# Withdrawal/Redaction Sheet
## Clinton Library

| DOCUMENT NO. AND TYPE | SUBJECT/TITLE | DATE | RESTRICTION |
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| 001. note | Notes re: phone numbers (partial) (1 page) | n.d. | P6/b(6) |

**COLLECTION:**
Clinton Presidential Records
Domestic Policy Council
Gaynor McCown (Subject Files)
OA/Box Number: 7383

**FOLDER TITLE:**
[Baltimore Visit - About Baltimore and Maryland]

2011-0255-S
rc174

## RESTRICTION CODES

**Presidential Records Act - [44 U.S.C. 2204(a)]**

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

**Freedom of Information Act - [5 U.S.C. 552(b)]**

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

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Globe-Weis ACCORDION

Alapco Office Products Group | Joplin, MO 64804 | Made in USA

| Red Rope Gusset | Expansion | Tyvek Gusset | Color Available |
|---|---|---|---|
| 1516C | 1 3/4" | G1516C | Red Rope |
| 1526E | 3 1/2" | G1526E | A, D, H, Y |
| 1536C | 7" | G1536C | Red Rope |

A - Assorted B - Blue H - Green Y - Yellow

Contains a minimum of 10% post-consumer recycled fibers

PHOTOCOPY PRESERVATION

## Demographic Change

| | 1990 | 1993 | 2000 |
|---|---|---|---|
| State population under age 18 | 1,162,000 | 1,241,000 | 1,405,000 |
| Percent of state population under age 18 | 24.3% | 25.0% | 26.4% |

## Social Characteristics

| | STATE | NATIONAL |
|---|---|---|
| Percent of women giving birth in 1990 who received adequate prenatal care | 76.8% | 68.3% |
| Percent of children without health insurance in 1992 | 11.1% | 13.0% |
| Percent of children living in households without a telephone in 1990 | 4.5% | 7.8% |
| Percent of adults (age 25+) with a high school diploma in 1993 | 82.6% | 80.2% |
| Percent of 4th grade students scoring below basic reading level in 1992 | 47% | 43% |
| Percent of 4th grade students scoring below basic mathematics level in 1992 | 43% | 41% |

## Income and Poverty

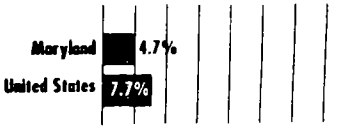
| | STATE | NATIONAL |
|---|---|---|
| Median income of families with children in 1992 | $42,400 | $35,100 |
| Per capita income in 1993 | $23,900 | $20,800 |
| Percent of children in extreme poverty (income below 50% of poverty level) in 1992 | 6.5% | 8.9% |
| Percent of children in poor and near-poor families (income below 150% of poverty level) in 1992 | 24.0% | 31.5% |
| Percent of mother-headed families receiving child support or alimony in 1992 | 28.7% | 31.8% |
| State AFDC and Food Stamp benefits as a percent of poverty line in 1994 | 65.4% | 65.4% |

## Fathers and Families

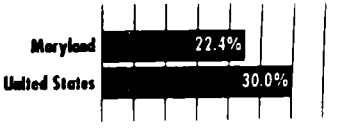
Percent of children living in households with no adult male (age 21+) present


Percent of children living in neighborhoods where more than half of all families with children are female headed


Percent of children living in neighborhoods where the majority of males (age 16+) worked less than six months of the year




Percent of all men (ages 25-34) earning less than the poverty level for a family of four

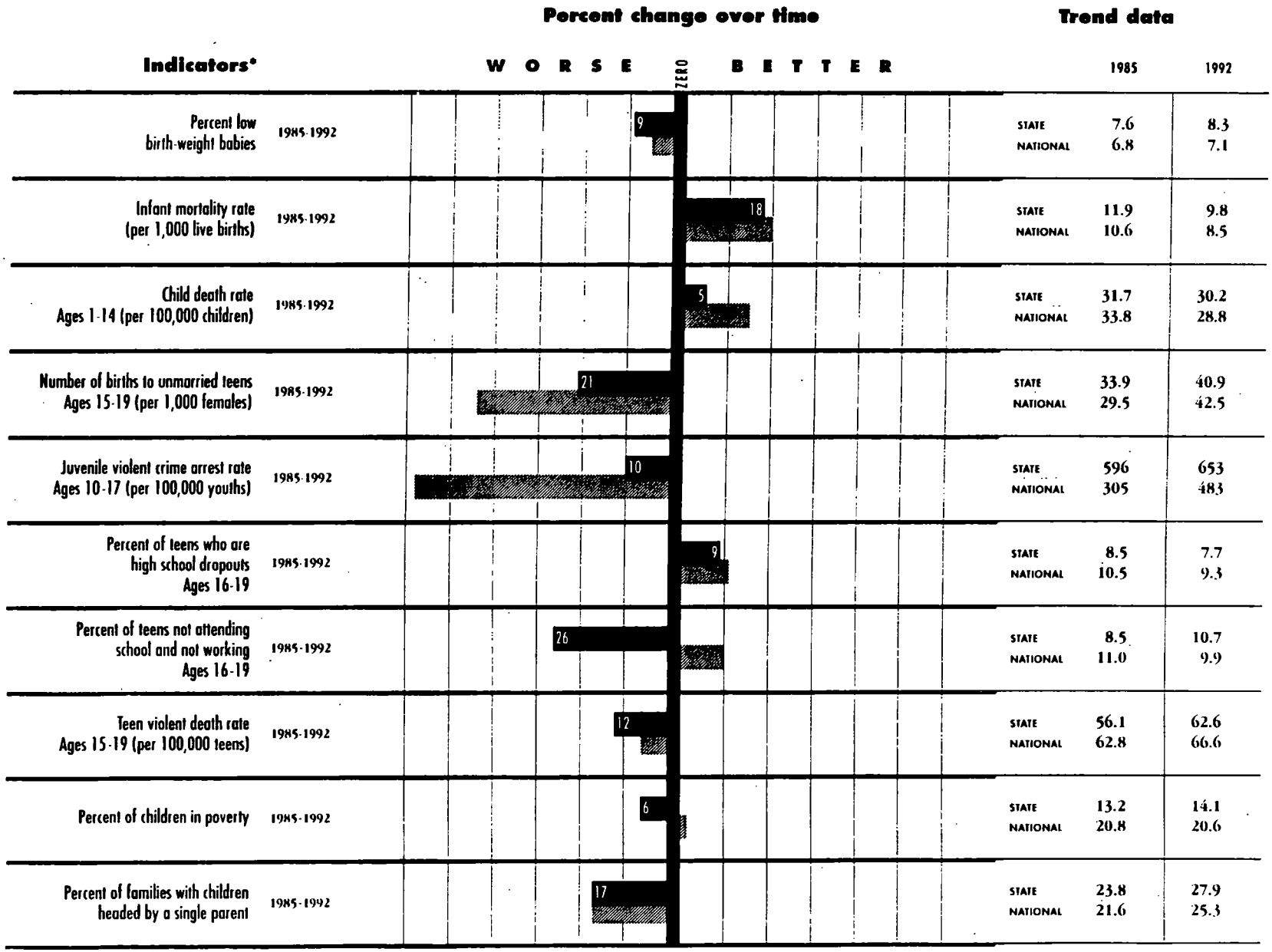



*Statistics are based on the 1990 Census.

# Maryland



National Composite Rank [ 30 ]




| Indicators* | | Trend data | 1985 | 1992 | National Rank (National Rank is based on most recent available data) |
|---|---|---|---|---|---|
| Percent low birth-weight babies | 1985-1992 | STATE | 7.6 | 8.3 | [ 42 ] |
| | | NATIONAL | 6.8 | 7.1 | |
| Infant mortality rate (per 1,000 live births) | 1985-1992 | STATE | 11.9 | 9.8 | [ 42 ] |
| | | NATIONAL | 10.6 | 8.5 | |
| Child death rate Ages 1-14 (per 100,000 children) | 1985-1992 | STATE | 31.7 | 30.2 | [ 29 ] |
| | | NATIONAL | 33.8 | 28.8 | |
| Number of births to unmarried teens Ages 15-19 (per 1,000 females) | 1985-1992 | STATE | 33.9 | 40.9 | [ 29 ] |
| | | NATIONAL | 29.5 | 42.5 | |
| Juvenile violent crime arrest rate Ages 10-17 (per 100,000 youths) | 1985-1992 | STATE | 596 | 653 | [ 47 ] |
| | | NATIONAL | 305 | 483 | |
| Percent of teens who are high school dropouts Ages 16-19 | 1985-1992 | STATE | 8.5 | 7.7 | [ 23 ] |
| | | NATIONAL | 10.5 | 9.3 | |
| Percent of teens not attending school and not working Ages 16-19 | 1985-1992 | STATE | 8.5 | 10.7 | [ 33 ] |
| | | NATIONAL | 11.0 | 9.9 | |
| Teen violent death rate Ages 15-19 (per 100,000 teens) | 1985-1992 | STATE | 56.1 | 62.6 | [ 22 ] |
| | | NATIONAL | 62.8 | 66.6 | |
| Percent of children in poverty | 1985-1992 | STATE | 13.2 | 14.1 | [ 12 ] |
| | | NATIONAL | 20.8 | 20.6 | |
| Percent of families with children headed by a single parent | 1985-1992 | STATE | 23.8 | 27.9 | [ 42 ] |
| | | NATIONAL | 21.6 | 25.3 | |

*See Definitions and Data Sources, page 155.

Patterned bars indicate national change. Solid bars indicate state change.

# MARYLAND 1994 KIDS COUNT FACTBOOK


**WHAT IS KIDS COUNT?**

Maryland KIDS COUNT is a four-year project, begun in January, 1993, funded by the Annie E. Casey Foundation. Maryland KIDS COUNT profiles the status of children in Maryland by tracking outcomes of economic well-being, health, safety and education. The objective of this project is to promote public education and accountability for the critical situation facing our children today. It is our hope that this increased awareness will prompt the interest of all Marylanders to work toward improving the quality of life for our children.

Maryland KIDS COUNT Partnership is a collaborative effort of the following: Advocates for Children and Youth, Inc. (lead agency), Baltimore Community Foundation, Baltimore Urban League, Inc., Friends of the Family, Inc., Office for Children, Youth and Families, Maryland Association of Resources for Families and Youth, Maryland Alliance Against Family Violence, Maryland Business Roundtable for Education, Maryland Committee for Children, Inc., Maryland Education Coalition, Maryland Food Committee and Mental Health Association of Maryland.

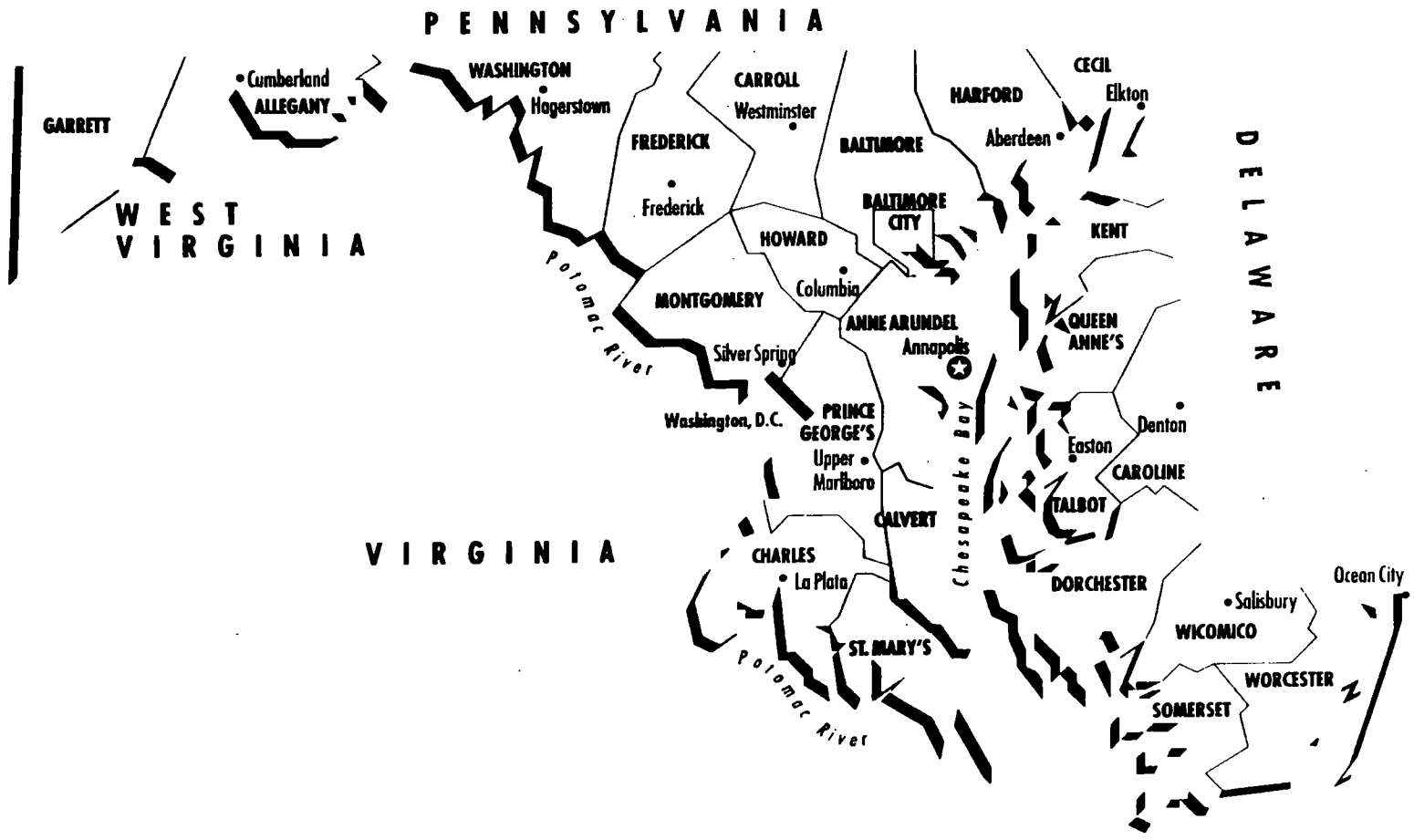
Additional copies of the ***Maryland 1994 KIDS COUNT Factbook*** are available for a fee of $15.00 (postage included). County specific factsheets are available free of charge.

For further information about KIDS COUNT publications contact:

Maryland KIDS COUNT
Advocates for Children and Youth, Inc.
300 Cathedral Street, Suite 500
Baltimore, MD 21201
(410) 547-9200 Fax (410) 547-8690

Please make checks payable to "ACY - KIDS COUNT."

# MARYLAND


PENNSYLVANIA
WEST VIRGINIA
VIRGINIA
DELAWARE
GARRETT
ALLEGANY
Cumberland
WASHINGTON
Hagerstown
FREDERICK
Frederick
CARROLL
Westminster
BALTIMORE
HARFORD
Aberdeen
CECIL
Elkton
BALTIMORE CITY
KENT
HOWARD
Columbia
MONTGOMERY
Silver Spring
Washington, D.C.
ANNE ARUNDEL
Annapolis
QUEEN ANNE'S
PRINCE GEORGE'S
Upper Marlboro
Easton
Denton
CAROLINE
TALBOT
CALVERT
CHARLES
La Plata
DORCHESTER
Salisbury
Ocean City
WICOMICO
ST. MARY'S
WORCESTER
SOMERSET
Potomac River
Potomac River
Chesapeake Bay

# OVERVIEW AND FINDINGS

## WHY THIS BOOK?

The *Maryland 1994 KIDS COUNT Factbook* presents the second comprehensive look at the conditions of children and families in Maryland. As an important tool in measuring how well or how poorly children are doing, this *Factbook* provides 15 baseline outcome measures of child health, education and socio-economic well-being in each Maryland county. These measures are categorized under the four **BASICS —ECONOMIC WELL-BEING, GOOD HEALTH, SAFETY AND PREPARING FOR ADULTHOOD.** The *1994 Factbook* also examines some of the services children receive. Together, these data illustrate the severity of risks faced by children and youth in Maryland today.

This *Factbook* is also an important tool in educating the public and decision-makers on the status of children in Maryland. It builds a strong and effective case for improving measurable outcomes for Maryland's children. It is our hope that this increased awareness will prompt the interest of business leaders, media, public servants, elected officials, community groups and citizens to work toward public and private solutions to the present and future crises our children face. Marylanders have a shared responsibility to ensure that all children have an equal opportunity to be safe, healthy and educated.

## WHAT'S NEW IN THE 1994 FACTBOOK?

The KIDS COUNT Factbook examines two additional indicators of adolescent safety: school violence (suspensions/expulsions) and adolescent substance use. These two data indicators show that too many teens engage in high-risk behaviors, threatening not only their health and well-being but that of their peers and communities.

## OUR VISION

*Maryland's children will have opportunities to achieve their full potential. They will reach adulthood having experienced a safe, healthy and nurturing childhood. Children in Maryland will have opportunities to grow physically, intellectually, emotionally and socially. They will be prepared to become responsible, self sufficient and contributing members of the community.*

# OVERVIEW AND FINDINGS

## GOOD NEWS

The *1994 Maryland KIDS COUNT Factbook* shows that there is encouraging news about infant mortality rates, percent of births to teens and education outcomes. The infant mortality rate fell 18% between 1985 and 1992. The proportion of babies who are born to teens declined from 12.1% in 1985 to 9.7% in 1992. Today, a greater percentage of students are graduating from high school on-time and are meeting the minimal requirements to enter the University of Maryland System. Some of the gains made in these areas are the result of prevention programs, new education accountability standards (measures) and persistent efforts of advocates, educators and providers.

## PROGRESS STALLED

Although we find evidence of improvements in some indicators of child well-being, the *Factbook* shows that little or no progress has been made in child and adolescent safety. Most children in Maryland are faring well: they live in caring and loving families, are succeeding in school and being prepared for responsible adulthood. Sadly, however, too many of our children's lives continue to be in jeopardy. We have witnessed an increasing number of child abuse and neglect investigations, arrests for violent crimes and violent deaths among teens. The threat of violent death is particularly significant for African-American youth. Between 1985 and 1992, the African-American teen death rate from homicide, suicide and accidents increased 82%, while the violent death rate among white teens declined 7%. In 1993, there were over 11,000 indicated child abuse and neglect investigations in Maryland -up 16.8% from 1990. The number of arrests for violent crimes among juveniles continues to climb-- rising 30% in four years. This growing epidemic of violence threatens the health and spirit of our children and communities.

**GOOD NEWS**

*The 1994 Maryland KIDS COUNT Factbook shows encouraging news about infant mortality rates, percent of births to teens and education outcomes.*

**PROGRESS STALLED**

*Little or no progress has been made in child and adolescent safety.*

# OVERVIEW AND FINDINGS

## KEY FINDINGS ABOUT MARYLAND'S CHILDREN

**IN MARYLAND, 150,620 CHILDREN RECEIVE AID TO FAMILIES WITH DEPENDENT CHILDREN (AFDC) AND THEREFORE LIVE IN POVERTY.** Between 1990 and 1994, the number of children receiving AFDC increased 23.6%.

**MANY ABSENT PARENTS DO NOT CONTRIBUTE TO THE ECONOMIC WELL-BEING OF THEIR CHILDREN.** In 1994, payment was made in only one-third of court-ordered child support cases.

**IMPROVEMENT IN THE PERCENTAGE OF BABIES BORN LOW BIRTHWEIGHT HAS STALLED.** The percentage of babies born weighing less than 5:5 pounds has increased slightly from 7.8% between 1985-88 to 8% between 1989-92.

**FEW CHILDREN ARE SCREENED FOR LEAD POISONING.** Although children under the age of six are especially vulnerable to lead poisoning, only one in eight is screened.

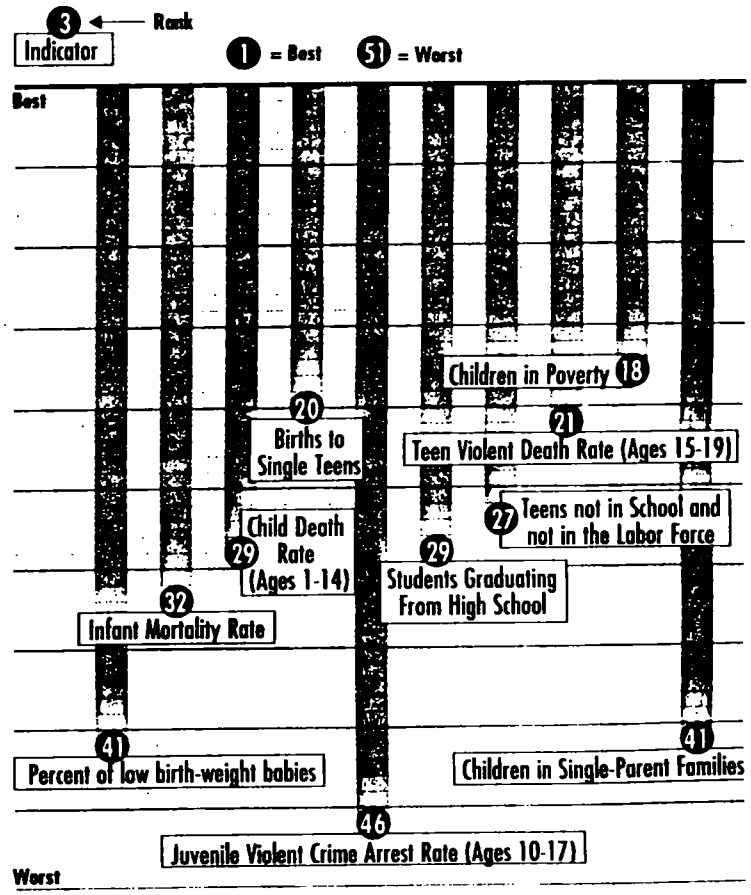
**MANY TEENS ENGAGE IN HIGH-RISK BEHAVIORS THAT THREATEN THEIR HEALTH AND SAFETY.** In 1992, 28% of Maryland public high school seniors reported that they used marijuana in the past year, and close to one-half reported that they had five or more servings of alcohol on any one occasion.

**VIOLENCE HAS INCREASED IN MARYLAND SCHOOLS.** Between 1985 and 1992, the number of school suspensions and expulsions for violence-related offenses increased 22.6%.

**THIRD GRADE TEST SCORES IN READING HAVE IMPROVED.** The percentage of third graders scoring satisfactory or above on the Maryland School Performance Assessment Program (MSPAP) in reading has increased from 28.6% in 1992 to 30.6% in 1994.

## HOW DO WE RANK?

**MARYLAND** has the **6TH HIGHEST** per capita income in the United States, yet it ranks **32ND** in the nation on the well-being of its children.




Source: *KIDS COUNT DATA BOOK, 1994.* The Annie E. Casey Foundation

# HOW ARE WE DOING?

The following chart provides an overview of Maryland's performance in 15 benchmark measures of child well-being.

| | Then | | Now | | Trend |
|---|---|---|---|---|---|
| **ECONOMIC WELL-BEING** | | | | | |
| Percent of Children in Poverty | 12.5% | (1979) | 10.9% | (1989) | ▲ |
| Child Support (payment rate) | 34.1 | (1993) | 32.9% | (1994) | ▼ |
| Percent of all Births to Teens | 11.6% | (1985-88) | 10.3% | (1989-92) | ▲ |
| **GOOD HEALTH** | | | | | |
| Percent of Babies Born Low Birthweight | 7.8% | (1985-88) | 8.0% | (1989-92) | ▼ |
| Infant Mortality Rate (per 1,000 live births) | 11.5 | (1985-88) | 9.8 | (1989-92) | ▲ |
| Pediatric AIDS Cases (children under 13) | 65 | (1988-90) | 94 | (1991-93) | ▼ |
| Percent of Children with Lead Poisoning | 3.0% | (1992) | 3.1% | (1993) | ▼ |
| **SAFETY** | | | | | |
| Child Death Rate (ages 1-14, per 100,000 children) | 31.0 | (1985-88) | 30.3 | (1989-92) | ▲ |
| Teen Violent Death Rate (ages 15-19, per 100,000 teens) | 55.8 | (1985-88) | 70.3 | (1989-92) | ▼ |
| Indicated Child Abuse and Neglect Rate (per 1,000 children) | 8.2 | (1990) | 9.2 | (1993) | ▼ |
| Juvenile Violent Crime Arrest Rate (ages 10-17, per 10,000) | 55.9 | (1990) | 69.5 | (1993) | ▼ |
| School Violence (suspensions/expulsions) | 23,913 | (1992) | 25,285 | (1993) | ▼ |
| **PREPARING FOR ADULTHOOD** | | | | | |
| Third Grade Reading* | 28.6% | (1992) | 30.6% | (1994) | ▲ |
| On-time Graduation Rate | 72.8% | (1990) | 75.8% | (1994) | ▲ |
| High School Program Completion** | 43.5% | (1991) | 48.1% | (1994) | ▲ |

*percent of students scoring satisfactory on Maryland School Performance Assessment Program tests
** percent of students meeting minimal requirements for the University of Maryland System

**SYMBOLS:**

▲ better ▼ worse

# LEAD POISONING

Although lead poisoning is preventable, it remains a pervasive health problem in the United States. It is estimated that 75% of all U.S. children live in housing that may contain lead paint or dust hazards.

Children are exposed to lead from paint, gasoline and solder from dust, water, food, soil, the air, and parents' occupations and hobbies. Children are commonly poisoned by ingesting lead contaminated dust while playing or eating. They may also be exposed through tap water with high concentrations of lead from the plumbing in their homes. Substandard housing and poverty increase children's risk of lead exposure.

The Centers for Disease Control (CDC) has found that blood levels as low as 10 µg/dL may have serious consequences for children's health. There is growing evidence that even low levels of lead may cause developmental delays, verbal, perceptual and motor disabilities and inattentiveness. High levels of lead exposure may lead to comas, convulsions, and even death.

Although children under age six years are particularly vulnerable to lead poisoning, only one in eight are screened in Maryland. Of the number of children screened in 1993, 1,601 had lead poisoning-- up 13.3% from 1992. The number of children who had some lead exposure (10-19 µg/dL) more than doubled between 1992 and 1993.

**COUNTY FINDINGS:**

Between 1992 and 1993, 13 Maryland counties had decreases in the percentage of children screened. In 16 Maryland counties, less than 10% of children were screened for lead poisoning in 1993. Baltimore City and Somerset County had the highest percentage of children screened at 48.9% and 26.5%, respectively.

# OCCURRENCES OF LEAD POISONING

Number of children screened, percent screened, number and percent lead poisoned and number and percent with lead exposure, Maryland, 1993:

| County | Number of Children under age 6 | Number of Children Screened | Percent Screened | Number of Children With Lead Poisoning [>= 20 µg/dL] | Percent with Lead Poisoning [>= 20 µg/dL] | Number of Children with Lead Exposure [10-19µg/dL] | Percent with Lead Exposure [10-19 µg/dL] |
|---|---|---|---|---|---|---|---|
| Allegany | 5,275 | 662 | 12.5 | 1 | 0.2 | 0 | 0.0 |
| Anne Arundel | 38,044 | 1,768 | 4.6 | 4 | 0.2 | 47 | 2.7 |
| Baltimore City | 67,936 | 33,207 | 48.9 | 1,517 | 4.6 | 6,162 | 18.6 |
| Baltimore County | 56,350 | 4,772 | 8.5 | 38 | 0.8 | 250 | 5.2 |
| Calvert | 4,899 | 88 | 1.8 | 0 | 0.0 | 2 | 2.3 |
| Caroline | 2,533 | 191 | 7.5 | 3 | 1.6 | 17 | 8.9 |
| Carroll | 11,589 | 567 | 4.9 | 1 | 0.2 | 37 | 6.5 |
| Cecil | 6,705 | 148 | 2.2 | 3 | 2.0 | 3 | 2.0 |
| Charles | 10,398 | 180 | 1.7 | 0 | 0.0 | 2 | 1.1 |
| Dorchester | 2,434 | 171 | 7.0 | 3 | 1.8 | 16 | 9.4 |
| Frederick | 14,294 | 314 | 2.2 | 2 | 0.6 | 26 | 8.3 |
| Garrett | 2,393 | 82 | 3.4 | 0 | 0.0 | 0 | 0.0 |
| Harford | 17,684 | 869 | 4.9 | 2 | 0.2 | 16 | 1.8 |
| Howard | 18,162 | 339 | 1.9 | 1 | 0.3 | 10 | 3.0 |
| Kent | 1,329 | 134 | 10.1 | 0 | 0.0 | 1 | 0.8 |
| Montgomery | 67,903 | 1,794 | 2.6 | 3 | 0.2 | 23 | 1.3 |
| Prince George's | 65,686 | 3,595 | 5.5 | 10 | 0.3 | 68 | 1.9 |
| Queen Anne's | 2,951 | 80 | 2.7 | 0 | 0.0 | 0 | 0.0 |
| St. Mary's | 8,119 | 418 | 5.1 | 0 | 0.0 | 0 | 0.0 |
| Somerset | 1,516 | 402 | 26.5 | 1 | 0.3 | 9 | 2.2 |
| Talbot | 2,323 | 342 | 14.7 | 0 | 0.0 | 2 | 0.6 |
| Washington | 9,722 | 1,003 | 10.3 | 4 | 0.4 | 13 | 1.3 |
| Wicomico | 6,291 | 715 | 11.4 | 1 | 0.1 | 2 | 0.3 |
| Worcester | 2,738 | 380 | 13.9 | 7 | 1.8 | 15 | 4.0 |
| MARYLAND | 427,274 | 52,221 | 12.2 | 1,601 | 3.1 | 6,721 | 12.9 |

Source: Maryland Department of the Environment

Notes: Number of children screened pertains to children under 72 months of age tested using all blood level tests. The number percent of children with lead poisoning or lead exposure pertains to children under 72 months of age tested with "confirmed" venipuncture blood lead tests.

Exposure is the level at which the Centers for Disease Control recommends and education to prevent further . Lead Poisoning is the level at which Maryland State and the Centers for Control recommend local health environmental intervention (investigation, order abatement, etc.). Counties respond at this level. Baltimore City Department doesn't intervene until 25 µg/dL due to insufficient resources.

# MEDICAID

Medicaid provides medical assistance to low-income elderly, the blind and disabled. It also serves families on AFDC and other low-income women and children. Medicaid is the principal source of health care coverage for poor women and children. Today, every state must provide Medicaid to all pregnant women with children under age six with family incomes less than 133% of the poverty level *($19,684 for a family of four)*. Many states, including Maryland, exercise an option to expand coverage for older children with family incomes below the poverty level.

Although they comprise over one-half of Medicaid recipients, persons under age 20 account for only one-quarter of total Medicaid expenditures. Children enrolled in Medicaid are eligible to receive comprehensive health services, including all preventive care and benefits in the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program.

In Maryland's Medicaid system, poor children and families either enroll in a Health Maintenance Organization (HMO), or receive health care from a primary provider in the Maryland Access to Care Program (MAC). MAC began in 1991 and saved the state $21 million in its first year. Children in the MAC program are more likely to use a primary care doctor and preventive services and less likely to make emergency room visits for non-emergencies than poor children outside the Medicaid system.

In October 1993, Maryland implemented an expansion program to provide preventive and acute care services for children born after September 30, 1983 with a family income up to 185% of the federal poverty level *($27,380 for a family of four)*. To date, this Medicaid program has enrolled fewer than 20% of those children expected to be eligible.

**COUNTY FINDINGS:**

Between 1990 and 1994, the number of children enrolled in Medicaid increased in all 24 of Maryland's counties. The highest rates of growth occurred in Frederick, Carroll and Harford counties. Baltimore City and Dorchester County experienced the lowest rates of growth.

# CHILDREN ENROLLED IN MEDICAID

Number of children enrolled in Medicaid under age 18, Maryland, 1990, 1992 and 1994, percent change 1990-1994:

| County | 1990 | 1992 | 1994 | Percent Change |
|---|---|---|---|---|
| Allegany | 3,023 | 4,400 | 4,715 | 56.0 |
| Anne Arundel | 6,114 | 9,249 | 10,839 | 77.3 |
| Baltimore City | 78,301 | 92,034 | 94,225 | 20.3 |
| Baltimore County | 9,760 | 15,174 | 18,157 | 86.0 |
| Calvert | 1,088 | 1,589 | 1,698 | 56.1 |
| Caroline | 672 | 1,150 | 1,322 | 96.7 |
| Carroll | 1,156 | 1,988 | 2,487 | 115.1 |
| Cecil | 1,681 | 2,823 | 3,216 | 91.3 |
| Charles | 2,373 | 3,324 | 3,819 | 60.9 |
| Dorchester | 1,300 | 1,867 | 2,026 | 55.8 |
| Frederick | 1,611 | 3,241 | 3,867 | 140.0 |
| Garrett | 1,020 | 1,631 | 1,937 | 89.9 |
| Harford | 2,501 | 4,087 | 5,212 | 108.4 |
| Howard | 1,346 | 2,116 | 2,731 | 102.9 |
| Kent | 340 | 546 | 615 | 80.9 |
| Montgomery | 7,190 | 10,939 | 13,574 | 88.8 |
| Prince George's | 14,752 | 22,189 | 28,717 | 94.7 |
| Queen Anne's | 571 | 931 | 1,005 | 76.0 |
| St. Mary's | 1,574 | 2,606 | 3,175 | 101.7 |
| Somerset | 866 | 1,332 | 1,478 | 70.7 |
| Talbot | 652 | 970 | 1,063 | 63.0 |
| Washington | 3,159 | 4,648 | 5,160 | 63.3 |
| Wicomico | 2,551 | 3,712 | 4,376 | 71.5 |
| Worcester | 945 | 1,517 | 1,862 | 97.0 |
| MARYLAND | 144,546 | 194,063 | 217,276 | 50.3 |

Source: Maryland Department of Health and Mental Hygiene, Division of Maternal and Child Health, Medical Care Policy Administration

# PRENATAL CARE

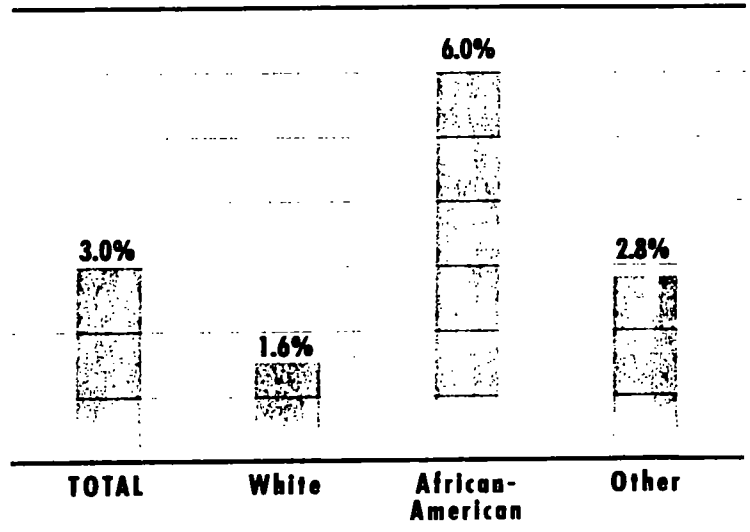
Comprehensive prenatal care is essential to ensure the health of every pregnant woman and her baby. Women who receive early (in the first trimester) and continuous care in their pregnancies are significantly more likely to deliver healthy, normal weight infants. The lack of adequate prenatal care increases the risk of low birthweight and infant mortality.

Women living in poverty are less likely than non-poor women to receive prenatal care. Young women, particularly adolescents, are less likely than older women to seek early prenatal care. Women face several barriers to receiving prenatal care. They maybe ineligible for Medicaid and cannot afford private health insurance. Even if a woman has insurance, she may lack transportation, find herself at a considerable distance from medical care, or not have available child care to go to a clinic to obtain prenatal services.

The number of Maryland women receiving late or no prenatal care improved slightly between 1990 and 1992: from 2,673 to 2,367, respectively. A disproportionate number of African-American women, however, do not receive early prenatal care. In 1992, African-American women were close to four times more likely than white women to receive late or no prenatal care.

**COUNTY FINDINGS:**
The counties with the highest percentage of women receiving late or no prenatal care were Somerset (6.1%), Dorchester and Baltimore City (5.2%) and Wicomico (5.0%).

**WOMEN RECEIVING LATE OR NO PRENATAL CARE**
Percent by race, Maryland, 1992




Source: Maryland Department of Health and Mental Hygiene, Division of Health Statistics

# WOMEN RECEIVING LATE OR NO PRENATAL CARE

Number and percent of mothers who received late or no prenatal care, by race, Maryland, 1992:

| County | Total | Percent | White | Percent | African-American & Other | Percent |
|---|---|---|---|---|---|---|
| Allegany | 20 | 2.3 | 20 | 2.3 | 0 | 0.0 |
| Anne Arundel | 108 | 1.6 | 63 | 1.1 | 45 | 4.2 |
| Baltimore City | 671 | 5.2 | 100 | 2.7 | 571 | 6.1 |
| Baltimore County | 213 | 2.2 | 128 | 1.7 | 85 | 4.3 |
| Calvert | 28 | 3.2 | 18 | 2.5 | 10 | 6.0 |
| Caroline | 10 | 2.4 | 3 | 0.9 | 7 | 8.5 |
| Carroll | 18 | 1.0 | 18 | 1.0 | 0 | 0.0 |
| Cecil | 19 | 1.6 | 16 | 1.4 | 3 | 5.4 |
| Charles | 61 | 3.7 | 25 | 2.1 | 36 | 8.6 |
| Dorchester | 22 | 5.2 | 1 | 0.4 | 21 | 11.0 |
| Frederick | 29 | 1.1 | 21 | 0.9 | 8 | 4.0 |
| Garrett | 10 | 2.5 | 10 | 2.6 | 0 | 0.0 |
| Harford | 80 | 2.7 | 53 | 2.0 | 27 | 7.5 |
| Howard | 21 | 0.6 | 12 | 0.4 | 9 | 1.6 |
| Kent | 4 | 1.8 | 2 | 1.2 | 2 | 3.9 |
| Montgomery | 214 | 1.7 | 106 | 1.2 | 108 | 3.2 |
| Prince George's | 641 | 4.8 | 80 | 1.8 | 561 | 6.3 |
| Queen Anne's | 8 | 1.7 | 4 | 0.9 | 4 | 8.0 |
| St. Mary's | 61 | 4.4 | 40 | 3.6 | 21 | 8.5 |
| Somerset | 17 | 6.1 | 6 | 3.8 | 11 | 9.2 |
| Talbot | 6 | 1.6 | 3 | 1.1 | 3 | 3.3 |
| Washington | 26 | 1.6 | 20 | 1.3 | 6 | 7.2 |
| Wicomico | 59 | 5.0 | 17 | 2.2 | 42 | 10.9 |
| Worcester | 21 | 4.2 | 7 | 2.0 | 14 | 9.5 |
| MARYLAND | 2,367 | 3.0 | 773 | 1.6 | 1,594 | 5.7 |

Source: Maryland Department of Health and Mental Hygiene, Division of Health Statistics

# JUVENILE SERVICES

In 1993, over 48,815 complaints against youths were screened and evaluated by the Maryland Department of Juvenile Services (DJS), a 26% increase from 1990. The 48,815 complaints involved a total of 33,984 youths. Property offenses (e.g., arson, auto-theft, theft, burglary/breaking and entering and malicious destruction) represented the largest proportion (43%) of intake cases. Person-to-person offenses (e.g., assault, robbery, sex offenses and murder/manslaughter) accounted for 21% of all juvenile intake cases. Alcohol and drug-related violations constituted 14% of intake cases. The number of intake cases for drug-related offenses (possesion and distribution) increased 53% from 1992 to 1993.

Males accounted for 80% of the total intake cases and approximately 88% of the formal cases. Close to 74% of the youth referred to intake were between the ages of 14 and 17. The average age at referral was 14.9 years. In 1993, about 42% of the total intake cases involved white youth, 56% were African-American and 2% were other races.

Of the 48,815 cases that were referred to the Department of Juvenile Services, 42% received formal court action. The most common court disposition was probation (26% of cases). Approximately 1,800 youths were committed to residential facilities (excluding secure detention and structured shelter care).

**COUNTY FINDINGS:**

In 1993, seven counties exceeded the State intake average of 114 cases screened per 1,000 youth ages 11-17 years. The counties with the highest intake rate were Baltimore City, Talbot and Dorchester counties. Although Worcester county had the highest rate at 291.7, only 37% of cases involved residents of the county. Garrett, Howard, Harford and Montgomery counties experienced the lowest rates.

# JUVENILE SERVICES

Number and percent of intake cases in the Department of Juvenile Services 1990-93, percent change between 1990-93 and rate of intake per 1,000 youths ages 11-17, Maryland, 1992 and 1993:

| County | 1990 | 1991 | 1992 | 1993 | Percent Change | 1992 Rate | 1993 Rate |
|---|---|---|---|---|---|---|---|
| Allegany | 510 | 560 | 566 | 585 | 14.7 | 85.3 | 83.4 |
| Anne Arundel | 2,716 | 2,703 | 3,513 | 3,581 | 31.8 | 90.9 | 91.1 |
| Baltimore City | 9,776 | 10,741 | 12,026 | 16,946 | 73.3 | 176.3 | 265.6 |
| Baltimore County | 5,405 | 5,211 | 5,796 | 5,783 | 7.0 | 99.0 | 108.6 |
| Calvert | 453 | 441 | 738 | 673 | 48.6 | 124.6 | 114.2 |
| Caroline | 213 | 210 | 371 | 329 | 54.5 | 138.7 | 123.4 |
| Carroll | 747 | 710 | 919 | 882 | 18.1 | 74.2 | 70.6 |
| Cecil | 748 | 731 | 779 | 838 | 12.0 | 95.3 | 111.9 |
| Charles | 987 | 1,102 | 1,114 | 1,218 | 23.4 | 98.3 | 105.9 |
| Dorchester | 354 | 309 | 390 | 433 | 22.3 | 130.3 | 170.5 |
| Frederick | 1,210 | 1,377 | 1,547 | 1,512 | 25.0 | 99.4 | 97.5 |
| Garrett | 226 | 207 | 229 | 167 | -26.1 | 70.4 | 55.5 |
| Harford | 1,060 | 1,046 | 1,302 | 1,074 | 1.3 | 74.0 | 58.4 |
| Howard | 825 | 1,018 | 879 | 868 | 5.2 | 50.1 | 49.4 |
| Kent | 173 | 147 | 174 | 176 | 1.7 | 129.1 | 108.4 |
| Montgomery | 4,065 | 4,233 | 4,664 | 3,515 | -13.5 | 74.3 | 56.9 |
| Prince George's | 5,483 | 5,993 | 6,295 | 5,600 | 2.1 | 93.7 | 82.7 |
| Queen Anne's | 232 | 243 | 321 | 327 | 40.9 | 95.9 | 101.6 |
| St. Mary's | 489 | 597 | 703 | 756 | 54.6 | 96.1 | 94.2 |
| Somerset | 101 | 142 | 209 | 217 | 114.9 | 99.7 | 96.7 |
| Talbot | 316 | 318 | 429 | 524 | 65.8 | 188.2 | 220.1 |
| Washington | 938 | 963 | 977 | 1,013 | 8.0 | 94.0 | 97.2 |
| Wicomico | 766 | 822 | 923 | 960 | 25.3 | 135.6 | 127.7 |
| Worcester | 911 | 822 | 960 | 838 | -8.0 | 306.3 | 291.7 |
| MARYLAND | 38,704 | 40,646 | 45,824 | 48,815 | 26.1 | 105.1 | 114.0 |

**Note: Worcester County intake is high because a resort town is located in this county.**
**Source: Department of Juvenile Services**

# MARYLAND SCHOOL PERFORMANCE ASSESSMENT PROGRAM (MSPAP)

The Maryland School Performance Assessment Program (MSPAP) measures school performance in relation to standards for 1996 and Maryland's educational goals for the year 2000. Schools must meet standards for satisfactory performance by 1996 in reading, mathematics, science and social studies. These assessments provide information primarily on school performance rather than individual student performance and focus on students' "higher level thinking skills" (i.e., their ability to apply knowledge and skills to solve problems, make decisions, and so forth). MSPAP assesses learning outcomes in reading, writing, language usage, mathematics, science and social studies. MSPAP assessments are performance-based: students write, sketch and diagram responses to assessment questions and other activities rather than select answers in multiple-choice items.

**COUNTY FINDINGS:**

In 1994, no local school system met the standard for satisfactory school performance (i.e., 70% of students at or above proficiency Level 3, which must be met by 1996). The state, however, is at least half way toward meeting the 70% standard in 8 of 18 MSPAP test areas.

**Family Preservation Initiative/Local Management Board**
**Systems Reform Initiative**

Sponsoring/partnering agencies

Local: Baltimore City Local Management Board (LMB)
Family Preservation Initiative (FPI) of Baltimore City

State: Office for Children, Youth and Families (OCYF)

Desired results

- Setting of a community agenda for families and children that is "family driven" and recognizes the individual needs and strengths of families.

- Building of new capacities to serve families and children, ensuring a core array of services that include prevention, early intervention, home and community based services, residential services and emergency and crisis intervention.

- Development of fiscal strategies to support a flexible, integrated service delivery system.

- Development of a evaluation and accountability systems that stress improved outcomes for families and children.

Strategies/mechanisms used to achieve results

FPI is currently evolving from a "rowing" organization focused on service delivery to a "steering" organization that will act as the staffing and support arm of the LMB and focus on planning, contracting, monitoring, and evaluating.

OCYF has challenged individual jurisdictions to implement systems reform initiatives that are family focused, non-categorical, community based, flexible, and based on principles of inter-agency coordination and collaboration. As a first step towards this, the Baltimore City LMB has set priority goals for families and children in Baltimore City and selected one of these goals--the creation of safe and supportive neighborhoods--as an initial focal point for systems reform efforts.

Initial work to establish a community agenda has been conducted through the VOICES conference, which brought together over 300 community members and agency representatives to discuss the needs and outcomes of communities, and the Federal Family Preservation and Family Support planning grant process, which involved focus groups

and surveys with over 400 community organizations and individuals in Historic East Baltimore over a six month period.

Fiscal strategies to support Maryland's reform agenda have been driven by the Governor's Subcabinet Fiscal Strategies Committee, which is composed of representatives of OCYF. Department of Human Resources (DHR), the Department of Juvenile Justice (DJJ), the Department of Health and Mental Hygiene (DHMH), and the Maryland State Department of Education (MSDE). Strategies implemented to date include redeployment of funds which would have been used to pay for children in out-of-home or out-of-state care and refinancing through use of open ended federal titles of the Social Security Act.

Number of people/families served

None.

Funding level and source of funds

Recent state legislative activity indicates that close to $100 million will be available for systems reform activity in FY 1996. Baltimore City's share of this state pool is about 40 percent. These funds would cover family preservation and return/diversion services currently funded and provided by DHR, DJJ, DHMH and MSDE.

Next steps and largest challenges

The challenge now is to move toward the development of a comprehensive interagency system of services for families and children.

Next steps include:

- Completing the staffing reorganization of FPI.
- Planning for management of the anticipated increase in the funding pool for family preservation and return/diversion services.
- Moving ahead with the work of obtaining community input on the needs of families and children and developing the capacity to meet those community needs.
- Developing realistic outcome goals and measures.
- Continuing to develop new fiscal strategies by encouraging more pooled funding and seeking access to more private funding sources.

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**Family Preservation Initiative/Local Management Board**
**Prevention of Out-of-Home Placement**

Sponsoring/partnering agencies

Local: Baltimore City Local Management Board (LMB)
Family Preservation Initiative (FPI) of Baltimore City

State: Office for Children, Youth and Families (OCYF)

Desired results

- Prevention of out-of-home placement of children.
- Improved ability of families to maintain their children in the home.
- Reduction of expenditures on out-of-home placements and redeployment of these funds to provide a range of preventive services for families and children.
- Demonstration that services can be provided to families and children in accordance with systems reform principles that stress flexible, family focused, non-categorical, community based services.

Strategies/mechanisms used to achieve results

- Families are referred by the Department of Social Services, the Health Department, the Department of Juvenile Justice, and Baltimore City Public Schools.
- Within 24 hours of referral, families receive an initial visit or call from a Family Worker to help them begin to develop individualized goals and strategies. These goals and strategies include, but are not limited to:
  - understanding age appropriate expectations for children;
  - finding and accessing services available in the community;
  - creating working relationships with extended family, neighbors and friends;
  - learning to take care of household tasks;
  - acquiring home maintenance skills;
  - preparing for the job market; and
  - scheduling family routines.

- Intensive services are provided within the home and community environment over a period of four to eight weeks, depending on the type of referral. Services are available 24 hours a day, seven days a week (including holidays).

- Additional, less intensive services are available beyond the initial period if needed.

- FPI and the LMB are closely monitoring the provision of prevention of out-of-home services in order to document the lessons learned and, if the results warrant it, to apply this knowledge to other areas of services for children and families.

Number of people/families served

A total of 1,857 imminent risk children and their families have received services since July 1991. The typical child receiving services in FY 1995 was under 8 years old and was referred for reasons of neglect or problem behavior at home or school. Of 768 children served in FY 1995, 54 percent were male and 88 percent were African-American, 60 percent were under 8 years old, 26 percent were aged 8 to 13, and 14 percent were older than 13. Ninety-three percent of the heads of household were female. Eighty-six percent of the children served through July 1994 have successfully remained in their homes with their families.

Funding level and source of funds

A legislatively approved budget amendment allows the use of state allocated out-of-home dollars for the prevention of out-of-home placement. In FY 1995, $2,828,701 was redirected from out-of-home placements to fund support services designed to help families maintain their imminent risk children in the home. This funding level represents a 28 percent increase over the total out-of-home placement dollars redeployed in FY 1994.

Next steps and largest challenges

The next step is to expand the number of children and families in Baltimore City receiving these preventive services. The challenge is to continue to do this in accordance with the principles of a family focused, non-categorical, community based, flexible system of services.

The most important step, and the greatest challenge, is to build on the lessons learned in this initiative and begin to develop comprehensive systems reform in other areas of service for children and families.

Additional information

As a result of successfully decreasing expenditures of out-of-home placements, FPI and the LMB have been awarded state incentive dollars. Utilizing these funds, grants have been awarded to provide services in the following areas:

- Sexual abuse treatment for children, families and offenders;
- School based mental health services and violence prevention;
- Respite care for families with seriously emotionally disturbed children; and
- Mental health/substance abuse services for children and families.

The grant for sexual abuse treatment has been partially utilized to develop a Baltimore Alliance Against Child Sexual Abuse. As more incentive dollars are received, the range of services funded through FPI/LMB will increase.

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**Family Preservation Initiative/Local Management Board**
**Return and Diversion from Out-of-State Placement**

Sponsoring/partnering agencies

Local: Baltimore City Local Management Board (LMB)
Family Preservation Initiative (FPI) of Baltimore City

State: Office for Children, Youth and Families (OCYF)

Desired results

- Return and diversion of Baltimore City youth from out-of-state residential care to appropriate services in Maryland.
- Redeployment of dollars that would otherwise have been spent on out-of-state care to fund community-based resources for youth concerned.
- Reintegration of youth into the Baltimore community with the support of community based resources, and gradual transition of youth to less restrictive living situations.
- Demonstration that services can be provided to families and children in accordance with systems reform principles that stress flexible, family focused, non-categorical, community-based services.

Strategies/mechanisms used to achieve results

- Families are referred by the Department of Social Services, the Health Department, the Department of Juvenile Justice, and Baltimore City Public Schools. The Baltimore City Local Coordinating Council determines eligibility and appropriateness for services.
- Upon acceptance for services, a comprehensive assessment is made of child and family strengths and needs. All youth in the program have a Child and Family Support team who, along with the family, assist in delineating resource needs and setting Individual Service plans. Case management services are available on a 24 hour a day, seven day a week basis to youth and their families.

- The primary facilitator and advocate for the family is an FPI Family Care Coordinator, who ensures that "wraparound" services are unconditional, flexible and delivered in a timely fashion. A wide range of resources are provided through public and private service vendors. Youth remain in the program for an average of two years.

- FPI and the LMB are closely monitoring the provision of wraparound services to youth who have been returned or diverted from out-of-state residential care in order to document the lessons learned and, if the results warrant it, to apply this knowledge to other areas of services for children and families.

Number of people/families served

One hundred and forty-five youths have received wraparound services since July 1991. Over the same time period, out-of-state placement of Baltimore youth has decreased by 59 percent. The typical youth receiving wraparound services was a 15.25 year old African-American male, with a primary diagnosis of Affective or Conduct disorder who, prior to entering FPI services, had been in out-of-home placement for approximately 6.8 years, with a range of 2 to 3.2 placements.

Funding level and source of funds

In FY 1995, 7.4 million dollars were available to be redirected from out-of-state placements to fund wraparound supports to maintain youth in Baltimore community based services. Redirected dollars came from the Department of Social Services, the Department of Juvenile Justice, Baltimore City Public Schools and the Baltimore City Health Department. Fifty-two percent of youth served were solely funded by one of the four agencies; 48 percent were funded by more than one placement agency.

Next steps and largest challenges

The next step is to expand the number of children and families in Baltimore City receiving these in-state wraparound services. The challenge is to continue to do this in accordance with the principles of a family focused, non-categorical, community based, flexible system of services.

The most important step, and the greatest challenge, is to build on the lessons learned in this initiative and begin to develop comprehensive systems reform in other areas of service for children and families.

Additional information

Traditionally, youth returning from residential treatment care have had great difficulty reintegrating into the education system. FPI's wraparound services have changed this with over 77 percent of eligible youth either in school or vocational training. All wraparound youth are tracked monthly by their FCC on critical adjustment behaviors. In FY 1995, 83 percent experienced no school suspensions, 85 percent experienced no acute psychiatric hospitalization, 97 percent made no suicide attempts, and 79 percent experienced no delinquent arrests.

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# MARYLAND'S SYSTEMS REFORM INITIATIVE

Making Government Work for Maryland's Children, Youth and Families
A Description Prepared for the Institute for Educational Leadership

Systems Reform Initiative is the name of Maryland's Reform Initiative.

Who are the sponsoring or partnering agencies at the local level?

The sponsoring entity on the local level is the Local Management Board (LMB), a quasi-public entity that pulls together leaders from the public, non-profit, and corporate sectors to address the needs of the community's children, youth and families. LMBs are comprised of:

- representatives of all local human service agencies that deal with children, youth and families;
- leaders of the local business community; and
- non-profit and community leaders.

Who are the sponsoring or partnering agencies at the state level?

The driving force behind Systems Reform at the State Level is the Governor's Subcabinet for Children, Youth and Families. The Subcabinet is chaired by the Special Secretary for Children, Youth and Families, and includes the following representatives:

- the Governor's Deputy Chief of Staff;
- the Secretary of Budget and Fiscal Planning;
- the Secretary of Human Resources;
- the Secretary of Housing and Community Development;
- the Secretary of Juvenile Justice;
- the Secretary of Health and Mental Hygiene;
- the Director of the Office for Developmental Disability;
- the Director of the Office of State Planning; and
- the State Superintendent of Schools.

What results does this initiative seek to produce?

SRI seeks to improve Maryland's delivery of services to children, youth and families by:

- stressing prevention and early intervention;

- planning for a single point of entry where families would receive all the help, and all the referrals they need in one place, at one time, with one stop;

- encompassing all services provided to children, youth and families, from the most rudimentary to the most complex;

- recognizing that, except in cases that pose a direct and immediate threat to a child's health and safety, the best instrument for raising a child is that child's own family; and

- preserving, strengthening, and empowering families by directly involving them in planning solutions to their problems, and by teaching them to solve problems and set goals.

Currently, SRI applies the principles of Systems Reform to two populations: children Maryland wishes to return or divert from out-of-state placements (return/diversion), and children at risk of being placed out of their homes (family preservation). The goal with these two populations is to reduce the number of children placed out of state, to increase the number of children returned to Maryland, and to reduce the number of children placed outside their homes. SRI has helped Maryland consistently achieve all three goals, thus demonstrating that we can serve our children and families better and more cost effectively when we coordinate across agencies to eliminate duplication and fragmentation of services.

What strategies or mechanisms does this initiative use to achieve these results?

The LMBs are the chief mechanism for achieving the results of systems reform. They coordinate efforts on behalf of the two populations, working across agencies to reduce the numbers of children placed out of state and out of home. Eventually, the LMBs will manage all services for children, youth and families in their local jurisdictions.

How many people or families are served?

In fiscal year 1995, SRI served 1,658 children and their families.

What is the funding level and the source of funds?

The LMBs are funded through the Subcabinet Fund, a pool of funds to which all the member agencies of the Governor's Subcabinet for Children, Youth and Families contribute. The Subcabinet Fund is currently $37 million. For fiscal year 1997, the Fund will increase to between $50 and $98 million.

What are the next steps and largest challenges for this initiative?

The immediate next step is to bring LMBs on-line and serving the two test populations by July 1, 1996. The Governor recently convened a task force to plan how to expand systems reform beyond return/diversion and family preservation.

## HOW DOES SYSTEMS REFORM WORK, AND WHAT DOES IT DO?

Systems Reform works through **Local Management Boards (LMBs)** comprised of representatives from local human service agencies and leaders of the business and non-profit communities. Working with the Governor's Office for Children, Youth and Families, and under the guidance of the inter-agency Subcabinet on Children, Youth and Families, these LMBs will transform the way we help Maryland's families. The vision is broad, and will take time to achieve, but we are well on our way.

**Where We're Headed:**

- *Communities Building and Supporting Healthy Families*. The ultimate vision of Systems Reform is to give local communities the power and autonomy to solve problems and support families in ways that make the most sense for those communities. It stresses prevention and early intervention to save families, money and lives. Now we have a top-heavy, fragmented, and duplicative bureaucratic system of care that focuses on deep-end problems. Systems Reform will build a uniform, integrated, seamless system of care that focuses on families and children (not specific programs), builds on existing family strengths, empowers Maryland's children and families, is locally managed and accountable, and helps families and children before problems get out of hand.

**Where We Are:**

- Twelve (12) LMBs serve 15 Maryland jurisdictions, and the remaining 9 jurisdictions are planning or launching LMBs.

- LMBs are applying the principles of systems reform only to services for two groups of children: those at risk of being placed out of home (family preservation), and those Maryland wishes to return or divert from placements in costly, out-of-state treatment facilities (return/diversion).

- Decategorized pooled funding is in place for these two populations.

**What We've Accomplished:**

- We've helped Maryland jurisdictions reduce the number of Maryland's children in out-of-state facilities.

- We've generated over 300 new private sector jobs in Baltimore City alone, and perhaps just as many across the state.

- We've enabled jurisdictions to heal families rather than break them apart, helping the children of approximately 1,400 families stay with those families in fiscal year 1995 alone.

**What Systems Reform Means**

- **To Families** -- A human service system that treats them with dignity and respect, includes them in solutions, and is free of red tape.

- **To Social Service Workers** -- An empowering work environment that leaves them free to be creative and innovative, gives them authority to make decisions, and values their professionals skills.

- **To the State of Maryland** -- The ability to respond to federal budget cuts *without* endangering our vital safety net.

- **To the Taxpayer** -- A government that makes the most of every tax dollar it spends.

In an era when budget cuts and tightening belts rend the social safety net, Systems Reform strengthens it by helping Maryland do more with less.

For more information about Systems Reform, contact:
The Governor's Office for Children, Youth and Families, Systems Reform Initiative
301 West Preston Street, NW, 15th Floor
Baltimore, Maryland 21201
(410) 225-4160

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## SYSTEMS REFORM:
## HELPING COMMUNITIES BUILD STRONG AND HEALTHY FAMILIES

Times are changing, and Maryland must either manage that change or be managed by it.

- We need to overhaul our human service systems to respond to changing economies, shifting demographics, increasing diversity, and the latest social science research.

- Maryland's families deserve to be able to go to one place to get the help and referrals they need.

- Each of Maryland's 24 jurisdictions, from the Atlantic to the Appalachians, from the Washington suburbs to Baltimore, needs to be able to tailor its family and children's services to the problems its families and children face.

- We must *work with*, not dictate to, families in crisis.

- We must focus on prevention and early intervention, to head off problems before they become acute.

- Finally, in this era of budget cuts and deficit reduction, with Congress turning more and more back to the states, we must learn to do more with less.

Systems Reform has begun to manage these changes to better serve our most precious resource: our children and the families that nurture them.

What is the vision of Systems Reform? The ultimate vision of Systems Reform is to re-engineer and unify the way we help Maryland's children, youth and families address the problems that confront them.

- It stresses prevention and early intervention.

- It plans for a single point of entry where families would receive all the help, and all the referrals, they need in one place, at one time, with one stop.

- It encompasses all services provided to children, youth and families, from the most rudimentary to the most complex.

- It recognizes that, except in cases that pose a direct and immediate threat to a child's health and safety, the best instrument for raising a child is that child's own family.

- It preserves, strengths, and empowers families by directly involving them in planning solutions to their problems, and by teaching them to solve problems and set goals.

What value do reformed systems add to Maryland? Plenty.

**Reformed Systems Are Smart.** They empower social workers and family therapists by teaching them how to work smarter and collaborate.

**Reformed Systems Are Family Focused and Strength Based.** They listen and respond to the needs and suggestions of families served, build upon existing family strengths, and treat families with dignity and respect.

**Reformed Systems Are Policy Driven and Community Based.** They marry the knowledge of experts with the common sense and creativity of families and communities, tailoring service to local community needs.

**Reformed Systems Measure Performance, not Process.** They ask, "how are we doing?" not, "what are we doing?"

**Most of All, Reformed Systems Are the Future.** In an increasingly uncertain future, they accomplish more with less over the long run, they prevent small problems from becoming larger problems, and they are highly flexible and responsive to change.

**STATE OF MARYLAND**
EXECUTIVE DEPARTMENT

**PARRIS N. GLENDENING**
GOVERNOR

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Governor's Office for Children, Youth and Families
Maryland Making the Grade

The Office for Children, Youth and Families (OCYF) leads a system-wide effort to address the unmet health needs of children by consolidating services in school-based settings. As an integral part of systems reform in Maryland, the Subcabinet is emphasizing the development of school-based and school-linked health services wherever they are appropriate, medically needed, and called for by a community. OCYF has been designated to receive and manage the Robert Wood Johnson Foundation grant, *Making the Grade - State and Local Partnerships to Establish School-Based Health Centers.* In its first two years of planning, Maryland Making the Grade (MMG) has received $200,000 from the Foundation, and has awarded planning grants of $9,000 each to two jurisdictions towards creation of school-based health centers (SBHCs). The annual budget of $100,000 enables OCYF to develop standards of quality and service, monitor the development of SBHCs, put in place systems to collect data and evaluate centers, and provide technical assistance to jurisdictions which are attempting to initiate or expand their school health efforts.

MMG has taken initial steps to form a statewide SBHC Network to enable localities to share expertise and resources and to develop new State policy. OCYF staff also serve to coordinate the efforts of program staff in the Departments of Education and Health who are working to meet the health needs of children in Maryland. OCYF personnel serve as staff to the Subcabinet for Children, Youth and Families and the subcommittee on school-based/linked services.

The Office for Children, Youth and Families' Maryland Making the Grade staff are currently applying for a $1.45 million implementation grant to facilitate the development of statewide school-based health centers. Goals of MMG include healthier students and families, expanded network of SBHCs, increased availability of mid-level practitioners trained to work in SBHCs, and dedicated funding for SBHCs. (See attached Executive Summary for further details regarding the $1.45 million implementation grant).

**Maryland Making the Grade:**
**Expanding School-Based Health Centers Statewide**
**Executive Summary**

Management office: Governor's Office for Children, Youth and Families
Submission date: February 1, 1996
Amount of grant: $1.45 million

**Maryland plans to create viable, sustainable, locally managed and comprehensive school-based health centers wherever they are needed and welcomed by the community.** As Maryland moves toward a managed care model for health reform, we have acknowledged school-based health centers as a core resource for underserved children and youth. We will attain our goal by 1) building partnerships with **two model jurisdictions** to lead the process, 2) developing **state infrastructure**, financing options and technical assistance capacity to support a statewide network for centers, and 3) share expertise and resources by creating a **statewide SBHC Network** of inter-agency teams working to establish and expand SBHCs locally in each and every jurisdiction. This vision is rooted in the mission of key state entities.

## 1) Model programs

Two jurisdictions have been selected to create model school-based health centers as Maryland seeks to take the concept of school-based health to scale across the state. A total of $800,000 will be awarded to these two jurisdictions to support their start-up effort and to move them toward a self-sustaining system of financing and quality assurance for their health centers. Montgomery and Talbot Counties were selected in an extensive review process, based upon readiness, technical capacity and needs assessment. Re-evaluation is required by the new statewide orientation of our proposal and will be complete June 1, 1996.

## 2) State Infrastructure

- Coordinate SBHC Network, distribute Seed Fund (see below)
- Oversee Model projects
- Develop/advocate for fiscal policies supporting school-based/linked health services
- Seek and secure state commitments for supportive funding (e.g., Public Schools Construction Budget for renovations, Subcabinet pooled funds, special program grant funds)
- Generate statewide, regional and local partnerships between private medical providers and school-based center implementation teams
- Develop training and technical assistance capacities for SBHCs
- Develop and monitor standards of service and quality for all SBHCs
- Develop system-wide implementation of uniform data-collection, billing and evaluation process for all SBHCs
- Provide legal and technical assistance to SBHCs for contract development with MCOs and other providers

We have designed a management structure that puts into practice the interagency approach we propose. The MMG Director at OCYF will coordinate a **Management Team** that includes its own coordination and monitoring/evaluation staff as well as loaned experts in health access fiscal policy and school health program development from MSDE and DHMH. In the future, we hope to add staff from the Department of Human Resources (DHR) and the Department of Juvenile Justice (DJJ) to the Team. The Management Team will oversee model programs, guide state policy, integrate related programs, coordinate Network activities and manage technical assistance teams.

The Governor's Office for Children Youth and Families will coordinate the development of the state's supportive infrastructure at a cost of $300,000 in RWJ funds, plus $1,000,000 (over 4 years) in-kind from DHMH, OCYF and MSDE.

**3) Statewide SBHC Network**

translate lessons of pilots into strategic building of infrastructure and developing supportive new state policy;

- identify barriers to service and propose enabling policies;
- facilitate planning and start-up;
- share expertise across jurisdictions;
- work collaboratively with private, public, and non-profit providers to develop mutually beneficial relationships that serve children in school-based settings;
- expand Network into new jurisdictions as they include SBHCs in local planning;
- access Seed Fund to incorporate school-based health in overall reforms;
- advocate for regulatory and legislative actions required to attain policy objectives.

OCYF will spend $50,000 over four years to support the Network during the grant period. We propose to create a $600,000 Seed Fund, with $300,000 in RWJ funds and a state match, to leverage planning and start-up of SBHCs in jurisdictions which join the Network. Should the uses prove to successfully leverage resources and generate significant activity in planning and start-up costs, as we anticipate, it is our intention to secure more, long-term funding for this Fund. Proposed uses of the Seed Fund include:

- support of local interagency planning team;
- hardware and software to join On-Line system;
- contracting with consultant to negotiate local MCO contracts;
- contracting with consultant to negotiate regional or statewide MCO contracts, used by Network as a whole or a group of jurisdictions together;
- annual publication of profiles of individual centers;
- match for private funding.

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