on dimensions of resource, capacity, staff qualifications, specialists needed, and supplemental services needed.
6. Reporting

The specific evaluation tasks, target dates, and projected hours for each of the three components are included in the following table.

PROJECT HOME-YEAR III
PROPOSED EVALUATION TASKS AND TARGET DATES

TASK	TARGET DATES	PROJECTED HOURS
I. Program Support/Meetings		
1. Participation in consortium and program meetings (5 hours x 4 months)	Monthly	20
2. Coordinate with project mgrs/ Univ of Md evaluation team	Ongoing	25
3. Provide consultation to program staff on consent, data collection procedures, and measures administration, scoring, and interpretation, and data management	April 2003	10
4. Finalize evaluation variables for inclusion of CWS families	April 2003	5
II. Process Evaluation		
1. Conduct status update on program implementation	April 2003	20
2. Collection and review of project documents: consent forms, quality assurance plan, staff training records, schedules, mtg minutes, newsletters, info on administration, staffing, linkages and referrals	April and June 2003	10
3. Data collection on families (demogs, risk status, services received, dosage)	June 2003	20
4. Collection of Participant and Staff Satisfaction Surveys	June 2003	10
III. Outcome Evaluation		
4. Data Login, Scoring, coding, and entry	July 2003	25
5. Data Analysis	Aug 2003	30
IV. Reporting		
1. Status report	April 2003	20
2. Satisfaction Survey Reports	August 2003	30
3. Annual evaluation report	October 2003	80
Project HOME SUBTOTAL HOURS		**305**
Home Visiting Consortium		
1. Qualitative analysis of consortium documentation (mtg minutes, outputs, membership list, attendance, goals and objs, common performance measure list)	July 2003	20
3. Develop evaluation survey for Retreat (focus on qualitative analysis of collaborative process and community context)/phone conferences to finalize	April 2003	5
4. Summary	June 2003	25
HV CONSORTIUM SUBTOTAL HOURS		**50**
TOTAL HOURS		**335**

Appendix E

Montgomery County Project HOME Logic Model

INDICATORS	PROGRAM SERVICE	COMMENTS
Child Health o IZ o Medical Provider/Home o Regular Checkups	o Health education o Linkages to health care services o Referrals to services for special needs	o IZs and health care data will be tracked using the *PAT Health Form* o Data can be collected on Tool 2
Child Social-Emotional Development o ASQ-SE	o Developmental curriculum o Role modeling by HV o Referrals/consultations Behavioral specialist	o Contract services are available for a behavioral specialist
Child Development o Language development o Literacy o Denver III/ASQ	o Developmental assessment o Referrals to ITP/Child Find as indicated o Partners in Learning Curriculum o Supplemental materials/ 'Learning parties'	o Emphasis on language and literacy for school readiness; other developmental concerns will be covered by assessment and referrals to ITP/Child Find;
Parent Child Interaction o Overall score and subtest scores on HOME Inventory	o Parenting curriculum (PAT) o Role modeling	
Parenting knowledge o Subtest scores on HOME	o Parenting curriculum (PAT) o Role modeling	
Parenting stress o Reduced levels on PSI	o Support from Home Visitor (linkages, referrals) o Parenting curriculum (realistic developmental expectations and discipline)	o HV will not case manage-Linkages will do this
Knowledge of Community Resources o Self-report of knowledge and use of community resources o Family Support Plan –list of referrals	o Linkages and referrals to available resources in the county	o HV will need training and information/directory of available resources in the county; HV will meet with key county personnel

Appendix F

Montgomery County Early Childhood Referral Checklist

Date: _____

Basic Information

Name of Parent: _____

Child's Name: _____ Date of Birth: _____

Address: _____ Zip: _____

Home Phone: _____Work Phone: _____ Other Phone: _____

Primary Language: _____

Prenatal Health

Is anyone in your household pregnant? Yes No

It yes, when is the due date? _____

Are there questions or concerns about the pregnancy? Yes No

Child Development

Do you have questions or concerns regarding your child's development? Yes No

Child Health

Do you have questions or concerns regarding your child's health? Yes No

Family Support

Do you have questions or concerns about other areas such as housing, finances, child care, insurance? Yes No

* I would like to contacted by the Early Childhood Consortium Project Coordinator to further discuss my questions and concerns and to obtain information about the Early Childhood programs and resources available in Montgomery County. Yes No

* I grant my permission for the information on this form to be shared with the Early Childhood Consortium Project Coordinator for the purpose of follow-up regarding my questions and concerns. Yes No

Verbal permission received from: _____ Date: _____

Signature of parent: _____ Date: _____

Name of community provider completing the Screen: _____

Phone Number: _____

Please Fax this form to the Project Coordinator at _____

Appendix G

Montgomery County Early Childhood Screening Checklist – 2

Name of person administering screen: _____ Date: _____

Organization: _____ Phone Number: _____

I. Basic Information

Mother: _____ DOB: _____ Marital Status: S M D W

Father: _____ DOB: _____ Marital Status: S M D W **Guardian (if applicable)**_____

Address of Primary Guardian:_____

_____

Phone:_____ **Primary Language**:_____

English Abilities: Fluent English Some English No English

Name of Child: _____**Gender:** M / F**DOB:** _____

Name of Child: _____**Gender:** M / F**DOB:** _____

Name of Child: _____**Gender:** M / F**DOB:** _____

Number of people (family) living in the household: #Adults_____ #Children_____

II. Prenatal Information (if currently pregnant) Estimated Date of Delivery: _____

	Y	N
First Time Pregnancy	☐	☐
High Risk Pregnancy	☐	☐

	Time Began Prenatal Care
☐	1st Trimester
☐	2nd Trimester
☐	3 Trimester

	Prenatal Care Provider
☐	Private Ob/ Gyn
☐	Clinic
☐	Other:
☐	None

III. Child Health

	Y	N			
Was the pregnancy full term?	☐	☐	If no, gestational age of infant:	_____	Birth Weight in Grams _____

Type of Health Insurance for Child
- ☐ Private
- ☐ Medicaid
- ☐ Other: _____
- ☐ None

Child's Primary Physician
- ☐ Private Physician
- ☐ Clinic
- ☐ Other
- ☐ None

Immunization Status
- ☐ Up to date for age
- ☐ Not up to date

IV. Concerns about Child's Health and/or Development

	Yes	No
Does the child have any medical problems/chronic conditions?	☐	☐
Did the mother receive prenatal care?	☐	☐
Were there birth defects or congenital anomalies?	☐	☐
Has the child had any hospitalizations?	☐	☐
Has the child received ongoing/routine medical care?	☐	☐

Highest Grade Completed

M= Mother F = Father

M	F	
☐	☐	Less than High School
☐	☐	High School Graduate
☐	☐	Vocational
☐	☐	College
☐	☐	Graduate School

Family Income
- ☐ Under $5,000
- ☐ $5,000- $14,999
- ☐ $15,000 - $29,999
- ☐ $30,000- $44,999
- ☐ $45 and over
- ☐ Unknown

Other Resources
- ☐ Child Support
- ☐ SSI
- ☐ WIC
- ☐ TANF
- ☐ Child Care Subsidy
- ☐ Other:_____
- ☐ None

V. Family Concerns *Concerns presented by family. Check all that apply

- ☐ Domestic Violence
- ☐ Depression
- ☐ Mental Illness
- ☐ Substance Abuse
- ☐ Unstable Housing
- ☐ Employment Needs
- ☐ Medical Illness
- ☐ Healthcare Insurance or Linkage
- ☐ Child Care
- ☐ Criminal History
- ☐ Legal Concerns
- ☐ Current/History of Child Abuse and Neglect
- ☐ Child Development/Behavior Concerns
- ☐ Financial Concerns
- ☐ Teen Pregnancy
- ☐ Parenting Concerns
- ☐ Education and/or Training Needs
- ☐ Other

VI. Current Services *Check all that apply

- ☐ Domestic Violence Intervention
- ☐ Mental Health Services
- ☐ Drug and Alcohol Treatment
- ☐ Housing Assistance
- ☐ Employment Assistance
- ☐ Financial Assistance
- ☐ Child care
- ☐ Developmental Services (Special Ed, Child Find)
- ☐ Legal Assistance
- ☐ Crisis Intervention Services
- ☐ Home Visiting Services
- ☐ Educational Assistance
- ☐ Family Preservation
- ☐ Other

VII. Positive Family Support Systems * Check all that apply

- ☐ Church
- ☐ Extended Family
- ☐ Friends
- ☐ Neighbors
- ☐ Home Visitor
- ☐ School System
- ☐ Employer
- ☐ Other _____

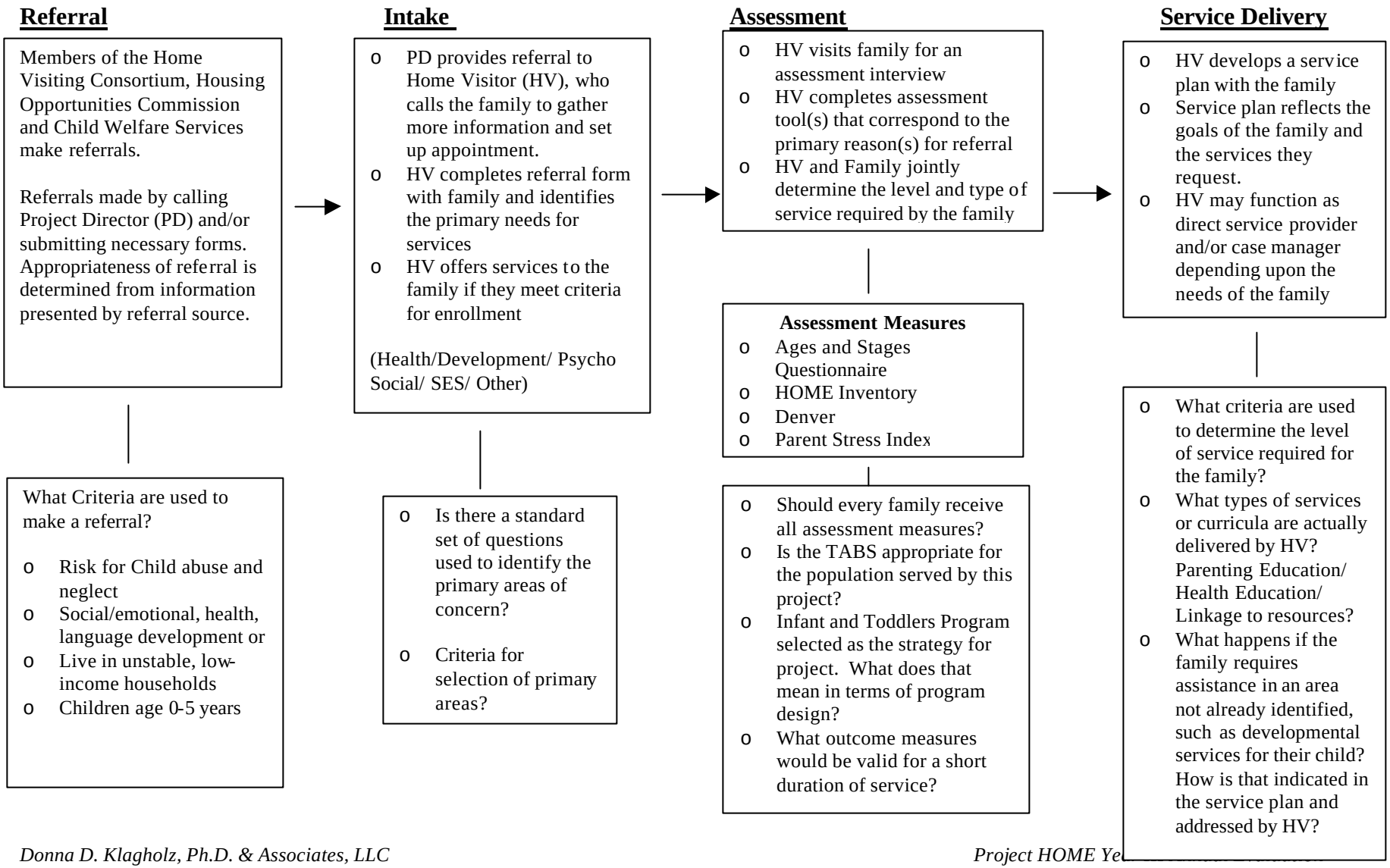
Referrals Completed by Triage Staff

Name of Resource	Contact Name and Phone Number	Reason for Referral	Outcome of Referral

Signature of Person Completing the Report: _____ Date Completed:_____

Appendix H

Montgomery County Project HOME Referral Flow Chart – Year III



Appendix I

HOME VISITING CONSORTIUM TRAINING FY '03

DATE & TIME	NAME OF TRAINING	BRIEF DESCRIPTION OF TRAINING AND PRESENTER	LOCATION	ATTENDEES	EVALUATION AND RESULTS
Oct. 29th: 1 - 4 p.m	Ages and Stages	Administration of the ASQ for early childhood professionals Donna Klagholz, Ph.D.	Children's Resource Center - D3	25 CWS= 10 ITP=15	Total Response: 20/24 = 80% Well Organized, Good overview, should be geared more to CES
Oct 29th 1 – 4 p.m.	Administering the Parent Stress Index (PSI)	Learn how to administer the Parent Stress Index (PSI) Donna Klagholz, Ph.D.	Children's Resource Center D2	23 CWS=0 HVC=4 ITP=19	Total Response: 13/23 = 56% Needs other assessment tools
Nov. 13th: 9 - 4 p.m.	So You Want to be a Home Visitor	Introduction to Home visiting for new home visitors or those who want a refresher Barbara Nathanson, LCSW Marlene Clark	Children's Resource Center - D2	Cancelled due to lack of registration	
Nov. 13th: 1-4 p.m.	Ages and Stages - Social Emotional	Administration of the ASQ-SE for early childhood professionals Donna Klagholz, Ph.D.	Children's Resource Center - D3	22 CWS=0 HVC=5 ITP= 17	Total Response: 13/22 = 59% Well Presented/good discussions, was clear and helpful. Need ideas for T= interactions/Caregivers & child. Provide video tapes/admin case studies
Jan. 27th: 9 - 4 p.m.	So You Want to be a Home Visitor	Introduction to Home visiting for new home visitors or those who want a refresher Barbara Nathanson, LCSW Marlene Clark	Crossways Community Center	14 CWS=1 ITP=10 HVC=3	Evaluation completed. Evaluation lost by staff at training site

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Jan. 27th: 1 - 12 p.m.	Ages and Stages	Administration of the ASQ for early childhood professionals Donna Klagholz, Ph.D.	Children's Resource Center - D2	19 CWS=4 ITP=6 ECMH=1 HVC=8	Total Response 7/24 = 29% Comment Summary – Presenters and workshops are good.it would be best for those who are unfamiliar with the instrument. Show grid filled out & how they could explain to parents. Avoid focusing on mother as resource since it should be more parent
Jan 27th 9 – 12 p.m.	Administering the Parent Stress Index (PSI)	How to administer the PSI Donna Klagholz Ph.D.	Children's Resource Center	15 CWS=0 ITP=11 HVC=4	Total Response 10/15 = 67% Comment Summary: Good info but took to long. List of community resources in county that deals with Mental Health issues for the uninsured. Community resources to give to families w/ S.E. issues.
Jan 28th 1 – 4 p.m.	Administering the Temperament and Atypical Behavior Scales (T.A.B.S)	How to administer and interpret the Temperament and Atypical Behavior Scale Presenter: Cheryl Holland Ph.D.	Children's Resource Center	21 CWS=0 ITP=18 ECMH=1 HVC=2	Total Response 15/22 = 72% Comment summary: guidelines for norms in S.E. dev, Goal writing/ activities helpful more IFSP process training. Presenter did awesome job. Very good ideas/ Liked how incorporated real goals and outcomes
Jan. 28th: 9 - 12 p.m.	Ages and Stages - Social Emotional	Administration of the ASQ-SE for early childhood professionals Donna Klagholz, Ph.D.	CRC	16 ECMH=1 CWS=0 HVC=14 ITP=1	Total Response 11/23 = 48% Comment Summary: Sensory integration issues. Needs more specifics /could use more implementation strategies
Feb 27th 10 – 1 p.m.	Administration of the Denver Developmental Assessment	Learn details of interpreting & incorporating the Denver Scale in their intake processing Presenter Karen Banks Ph.D.	401 Fleet St Lower Level Conference room	6 CWS=2 HVC=3 ITP=1	Total Response 5/6 = 83% No comments provided

DATE & TIME	NAME OF TRAINING	BRIEF DESCRIPTION OF TRAINING AND PRESENTER	LOCATION	ATTENDEES	EVALUATION AND RESULTS
Mar. 19th, 20th,21st: 9 to 4 p.m.	Filial Therapy	Learn the practice of Filial Therapy and its application with young children and their families Louise Guerney, Ph.D. Carrie Hansen, MSW	Children's Resources Center	24 CWS=6 ITP=12 HVC=6	Total Response 20/24 = 83% Basic response to questions: Overall this training was excellent and provided a different play therapy for children. Very positive about using this therapy for the children./Poor audio visual..
May 6 9:30 – 12 p.m.	Home Visiting Retreat	Helping all HVC programs focus on reporting results Survey of HVC Members Donna Klagholz Ph.D.	Wellspring Retreat Center	15 HVC=15	See report from Donna Klagholz of survey results
May 6,	Administering the Denver II Developmental Screening	Demonstrate knowledge of the Denver II and how to use it to identify developmental concerns and warning signs Dr. Karen Banks, Ph.D.	Juvenile Assessment Center 7300 Calhoun Place	17 CWS only	Total Response 15/17 = 82% Comments: Helpful sessions/ Want more time
May 21	ASQ	Administration of the ASQ for early childhood professionals Donna Klagholz Ph.D.	Juvenile Assessment Center 7300 Calhoun	Cancelled	CWS unit requested but conflicts required cancellation.
TOTAL		**Fourteen events were scheduled Twelve were conducted.**		**217 attended CWS=40 ITP=110 HVC=64 ECMH=3**	

KEY: Child Welfare Services=CWS
Home Visiting Consortium (not ITP) =HVC
Infants and Toddlers (HVC Member) = ITP
Early Childhood Mental Health=ECMH

NOTE: Due to the size of the ITP's staff, the data breaks out Infants and Toddlers separately

Appendix J

Date ___/___/

Project HOME Program
Staff Survey

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

1. In what capacity do you work with Project HOME? ***(Please check one)***

- o Administrative
- o Management/Supervisory
- o Home Visitor
- o Other _____

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

Program Services	**Strongly Agree**	**Agree**	**Not Sure**	**Disagree**	**Strongly Disagree**
I understand the goals and objectives of Project HOME .					
I receive an adequate amount of supervision to help me get my job done in a quality manner.					
Project HOME is designed to optimize child development through comprehensive support to families.					
The program management is responsive to the needs of staff.					
Project HOME is responsive to the needs of children and their families.					
I have participated in training that adequately prepared me for my position.					
Project HOME materials are appropriate and culturally sensitive to the families served.					
Project HOME helps prepare children to be ready for school.					
Project HOME staff coordinate well with the CWS and LTL staff to process referrals and meet families' needs.					

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

3. Which areas of the program are particularly strong?

_____

_____

_____

_____

4. Which areas of the program need improvement?

_____

_____

_____

_____

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

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

Additional Comments (*use reverse side for more space*):

THANK YOU VERY MUCH!

Appendix K

Project HOME Participant Questionnaire

Today's Date _____ **FSW Initials____**

Please share the following information:

1. Your DOB:_____

2. Your educational level: ☐ Elementary ☐ Some High School ☐ HS Graduate ☐ Some College ☐ College Graduate

3. Number of Children in the family:_____ Ages of Children:_____

4. How often were you visited? ☐ Once a week ☐ Twice a month ☐ Once a month ☐ Don't know

5. How long have you been in Project HOME? _____Months

6. About how many times did your Home Visitor meet with you? _____

7. Did you have the same home visitor every time? ☐ YES ☐ NO

Please circle the correct number to the following questions:
1 (Strongly Disagree) 2 (Disagree) 3 (Neutral) 4 (Agree) 5 (Strongly Agree)

8. Do you feel you were visited often enough?	1	2	3	4	5
9. Did your home visitor help you understand your child's development and behavior?	1	2	3	4	5
10. Did your home visitor provide positive feedback and support?	1	2	3	4	5
11. Did your home visitor talk with you about the importance of doctor visits and shots for your child's health?	1	2	3	4	5
12. Do you feel your home visitor respected your family's way of doing things including your family's culture and ethnicity?	1	2	3	4	5
13. Did your Home Visitor give you materials that respected your and language?	1	2	3	4	5
14. Was this program helpful to you as a parent?	1	2	3	4	5

15. Were you given the opportunity to participate in setting goals?	1	2	3	4	5

16. Was there any service or help you expected or needed from the program, but did not receive? ☐ YES ☐ NO

If YES, please explain: _____

17. Did the home visitor assist you in arranging for other services (ex., ESOL; GED; Housing; Food; Health Care; Employment;
Mental Health; etc.) ?

☐ YES ☐ NO ☐ DIDN'T NEED OTHER SERVICES

If YES, what other services? _____

18. Would you recommend that a friend or neighbor use this program's service? ☐ YES ☐ NO

19. What did you like most about the program?

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

21. Overall, how would you rate this program?

☐ EXCELLENT ☐ GOOD ☐ AVERAGE ☐ POOR

Thank You!!